



SOUTH AFRICA

“Stop Making Excuses”

Accountability for Maternal Health Care in South Africa

HUMAN
RIGHTS
WATCH



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Summary	1
Methodology.....	7
Scope and Limitations	8
I. Background.....	10
Maternal Mortality Globally; Calls for Accountability	10
Maternal Mortality in South Africa and Eastern Cape	12
II. Maternity Care Failures and Patient Abuse.....	21
Substandard Care and Negligence	24
Poor Communication with Patients; Problems with Informed Consent.....	30
Physical and Verbal Abuse.....	33
Services in Exchange for “Gifts” or Bribes	35
Impact of Abuses.....	36
Health Worker and Government Response	37
III. Problems with Eastern Cape’s Individual Complaint Mechanisms	41
Poor Awareness of Rights and Complaints Procedures	42
Suggestion Boxes for Written Complaints.....	45
Failure to Respond to Complaints and to Provide Redress	45
Lack of Quality Assurance Officers and Training	47
Failure to Address Root Causes of Complaints.....	47
The Need for an Emergency Helpline	49
The Ombudsperson’s Office.....	49
IV. International Human Rights and South African Legal Framework.....	51
Accountability Mechanisms in the South African Health Care System	51
South Africa’s Constitution and National Health Act.....	52
Patients’ Rights Charter and Batho Pele Principles	53
Accountability Policies in the Eastern Cape Health System	54
International Law.....	55
The Right to Life	56
The Right to Health.....	57
The Right to a Remedy	58
The Right to be Free from Cruel, Inhuman, or Degrading Treatment.....	60

V. Recommendations	62
To the National Department of Health	62
To the National and Eastern Cape Departments of Health	62
To the Eastern Cape Department of Health	63
To the South African Human Rights Commission	65
To the South African Parliament.....	65
To South Africa’s International Partners	65
Acknowledgements	66

Definition of Terms

In this report, the following terms have these meanings:

“Nurse” refers to various cadres of nurses providing maternity services, including midwives, enrolled nurses, nursing assistants, and professional nurses. It does not refer to community health workers.

“Health worker” refers to medical and other workers at health facilities.

“Health facility” refers to clinics, community health centers, and hospitals.

“Quality assurance officials” refers to quality assurance officers and representatives employed by health facilities or by district or provincial health agencies.

Summary

We must stop creating excuses [for poor maternity care] by fixing our system. We must also stop making excuses for nurses, saying that they are overworked. Yes they are. There could be a few rotten apples, or even those who are disillusioned. But there has to be individual accountability.

—Nolwazi Gaza, Department of Monitoring, Performance and Evaluation, Pretoria, April 6, 2011

When Babalwa L. discovered she was pregnant in 2009, her doctor referred her for antenatal care and delivery to Dora Nginza, a public district hospital in South Africa's Eastern Cape Province, because she had severe asthma. When she went into labor in June 2010, Babalwa was reluctant to go; she knew of other women whom nurses had sent away without help. After laboring for 12 hours at home, Babalwa went to Dora Nginza Hospital. Once there, she waited an hour-and-a half to be examined by a nurse, who then accused her of “lying about being in labor” and sent her to the waiting area. Three hours later, Babalwa delivered a stillborn baby: the doctor and the nurse who assisted at the birth did not explain the possible reason for the stillbirth. Babalwa, who was angry and confused, said that she wanted to lodge a formal complaint to protest the way she was treated but that she did not know how to do so.

Babalwa's experience is far from uncommon. Maternity patients seeking care in public health facilities in Eastern Cape face a range of abuses by health workers and substandard care that put them and their newborns at high risk of death or injury. Women told Human Rights Watch they were physically and verbally abused, turned away from clinics without examination while in labor, ignored by nurses when they call for help, and forced to wait hours or even days for care. Several women also described risky practices in maternity units, including a directive that women make their own beds, and walk and carry their newborns between wards despite being weak after giving birth. Others said they were left unattended for hours after delivery and not told about issues central to their obstetric care.

Refugee women experience specific abuses—such as active discrimination and delayed or denied care—in addition to the systemic failures that affect all patients, compounding the vulnerability they already face.

Abuse of maternity patients in health facilities can have indelible psychological effect, and drive women away from seeking care, leading to delayed diagnosis and treatment, and

increased morbidity and mortality. Indeed, South Africa's maternal mortality ratio (MMR) has more than quadrupled in the last decade, leaping from 150 to 625 deaths per 100,000 live births between 1998 and 2007, according to government data. Data on maternal mortality is notoriously difficult to gather and evaluate, and the increase is probably due to an increase in both reporting and in actual deaths (especially among women living with HIV). But even without decisive data, public health experts agree that South Africa has a major problem on its hands: thousands of women still die needlessly each year, and maternal mortality is apparently increasing, even as the number of deliveries in facilities rises.

Underlying this problem are shortcomings in accountability and oversight mechanisms that authorities use to monitor health care system performance, identify failings and needs, and make timely interventions. Such mechanisms exist in the Eastern Cape—one of South Africa's nine provinces—and in the country more generally. Instead, the problem is one of implementation and ineffective use of the important information that *is* gathered to address recurring health system problems contributing to maternal mortality.

Based on visits between August 2010 and July 2011 to health care facilities providing maternity service, and interviews with patients, medical staff, health officials, and experts in the Eastern Cape—where the need for stronger health system accountability is most pressing—this report examines accountability frameworks and oversight mechanisms that facilitate the government's internal monitoring of policies, practices, and performance. These include facility-based complaint mechanisms that patients are most likely to use first, and which should provide the most expeditious remedies.

While failures in health system accountability affect all patients, this report focuses on the experience of patients seeking maternity care, since improving maternal health care is a top priority for the national and Eastern Cape governments. Furthermore, maternal health services, like all reproductive health services, are part of an integrated health care package rather than a stand-alone service, and can be used to gain insights into the health system as a whole.

The report finds the government is not addressing recurrent health system failures that contribute to poor maternal health outcomes, and is failing to provide oversight and accountability to ensure implementation of existing reproductive and sexual health-related laws and policies that could greatly improve maternal health care and overcome abuses documented here and elsewhere.

The South African health care system faces many challenges that undoubtedly impact maternal health care. These include administrative and financial management inefficiencies; low motivation among, and poor pay for, some health workers; lack of medical supplies and equipment; poor quality of care; lack of accountability of health professionals and public administrators, and a high burden of disease particularly HIV/AIDS, which has impacted maternal care by increasing demand for health services and indirectly causing maternal deaths.

The government has made a genuine commitment to address these problems. Since the end of apartheid in 1994, for example, South Africa has passed important sexual and reproductive health-related laws and policies, and a constitutional guarantee of the right to health. Acknowledging that maternal deaths are unacceptably high, the government has identified reducing maternal mortality as a national priority, and stated that decreasing maternal and child mortality is one of four “strategic outputs” that the health sector must achieve by 2014.

The government has also embarked on a number of initiatives that could positively impact reproductive and maternal health, such as expanding provider-initiated HIV counseling and testing for antenatal patients, and strengthening primary health care.

Such initiatives have borne fruit: today, 92 percent of South African women attend antenatal care, almost 87 percent deliver in health facilities, and South Africa is one of the few African countries where maternity care is free, abortion is legal, and there is a system of confidential inquiries to assess levels, causes of, and contributors to maternal deaths.

But these important steps can only positively impact maternal health care—and indeed health care generally—if authorities implement South Africa’s existing health policies and laws, identify barriers to care, and use that information to strengthen the health system.

For example, although confidential enquires into maternal deaths (CEMDS) and facility-based maternal death reviews provide a good system for monitoring maternal deaths, the information gathered is not adequately used to ensure that systemic problems with the provision of care are not repeated. As a result, very little has changed for South Africa’s women, who continue to die due to the same health system shortcomings. The country also lacks reliable estimates for the maternal mortality ratio (MMR), even though quality data on impact and process indicators for measuring maternal mortality and access to maternal health services is an important part of accountability for women’s health. South Africa has also not conducted a demographic and health survey (DHS) since 2003, which

could gather critical data to help plan, monitor, and evaluate activities designed to reduce maternal mortality, including the MMR. (The 2003 DHS failed to generate an MMR due to poor data quality). Routine monitoring of maternal healthcare programs does not take into account all the emergency obstetric care indicators that experts consider to be important to monitor maternal health in South Africa, which also lacks critical information on resources available for providing maternity services.

Failures in accountability extend to mechanisms available to individual health care users. Women seeking maternity care, and indeed all health care users, need accessible, easily comprehensible, effective ways to lodge complaints about mistreatment suffered while accessing health services, and getting redress. This is important to hold accountable those responsible for past violations and for preventing recurrence of similar practices in the future. Effective complaints mechanisms would highlight discrimination and denial of care for vulnerable women, such as refugee women and those living with HIV/AIDS; illustrate resource constraints, including for maternity care; and emphasize emergency transport problems. They would also underline failures in supervision of maternity staff, failure to adhere to standard protocols for maternity care, and breaches in ethical practice, including abuse and other risky practices by health workers during maternity care that compromise quality care offered to women. In situations where progress is being made, a good grievance and redress system offers mechanism against relapse.

Of all South Africa's nine provinces, the Eastern Cape had the highest increase in maternal mortality between 2001 and 2007, and has the highest levels of infant mortality (children dying under the age of one), the second highest number of child deaths under the age of five, and the lowest rate of facility deliveries, according to governmental and nongovernmental health experts.

The province's ineffective patient complaint procedures exacerbate this already serious situation. For example:

- Few mechanisms exist for informing health care users that procedures and processes exist for lodging complaints: facilities leave this almost entirely to nurses who often are overworked and unfamiliar with the objectives and procedures for complaints.
- Patients and administrators told Human Rights Watch the "suggestion boxes" in Eastern Cape's health facilities are essentially defunct.
- Those who are expected to use the province's call-center system are unaware of its existence and facilities do not display information about it.

- Patients said that they were too afraid to submit complaints directly to officers in charge of facilities due to fear of retaliation. Others told us they did not complain due to lack of trust that their complaints would be investigated and changes made.
- Facilities often fail to respond and to provide redress when patients complain.
- Health authorities fail to address problems that give rise to complaints, and which contribute to poor quality maternity care. Instead, the main focus is on individual abuses by health staff. As a result, the province's complaint procedures fail to meet a key objective of accountability mechanisms: ensuring non-recurrence of systemic failures and gaps, as well as promoting interventions at the most appropriate level.
- Since the Eastern Cape's patient complaints procedures do not address larger problems that affect health care delivery in the province, some health workers resent the system and see it as intended primarily to identify performance problems that could lead to discipline.

The maternity care failures that women describe, and the ineffective complaint mechanisms in Eastern Cape's public health sector, undermine the right to a remedy, and contribute to violations of the right to life, health, and the right to freedom from cruel, inhuman and degrading treatment. South Africa as a nation and its provinces have a legal obligation to uphold these rights under international and regional human rights treaties.

Individual health care users must have access to such accountability mechanisms, which are crucial in health system reforms—including those intended to reduce maternal mortality— according to international experts and bodies working on human rights and health. For example, in a 2008 report focused on accountability in health systems, the UN special rapporteur on the right to health stated that: “Under the right to health, those with responsibilities should be held to account so that misjudgments can be identified and corrected. Accountability can be used to expose problems and identify reforms that will enhance health systems for all.”

Despite its challenges, South Africa has many building blocks needed for a functioning health system, such as health staff, budgetary allocations, and information systems. As one of few middle-income African countries and the only G20 member, it is widely regarded as having unrivaled medical infrastructure and expertise in Africa, and the highest per capita spending on health—US\$748—in sub-Saharan Africa. Despite inequalities based on geographical, racial, and socioeconomic status, access to health care, including maternal health care, is relatively good. As a result, South Africa has the potential to be a leader among African countries in tackling maternal mortality and

meeting its UN Millennium Development Goals (MDG) commitments, which include reducing maternal death by 75 percent between 1990 and 2015.

Human Rights Watch calls on the national and Eastern Cape governments in South Africa to take immediate steps to strengthen health system accountability to ensure that women have access to the health care they need. The two governments should improve maternal health data, inform patients of their rights and options for lodging complaints; improve complaint procedures to solicit needed information and enable remedies; ensure that health workers are involved in devising strategies to address systemic problems that lead to complaints, and develop systems to assess patterns of complaints and address systemic problems.

Preventable maternal mortality and morbidity are costly to families, communities, and the health system. But the ultimate consequence of poor accountability to maternity patients and other health care users is needless suffering, and sometimes even death.

Methodology

This report is based on research conducted between August 2010 and April 2011. During this period, Human Rights Watch researchers interviewed 157 women who received maternal health services, or accompanied other women seeking such services, in Eastern Cape public health facilities over the past five years, and observed health facilities in Eastern Cape Province. In addition to interviewing other experts, Human Rights Watch also reviewed laws, policies, official health strategies, and reports by academics, national and international organizations, and United Nations agencies.

Human Rights Watch visited 16 health facilities (clinics, community health centers, and hospitals providing maternity services) in O.R. Tambo, Amatole, and Nelson Mandela Metropolitan Municipality districts in Eastern Cape Province. These districts had the highest maternal mortality ratios in the province in 2008 and 2009.¹ The National Department of Health listed Amatole and O.R. Tambo districts (among others in Eastern Cape) among the “18 priority districts” in the country with poor health outcomes and in need of health service delivery improvements.

Human Rights Watch interviewed women individually and in small groups. Most group interviews involved four to six women, but others were larger. Almost half of those interviewed in groups were community care givers that interact closely and regularly with women needing health services and with health workers. As a result, they were able to relay experiences of other maternity patients in the communities they serve. Nongovernmental organizations (NGOs) providing services to women and individual advocates assisted Human Rights Watch in identifying women and families to interview. Interviewees also referred other women to Human Rights Watch.

Human Rights Watch interviewed thirty nurses—mostly working in maternity units—and four emergency medical services staff (three drivers and a supervisor), quality assurance officials, facility managers, and managers in maternity units. This is in addition to maternal health experts, staff of NGOs working on health and women’s rights, an official with a professional association for nurses, representatives of international donors and UN agencies, and government officials at the national, provincial, and district levels.

¹ Eastern Cape Department of Health, “Five Year Strategic Plan: 2009/2010 – 2014/2015,” <http://www.ecdoh.gov.za/uploads/files/051010112948.pdf> (accessed June 3, 2011), p. 19.

Before each interview with women, Human Rights Watch explained the purpose of the interview and the overall research, the kind of issues that would be covered, the ways in which the interview would be used and its voluntary nature. Women were told that they could decline to answer questions, could take a break, or could end the interview at any time. During group interviews, women were informed that those who did not wish to share their experiences in the group could do so privately, or not at all. Human Rights Watch took great care to interview women in a sensitive manner and ensured that the interviews took place in comfortable and safe settings. Interviews were carried out in English without interpretation and IsiXhosa and in Somali with the assistance of female interpreters.

Interviewees did not receive any material compensation and Human Rights Watch made it clear at the start of each interview that it could not provide individual support or services. Human Rights Watch gave the women basic information about local services, such as legal or health services, when relevant. To protect their privacy, pseudonyms are used in place of the real names of the women interviewed in this report. The identities of some other interviewees have also been withheld at their request.

Scope and Limitations

This report uses a human rights framework to examine accountability for maternal health care. It sets out several specific steps that South African and Eastern Cape governments should take to better integrate accountability into maternal health care programs and ensure their implementation through the health system. It does not explore all available tools for accountability such as external surveys, public hearings, social audits, or community-based monitoring.

In addition, the report does not discuss all available accountability avenues in the South African public health care system. Mechanisms outside the health system—such as recourse to courts, the National Human Rights Commission, the Office of the Public Prosecutor, and professional health councils such as the South Africa Nursing Council and the Health Professions Council of South Africa—may also serve to promote accountability for health services. However, this report examines the accountability frameworks that address government’s internal monitoring of policies, practices, and performance, including complaint mechanisms within the health system itself which are tied to health facilities. Facility-based complaint mechanisms are the ones patients are most likely to resort to first and should provide the most expeditious remedies. These, plus government’s internal monitoring of policies, practice, and performance, should ensure

systemic reforms and interventions at the most appropriate level to achieve prioritized health outcomes, as well as promote fiscal responsibility.

Failures in health system accountability certainly affect all patients, but this report focuses on the experiences of patients seeking maternity care, as improving maternal health care is a top priority for the national and provincial governments. Moreover, maternal health services, like all reproductive health services, are provided as part of an integrated health care package, not as a stand-alone service. Therefore, although this report is concerned with accountability in relation to maternal health care, its findings can be used to gain insights into the health system as a whole. The findings of this report can be applied beyond the Eastern Cape Province because government and health experts' analyses indicate that the shortcomings identified in this report are not unique to the Eastern Cape Province. Provinces generally exhibit similar recurring health system shortcomings.

However, the need for stronger health system accountability is pressing in the Eastern Cape Province, which has some of the worst health indicators in South Africa. Of all provinces in the country, it has the highest levels of infant mortality (children dying under the age of one), the second highest number of child deaths under the age of five, and the lowest rate of facility deliveries according to the 2010 District Health Barometer (covering the years 2008 and 2009). The Barometer is an annual overview of public health services prepared by governmental and nongovernmental health experts. Trends in increasing maternal mortality for the nine South African provinces are comparable according to the latest report on confidential enquires into maternal deaths (CEMD). CEMD reviews deaths that occur in health facilities. But according to an analysis by maternal health experts of the 2007 population-based Community Survey, Eastern Cape experienced the highest increase in maternal mortality between 2001 and 2007. O.R. Tambo, Amatole, and Nelson Mandela Metropolitan Municipality districts had the highest maternal mortality ratios in the province in 2008 and 2009.²

The National Department of Health listed Amatole and O.R. Tambo districts (among others in Eastern Cape) among the “18 priority districts” in the country with poor health outcomes and in need of accelerated health service delivery improvements. Government reports and analysis by health experts and human rights monitoring groups show that health services in Eastern Cape also suffer from poor governance by provincial and district authorities and corruption by individual health providers on a larger scale than in other provinces.

² Eastern Cape Department of Health, “Five Year Strategic Plan: 2009/2010 – 2014/2015,” <http://www.ecdoh.gov.za/uploads/files/051010112948.pdf> (accessed June 3, 2011), p. 19.

I. Background

Maternal Mortality Globally; Calls for Accountability

Global maternal mortality rates have declined in recent decades as countries strive to achieve the Millennium Development Goals (MDGs), a set of anti-poverty goals agreed by 189 countries in 2000. One of those goals is for countries to improve maternal health, with targets of reducing the maternal mortality ratio (MMR) from 1999 by 75 percent and achieving universal access to reproductive health by 2015.³ United Nations agencies estimated in 2010 that maternal deaths had dropped 34 percent between 1990 and 2008, with approximately 358,000 maternal deaths occurring in 2008.⁴ While promising, the UN emphasized that this rate of decline is insufficient to meet by 2015, the MDG target on reducing maternal deaths, and that too many women and girls still die every year as a result of preventable and treatable complications of pregnancy and childbirth.

The region hardest hit by maternal deaths—and least likely to meet the MDG maternal health goal—is sub-Saharan Africa. Nearly three-fifths of global maternal deaths between 1990 and 2008 occurred in that region.⁵ Although the MMR declined 26 percent in sub-Saharan Africa in that period, with 640 deaths per 100,000 live births, it remains higher than in any other region. Sub-Saharan Africa’s MMR stands in stark contrast to the 14 deaths per 100,000 live births for developed regions, and even to the 280 deaths per 100,000 live births in South Asia, the second hardest-hit region.⁶ The lifetime risk of death (the probability that a 15-year-old female will die eventually from a maternal cause) as measured in 2008 was 1 in 31 in

³ WHO defines “maternal mortality ratio” as the number of maternal deaths in a population divided by the number of live births, and notes that it represents the risk associated with each pregnancy.

⁴ WHO et al., *Trends in Maternal Mortality: 1990 – 2008, Estimates Developed by WHO, UNICEF, UNFPA and The World Bank* (Geneva: WHO Press, 2010), http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf (accessed May 24, 2011), p. 1. Another 2010 analysis of maternal mortality for 181 countries between 1980 and 2008 shows an estimated 342,900 maternal deaths occurred in 2008, down from 526,300 in 1980. The study notes that the decline reflects progress only in some regions, and very little progress has been made in sub-Saharan Africa. Margaret C. Hogan et al., “Maternal Mortality for 181 Countries, 1980–2008: A Systematic Analysis of Progress towards Millennium Development Goal 5,” *The Lancet*, April 12, 2010, <http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673610605181.pdf?id=e16241398b8e460:73a56a81:128> (accessed April 15, 2011), p. 1.

⁵ WHO et al., *Trends in Maternal Mortality: 1990 – 2008*, p. 17.

⁶ *Ibid.*

sub-Saharan Africa, compared to 1 in 4,300 in developed regions.⁷ In sub-Saharan Africa, nine percent of all maternal deaths in 2008 were HIV-related.⁸

With the news in 2010 that maternal deaths were declining but still unacceptably high, and with just five years remaining before the 2015 MDG deadline, 2010 saw an unprecedented level of financial, political, and technical commitments by governments, intergovernmental agencies, and private actors to tackle maternal mortality. At the international level, top among these was the launch of the United Nations' Global Strategy for Women's and Children's Health, resulting in pledges by governments and other actors of approximately US\$40 billion in resources over five years.⁹ The UN also established a Commission on Information and Accountability for Women's and Children's Health, charged with developing a reporting and accountability framework to track whether these pledges are delivered on time, are spent wisely and transparently, and are achieving the desired results.¹⁰

Recent years have seen international consensus by experts and human rights groups on the role of accountability to improve health systems, and to reduce maternal mortality. For example, the UN special rapporteur on the right to health focused on accountability in health systems in a 2008 report. He wrote, "Under the right to health, those with responsibilities should be held to account so that misjudgments can be identified and

⁷ Ibid., p. 1.

⁸ Ibid.

⁹ See United Nations, "UN Secures \$40 Billion for Women's and Children's Health," September 22, 2010, <http://www.un.org/en/mdg/summit2010/> (accessed February 15, 2011). In 2010, leaders of the G8 countries pledged a total of \$5 billion to maternal, newborn, and child health, prioritized maternal and child health in the G8 Communiqué, and launched the "Muskoka Initiative" to accelerate efforts towards improving maternal and child health in developing countries. G8, "The Muskoka Declaration: Recovery and New Beginnings," June 2010, http://canadainternational.gc.ca/g8/assets/pdfs/2010-declaration_eng.pdf (accessed February 15, 2011). Furthermore, in September 2010, the United States Agency for International Development (USAID), the United Kingdom Department for International Development (DFID), The Australian Agency for International Development (AusAID), and the Bill & Melinda Gates Foundation announced "a five-year public/private global alliance to contribute to the goal of reducing the unmet need for family planning by 100 million women, expand skilled birth attendance and facility-based deliveries, and increase the numbers of women and newborns receiving quality post-natal care by 2015." Another focus of this effort will be to encourage country ownership of this work and streamline investments among donors. See "International Alliance Launched to Support Country-Led Progress in Reproductive, Maternal, and Newborn Health," USAID press release, September 22, 2010, <http://www.usaid.gov/press/releases/2010/pr100922.html> (accessed February 15, 2011).

¹⁰ "UN Establishes High-level Commission to Track Results and Resources for Women's and Children's Health," UN press release, December 16, 2010, http://www.un.org/millenniumgoals/pdf/Press_Release_Accountability_16Dec_final.pdf (accessed February 17, 2011).

corrected. Accountability can be used to expose problems and identify reforms that will enhance health systems for all.”¹¹

In sub-Saharan Africa, governments and regional bodies also launched or reinforced initiatives on maternal and child health in 2010. The African Union (AU) made maternal and child health the main theme of the July 2010 AU Assembly, continued its Campaign on Accelerated Reduction of Maternal Mortality in Africa,¹² and declared women’s health a prime focus of the 2010-2020 AU African Women’s Decade.¹³ AU member states agreed to report annually on maternal and child mortality and to establish an AU task force on maternal, newborn, and child health to monitor progress on commitments.¹⁴ They also reaffirmed the Maputo Plan of Action on sexual and reproductive health and rights.¹⁵ While the declaration issued at the 2010 AU Assembly concerning maternal, newborn, and child health did not directly address accountability through individual redress mechanisms, it called on governments to institute monitoring and evaluation frameworks,¹⁶ currently a key challenge for many African countries.

Maternal Mortality in South Africa and Eastern Cape

South Africa’s maternal mortality ratio varies widely by source, but in its 2010 MDG report, the government estimated the country’s MMR was approximately 625 deaths per 100,000

¹¹ Human Rights Council, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, A/HRC/7/11, January 31, 2008, <http://daccessdds.un.org/doc/UNDOC/GEN/Go8/105/03/PDF/Go810503.pdf?OpenElement> (accessed June 3, 2011), para.122.

¹² African Union, “Decisions, Declarations, Resolution adopted by the Fifteenth Ordinary Session of the Assembly of the Union on July 27, 2010 in Kampala, Uganda,” Assembly/AU/Decl.1(XI).

¹³ Women, Gender and Development Directorate, “The Road Map for the African Women’s Decade: 2010-2020,” October 2009, http://www.africanwomendecade.org/index.php?option=com_docman&task=cat_view&gid=36&Itemid=50 (accessed March 20, 2011).

¹⁴ African Union, “Decisions, Declarations, Resolution adopted by the Fifteenth Ordinary Session of the Assembly of the Union on July 27, 2010 in Kampala, Uganda,” Assembly/AU/Decl.1(XI).

¹⁵ African Union, “Decision on the Report of the Special Session of the African Union Conference of Ministers of Health (CAMH4) on Maternal Infant and Child Health in Africa,” Doc. EX.CL/592(XVII). The Maputo Plan of Action was adopted by African heads of state in 2006. It sets out a framework for countries to improve women’s and girls’ reproductive and maternal health. African Union, “Plan of Action on Sexual and Reproductive Health and Rights (Maputo Plan of Action) 2007 – 2010,” Sp/MIN/CAMH/5(I), http://www.unfpa.org/africa/newdocs/maputo_eng.pdf (accessed April, 5, 2011). The Campaign on the Accelerated Reduction of Maternal Mortality in Africa is meant to help countries achieve the goals of the MPoA.

¹⁶ African Union, “Decisions, Declarations, Resolution adopted by the Fifteenth Ordinary Session of the Assembly of the Union on July 27, 2010 in Kampala, Uganda,” Assembly/AU/Decl.1(XI), para. 2(viii).

live births in 2007,¹⁷ up from approximately 150 deaths per 100,000 live births in 1998. The government indicates that it is unlikely to meet the MDG target on reducing maternal deaths,¹⁸ which would require an MMR of 38 deaths per 100,000 live births.¹⁹ While many sub-Saharan African countries are not on track to meet their MDG targets, South Africa is one of only six countries in sub-Saharan Africa that made no progress in reducing maternal deaths by 2008, and one of five (together with Botswana, Lesotho, Swaziland, and Zimbabwe) that experienced the largest percentage increases.²⁰

Trend data from maternal death reviews by the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD), which issues periodic reports on confidential enquiries into reported maternal deaths, shows that the institutional maternal mortality ratio—NCCEMD reviews deaths occurring in health facilities only—in the Eastern Cape Province tripled from 45.9 deaths per 100,000 live births in 1998 to 138.7 in 2007.

The main reasons behind South Africa's high and increasing maternal deaths according to public health experts are HIV/AIDS, poor administrative and financial management, poor quality of care, and lack of accountability.²¹ South Africa's past failures to address HIV/AIDS

¹⁷ Government of South Africa, "Millennium Development Goals: Country Report 2010," 2010, http://www.statssa.gov.za/news_archive/Docs/MDGR_2010.pdf (accessed January 15, 2011), p. 67.

¹⁸ National Department of Health (NDOH) and Medical Research Council, "South Africa Demographic and Health Survey 1998," 2002, <http://www.measuredhs.com/pubs/pdf/FR131/01Chapter01.pdf> (accessed May 24, 2011), p. xiii. See also, Government of South Africa, "Millennium Development Goals: Country Report 2010," p. 67. South Africa has not conducted a demographic and health survey since 2003. The 1998 DHS provides the estimate closest to 1990, and is therefore used as the baseline for the maternal mortality ratio in the country. Another DHS was conducted in 2003 but data quality was contested, and the study was only published in 2007. Plans for the next DHS are unclear. *Ibid.*, p. 23. The WHO study referred to earlier estimates the South Africa MMR to be 410 deaths per 100,000 live births, with 4,500 annual maternal deaths. Various studies note that increasing MMR in South Africa is probably due to improved reporting and the HIV and AIDS epidemic. For a detailed discussion of various methods used to estimate the MMR in South Africa, see Duane Blaauw and Loveday Penn-Kekana, "Maternal Health," *South African Health Review* (2010), pp. 6-9.

¹⁹The government has now set a target of 100 deaths per 100,000 live births to be achieved by 2015. NDOH, "National Department of Health Strategic Plan 2010/11-2012/13," 2010, http://hs.ukzn.ac.za/Libraries/Post-graduate_Administrative_Procedure/NDOH_STRATEGIC_PLAN_201011-201213_01_MARCH_2010_1_1.sflb.ashx (accessed September 20, 2010), p. 26.

²⁰South Africa's increase was estimated at 80 percent. The other countries are Botswana (133 percent), Zimbabwe (102 percent), Swaziland (62 percent), and Lesotho (44 percent). WHO et al., *Trends in Maternal Mortality: 1990 – 2008*, 2010, pp. 19, 26, and 31.

²¹See NDOH, "National Department of Health Strategic Plan 2010/11-2012/13," 2010, p. 26; NDOH, Department of Health Annual Report 2009/2010, <http://www.info.gov.za/view/DownloadFileAction?id=133115> (accessed June 10, 2011), p. 3; NDOH, "National Service Delivery Agreement: A Long and Healthy Life for All South Africans," 2011, <http://www.doh.gov.za/docs/summit/nsda.pdf> (accessed June 3, 2011) pp. 5-9; Mickey Chopra et al., "Achieving the Health Millennium Development Goals for South Africa: Challenges and Priorities" *The Lancet* Vol. 374 (2009), pp.1029-1030; and David Harrison, "An Overview of Health and Health care in South Africa 1994 – 2010: Priorities, Progress and Prospects for New Gains," 2010, <http://www.doh.gov.za/docs/reports/2010/overview1994-2010.pdf> (accessed April 10, 2011), pp. 28-31.

by opposing the use of antiretroviral drugs, including for prevention of mother-to-child HIV transmission, in the public health system, coupled with an epidemic of sexual violence, have left an estimated 5.7 million South Africans (18 percent of the population) infected with HIV.²² This is the highest number of people in any single country infected with HIV. The impact of HIV/AIDS on maternal health is felt at two levels: firstly through increased demand for health services that has significant impacts on existing health resources, and secondly as an indirect cause of deaths. NCCEMD states that HIV/AIDS caused 43.7 percent of maternal deaths between 2005 and 2007—37.6 percent for Eastern Cape—and that the national MMR for HIV positive women was nearly 10 times higher than for HIV negative women.²³ The report notes that without the HIV epidemic, South Africa’s institutional MMR would be similar to other mid-income countries like Brazil, Argentina, and Thailand.²⁴

The analysis of government and other experts show that there are serious administrative and financial management inefficiencies at all three levels of the South African public health care system, and at the health facilities level, that hamper quality health care. These are a result of the lack of separation of political and management responsibilities to enable senior health managers to focus on service management, lack of clear devolution of management responsibilities linked to accountability for performance, incompetent managers, corruption, weak accountability, and poor monitoring and evaluation.²⁵ Low staff morale, attributed to being overworked and a sense of neglect and lack of support by managers, also impacts quality maternal health care.²⁶

An equitable, well-resourced, accessible (physically and financially), and integrated health system is widely accepted as being vital for guaranteeing women’s access to the interventions that can prevent or treat the causes of maternal deaths and injuries. Public health experts agree that to a large extent, the building blocks of a functioning health system, finances, and health infrastructure are present in South Africa and that although

²²NDOH, “National Service Delivery Agreement: A Long and Healthy Life for All South Africans,” 2011, p. 5.

²³ National Committee for the Confidential Enquiries into Maternal Deaths (NCCEMD), “Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa,” 2009, http://www.hst.org.za/indicators/ChildHealth/Saving_Mothers_4th_comprehensive.pdf (accessed April 5, 2011), p. 229. The report also notes that a significant number of women, both HIV-negative and HIV-positive, still die of preventable direct obstetric causes. Direct causes of maternal mortality include hypertension (15.7 percent), obstetric hemorrhage (12.4 percent), pregnancy-related sepsis (9 percent), and preexisting maternal disease (6 percent). *Ibid.*, p. xi.

²⁴ *Ibid.*, p. 16.

²⁵ See, David Harrison, “An Overview of Health and Health care in South Africa 1994 – 2010: Priorities, Progress and Prospects for New Gains,” pp. 28-31.

²⁶ *Ibid.*, p. 32. Also see Candy Day and Andy Gray, “Health and Related Indicators,” *South African Health Review* (2010), p. 216 for further discussion on health system challenges in South Africa in the last fifteen years.

inequalities based on geographical, racial, and socioeconomic status exist, access to health care is generally good. Furthermore, since the end of apartheid in 1994, South Africa has passed important sexual and reproductive health-related laws and policies that, if implemented, would greatly improve maternal health care as well as overcome the abuses documented in this report and elsewhere.

South Africa has the highest per capita spending on health—US\$748—in sub-Saharan Africa,²⁷ and a strong legal and policy framework, including a constitutional guarantee of the right to health. It is one of the few African countries where maternity care is free and abortion is legal.²⁸ South Africa has succeeded in getting 92 percent²⁹ of women to attend antenatal care, and almost 87 percent of deliveries happen in health facilities.³⁰ The cesarean section rate for South Africa is 21 percent,³¹ and although provincial averages differ, all are above the 5 percent minimum recommended by the WHO,³² suggesting that national access to surgical interventions is reasonable.³³ The tragedy of maternal deaths in South Africa is that many women who eventually die have had contact with the health care system—through attending antenatal care and delivery in health facilities—meaning that some of the deaths could have been prevented.³⁴

The neglect of the quality dimension of maternal health services, in terms of both clinical care and human quality of care, is one principle bottleneck to achieving the MDG targets on maternal and child health in South Africa.³⁵ Yet efforts to address this contributory factor to maternal and newborn mortality have received less attention compared to barriers of access to care. A recent article in *The Lancet* notes that the sub-optimal

²⁷ “Health in South Africa: An Executive Summary for the Lancet Series,” *The Lancet*, vol. 28 (2010), p. 75.

²⁸ For a detailed presentation of the South African government’s achievements on reproductive health see http://www.doh.gov.za/departments/subdir_maternal.html (accessed June 3, 2011).

²⁹ NDOH et al., “South Africa Demographic and Health Survey 2003,” 2007, <http://www.measuredhs.com/pubs/pdf/FR206/FR206.pdf> (accessed September 2010), p. 120.

³⁰ Health Systems Trust, “District Health Barometer 2008/2009,” May 2010, <http://www.hst.org.za/uploads/files/DHBo809.pdf> (accessed May 24, 2011), p. 108.

³¹ Candy Day and Andy Gray, “Health and Related Indicators,” p. 270.

³² WHO et al., *Monitoring Emergency Obstetric Care: A Handbook*, (Geneva, WHO Press, 2009), p. 25.

³³ Duane Blaauw and Loveday Penn-Kekana, “Maternal Health,” p. 14.

³⁴ NCCEMD, “Saving Mothers 2005-2007,” p. 11.

³⁵ There is no universally accepted definition of quality of care, but increasingly the composite nature of quality is acknowledged, and is seen to encompass the following elements: “effectiveness, safety, timeliness, efficiency, equity and responsiveness to the preferences, needs and values of mothers and their families – as individuals and populations.” N.R. van den Broek and W.J. Graham, “Quality of Care for Maternal and Newborn Health: the Neglected Agenda,” *An International Journal of Obstetrics and Gynecology* Vol. 116 (2009), <http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2009.02333.x/pdf> (accessed June 19, 2011), p. 18.

implementation of interventions that are known to be effective and affordable is a key explanation for why South Africa is unlikely to meet MDG five. The authors further note the need for strategies to improve health worker motivation and commitment to providing good quality, patient-centered care, and for strengthening health system accountability.³⁶

The NCCEMD said in the 2005-2007 report that 38.4 percent of maternal deaths occurring in facilities were evidently avoidable within the health care system, patient orientated factors being excluded.³⁷ Poor quality of care happens when health workers do not have the tools they need to do their work effectively. The NCCEMD report identified problems such as lack of blood for transfusion, inadequate emergency transport, poor referral systems, insufficient intensive care unit facilities, and lack of appropriately trained staff to manage obstetric emergencies. There is also evidence of abusive treatment of maternity patients that also contributes to poor maternity care (discussed in more detail in Chapter Two).³⁸

The current leadership in the National Department of Health has shown greater political will and efforts to tackle maternal mortality, particularly in relation to HIV-related maternal deaths. Acknowledging that maternal deaths are unacceptably high, the South African government has identified maternal mortality reduction as a national priority. Decreasing maternal and child mortality is included as one of four “strategic outputs” that the health sector must achieve by 2014, according to a service delivery agreement signed by South Africa’s Minister of Health, Dr. Aaron Motsoaledi and President Jacob Zuma in 2010.³⁹ Some of the DOH’s initiatives to reduce maternal mortality include expanding the provider-initiated HIV counseling and testing for antenatal patients, early initiation of prevention of mother-to-child prophylaxis at 14 weeks, and providing antiretroviral treatment for pregnant women with a CD4 (immunity level) count of 350 or less.⁴⁰

³⁶Mickey Chopra et al., “Achieving the Health Millennium Development Goals for South Africa: Challenges and Priorities” *The Lancet* Vol. 374 (2009), p.1030.

³⁷NCCEMD, “Saving Mothers 2005-2007,” p. 11.

³⁸ NCCEMD, “Saving Mothers 2005-2007,” p. xi.

³⁹ The South African government has identified 12 outcomes as key indicators for its program of action for the period 2010 -2014. The Negotiated Service Delivery Agreements are performance charters signed by all ministers, and that reflect key strategic outputs and targets that each ministry must achieve by 2014. The health sector has four strategic outputs under the vision, “A long and healthy life for all South Africans”: increasing life expectancy, decreasing maternal and child mortality, combating HIV and AIDS and decreasing the burden of disease from Tuberculosis, and strengthening health system effectiveness. NDOH, “Negotiated Service Delivery Agreement,” 2011, <http://www.doh.gov.za/docs/summit/nsda.pdf> (accessed June 3, 2011) p. 4.

⁴⁰ NDOH, “Negotiated Service Delivery Agreement,” pp. 12-13. Other planned reforms include review and strengthening of the referral system including by providing maternity and child ambulances in health facilities, building maternity “waiting homes” for women who live far from facilities so that they do not have to travel far while in labor, appoint teams of experts/specialists in maternal and child health in each district to support doctors and midwives in managing maternal and child health problems, employing community health care

Monitoring of Maternal Deaths

South Africa monitors maternal deaths through confidential enquires into maternal deaths (CEMD), introduced in 1997, and facility-based maternal death reviews. Facility-based maternal death reviews are conducted whenever there is a maternal death. The objective is to learn from the experience in order to prevent mistakes that may have contributed to the death. NCCEMD conducts the confidential enquiries and produces a report every three years to “provide evidence of where the main problems in overcoming maternal mortality lie and an analysis of what can be done in practical terms, and highlight the key areas requiring recommendations for health sector and community action as well as guidelines for improving clinical outcomes.”⁴¹

Maternal death reviews are an important accountability mechanism, but are only useful if the information gathered is used to ensure that systemic problems with the provision of care are not repeated. Despite initiating the CEMD in 1997, very little has changed for women in South Africa and women continue to die due to the same health system shortcomings. According to the head of the maternal, child, and women’s health directorate in South Africa, one of the reasons for this failure is “Lack of managerial leadership; [that] managers of the institutions [health facilities] do not own the recommendations.”⁴² But a key reason for this failure is a lack of effective oversight and accountability from the national level. Information on how provinces are implementing recommendations from the CEMD reports is unavailable, although provinces should report about this in each report. Those who do not comply are not sanctioned. NCCEMD has suggested that recommendations of the CEMD reports be integrated into key performance areas of provincial and district health managers to ensure implementation (and thus tied to income and promotions), but this has not been taken forward by the government. Besides, the government has not conducted an analysis of resources and competencies needed to implement the findings of the reports.

workers to link families and communities to facilities for maternal and child health. Ibid. It is also hoped that planned broader changes to the health sector, including the national health insurance plan, will positively impact maternal health care.

⁴¹ NCCEMD, “Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa,” 2009, http://www.hst.org.za/indicators/ChildHealth/Saving_Mothers_4th_comprehensive.pdf (accessed April 5, 2011), p. 3.

⁴² Human Rights Watch interview with Prof. Eddie Mhlanga, head, maternal, child, and women’s health directorate, Pretoria, November 5, 2010.

Maternal Health Data Shortfalls and the Need for Better Monitoring

Quality data on impact and process indicators for measuring maternal mortality is an important part of accountability for women's health. While the South African government has made great efforts to gather important data on maternal health⁴³ critical gaps exist. South Africa does not have reliable maternal mortality ratio estimates, these estimates serve as one of the main MDG five outcome indicators. Although a number of studies are able to extract estimates, these cannot reliably measure trends in maternal mortality in the country.⁴⁴ Also, South Africa has not conducted a demographic and health survey since 2003, although this survey could gather critical data to help plan, monitor and evaluate maternal health programs.⁴⁵

Furthermore, routine monitoring of maternal health care programs does not take into account all the emergency obstetric care (EmOC)⁴⁶ indicators—or the UN process indicators

⁴³The main maternal health indicators used in South Africa include antenatal care attendance, institutional deliveries, proportion of women receiving tetanus toxoid injections, the Cesarean section rate and the maternal mortality ratio. The government emphasizes increased institutional deliveries and the relatively high rates of C-section births as indicators of availability of emergency obstetric care facilities, and utilization by women; but there are questions around quality of data and care. With regard to antenatal care, the timing, number of women attending the recommended four visits, and the provision of essential services such as HIV testing, tetanus toxoid; and the provision of vital information such as possible complications during pregnancy are suboptimal. With regard to institutional deliveries including through C-sections, there are problems of substandard care and lack of skilled medical staff. See NDOH, "SADHS," pp. 121 – 128; NCCEMD, "Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa," pp. 3-4; Every Death Counts Writing Group, "Every Death Counts: Use of Mortality Audit Data for Decision Making to Save the Lives of Mothers, Babies, and Children in South Africa," *The Lancet*, vol. 371, 2008, <http://motherchildnutrition.org/resources/pdf/mcn-every-death-counts.pdf> (accessed June 20, 2011), pp. 1300-1301.

⁴⁴ For detailed discussion of problems with current maternal mortality estimates in South Africa see, Loveday Penn-Kekana and Duane Blaauw, "Maternal Health," pp. 6 and 23.

⁴⁵ Duane Blaauw and Loveday Penn-Kekana, "Maternal Health," *South African Health Review* (2010), p. 3.

⁴⁶ One way of reducing maternal mortality is by improving the availability, accessibility, quality and use of services for the treatment of complications that arise during pregnancy, childbirth, and after delivery. These services are collectively known as Emergency Obstetric Care, and involve a set of life-saving services or interventions called "signal functions"—key medical interventions that are used to treat the direct obstetric complications that cause the vast majority of maternal deaths—that should be available in a facility that provides emergency care for women with pregnancy-related complications. WHO et al., *Monitoring Emergency Obstetric Care: A Handbook* (Geneva: WHO Press, 2009), p. vii. These "signal functions" are proven to significantly reduce maternal deaths and improve birth outcomes for the newborn, and they must be performed at a facility in order for that facility to be recognized as an emergency obstetric care facility. The emphasis is on actual rather than theoretical functioning. A facility can either be classified as a basic emergency obstetric care or a comprehensive emergency obstetric care facility. The basic emergency obstetric care signal functions are seven and include: administration of parenteral antibiotics, administration of uterotonic drugs (i.e. drugs that expand the cervix or vagina to facilitate delivery), administration of anticonvulsants, manual removal of placenta; manual vacuum aspiration of retained products of conception; assisted vaginal delivery, and basic neonatal resuscitation. Comprehensive emergency obstetric care includes the all seven basic signal functions, plus performing surgery (for example, cesarean section), and blood transfusion. *Ibid.*, pp. 6-7. The UN process indicators as they are popularly known, address the minimum required number of basic and comprehensive

as they are widely known—despite their relevance in monitoring maternal health services and deaths. Process and output indicators are especially useful in this regard because they provide information not only for the final evaluation, but also for ongoing management and improvement of program components. The UN Special Rapporteur on the right to the highest attainable standard of health has indicated that indicators for EmOC are essential to identify needs, monitor implementation, measure progress, and enhance accountability.⁴⁷

Periodic surveys like the CEMD provide useful information about the status of maternal health in the country including information on aspects of access to EmOC. They also give recommendations for addressing the gaps. But they do not provide information on key indicators such as whether the need for emergency obstetric care was met in all cases, whether there are adequate EmOC facilities, the proportion of maternal deaths among women with obstetric complications admitted to facilities, or geographic and socioeconomic disparities in access to these services.⁴⁸

The need to use EmOC indicators in South Africa is made urgent by the fact that current routine indicators are not adequate in monitoring maternal health services to reduce maternal mortality. Although antenatal care and rates of delivery in facilities are high, many women continue to die. Institutional delivery is important for reducing maternal mortality, but does not always provide access to life-saving care, such as emergency obstetric care. It therefore cannot be regarded as always representative of access to life saving care. A recent analysis of maternal health in the country notes that:

emergency obstetric care facilities for a given population, their geographical distribution, minimum proportion of births that should occur in basic and comprehensive emergency obstetric facilities, whether women with pregnancy complications were in fact treated in emergency obstetric care facilities, acceptable proportion of births through cesarean sections, the number of deaths among women with pregnancy complications admitted to facilities equipped with emergency obstetric care, number of deaths to babies during or seven days after birth, and the number deaths due to indirect causes. In other words, they can be used to measure progress in a programmatic continuum: from the availability of and access to EmOC to the use and quality of those services.

⁴⁷ Human Rights Council, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Addendum, Mission to India, A/HRC/14/20/Add.2, April 15, 2010, <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G10/128/66/PDF/G1012866.pdf?OpenElement> (accessed march 17, 2011), para. 76.

⁴⁸A recent analysis of maternal health in the country notes that “[t]here has been no recent audit of the resources available for providing maternal health-care services in South Africa. For example, the distribution of hospitals able to perform a caesarean section, or the availability of skilled midwives working in labor wards, or the performance of ambulance services, are not known with any accuracy for the whole country.” Loveday Penn-Kekana and Duane Blaauw, “Maternal Health,” p. 16.

With the exception of the Caesarean section rate, these [UN process indicators] have not been used in South Africa.... [T]here is no national data on the availability of emergency obstetric care facilities or the unmet need for emergency obstetric care ... there has been no recent audit of the resources available for providing maternal health-care services in South Africa. For example, the distribution of hospitals able to perform a Caesarean section, or the availability of skilled midwives working in labor wards, or the performance of ambulance services, are not known with any accuracy for the whole country.⁴⁹

The South African government should therefore incorporate all the UN process indicators into routine health management information systems to track progress at district, provincial, and national levels, as well as conduct needs assessments, or situational analysis of emergency obstetric care in the country.

⁴⁹ Duane Blaauw and Loveday Penn-Kekana, "Maternal Health," pp. 14 and 16. On the concern that the high rates of antenatal care coverage and delivery by a skilled attendant in South Africa have not had any impact on the MMR, the study recommends: "New indicators that are better correlated with maternal mortality in South Africa are required for planning and monitoring," p. 3.

II. Maternity Care Failures and Patient Abuse

Better quality of care is fundamental in improving South Africa's current poor health outcomes and in restoring patient and staff confidence in the public and private health care system.... The factors that contributed to the current situation must also be taken into account.

—Dr. Aaron Motsoaledi, South African Minister of Health, foreword to National Core Standards for Health Establishments in South Africa, 2011

Many of the health care delivery failures that lead to poor maternal health outcomes could be identified and ultimately addressed through oversight and accountability systems. South Africa and Eastern Cape have, indeed, developed and implemented a relatively complete system for ensuring such oversight, but it is malfunctioning and rarely put to work for women. The sections below depict a range of mistreatment and substandard care of maternity patients in public health facilities in Eastern Cape that put women at risk of maternal death and injury, and violate their rights to respectful and dignified care. Concerns that could be addressed by a robust complaint system that focuses not just on individual claims, but also systemic reforms.

Effective complaints mechanisms would highlight: discrimination and denial of care for vulnerable women such as migrant women and those living with HIV/AIDS; resource constraints, including human resource problems for maternity care in a larger sense; emergency transport problems; and failures in supervision of maternity staff. Such mechanisms would also underline the failure to adhere to standard protocols for maternity care and breaches in ethical practice including abuse and other risky practices by health workers during maternity care that compromise the quality of care offered to women.

Abeba M.: The Worst Time of Her Life

Abeba M., a refugee from Ethiopia living in Port Elizabeth, described to Human Rights Watch a range of delays, abuses, and negligent care she experienced when she sought help in 2008 for severely high blood pressure when she was 28 weeks pregnant. Her private doctor had referred her to Dora Nginza hospital for blood pressure treatment. She said after first reporting there, she soon left because nurses treated her badly. Her condition worsened, and she returned to the hospital. She told Human Rights Watch:

The nurses swore at me and insulted me... I was admitted at the hospital and told I would stay there until my blood pressure stabilized. But it was going up every day. I was supposed to be taken for a scan to check if the baby was okay. The doctor kept telling me he would take me to have the scan but he did not. He kept saying he had forgotten. So, for 10 days he forgot about me and I was there in the ward where everybody could see me? On the tenth day I was taken for the scan. The doctor said there is nothing in my uterus; that they could not see the baby. They then said they will take me for another scan. They made me walk to the scan room, two floors away, while I was so weak and my whole body swollen. I was so scared....

A lady and her baby died in our ward. I did not think I would survive. Later, another woman suffering from high blood pressure also died. I thought I was next. I was so sick. I had blurred vision. When the second lady died, the nurse asked me, "oh, you are still alive?" and the doctor said, "That lady is dead? Who is next?"....

I was suffering the whole night and I was calling the nurses and they did not come. I remember it was on a Sunday. The nurse I was calling was playing a gospel song on her cell phone and dancing. I told her I was feeling very sick. She said, "I know, and what do you want me to do?" She was walking up and down whistling and dancing....

Another nurse saw I was very sick, and she called a doctor who said that I [should] be transferred to the high care unit. They did not take me for another scan as they had told me. They kept saying today, tomorrow, but they just delayed. After three days another doctor came to see me ... I cried and begged the doctor to help me and save my baby. He said he will take me to do the scan in the afternoon. He never came back....

While I was this sick, the nurses were rude and uncaring. If I complained that I was

in pain, the nurse would insult me. One time she told me, “Now you are saying you are sick and next year you will come with another pregnancy. This is not a place to enjoy or be on holiday.” When I put a cushion on my back she mocked me. She said, “Who do you think you are? You think you are rich? Why don’t you go to a private hospital where you will get treated like a queen?”....

One day I was waiting on a long queue to check my blood pressure when I started to nose bleed. A nurse saw me, examined me and immediately called the doctor.... They asked me if I had done a scan before coming to the hospital that showed there was a baby in the uterus. I confirmed and called my husband to bring the scan from the private doctor I was seeing earlier in the pregnancy. When they saw the scan, they did a Cesarean section at midnight. During the operation, there were two doctors, the one who used to see me and another one. They were playing music, clapping and dancing. I was so worried I would die. I delivered a baby girl weighing one kilogram....

They took me to the high care unit after delivery. But at 4 a.m. they said I should go to the maternity ward. They told me to walk to the ward myself. I walked there; there was nothing I could have done. When I got to the ward, I was so tired and my body was shaking. There was a lady I was sharing the room with. She gave me a little juice and water. I gained a little energy. The nurse told me not to lie on the bed because it is the policy of the ward. I had to sit the whole day. Later when I was being discharged, I saw the doctor had written on my file that I should lie on the bed day and night....

I had to feed the baby every two hours, so I kept walking day and night. I was bleeding. The nurse shouted at me as if I had done it deliberately, and told me to get a mop and clean the blood.... They did not let me use the mop to clean the blood. I had to bend so I could use tissue to wipe it, and then use the mop....

I went home after two weeks when the baby got out of the incubator. That was the worst time of my life. It was really a tough time for me.

—Human Rights Watch interview with Abeba M., Port Elizabeth, November 24, 2010⁵⁰

⁵⁰ Human Rights Watch raised Abeba M.’s case with Dr. P.L. Gaul, acting head of the department of obstetrics and gynecology at Dora Nginza Hospital during an interview with her. Although she confirmed that the hospital

Substandard Care and Negligence

While I was at the hospital, I saw this South African woman who had come from having a C/S [Cesarean section]. She was in great pain. She kept ringing the bell but no one responded. The nurses were seated and chatting about Christmas specials. One nurse said to her, “Stop disturbing us and wait.” She was calling for about 30 minutes and no one was coming. I went to the woman and she told me to call a nurse for her. But I could not because I was also in pain and I feared they would mistreat me as well. When the nurse finally came, her C/S wound was bleeding. They had to take her back to [the operating] theater.

— Abeba M., Port Elizabeth, November 24, 2010

Several maternity patients who sought care in Eastern Cape public health facilities described instances of substandard care by health workers, in some cases putting women or their newborns in life-threatening situations. Women described being turned away from clinics without examination while in labor, being ignored by nurses when they called for help, waiting hours or even days for care, being denied referrals to specialized care, and being told to walk with their newborns between wards immediately after delivery while weak and bleeding heavily. These risky practices are a particular concern in South Africa where the government has succeeded in getting many women to deliver in facilities yet maternal death rates are still high.

Several women said that they witnessed nurses refusing to admit women to health facilities, in some cases putting the women at serious risk of injury or death. One community care giver said that in 2009 she had tried to assist a woman seeking care at a community health center. She said the woman had obstructed labor, which can be life threatening, but nurses repeatedly sent her away:

She went to Ngangelizwe Health Center at night, but they told her she had not dilated properly and sent her back home. She said she was in pain and they told her she was talking too much. She lived about 10 kilometers from

had received many complaints about abuse of women in the maternity unit, including rude attitudes, breaches of confidentiality, and physical assault, she maintained, “I am 99 percent sure that this [Abeba’s case] could not have happened [because] supervision is tight [in the maternity unit]... We have matrons doing rounds twice daily. Input of specialists is quite high. In the past bad things happened but in the last three years we have made important changes.” Human Rights Watch interview with Dr. P.L Gaul, acting head, obstetrics and gynecology, Dora Nginza hospital, March 29, 2011.

the hospital. They were not concerned that it was at night and she lived far [away]. She went back to Ngangelizwe in the morning and they sent her back again without examining her. When she went back in the afternoon, they realized she had problems and referred her to Umtata General Hospital. They did a C/S because they said the baby was too big.⁵¹

Another woman described what she witnessed happen to her cousin when she sought delivery care in Amatole district in 2008:

My cousin was rejected twice at [the community health center]. When we went ... [the nurses] did not even check her but just said she should come back when she had labor. Because she was in a lot of pain, we borrowed transport money to go to Cecilia Makiwane Hospital where she had a Cesarean section delivery. The doctor complained that she had delayed [and] her old C/S operation [scar] was swollen, and he was worried she may develop further complications. But it is the nurses that delayed us because of their bad attitude. This was her third child. She had had the previous two by Cesarean section as well.⁵²

Several women also experienced or witnessed significant delays after being admitted to health facilities, in some cases with grave consequences. One woman described delays in maternity care, related to getting an ambulance for her daughter and how it took a considerable period of time for her to be attended to at a community health center and public hospital in Port Elizabeth. She said that one day in 2008 her pregnant daughter, Fezeka B., complained of severe stomach pains:

We took a private taxi to [the] community health center and went to the maternity unit. On examination, the nurse said the baby was dead. They called an ambulance to transfer [Fezeka] to Dora Nginza Hospital. She was bleeding but they told her to wait at casualty for the ambulance. She waited for about an hour. When the ambulance arrived, she delivered as she was walking to the ambulance and the baby got stuck in her trousers. She told them [EMS staff], “here is the baby,” but they said she must get into the ambulance and would be helped at Dora Nginza. The ambulance people did

⁵¹ Human Rights Watch interview with Nontsikelelo L., O.R. Tambo district, November 3, 2010.

⁵² Human Rights Watch interview with Zuzwe Y., Amatole district, November 26, 2010.

not assist her. She got into the ambulance with the baby stuck in her trousers and she was still bleeding. She stayed that way for many hours at Dora Nginza with the dead baby without help.⁵³

In several cases, witnesses told Human Rights Watch that they were convinced that women's positive HIV status contributed to delays. For example, one community care giver said:

I have seen nurses discriminate against pregnant HIV positive women. They take them and put them in one ward and refuse to touch them. I saw them fighting and saying, not me, not me. They don't want to touch her.... And the time is going.⁵⁴

Fezeka B.: Twice failed by the health system

The mother of Fezeka B., whose 20-year-old HIV positive daughter died in 2009 at Dora Nginza hospital after a long delay in receiving care for what appeared to be childbirth complications, said she believed Fezeka's HIV status may have contributed to the delay. She told Human Rights Watch what she witnessed a week after Fezeka delivered a stillborn baby:

One week after Fezeka delivered in 2009, I could see that she was very weak and dizzy. She couldn't walk from her room to the toilet.... On a Monday at 6 p.m. she began complaining of shortness of breath and pain when she breathed. My neighbor called the ambulance but it did not come. We took public transport to Motherwell Community Health Center. They gave her a drip, and referred us to Dora Nginza Hospital. On arrival at Dora Nginza, Fezeka was seen by a doctor who ordered blood tests and x-rays. He told the sister [nurse] to admit her, saying she was critical. A porter came and took us to what looked like an examination room. It was just me and Fezeka in the room. I was wondering why he did not take us to the ward, but I did not ask him. We were taken into the room at about 10 p.m. By 4 a.m. no one had come to see Fezeka although she was very critical. Fezeka was in great pain and she kept asking me to go and call the doctor, but I did not know where the doctor was, and I did not want to leave her alone in that room. A nurse came in at 4 a.m. and just started writing things. She did not even talk to us or ask us anything. The nurse took the blood pressure and said Fezeka's legs were cold,

⁵³ Human Rights Watch interview with mother of Fezeka B., Port Elizabeth, November 13, 2010.

⁵⁴ Human Rights Watch interview with Pumeza J., East London, November 17, 2010.

and left. Fezeka said she was very tired and wanted to sleep. That was when she died. When Fezeka died, the nurse who had taken her blood pressure called a doctor. It was not the doctor who had seen her earlier. He [the doctor] was so upset and started shouting at the nurse saying the hospital will be in trouble or the nurse would be arrested because Fezeka had been sent to the wrong place. He said the body should be sent back to casualty. This made me very angry because they were trying to cover up their mess. The same porter who had brought us to the wrong room came and took Fezeka's body to casualty.... Even if they knew she would not make it, they should have explained it to her, to us, and tried to help. They never tried. They never at any time explained to me what was wrong. I was never told about the cause of Fezeka's death.

—Human Rights Watch interview with mother of Fezeka B., Port Elizabeth, November 11, 2010

Migrants who experienced delayed care also said they suspected that nurses were reluctant to treat them because they were non-citizens. A migrant man who accompanied a pregnant relative to the hospital when she was bleeding told Human Rights Watch:

We went to the hospital immediately but they took so long to attend to us. They were saying we are foreigners. When finally they examined her, they said the baby was dead. Her baby died because she is a foreigner.⁵⁵

Refugee women also complained that they had to wait longer to be served, and nurses would attend to them last even when they were early at the health facility.

Human Rights Watch has documented in another report barriers to health care by migrants, including refugees and asylum seekers, in South Africa. The report noted that, “The most serious barrier to health care access for asylum seekers, refugees and undocumented migrants is discrimination by individual health care providers ... simply for being foreign.”⁵⁶ The report also discusses the potential negative impact of this treatment on the South African health system.⁵⁷

⁵⁵ Human Rights Watch interview with Benian A., Port Elizabeth, November 22, 2010.

⁵⁶ Human Rights Watch has documented in other research the abuses and discrimination faced by migrants, including refugees and asylum seekers, when seeking health care, and the potential negative impact of this treatment on the South African health system. See Human Rights Watch, *No Healing Here: Violence, Discrimination and Barriers to Health for Migrants in South Africa* (New York: Human Rights, 2009), p. 5.

⁵⁷Ibid.

Women also complained about nurses or doctors refusing to issue referral letters when the patients felt they needed specialized care for pregnancy or childbirth-related problems. Nomqondiso X. told Human Rights Watch that for more than a year after giving birth she had asked staff at the Ngangelizwe community health center for a referral letter because her Cesarean section wound was causing her extreme abdominal pain, but they refused. She said, “I cannot go direct to the general hospital because I need a referral letter from my clinic here but they have refused to refer me. Nurses say it is ok, I will be well. It is over one year since I gave birth, and they say I will be ok.”⁵⁸

In another case, a community care giver said that nurses at a community health center refused to refer a woman for specialized care when she was bleeding heavily early in her pregnancy. She explained:

In 2007 a neighbor was bleeding. We called the ambulance at about 6 a.m. and it didn't come. We hired a private car and arrived at Ngangelizwe [community health center]. There were two sisters [nurses] busy helping a lady in labor. They said they could not give her a drip because they were busy. We threatened to complain, and that is when they attended to her. They gave her a drug. We had to go back home yet she was bleeding. We asked them to refer her to the general hospital but they refused. When we got home, she became very serious. We took her to a private hospital where she died after two days.⁵⁹

Women also talked about being discharged inappropriately, and being sent home without pain medication or antibiotics, sometimes after Cesarean births. Aisha B., a refugee woman, said that three days after delivery through Cesarean surgery, she discovered the wound had started opening. Her husband immediately hired a car from a neighbor and took her to Dora Nginza hospital where, she said, “They stitched me and told me to go home the same day.” Despite the pain she was in and the danger that her wound could become infected, Aisha said the hospital, “never gave me any pain medication or antibiotics.” She said of her experience, “It is not just me. Many Somali women face similar problems.”⁶⁰

⁵⁸ Human Rights Watch interview with Nomqondiso X., O.R. Tambo district, November 4, 2010.

⁵⁹ Human Rights Watch interview with Vela K., O.R. Tambo district, November 3, 2010.

⁶⁰ Human Rights Watch interview with Aisha B., NMM district, November 14, 2010.

Other studies have identified failure to provide adequate pain relief after obstetric procedures. For example, a study that examined barriers to access to priority health services in South Africa, including obstetric care, found that “Between 45 [and] 68 percent of women from the different sites reported that they did not receive sufficient pain relief.”⁶¹

Several women also described risky health facility practices, including the request that women make their own beds, walk to sluice rooms to collect linen, carrying their newborns and walking between wards sometimes when weak after delivery or Cesarean section surgeries, or leaving women unattended for several hours after delivery. For example, one woman told Human Rights Watch:

I was bleeding so much after delivery. My mum kept calling the nurse to help me and to change my bedding but she ignored her. Later, another nurse came and removed the bedding. I was dizzy and the nurse forced me to stand up so she could change the bed. I fell under the bed and she did not help me. My mum came to help me.⁶²

Nonkululeko F. told us about her friend’s experience:

My friend told me her placenta didn’t come out after delivery. The nurses didn’t wait for her to deliver the placenta. She was just bleeding. Lots of blood was coming out. They told her to walk to another ward to breastfeed. She collapsed and fainted on the way to the other ward. Another patient helped her.⁶³

Some women said health facility cleaners shouted at them for “messing up” when they bled on the floor, and some cleaners or nurses ordered women to clean up their own blood. A woman who gave birth in O.R. Tambo district in 2009 told Human Rights Watch:

⁶¹Quoted in Duane Blaauw and Loveday Penn-Kekana, “Maternal Health,” p. 18. The study also made similar findings to those discussed in this report. It notes that during facility observations, “it was clear that there were times that health care workers were very busy, but there were also times when health care workers sat around chatting seemingly unconcerned with patient care. Problems in communication between patients and providers were observed, with patients often not understanding what was happening or why. It was also noted that some women were left alone, scared, in pain and uncared for. At one site, problems with the referral criteria and relationships between clinics and hospitals resulted in patients suffering due to health care workers’ frustrations with their colleagues in other facilities. Ibid.

⁶² Human Rights Watch interview with Mandisa P., O.R. Tambo district, November 3, 2010

⁶³ Human Rights Watch interview with Nonkululeko F., NMM district, November 11, 2010.

The cleaner shouted at me saying I am making the floor dirty by bleeding all over, and told me to wipe the blood off the floor.... You cannot even rest after delivery. The nurses and cleaners said we have to keep going to the toilet so that we don't mess up the bedding.⁶⁴

The National Committee on Confidential Enquiries into Maternal deaths reported instances of women being left unobserved for long periods of time in a large number of maternal deaths they had reviewed, noting in some cases lack of monitoring of women with serious complications for up to five hours.⁶⁵ They recorded a number of instances where women were found dead in their beds with no indication that they had been monitored after birth. In one case, they suspected a woman who died after a Cesarean section had not been observed for about 16 hours.⁶⁶

Poor Communication with Patients; Problems with Informed Consent

South Africa's National Health Act requires that health care providers inform health users of their health status in a language the user understands and in a manner which takes into account the user's level of literacy.⁶⁷ It also provides that, except in limited circumstances, medical interventions should not be undertaken without the patient's informed consent.⁶⁸ The Eastern Cape Provincial Health Act includes similar provisions.⁶⁹

However, many women told Human Rights Watch that health workers failed to inform them about issues central to their obstetric care, including failing to obtain informed consent from women before Cesarean surgery. Some families of women or newborns who died, or women who had stillbirths, said they were left with little or no information about what caused the deaths. 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.

Nadifa A. said she started bleeding heavily in July 2010, at three months pregnant, and went to Dora Nginza hospital, where she became unconscious and miscarried. She said: "A nurse came to me and said, 'you had a miscarriage and we have given you a drip so you

⁶⁴ Human Rights Watch interview with Nomgcobo T., O.R. Tambo district, November 3, 2010.

⁶⁵ See NCCEMD, "Saving Mothers 2005-2007," pp. 57, 86, 89, and 88.

⁶⁶ *Ibid.*, p. 164.

⁶⁷ NHA, art. 6.

⁶⁸ *Ibid.*, art. 7.

⁶⁹ Eastern Cape PHA, art. 16.

can go home.’ There was no further explanation. She just said I could go home.”⁷⁰ Xola T. told Human Rights Watch about her newborn dying shortly after delivery at Dora Nginza Hospital in 2008, and receiving no information about the cause of death. She said:

I delivered a baby boy. After delivery the baby was crying. The doctor did not clean the baby. He cut the cord, wrapped the baby in a small piece of linen, and put him on something next to me.... The doctor came back 20 to 30 minutes later and said the baby was dead. I asked the doctor why the baby had died and he had cried after birth, and he didn’t say anything. I never got further explanation from the hospital.⁷¹

Some women told Human Rights Watch how poor, or lack of, communication from ambulance dispatchers resulted in women not being able to deliver in a health facility. Nomzamo R., a community care giver said: “I called the ambulance for a patient. They said they will come and never came. They never called to say they were not coming.”⁷² More than three dozen women told Human Rights Watch that when they were in labor they called ambulances, were told one would come, and waited for hours to no avail. Several women said they ended up giving birth at home because the ambulance never arrived, and the dispatcher never informed them that it was not coming.⁷³

A senior government official at the National Department of Health acknowledged that poor communication with patients happens not just in Eastern Cape, but across the country. He told Human Rights Watch:

Miscommunication and lack of communication is a big problem in the Department [of Health]. We receive many complaints from women who lost babies and were not informed about the cause of death. That is the most common complaint we receive.⁷⁴

⁷⁰ Human Rights Watch interview with Nadifa A., Port Elizabeth, November 24, 2010.

⁷¹ Human Rights Watch interview with Xola T., Port Elizabeth, November 13, 2010.

⁷² Human Rights Watch interview with Nomzamo R., East London, November 11, 2010.

⁷³ Human Rights Watch group interview with women and community care givers, O.R. Tambo district, November 2, 2010; Human Rights Watch a group interview with women, Amatole district, November 17, 2010; and Human Rights Watch group interview with women and community care givers, NMM district, November 23, 2010.

⁷⁴ Human Rights Watch interview with Dr. Louis Claassens, director, Quality Assurance Directorate, National Department of Health, Pretoria, April 6, 2011.

Migrant women who were not native English or IsiXhosa speakers said that when they sought maternity services in Eastern Cape health facilities, health workers made little effort to communicate with them and interpreters were not available. As a result, women said they found it difficult to navigate hospital procedures—and this sometimes contributed to delays in getting care—and had little information about their health condition.

The Eastern Cape Department of Health does not employ interpreters for health facilities. Patients requiring interpretation must find their own solution, but migrant women told Human Rights Watch that it is hard to find people willing to spend the hours it takes to wait for health services, and one said that even when she arranged for someone to interpret, the hospital guard tried to deny her interpreter entry. Ayan A. said that when she went into labor in August 2009, her aunt accompanied her to the hospital because she could not speak English. When they arrived at Dora Nginza hospital, the guard said her aunt could not enter. “It was difficult for me to get around the hospital because I don’t know English. I was looking lost and confused, but no one came to assist me. I just sat and hoped my aunt would come,” she said. Her aunt did manage to get in, but only after she bought “cold drink” for the security guard, a term used to describe having to pay a bribe. A hospital official at Dora Nginza told Human Rights Watch that family or friends are supposed to be allowed entry to interpret for women receiving maternity services.

Some women said 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. In four cases, refugee women said they felt pressured into Cesarean sections without actually being in a position to provide informed consent. Aasiya H. told Human Rights Watch:

In August this year [2010], I went into labor and was admitted at Dora Nginza Hospital. When the baby was near, they said I needed a Cesarean section instead of normal delivery. They didn’t tell me why they wanted to operate on me, but they did. Now I am still sick. I get pain because of the operation.⁷⁵

Amina A. also said that in May 2008 a doctor told her she needed a Cesarean section, without explanation. Amina spoke little English and told us that she had difficulties

⁷⁵ Human Rights Watch interview with Aasiya H., Port Elizabeth, November 14, 2010

understanding the little explanation the doctor provided. Amina said she refused until the doctor told her, “If you don’t accept to have a Cesarean right now, no one will help you if you have problems later.”⁷⁶

Human Rights Watch spoke to three managers at two district hospital maternity units who agreed that they face major challenges communicating with migrant women due to language barriers, and expressed the need for interpreters.⁷⁷ Dr. P.L Gaul, acting head of the department of obstetrics and gynecology at Dora Nginza hospital, said that the hospital allows spouses to accompany women in labor into the hospital but not into the labor ward because women share delivery rooms and this would compromise other patients’ privacy. She added that the hospital has volunteers who are trained to assist women through labor. Dr. Gaul also told Human Rights Watch that due to cultural beliefs that associate Caesarean birth with maternal death or morbidity, the hospital faces particular challenges with Somali women who require Cesarean section delivery. She said the hospital is continually training nurses and reminding them of the importance of obtaining informed consent, including from patients with language barriers, because “we have suffered [through legal suits] in the past when documentation was faulty.”⁷⁸

Physical and Verbal Abuse

Physical and verbal abuse at the hands of health workers by women seeking maternity care was reported by more than half of the women interviewed by Human Rights Watch, all of whom sought care or accompanied women seeking care in public health facilities in Eastern Cape over the past five years. At least 30 women told Human Rights Watch that nurses pinched, slapped, and handled them roughly during labor. One woman who gave birth at a health facility in O.R. Tambo district showed Human Rights Watch a scar on her thigh as a result of a nurse using “a pair of scissors to make me open my legs when I was in labor.”⁷⁹ Another woman who gave birth in Amatole district said that she was “beaten [by a nurse] with a ruler and slapped on the face” at a community health center in 2009.⁸⁰

⁷⁶ Human Rights Watch interview with Amina A., Port Elizabeth, November 14, 2010.

⁷⁷ Human Rights Watch interview with Dr. P.L Gaul, acting head, obstetrics and gynecology, Dora Nginza hospital, March 29, 2011; and with P. L. Sompeta , operational manager, maternity unit and N. R. Manjcotuyula, operational manager, puerperium, Umtata General Hospital, March 23, 2011.

⁷⁸ Ibid.

⁷⁹ Human Rights Watch interview with Vela R., O.R. Tambo district, November 3, 2010.

⁸⁰ Human Rights Watch interview with Nosine M., Amatole district, November 17, 2010.

Far more women—at least three quarters of the 157 women interviewed—told Human Rights Watch that health personnel verbally abused them or women they had accompanied. Some women experienced both physical and verbal abuse. For example, a 20-year-old woman said that when she was in labor at a community health center in O.R. Tambo district in 2010, “The nurse pinched me really hard on the thighs as she was abusing me. She told me, ‘it was very good when you were making the baby. Open up.’”⁸¹

Women said they had experienced or witnessed nurses verbally lash out at patients who told nurses they were having labor pains or who pleaded for assistance when they thought they were about to deliver. Several women said nurses told them to “shut up,” or said “you think you are too clever,” or asked “are you a doctor to know you are in labor?”⁸² As with the 20-year-old in O. R. Tambo district, other women also experienced nurses making snide statements about women having enjoyed sex when they conceived, and so having “no right” to complain about pain during labor. One woman explained what she witnessed at the district hospital in NMM district in 2009:

I had gone to deliver at Dora Nginza Hospital in 2008. There was a lady in labor, but the nurse told her she was pretending. She called the nurse and said, “I am in pain,” but the nurse shouted at her to be quiet, saying, “When you were making the baby you enjoyed, so don’t come and scream here.” She told her to keep walking so that the baby could come quickly. The baby nearly fell while she was walking. The nurse again shouted at her telling her she wanted to kill her baby.⁸³

Several women living with HIV, said nurses publicly ridiculed them for becoming pregnant. One woman said a nurse criticized her for being HIV positive and not having used condoms. “I was in labor and in pain but the nurse abused me about my status saying, ‘you are positive and did not use condoms.’ And people are listening. It is very humiliating.”⁸⁴

Migrant and refugee women who sought maternity care told Human Rights Watch how health personnel were verbally abusive with them, including by calling them derogatory names such as kwerekwere (a slur meaning foreigner). Two nurses working at Dora Nginza

⁸¹ Human Rights Watch interview with Nonkosazana C., Amatole district, November 17, 2010.

⁸² Human Rights Watch group interview with women and care givers, Amatole district, November 17, 2010; Human Rights Watch group interview with women and care givers, O.R. Tambo district, November 2, 2010.

⁸³ Human Rights Watch interview with Nomsa D., NMM district, November 16, 2010.

⁸⁴ Human Rights Watch interview with Nomqondiso G., O.R Tambo district, November 16, 2010.

Hospital interviewed by Human Rights Watch shared their views about migrant patients, calling them “arrogant and lazy.”⁸⁵

Araya Y., a Somali migrant who experienced verbal abuse and a four-hour delay in care at Dora Nginza hospital told Human Rights Watch:

In July this year [2010], I had gone to Dora Nginza Hospital to give birth. The nurse spoke to me disrespectfully. She called me “kwerekwere.” No one came to see me for more than four hours and I was in pain. I feared I may die there. I left the hospital. The Somali community contributed money and I went to [a] private hospital. Here I got help and was treated with respect.⁸⁶

Some women also told Human Rights Watch that other health personnel made rude, insulting, or abusive remarks. For example, several women said that ambulance dispatch personnel made inappropriate comments when they had called for emergency transport for maternity care. One woman said an ambulance dispatcher asked her, “[W]hy don’t you get your own transport instead of pressurizing us?”⁸⁷ Another woman said a dispatcher told her, “You are calling and it’s not an hour yet. Why are you getting pregnant if you can’t afford to go to hospital on your own?”⁸⁸

Services in Exchange for “Gifts” or Bribes

Refugee women—and some health workers—told Human Rights Watch that some workers in health facilities withheld or delayed maternity services until patients or their families produced “gifts,” and in some cases the workers directly asked for “cold drink” money (the local term for bribes). Some patients believed that health workers would not provide care without bribes.

Afraxo D. said that when she was at a public hospital in NMM district in 2008 for maternity care, “The nurses were asking for money. They ask for ‘cold drink’ money or that you buy them KFC [Kentucky Fried Chicken] before they can help you.”⁸⁹ Another woman said nurses demanded money in exchange for medication:

⁸⁵ Human Rights Watch separate interviews with two nurses (who requested anonymity) working at Dora Nginza Hospital maternity unit, November 24, 2010.

⁸⁶ Human Rights Watch interview Araya Y., Port Elizabeth, November 14, 2010.

⁸⁷ Human Rights Watch interview with Nombasa P., Port Elizabeth, November 14, 2010.

⁸⁸ Human Rights Watch interview with Nokuthula D., Port Elizabeth, November 11, 2010.

⁸⁹ Human Rights Watch interview with Afraxo D., Port Elizabeth, November 23, 2010.

I was admitted ... for Cesarean delivery in 2008. I was ordered [by the nurses] to call my husband to bring money so that I can be given medication. I called him, he did not bring money but he brought the KFC and that is when I got medicine. He bought lunch for three nurses.⁹⁰

Several women said receptionists or watchmen at health facilities in Eastern Cape had demanded money before they would let them enter. Aziza I., said, “When we [Somalis] go to the hospital to open a file, the receptionist asks for ‘cool drink,’ otherwise she will not help us,” and said this had happened to her personally when she sought care at health facilities in NMM district.⁹¹ Another woman remarked, “When I visited a sick person at the hospital, a security man asked for money so that he can let me in.”⁹²

An official at Dora Nginza hospital said she was “99 percent sure” that bribery was not happening in that facility.⁹³ However, three midwives working in the Dora Nginza maternity unit admitted to Human Rights Watch that nurses accept money or lunch offers, especially from migrants, and even called it “bribery.”⁹⁴

Impact of Abuses

Abuse of maternity patients in health facilities can have indelible psychological effect, and discourage women from seeking care. Human Rights Watch interviewed women who said they had delayed or failed to go to hospital for maternity care for fear of being abused. A woman living with HIV who delivered at home with near-fatal consequences said:

I gave birth at home. I had heard about another lady who gave birth in the hospital and she did not get help. She was beaten and abused a lot so I am very scared of giving birth in the hospital. I hear the nurses are very rude and they are too rough and slap people. My uncle advised me to call the ambulance when labor started but I did not want to go to the hospital. I was scared of how I would be treated. After giving birth I developed serious problems. I was bleeding too much and I couldn’t breathe properly. Luckily

⁹⁰ Human Rights Watch interview with Dhuuxo F., Port Elizabeth, November 23, 2010.

⁹¹ Human Rights Watch interview with Aziza I., Port Elizabeth, November 23, 2010.

⁹² Human Rights Watch interview with Halgan B., Port Elizabeth, November 23, 2010.

⁹³ Human Rights Watch interview with Dr. P.L Gaul, acting head, obstetrics and gynecology, Dora Nginza Hospital, March 29, 2011.

⁹⁴ Human Rights Watch separate interviews with three nurses (who requested anonymity), November 23, 2010.

the HIV treatment center took me to hospital, and eventually I got treated. I had a clot in my lung.⁹⁵

A woman who said she was mistreated at a district hospital in NMM district said:

In 2009, I gave birth at Dora Ngiza. The nurses were shouting and pinching us on the thighs telling us to open up. After delivery, I was feeling very weak but the nurse told me to leave the bed [and to] carry the child to another ward. She was very rude and said I was lazy. After this experience I told myself I will never again go to government hospitals. If I have no money to go to a private hospital, I will deliver at home.⁹⁶

A woman who runs a private maternity home in Amatole district narrated the story of a woman from the local community who refused to be referred to a public hospital although she was bleeding heavily after delivery, for fear that she would be neglected:

A woman delivered here last week and later started bleeding badly. I wanted to take her to Nomphumelelo [hospital] because she was [in] serious [condition] and I felt she needed a doctor to see her. But she refused. She said, “They will leave me to die.” She was bleeding and had started getting dizzy, but she wanted to be taken home. She said there is no care at the hospital.⁹⁷

Health Worker and Government Response

Most nurses, facility managers, and government officials interviewed by Human Rights Watch acknowledged that negative attitudes by health workers are widespread, and that health workers sometimes abuse patients. For example, a senior government official at the national DOH told Human Rights Watch: “We cannot say that these things are not happening; we know they are.”⁹⁸ Some justified this behavior by arguing that it was necessary to make women comply with birth procedures—adding that some women appreciated this treatment after delivery because they had feared being in labor—while

⁹⁵ Human Rights Watch interview with Khensani M., Amatole district, November 19, 2010.

⁹⁶ Human Rights Watch interview with Salenta B., NMM district, November 3, 2010.

⁹⁷ Human Rights Watch interview with Karen Nomzamo, manager of Busfare Babies, Amatole district, November 19, 2010.

⁹⁸ Human Rights Watch phone interview with Dr. Yogan Pillay, deputy director-general” strategic health programs, April 17, 2011.

others said it was rare, and occurred just with “a few rotten apples.”⁹⁹ For example, a district manager remarked, “I was in [medical] practice and I can tell you nurses are sometimes forced by circumstances to be harsh. When in the labor ward your objective is a healthy baby and a healthy mother. Even when you are shouting, your objective is that.”¹⁰⁰

A manager of a maternity unit at a hospital in O.R. Tambo district told Human Rights Watch about a nurse who had abused a patient in August 2009. The nurse was punished—suspended for three months without pay—but the manager tried to explain the nurse’s behavior by claiming that they were very busy and understaffed at the time: “The nurse asked the client about her HIV status and an argument ensued. The sister slapped the client. It was a busy time and we had gross shortage of staff on that day. We had many complicated cases and were preparing women for theater. So everybody was stressed.”¹⁰¹

None of the health workers admitted to Human Rights Watch that they personally mistreated patients, but one midwife at a district hospital said that she found it necessary to “discipline” women in labor wards to get them to comply with orders,¹⁰² while another one at a community health center said, “These days we do not pinch, but truly speaking you cannot get soft in the labor ward because women don’t do what they are told to do.”¹⁰³ A manager at a district hospital maternity unit made similar comments: “We don’t shout and beat but we raise the voice because of the pressure of the baby. Women don’t cooperate. You have to be firm for the sake of the baby. They close the legs even when the baby is coming out.”¹⁰⁴

⁹⁹ Human Rights Watch interviews with T. Lunika, quality assurance manager, E. Putta, manager, maternal, women and child health, Dr. B. Noruka, chief executive officer, Amatole Health District Office, East London, April 1, 2011; P. Khumalo, quality assurance manager, NMM health district office, March 29, 2011; V. Gumbi, member of the quality assurance committee, Mhlakulo Community Health Center, O.R. Tambo district, March 23, 2011; three midwives at MalizoMphehle Memorial Hospital, November 2, 2010; Dr. P.L Gaul, acting head, obstetrics and gynecology, Dora Nginza hospital, March 29, 2011; and P. L. Sompeta, operational manager, maternity unit and N. R. Manjcotuyula, operational manager, puerperium, Umtata General Hospital, March 23, 2011; Dr. Yogan Pillay, Deputy Director-General Deputy Director-General: Strategic Health Programmes, Prof. Eddie Mhlanga, head, Maternal, Child and Women’s Health Directorate, April 29, 2011.

¹⁰⁰ Human Rights Watch interview with Dr. B.S. Noruka, chief executive officer, Amatole District Health Office, April 1, 2011.

¹⁰¹ Human Rights Watch interview with P. L. Sompeta, operational manager, maternity unit, Umtata General Hospital, March 23, 2011.

¹⁰² Human Rights Watch interview with three midwives at MalizoMphehle Memorial Hospital, November 2, 2010.

¹⁰³ Human Rights Watch group interview with nurses, Ngangelizwe Community Health Center, O.R. Tambo district, March 25, 2010.

¹⁰⁴ Human Rights Watch interview with P. L. Sompeta, operational manager, maternity unit, Umtata General Hospital, March 23, 2011.

Several nurses and facility managers said systemic problems such as understaffing, poor pay, heavy workloads, and lack of equipment and medical supplies contribute to negative attitudes, abuses and poor quality of care. One nurse said: “It is really difficult to treat many people. I would say things have improved but there are instances [of abuse] due to pressure of the work.”¹⁰⁵ And another, “I know we are not always right, but the department forgets our problems. You work so hard and there is no appreciation. At the end of the month you earn peanuts.”¹⁰⁶

A midwife at a community health center tried to illustrate how understaffing can cause substandard care and complaints from maternity patients or their families:

A lady came here yesterday with obstructed labor. I forgot to insert a catheter as the guidelines say because it was an emergency and I was alone. I was running all over the place calling the [referral] hospital and trying to get the ambulance. I remembered this when I went home and I got so worried, that maybe the woman or her family will complain about me. If we were two, maybe my colleague could have remembered.¹⁰⁷

District, provincial, and national Department of Health officials responded to this by calling for a change in how nurses are trained. Most felt that the current system of training nurses in universities did not offer adequate practical experience, and as a result nurses graduated unprepared for hospital experience. For example, Eddie Mhlanga, head of Maternal, Child and Women’s Health directorate said, “They come [out of university] with degrees and low attitude of caring,” adding that the government was “reviving bedside training of nurses and midwives.”¹⁰⁸

¹⁰⁵ Human Rights Watch interview with midwife (identifying information withheld), November 24, 2010. A study examining health providers’ perspectives on the Patients’ Rights Charter made similar observations. The study notes that some health workers complained that the Charter was not in line with realities in health facilities, such as lack of adequate numbers of health workers, which leads to patients having to wait for long hours and reporting this as poor quality care. NikaThandiweRaphaely, “Providers’ Response to the Patients’ Rights Charter in South Africa: A Case Study in Policy Implementation,” 2009, <http://wiredspace.wits.ac.za/bitstream/handle/10539/7485/MPH%20research%20report%20N%20RAPHAEL%20with%20corrections.pdf?sequence=1> (accessed June 6, 2011), p. 32.

¹⁰⁶ Human Rights Watch interview with NumbuleloMaja, midwife, Ngangelizwe Community Health Center, O.R. Tambo district, March 25, 2011.

¹⁰⁷ Human Rights Watch interview with Nogozide Magda, midwife, Ngangelizwe Community Health Center, O.R. Tambo district, March 25, 2011.

¹⁰⁸ Human Rights Watch interview with Prof. Eddie Mhlanga, head, maternal, child and women’s health and nutrition directorate, Pretoria, October 5, 2010.

In May 2011 the national department of health organized the first ever nursing summit in South Africa under the theme “Reconstructing and revitalising the nursing profession for a long and healthy life for all South Africans.” Some of the objectives were to “Examine how nursing education and training can be improved to ensure alignment to patients and community needs,” to “Reflect critically and discuss key issues affecting nurses and the nursing profession,” and to “Discuss the role of nurses in major health policies and transformation initiatives (revitalising primary healthcare, national health insurance, millennium development goals, negotiated service delivery agreement).”¹⁰⁹

The head of the South Africa Nursing Council (SANC) noted that while changing the way nurses are trained is important to address some of the quality care problems, it is crucial to address persistent health system challenges so that nurses have the tools they need to do their work efficiently:

The Council cannot continue punishing nurses when the root causes [of complaints against them] are not improving. These problems are in the system itself. We need to make the nursing environment conducive and safe for nurses. Before judging a nurse’s behavior you need to ask, “How is the labor ward, how many midwives are there?” and think about the equipment that go for repair and never come back.¹¹⁰

¹⁰⁹NDOH, National Nursing Summit 2011,” undated, <http://www.doh.gov.za/docs/summit-f.html> (accessed June 10, 2011).

¹¹⁰ Human Rights Watch phone interview with Makhanya N., head, South Africa Nursing Council, May 10, 2011.

III. Problems with Eastern Cape’s Individual Complaint Mechanisms

They [facility managers and quality assurance officials] are not investigating the factors that lead to the complaint. We say look at the larger issues but this is not happening. They ask, “With each complaint must I have an improvement plan?” They do not understand the full purpose of investigating complaints.

—P. Khumalo, quality assurance manager, NMM District Health Office, March 29, 2011

Effective health system accountability mechanisms have two main functions: redressing past grievances and correcting systemic failures. Effective individual complaint and redress mechanisms are a key element of accountability systems and contribute to the fulfillment of both of these functions. Women seeking maternity care, and indeed all health care users, need accessible easily understood, and effective ways of lodging complaints about mistreatment suffered while accessing health services and of getting redress. This improves implementation as well as trust in health facilities.

Accountability is sometimes narrowly understood as blame or punishment of individual health workers. While individual responsibility is important in appropriate cases, the ultimate goal of accountability mechanisms is to identify where health systems as a whole are working well and where they are not so that they can be adjusted.¹¹¹ Accountability mechanisms are important for ensuring that the right to the highest attainable standard of health is being progressively realized for all, including disadvantaged individuals, communities, and populations.¹¹²

If the South African health system were able to deliver the care it is mandated and obligated to deliver, much of the suffering documented in this report could be mitigated. However, not only does the state fail to deliver care, it also fails to provide oversight and accountability for abusive personnel and systemic failures. In fact, effective health system accountability promotes fiscal responsibility as it would enable constant monitoring and review of health interventions to ensure the most effective use of resources.

¹¹¹ Human Rights Council, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, A/HRC/7/11, January 31, 2008, para. 99.

¹¹² Ibid.

Eastern Cape’s patients’ complaint mechanism is one of the provincial government’s main tools for identifying problems in the delivery of care, and correcting them. The system, however, is ineffective, exacerbating an already serious maternal health problem. The sections below describe a range of problems women confronted when considering making—or when making—complaints about mistreatment in Eastern Cape health facilities.

Poor Awareness of Rights and Complaints Procedures

The first problem is that there are few mechanisms for informing health care users of their rights and the process for lodging complaints. Instead facilities leave this almost entirely to nurses who often are overworked and have little time to give patients this information, and are often unfamiliar with the objectives and procedures for complaints. Most facilities Human Rights Watch visited had posters on walls describing patients’ rights, but this is not sufficient considering that some are not posted in strategic places where patients can see them, some health users are illiterate, or may not have time to read the posters as they are confront the often long queues.

Low awareness of rights and complaints mechanisms deters health care users from lodging complaints about poor treatment by health staff. For example, Thuliswa C., a relative to Busisiwe W., a deceased HIV positive woman, said she did not complain about the nurses who she felt had provided substandard care to her sister, because she did not know the complaint procedures at the facility. After laboring for close to 36 hours and having been refused admission twice because she was not in active labor according to the nurses examining her at a community health center, Busisiwe W. delivered a baby boy on a Saturday morning in May 2009. She was discharged six hours later, although, according to Thuliswa, “She was looking very weak as she had been sickly before delivery.” On Monday, Busisiwe’s health deteriorated and she was returned to the community health center where she was given treatment and sent home. Thuliswa remarked, “I thought they would refer her to [the general hospital for specialized care] because she was looking very bad, but they just told us to go back home.” Busisiwe died the following day at the general hospital. “I felt the nurses were careless with my sister because they knew she was [HIV] positive and sick, yet they did not act quickly to save her.... I did not complain because I did not where to go,”¹¹³Thuliswa told Human Rights Watch.

¹¹³ Human Rights Watch interview with Thandiswa C., O.R. Tambo district, November 17, 2010.

Babalwa L.'s Story

Babalwa's private doctor had referred her to the Dora Nginza public district hospital for obstetric care because she had serious asthma. But when she went into labor in June 2010 and went to the hospital, health staff did not examine her for about an hour and a half. When a nurse finally examined her, Babalwa said, "The sister said I was lying about being in labor and sent me to the waiting area." She told the nurse she was worried because a previous scan had shown the baby was in breach position, but the nurse ignored her. A doctor examined her three hours later, but it was too late. She delivered a stillborn baby. Neither the doctor nor the nurse explained what may have caused the stillbirth. Babalwa said, "The doctor came to me while the baby was by my side and asked, 'Sissy [sister], did you know that the baby was dead?' I asked him how I was supposed to know that. I said I was feeling the movements and for me that meant the baby was well. He said the baby must have been dead for about three or four days in me. Then that was the end."

Babalwa told Human Rights Watch that she would like to make a formal complaint with the hospital, but did not know how:

I was not blaming them because the baby was dead, but I was unhappy about the way I was treated; being told that I was lying about being in labor pain, and being delayed. What is still paining me most is that I don't know what happened. I don't know what killed my baby. I did not ask any questions because I was waiting for them to give me the report, but they did not. I did not complain to the hospital. I wanted to make an appointment with another private doctor to ask him how doctors and nurses are supposed to treat someone if something like this happens, but I didn't. I did not know where to go to ask these questions at the hospital. They say the patient has rights but when you are there [in the hospital] you don't feel it. People don't know their rights. You don't know what questions to ask, or who to ask. You want to complain but you don't know where or whom to complain. You feel powerless.

—Babalwa L., Port Elizabeth, November 13, 2010.¹¹⁴

¹¹⁴ When Human Rights Watch raised Babalwa L.'s case with Dr. P.L. Gaul during an interview with her, she told us that the hospital offers grief counseling to all women who lose their babies. Babalwa confirmed that she had received grief counseling while at the hospital. She added that she would have wanted to complain about how she was treated so that an investigation could be done and those responsible held accountable; and to

If Thuliswa had filed a complaint, an investigation into this case could potentially highlight failures to refer patients to higher level facilities for specialized care, which in South Africa has been identified by NCCEMD as a huge contributor to maternal mortality.

The Eastern Cape Department of Health also has a 24-hour customer care call center (known as “Shared Contact Center”) that health users can contact to register complaints about unsatisfactory treatment in health facilities.¹¹⁵The province’s call center system is not known by women, and facilities do not display information about it.

Also, women said they either had no knowledge, or were too afraid, to make complaints directly with officers in charge of facilities due to fear of retaliation. None of the facilities visited by Human Rights Watch displayed information about how to make verbal complaints to officers in charge. There were no posters with the name and contact details of officers who can receive such complaints, and none had the forms for registering verbal complaints developed by provincial Department of Health.¹¹⁶A manager at a district hospital maternity tried to justify their failure to display this information claiming that, “Patients are very observant and will see who is senior and go to them to complain.”¹¹⁷

Nurses at two facilities showed Human Rights Watch a register for recording verbal complaints, although they were unsure whether the complaints were investigated and resolved. At one facility, the manager said they record verbal complaints in a register. However, when Human Rights Watch checked the register in March 2011, the last complaint entry was from January 28, 2011.¹¹⁸ No complaints were registered for two months, although the manager said earlier that they received many verbal complaints because they encouraged patients to complain this way. Some quality assurance officers and a district quality assurance manager also said she did not know that facilities should report verbal complaints.

In accordance with the National Health Act and the Eastern Cape Provincial Health Act, many health centers and clinics have “health committees” and hospitals have established

prevent such practices from recurring. Human Rights Watch interview with Dr. P.L Gaul, acting head, obstetrics and gynecology, Dora Nginza hospital, March 29, 2011.

¹¹⁵ ECDOH, Complaints Policy Guidelines, p. 13.

¹¹⁶ NDOH, National Core Standards for Health Establishments, p. 20.

¹¹⁷ Human Rights Watch interview with N.R. Manjcotuyula, operational manager, puerperium, Umtata General Hospital, March 23, 2011.

¹¹⁸ Human Rights Watch group interview with Mr. S. Mtshayi, facility manager, Z. Mrauzeli, operational manager, and Mrs. M. Zaka, quality assurance representative, Kwazakhele Community Health Center, March 29, 2011.

“boards.” While communities can air their grievances about the quality of care they receive through the health committees and boards, there are barriers to this happening. First, some facilities have not established health committees. In other cases, the committees or boards are not functional. Moreover, some committee members lack training and a good understanding of their role, according to the three committee representatives interviewed by Human Rights Watch.¹¹⁹ Many of the women interviewed said they were unaware of the health committees or boards and their functions.

Suggestion Boxes for Written Complaints

Suggestion boxes were present in all Eastern Cape health facilities visited by Human Rights Watch, and health staff and officials pointed to them as the main mechanism for patients to lodge complaints. The boxes were marked with the words, “compliment, criticize, and complain,” but in reality they were almost totally defunct. In some facilities, health workers admitted the boxes are rarely opened, and there are no sanctions for facilities that fail to do so. Some boxes lacked paper, pens, or both. There was no standard form for patients to fill in contact information to enable follow-up, just the occasional blank piece of paper, sometimes too small to explain the complaint in the detail needed in order to gather useful information for individual redress and to take systemic corrective action.

Some suggestion boxes are hidden from the view of patients, or in locations such as close to nurses’ stations that discourage their use, and no provision was made to assist illiterate patients or migrants who cannot write in English or IsiXhosa in submitting suggestions or complaints. Five managers said the reason their facilities do not open their suggestion boxes or do so irregularly was because they should do this together with the community health committee members as required by provincial complaints policy, and the committee was inactive, unavailable, or never formed.¹²⁰

Failure to Respond to Complaints and to Provide Redress

Provincial and national laws recognize that patients have a right to a remedy if they experience abuse or mistreatment whilst in health facilities. Providing individual redress can help build women’s trust in the health care system and increase utilization of maternity services. Failure to do so can also discourage women from complaining, rendering the complaint mechanism useless.

¹¹⁹ Human Rights Watch did not interview any hospital board members. However, we asked managers and other health workers at the four hospitals visited if the facility had a functional board.

¹²⁰ ECDOH, “Complaints Policy Guidelines,” p. 8.

In cases where health care users complain about individual health staff members, managers told Human Rights Watch that the health workers are asked to apologize to the complainant. But patients who manage to lodge verbal or written complaints in Eastern Cape health facilities do not always get redress. For example, Nobantu M. made a written complaint in July 2009 about nurses abusing her in a health clinic, but as of November 2010, the clinic had not been in contact with her. She told Human Rights Watch:

Last year [2009], I wrote a complaint because the nurses were not treating us in a good way. If they don't know you they shout at you and don't give you medication. But if they do, they are nice to you and they will treat you. I wrote the complaint because this is discrimination. I even put down my name and telephone number. But up to today, the clinic has not called me to say if they saw my complaint, and if this practice would change.

In another case, a community care giver said she made a written complaint in 2008 on behalf of a woman who gave birth on the street just meters from a clinic after nurses had turned her away. As of November 2010, the clinic had not responded. She said:

There was this lady who was in labor. She went to the clinic and they sent her back saying she had come early. She returned home, but went back to the clinic after a few hours. Again, she was told she was still far and told to go home. She gave birth about 100 meters from the clinic. I heard people shouting that a lady has given birth by the roadside. We were very bitter. I wrote to the clinic to say they don't care about women. I have never got a response to this day. It is like they are telling you not to complain. So why complain?¹²¹

Another woman told Human Rights Watch: "Last year [2009] we [care givers] verbally complained about the receptionist [at a health clinic]. She is rude and she speaks to everybody in Afrikaans even when they don't understand. As a result people were not getting treatment in time because they did not know where to go for help. But she is still there behaving the same way. So sissy [sister], why should we complain?"¹²² She said the clinic never responded to the complaint.

¹²¹ Human Rights Watch interview with Nolundi H., Amatole district, November 18, 2010.

¹²² Human Rights Watch interview with Vuyokazi L., NMM district, November 10, 2010.

Lack of Quality Assurance Officers and Training

Few health facilities have quality assurance officers dedicated to handling patients' complaints. Instead, many facilities have appointed nurses to act as quality assurance officers but they also have to perform their clinical duties, and this affects their ability to address complaints. For example, one manager said, "Because we have a lot of work, we do not open the suggestion boxes. Instead we focus on looking after patients."¹²³ While the province emphasizes that dealing with complaints is part of providing care for patients, it is unreasonable to expect that complaints boxes will be opened several times weekly as suggested in the provincial complaints policy, that complaints will be addressed in a timely manner, or that a detailed analysis that generates useful information to make systemic changes will be done when there are no dedicated officers to do this.

Failure to Address Root Causes of Complaints

A major weakness of Eastern Cape's patient complaint system is the health authorities' failure to address problems that give rise to complaints, and which contribute to poor quality maternity care.¹²⁴ Eastern Cape's complaint procedures therefore fail to meet one of the key objectives of accountability mechanisms: ensuring non-recurrence of systemic failures and gaps, as well as promoting interventions at the most adequate level.

Some of the reasons for this are that quality assurance officials view their role as exclusively investigating and responding to individual cases, not assessing patterns of problems or needs for systemic changes as required by the provincial complaints policy, and others said they had too much work. Several facility quality assurance officers said they felt they had no role in discussing systemic problems with facility management. For example, a quality assurance representative in Amatole district said, "I just collate data. I do not make recommendations for what should be done. The district wants to know if we are resolving cases."¹²⁵ Another facility quality assurance manager in the same district told

¹²³ Human Rights Watch interview with Bridget Plaatjies, operational manager, Kwazakhele Community Health Center maternity unit, Port Elizabeth, March 29, 2011.

¹²⁴ A 2009 ministerial report looking into the performance of provincial health departments concluded that accountability mechanisms are weak in the Eastern Cape and notes that monitoring and evaluation is inadequate: "Although much time and resources are invested in data collection these data are not analysed, interpreted or used for decision making and there is little or no feedback of information from one level to the next.... An appropriate climate of mutual responsibility (rather than blame) is required for successful implementation of an effective M&E programme." Peter Baron et al., "Eastern Cape Department of Health Report of the Integrated Support Team," May 2009, www.health-e.org.za/uploaded/84ef7285011a0b32a33b3638dd0370c.pdf (accessed June 4, 2011), p. 11.

¹²⁵ Human Rights Watch with a former quality assurance representative (who requested anonymity), location details withheld, March 31, 2011.

Human Rights Watch, “I don’t do trend analysis of the complaints received. I am unable to do it due to work overload.”¹²⁶

A district quality assurance manager confirmed that their main focus is on resolving individual complaints, not analyzing patterns or suggesting systemic reforms, “We look at which cases they [facilities] have resolved or not and why. If we need to intervene in resolving a case then we do. The only feedback given to hospitals is about unresolved cases. The following month, I again check if the outstanding cases have been resolved.”¹²⁷ When Human Rights Watch queried if she is aware of what the major patients’ complaints in the district were, she responded, “Sometimes if we see a recurring problem we try to find out what is the cause. But we do not do trend analysis.”¹²⁸

Also, although facilities submit complaint reports to district officials and districts report to provincial officials, the higher offices do not provide feedback on complaint patterns, or address challenges leading to complaints. The primary focus is on the resolution of individual cases. There is little analysis of patterns of problems, and to use this information to make changes. One health facility manager in NMM district told Human Rights Watch:

We get little in terms of feedback. The issues that they should really be addressing are referred to the province, and we are kept hanging. For example, we have a serious problem of space. This facility was established in 1974, and the capacity then was 500 patients per month. The space is still the same, but now we see between 8,000 and 10,000 clients in a month. How can there not be complaints?.... So, to answer your question, we get feedback, but it is not feedback that can help us solve the root cause of our problems.¹²⁹

Because Eastern Cape’s patient complaint procedures are not addressing larger problems that affect health care delivery in the province, and instead focus more on individual abuses by health staff, some health workers are resentful of the system and see it as

¹²⁶ Human Rights Watch interview with L. Magaga, quality assurance manager, East London Hospital Complex, April 1, 2011.

¹²⁷ Human Rights Watch interview with N. Msenga, assistant director, quality assurance, O.R. Tambo District Health Office, March 24, 2011.

¹²⁸ Ibid.

¹²⁹ Human Rights Watch interview with, S. Mtshayi, facility manager; Kwazakhele Community Health Center, March 29, 2011.

intended primarily to identify performance problems that could lead to discipline. A quality assurance manager at NMM district health office told Human Rights Watch, “I am having problems with reporting of complaints. Many of my facility managers fear to report complaints because they think it is a bad reflection on their performance. I have held a workshop with managers to help remove this fear. I wanted them to understand that reporting complaints is about improving services. But we still have a long way to go.”¹³⁰ A quality assurance officer at the East London hospital complex made a similar comment, “People are afraid to report complaints. A high number of complaints for them mean poor performance.”¹³¹

The Need for an Emergency Helpline

In addition to strengthening complaints mechanisms, Eastern Cape authorities should develop an emergency response system which promptly intervenes when they learn that a pregnant woman is facing barriers to care, for example due to discrimination, negative attitudes, poor communication, lack of emergency transport, or such other factors. Such an emergency helpline should be under the control of district authorities. Eastern Cape has a 24-hour call center, but it should establish these services at the district level to ensure timely interventions.

The Ombudsperson’s Office

South Africa’s National Health Act (NHA) of 2003 requires the director general for health to establish the Office of Standards Compliance, which must develop, ensure, and monitor implementation of quality standards for the health sector. It also requires that provinces establish Inspectorates for Health Establishments, which monitor and evaluate compliance with the NHA.¹³² However, these bodies in their current form lack the capacity to carry out these functions because they are not fully established, and because, until recently, there were no national standards against which compliance could be measured¹³³ Besides, there is no overarching institution where quality of care, including monitoring management of patients’ complaints and ensuring compliance with ethical standards in both public and private sectors is considered, and national efforts coordinated. But in

¹³⁰ Human Rights Watch interview with P. Khumalo, quality assurance manager, NMM District Health Office, March 29, 2011.

¹³¹ Human Rights Watch interview with L. Magaga, quality assurance manager, East London hospital complex, April 1, 2011.

¹³² NHA, arts. 77–79.

¹³³ Human Rights Watch interview with Dr. Louis Claassens, director, Quality Assurance Directorate, National Department of Health, Pretoria, April 6, 2011.

January 2011, the Minister of Health published a bill to address these shortcomings. The bill, the National Health Amendment Act 2011, would establish an Office of Health Standards Compliance and ombudsperson to ensure that “complaints from health care users are investigated properly and dealt through an independent mechanism, and to facilitate compliance by health care providers, health establishments, health facilities and health workers with the norms and standards of the national health system.”¹³⁴ At the time of writing, the Bill has not been introduced to parliament for discussion.

¹³⁴ NDOH, National Health Amendment Act 2011, Government Gazette vol. 547, no. 33962, January 24, 2011, <http://www.doh.gov.za/docs/bills/health11.pdf> (accessed May 25, 2011), art. 2. In a submission to the DOH in April 2011, Human Rights Watch raised concerns about the independence of this body, and made recommendations on functions and essential features that should be incorporated into the role of the proposed ombudsperson for health, in order to ensure effective execution of its mandate.

IV. International Human Rights and South African Legal Framework

Accountability Mechanisms in the South African Health Care System

The South African government recognizes, at least on paper, the importance of an effective system for handling complaints from patients and other health care users. Accountability underlies the “quality assurance” mechanisms called for in the Department of Health’s “Service Delivery” agreement,¹³⁵ the National Health Act,¹³⁶ the Policy on Quality Health Care for South Africa,¹³⁷ the National Core Standards for Health Establishments in South Africa,¹³⁸ and the national Department of Health’s “Fast Track to Quality: The Six Most Critical Areas for Patient-Centered Care.”¹³⁹ The principle of accountability is also at the heart of the Patients’ Rights Charter (PRC) and the Batho Pele (“people first”) Principles (BPP), as well as the constitutional guarantee of the right to health.¹⁴⁰ Moreover, it is embedded in Eastern Cape provincial health policies.¹⁴¹

¹³⁵ NDOH, “Negotiated Service Delivery Agreement,” pp. 17 and 26.

¹³⁶ National Health Act No. 16 of 2003, arts. 18 (1-4).

¹³⁷ NDOH, “A Policy on Quality Health Care for South Africa,” 2000, <ftp://ftp.hst.org.za/pubs/govdocs/policy/qualcare.pdf> (accessed May 25, 2011), p. 41. The policy addresses ways of improving the quality of care in both public and private facilities, such as the need for facilities to establish hospital boards and clinic/community health center committees and for provincial departments of health to develop and implement complaints procedures.

¹³⁸ NDOH, “National Core Standards for Health Establishments in South Africa,” 2011, http://www.doh.gov.za/docs/tenders/NCS%20for%20Health%20FINAL_1.pdf (accessed May 25, 2011), p. 11. The objective of the National Core Standards for Health Establishments is to provide a common definition of quality care which should be found in all health establishments in South Africa. They are divided into seven domains. The “patients’ rights” domain, which addresses complaints, “sets out what a hospital or clinic must do to make sure that patients are respected and their rights upheld, including getting access to needed care and to respectful, informed and dignified attention in an acceptable and hygienic environment, seen from the point of view of the patient, in accordance with Batho Pele principles and the Patient Rights Charter.”

¹³⁹ NDOH, “Fast Track to Quality: The Six Most Critical Areas for Patient-Centered Care,” 2011, <http://www.doh.gov.za/docs/tenders/FAST%20TRACK1.pdf> (accessed May 25, 2011), pp. 4 and 5. In this document, the Department of Health identifies six critical areas that are fundamental to the provision of quality health care, but which are performing poorly: caring staff and the feeling of being cared for (which talks about uncaring and rude attitudes by health workers), cleanliness of facilities, waiting times to receive care, safety from accidental harm or medical errors, the risk of being infected in hospital, and shortage of medicines.

¹⁴⁰ National Department of Health, “Patients’ Rights Charter,” 1997, <http://www.doh.gov.za/docs/pamphlets/patientsright/chartere.html> (accessed March 12, 2011); Department of Public Service and Administration, “Batho Pele Principles,” undated, <http://www.dpsa.gov.za/batho-pele/Principles.asp> (accessed May 25, 2011), and Constitution of the Republic of South Africa, 1996 (taking effect February 1997).

¹⁴¹ For example see, Eastern Cape Provincial Health Act No. 10 of 1999 (Eastern Cape PHA), arts. 19 and 20; and the provincial Complaints Policy Guidelines. Eastern Cape Department of Health (ECDOH), “Complaints Policy Guidelines,” 2008.

The National Core Standards for Health Establishments set two standards regarding patients' complaints: one is that "Patients who wish to complain about poor service are helped to do so and their concerns are properly addressed," and the second, that "Complaints are used to improve service delivery."

On the former, the National Core Standards require facilities to have clear procedures for dealing with complaints and to inform patients about the complaints procedure. On the latter, all complaints should be recorded using a formal procedure, screened to ensure adverse events are identified and appropriately managed, and addressed within nationally agreed timeframes.¹⁴²

South Africa's Constitution and National Health Act

The South African Constitution provides for the right to access health care for "everyone" in South Africa,¹⁴³ and also provides for the right to a remedy for disputes.¹⁴⁴ The National Health Act (NHA) of 2003 establishes national standards for handling complaints by health users, and mandates provincial health departments to establish concrete complaint procedures.

Article 18 of the NHA states that all complaints must be investigated and that complaints procedures must be: a) displayed by all health establishments in a manner that is visible for any person entering the establishment; b) communicated to users on a regular basis; c) include provisions for the acceptance and acknowledgment of every complaint directed to a health establishment; d) allow for referral of complaints.¹⁴⁵

To strengthen community participation in health decision-making and accountability of health facilities, the NHA also requires provinces to establish clinic or health center committees and hospital boards and to establish their functions. It states that such committees must at least include: a) one or more local government councilors, b) one or more members of the community served by the health facility, and c) the head of the clinic or health center in question.¹⁴⁶ These committees and boards are supposed to play a role in

¹⁴² NDOH, "National Core Standards for Health Establishments in South Africa," p. 20.

¹⁴³ Constitution of the Republic of South Africa, art.27 (1a and 2).

¹⁴⁴ Ibid., art. 34, which provides, "Everyone has the right to have any dispute that can be resolved by the application of law decided in a fair public hearing before a court or, where appropriate, another independent and impartial tribunal or forum."

¹⁴⁵ NHA, art. 18 (3 and 4).

¹⁴⁶ NHA, arts. 41 and 42. Hospital boards—primarily for hospitals—must include: a representative from the provincial department, not more than three representatives of the communities served by the hospital, and not

addressing patients' complaints in two ways: by lodging complaints with facility authorities on behalf of patients, and ensuring that patient complaints are investigated and resolved.

Patients' Rights Charter and Batho Pele Principles

The South African Patients' Rights Charter and the Batho Pele ("people first") Principles also embody the principle of accountability, and the National Department of Health requires that both be displayed in health facilities.

The Patients' Rights Charter is effectively a "patients' bill of rights" in South Africa. One of its 12 patients' rights is "to complain about health care services and to have such complaints investigated and to receive a full response on such investigation."¹⁴⁷ The National Department of Health says of the charter:

The purpose and expected outcome of the patients' rights charter and complaints procedure is to deal effectively with complaints and rectify service delivery problems and so improve the quality of care, raise awareness of rights and responsibilities, raise expectations and empowerment of users, change attitudes by strengthening the relationship between providers and users, improve the use of services and develop a mechanism for enforcing and measuring the quality of health services.¹⁴⁸

The Batho Pele Principles, while not exclusive to the health system, are intended to guide health policy and all public services in South Africa. They were developed to address citizen's negative perceptions of public service provision.¹⁴⁹ The Batho Pele principle on "redress" provides:

more than five representatives of staff and management of the hospital (who may not vote at board meetings). Clinic or community health center committees must include: one or more local government councilors, one or more members of the community served by the health facility, and the head of the clinic or health center in question.

¹⁴⁷ NDOH, "Patients' Rights Charter." Other rights included in the Patients' Rights Charter include the right to: a healthy and safe environment, participation in decision-making, access to health care, have knowledge of one's health insurance/medical aid scheme, choice of health services, be treated by a named health care provider, confidentiality and privacy, informed consent, refusal of treatment, be referred for a second opinion, and continuity of care.

¹⁴⁸ NDOH, "Patients' Rights Charter: Standards," undated, <http://www.doh.gov.za/docs/policy/norms/part1b.html> (accessed September 22, 2010).

¹⁴⁹ Department of Public Service and Administration, "Principles," undated, <http://www.dpsa.gov.za/batho-pele/Principles.asp> (accessed June 3, 2011).

This principle emphasises a need to identify quickly and accurately when services are falling below the promised standard and to have procedures in place to remedy the situation. This should be done at the individual transactional level with the public, as well as at the organisational level, in relation to the entire service delivery programme. Public servants are encouraged to welcome complaints as an opportunity to improve service, and to deal with complaints so that weaknesses can be remedied quickly for the good of the citizen.¹⁵⁰

Accountability Policies in the Eastern Cape Health System

Eastern Cape laws and policies on health system accountability are essentially in line with national policies and guidelines. They are set out in the Eastern Cape Provincial Health Act (PHA) No. 10 of 1999, the Complaints Policy Guidelines,¹⁵¹ and the Policy Framework for the Establishment and Functioning of Hospital Boards.¹⁵²

Article 19 of the Provincial Health Act deals with complaints procedures, and sets out timeframes for investigations.¹⁵³ The PHA recognizes health care users' rights to pursue any legal remedies available under South Africa criminal and civil law in case their right to access health care is breached by the provincial health system.¹⁵⁴ It also requires the province to define the terms of reference for community health center or clinic committees and hospital boards.¹⁵⁵

The Eastern Cape Department of Health's Complaints Policy Guidelines provide a standard for addressing patients' complaints within all health facilities in the province. It states that all complaints procedures should include the following elements: a) availability of an

¹⁵⁰ Ibid.

¹⁵¹ ECDOH, "Complaints Policy Guidelines."

¹⁵² ECDOH, "Policy Framework for the Establishment and Functioning of Hospital Boards," May 2006, <http://www.ecdoh.gov.za/uploads/files/270509144646.pdf> (accessed May 10, 2011), pp. 5 and 7. The policy sets forth procedures for the establishment and functioning of hospital boards. The functions of the hospital boards are to ensure that: "the institutional management meets its obligations in terms of pursuing the provincial strategic plans," and "hospitals render quality health care services to community in line with Batho Pele principles of service delivery." According to the policy, "hospitals boards should provide a forum to hear the grievances of patients and the public at large, and monitor the investigation and resolution of complaints, take an active interest in the welfare of patients and the development of an ethos of caring at all levels in the hospitals, [and] sensitize the community about the presence of the hospital board."

¹⁵³ Eastern Cape PHA, art. 19 (2).

¹⁵⁴ Ibid., art. 19 (4).

¹⁵⁵ Ibid., arts. 34 (a), (b), and (11).

office at institutional (facility) level for the public to lay complaints; b) availability of an officer at institutional level to receive complaints; c) information to the public on how to lay a complaint by means of step by step poster; d) formal ways of receiving, recording, investigating, and responding to complaints; e) methods for collating, analyzing and providing feedback on complaints.¹⁵⁶

In addition, it requires that, “All complainants should be informed that, in the event they are not satisfied with the response [of investigation by the facility], they may appeal through the Chief Director [quality assurance], the Head of [provincial health] Department or follow the provisions of Section 19 of the Eastern Cape Provincial Health Act No 10 of 1999.”¹⁵⁷

The Complaints Policy Guidelines also provide a step-by-step guide on handling of patients’ complaints. It sets out timeframes for doing this. For example, health facilities should: a) acknowledge a complaint within three working days of receipt; b) commence investigation within five days of receipt; and c) complete the investigation within 25 working days for complaints involving an adverse effect such as death or injury and fraud and within 12 days for other complaints, and communicate with the patient in case of delay. The guidelines allow patients 30 days to appeal the health facility’s decision.¹⁵⁸ In terms of remedial action, the policy requires the investigating authority to consider “what action is required to deal with the matter and prevent a recurrence of similar events,” such as taking disciplinary action against a staff member, training personnel, recommending introduction of changes to systems, purchase of equipment, environmental changes, and policy and procedural changes.¹⁵⁹

International Law

The South African government has obligations under international and regional legal standards to ensure that all human rights are fulfilled, including the rights to health, to life, to a remedy, to be free from cruel and inhuman and degrading treatment, and to nondiscrimination. South Africa’s Constitution requires that international law must be taken into account when interpreting domestic legislation. South Africa’s international and regional law obligations are also binding on sub-national, provincial authorities, including those in Eastern Cape.

¹⁵⁶ ECDOH, Complaints Policy Guidelines, p. 9. The step by step guide describes actions at each stage of handling complaints, but it does not include timeframes. Ibid., p. 11.

¹⁵⁷ Ibid., p. 12.

¹⁵⁸ Ibid., pp. 10 and 11.

¹⁵⁹ Ibid., p. 13.

South Africa is a party to many international and regional human rights treaties relevant to health care and access to remedies. At the international level, South Africa has ratified the International Covenant on Civil and Political Rights (ICCPR), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Convention on the Rights of the Child (CRC). At the regional level, it has ratified the African Charter on Human and Peoples' Rights (African Charter), the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol), and the African Charter on the Rights and Welfare of the Child.¹⁶⁰ It has signed but not ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR). As a signatory, South Africa undertakes not to undermine the object and purpose of the treaty.¹⁶¹

The Right to Life

International and regional guarantees of the right to life require states to take measures to protect individuals from arbitrary and preventable loss of life, and have recognized the obligation of states to protect women's right to life in the context of pregnancy and childbirth.

Article 6 of the ICCPR sets out that everyone "has the inherent right to life," which shall be protected by law. It guarantees that no one shall be arbitrarily deprived of life. The UN Human Rights Committee which oversees the implementation of the ICCPR has advised states that the right to life should not be considered in a restrictive manner but requires states to adopt a range of positive measures to protect deprivation of life.¹⁶² The Human

¹⁶⁰ International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc A/6316 (1966) 999 U.N.T.S. 171, entered into force March 23, 1976, ratified South Africa December 10, 1998; Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted December 18, 1979, G.A. Res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46, entered into force September 3, 1981, ratified by South Africa December 15, 1998; Convention on the Rights of the Child (CRC), adopted November 20, 1989, G.A. Res. 44/25, annex, 44 U.N. GAOR Supp. (No 49) at 167, U.N. Doc. A/44/49 (1989), entered into force September 2, 1990, ratified by South Africa June 19, 1995; International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16), U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force January 3, 1976, signed by South Africa October 3, 1994; African [Banjul] Charter on Human and Peoples' Rights, adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 L.M. 58 (1982), entered into force October 21, 1986, ratified by South Africa June 9, 1996; Protocol to the African Charter on Human and Peoples' Rights on The Rights of Women in Africa (the Maputo Protocol), adopted July 11, 2003, entered into force November 2005, ratified by South Africa December 17, 2004; the African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.9/49 (1990), entered into force Nov. 29, 1999, ratified by South Africa on January 7, 2000.

¹⁶¹ Vienna Convention on the Law of Treaties 1969, United Nations, Treaty Series, vol. 1155, p. 331, entered into force on January 27, 1980, art. 18.

¹⁶² ICCPR General Comment 6, The right to life (Article 6), UN ESCOR Human Rights Commission, 16th Session, UN Doc HRI/GEN/1/Rev. 1 (1994) para.5.

Rights Committee has specifically said that when reporting on the right to life protected by article 6, states “ought to provide data on birth rates and on pregnancy and childbirth-related deaths of women.... States parties should give information on any measures taken by the state to help women prevent unwanted pregnancies, and to ensure that they do not have to undergo life-threatening clandestine abortions.”¹⁶³ In the context of preventable maternal mortality and morbidity, the Committee has said that where there is a high maternal mortality, in order to protect the right to life, the state should “[ensure] the accessibility of health services including emergency obstetric care ... ensure that its health workers receive adequate training ... [and] help women avoid unwanted pregnancies ... by strengthening its family planning and sex education programmes.”¹⁶⁴ The African Commission on Human and Peoples’ Rights also characterizes preventable maternal mortality as a violation of women’s right to life.¹⁶⁵

By failing to take appropriate measures and to exercise due diligence to prevent, investigate, or redress harms that may lead to loss of life, the national South African and provincial Eastern Cape are not fulfilling their obligations under international and regional law to protect the right to life.

The Right to Health

Treaties that South Africa has ratified or signed require that it fulfills the right to the highest attainable standard of health on a nondiscriminatory basis. Several treaties and authoritative interpretations specifically note that reducing maternal mortality rates and improving maternal health services should be considered right to health priorities. For example, CEDAW provides that governments “shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period,”¹⁶⁶ and the Maputo Protocol provides that states must take appropriate measures to “establish and

¹⁶³ ICCPR General Comment No. 28: Equality of rights between men and women (article 3) CCPR/C/21/Rev.1/Add.10, para. 10.

¹⁶⁴ Concluding Observations of the Human Rights Committee: Mali, 04/16/2003, CCPR/CO/77/MLI, para. 14. Also see the Resolution on Maternal Mortality in Africa which states that “preventable maternal mortality in Africa is a violation of women’s right to life ...enshrined in the African Charter on Human and Peoples’ Rights and the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa.” African Commission on Human and Peoples’ Rights, Resolution on Maternal Mortality in Africa, ACHPR/Res.135 (XXXXVIII).08, http://www.achpr.org/english/resolutions/resolution135_en.htm (accessed February 16, 2011).

¹⁶⁵ It states: “preventable maternal mortality in Africa is a violation of women’s right to life ...enshrined in the African Charter on Human and Peoples’ Rights and the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa.” African Commission on Human and Peoples’ Rights, Resolution on Maternal Mortality in Africa, ACHPR/Res.135 (XXXXVIII).08, http://www.achpr.org/english/resolutions/resolution135_en.htm (accessed February 16, 2011).

¹⁶⁶ CEDAW art. 12(2).

strengthen existing pre-natal, delivery and post-natal health and nutritional services” and to provide adequate health information.¹⁶⁷

The scope and content of the guarantee in the ICESCR of the highest attainable standard of health was set out by the Committee on Economic, Social and Cultural Rights, which oversees implementation of the treaty by states parties, in its General Comment 14. That comment specifically notes that the failure to reduce maternal mortality rates may constitute a failure of a government to fulfill the right to health.¹⁶⁸ The comment also notes that ensuring “reproductive, maternal (pre-natal as well as post-natal) and child health care” is of comparable priority to the treaty’s core obligations,¹⁶⁹ and calls lowering maternal mortality a “major goal” for governments.¹⁷⁰ The Committee on the Elimination of Discrimination against Women in its recent concluding observations on South Africa expressed concern over the high levels of maternal mortality rates.¹⁷¹

In terms of the application of the right to health to non-citizens, such as the migrants Human Rights Watch interviewed who sought maternity care in South Africa, the UN Committee on Economic, Social and Cultural Rights has stated that asylum seekers and even undocumented migrants should enjoy the right to health.¹⁷²

South Africa’s increasing maternal mortality ratio and the problems of abuse, substandard care, failures of information and consent, and discrimination experienced by migrant women in health facilities described in the preceding chapters are evidence that South Africa is failing to meet its obligations required by international and regional guarantees of the right to health.

The Right to a Remedy

Regional and international treaties, including those ratified by South Africa, establish the basic right of individuals to an effective remedy when their human rights have been violated. The ICCPR provides that governments must ensure that any person whose rights

¹⁶⁷ Maputo Protocol, art. 14(2).

¹⁶⁸ UN Committee on Economic, Social and Cultural Rights, “Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights,” General Comment No. 14, The Right to the Highest Attainable Standard of Health, E/C.12/2000/4 (2000), para. 52.

¹⁶⁹ *Ibid.*, para. 44.

¹⁷⁰ *Ibid.*, para. 21.

¹⁷¹ Committee on the Elimination of Discrimination against Women, Concluding Observations of the Committee on the Elimination of Discrimination against Women on South Africa, April 5, 2011, CEDAW/C/ZAF/CO/4, para. 35.

¹⁷² CESCR, General Comment No. 14, para. 34.

under the Covenant are violated “shall have an effective remedy,” and that any person claiming a remedy “shall have his right thereto determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State.”¹⁷³ The African Charter includes the right of an individual “to have his cause heard” when fundamental rights are violated.¹⁷⁴ Likewise, the Maputo Protocol requires that states “provide for appropriate remedies to any woman whose rights... have been violated... [and] ensure that such remedies are determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by law.”¹⁷⁵

In its General Recommendation on Women and Health adopted in 1999, the Committee on the Elimination of Discrimination against Women calls specifically for the enactment and enforcement of laws to provide sanctions for, among other things, discrimination and abuse of women and girls in health care settings, including by private persons and organizations.¹⁷⁶ The Committee on Economic, Social and Cultural Rights has recognized the rights of victims of violations of the right to health to access judicial or other remedies and adequate reparation in “the form of restitution, compensation, satisfaction or guarantees of non-repetition.”¹⁷⁷ The Human Rights Committee, which monitors implementation of the ICCPR, establishes that the duty to provide an effective remedy to victims of human rights violations, whether at the hands of public officials or private individuals, includes the obligation to “exercise due diligence to prevent, punish, investigate, or redress the harm caused by such acts.”¹⁷⁸ The Committee emphasized that states must ensure “accessible and effective remedies” for human rights violations and to take into account “the special vulnerability of certain categories of person,” further noting that “a failure by a State Party to investigate allegations of violations could in and of itself give rise to a separate breach of the Covenant.”¹⁷⁹

¹⁷³ ICCPR, art. 2.

¹⁷⁴ ACHPR, art. 7.

¹⁷⁵ Maputo Protocol, art. 25(a).

¹⁷⁶ CEDAW Committee, General Recommendation No. 24, Women and Health, A/54/38/Rev.1, chap. I (1999), <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24> (accessed June 5, 2011), para. 15 (a and c).

¹⁷⁷ CESCR, General Comment No. 14, para. 59.

¹⁷⁸ Human Rights Committee, General Comment 31, Nature of the General Legal Obligation on States Parties to the Covenant, U.N. Doc. CCPR/C/21/Rev.1/Add.13 (2004), para. 8.

¹⁷⁹ UN Human Rights Committee, General Comment 31: Nature of the General Legal Obligation on States Parties to the Covenant, U.N. Doc. CCPR/C/21/Rev.1/Add/13 (2004), para. 15.

The Eastern Cape Department of Health has invested resources into developing complaint mechanisms, but has not followed up to ensure that these mechanisms are working and that patients can access remedies. As a result, patients, including women seeking maternity care, face abuses and substandard care that put the health and lives of the women and their newborns at risk. Furthermore, existing mechanisms for redress in Eastern Cape are largely focused on individual faults, rather than institutional and systemic factors, and are therefore inadequate to provide appropriate accountability in the context of maternal mortality, where underlying causes are generally systemic.

The failure to ensure that health facilities have effective complaint procedures, that patients know about them, complaints are investigated, and appropriate remedies are provided is a violation of the right to redress. It also leads to a lack of accountability and undermines trust in the public health system, as well as government's objective to reduce maternal deaths.

The Right to be Free from Cruel, Inhuman, or Degrading Treatment

South Africa has an obligation under the ICCPR,¹⁸⁰ the African Charter,¹⁸¹ the Maputo Protocol,¹⁸² the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,¹⁸³ and other treaties to ensure that no one is subject to cruel, inhuman, or degrading treatment, including women seeking maternity care.

The UN Human Rights Committee has stated that the ICCPR prohibition on cruel, inhuman, or degrading treatment, does not apply only to physical treatment, but also to conduct that causes "mental suffering to the victim," and has stated that the article 7 applies to patients in "medical institutions."¹⁸⁴ This Committee also notes that apart from prohibiting

¹⁸⁰ICCPR art. 7 states: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation."

¹⁸¹African Charter, art. 5.

¹⁸²Maputo Protocol, art. 4.

¹⁸³Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted December 10, 1984, G.A. res. 39/46, annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984), entered into force June 26, 1987, ratified by South Africa in 1998. Article 16 of the convention provides: "Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article I, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity."

¹⁸⁴UN Human Rights Committee, "General Comment 20, Article 7 (Forty-fourth session, 1992)," U.N. Doc. HRI/GEN/1/Rev.1 art.30 (1994). Also see CCPR General Comment 20, para. 5.

cruel, inhuman, or degrading treatment, the right also creates a positive obligation for states to protect persons in their jurisdiction from such treatment.¹⁸⁵

In its General Comment 2, the UN Committee on Torture provides that “each state party should prohibit, prevent and redress torture and ill-treatment in all contexts of custody or control, for example, in ... hospitals....”¹⁸⁶ The UN special rapporteur on torture and other cruel, inhuman or degrading treatment or punishment suggests that cruel, inhuman, or degrading treatment is distinguished from torture in that it may occur out of intentional and negligent actions,¹⁸⁷ and that it covers “treatment as deliberately caus[ing] severe suffering, mental or physical, which in the particular situation is unjustifiable.”¹⁸⁸

The verbal and physical abuse, denial of care, neglect and delays, and some cases of treatment without informed consent that patients experienced in Eastern Cape public health facilities, sometimes for extended periods of time (especially during the particularly vulnerable periods immediately before, during, and after childbirth when women are under the control of health facilities) can amount to cruel, inhuman, or degrading treatment. In this case, government officials at the national, provincial, and district levels and health staff have indicated to Human Rights Watch, and it is evidenced by analysis in government policies and reports, that the South African government should be and is, aware of the extent and level of abuses and suffering caused.

¹⁸⁵ *Ibid.*, para. 8.

¹⁸⁶ UN Committee against Torture, “General Comment 2, Implementation of article 2 by States parties,” CAT/C/GC/2, January 2008, <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G08/402/62/PDF/G0840262.pdf?OpenElement> (accessed June 1, 2011), para. 15.

¹⁸⁷ Manfred Nowak and Elizabeth McArthur, *The United Nations Convention Against Torture. A Commentary* (New York: Oxford University Press, 2008), p. 553.

¹⁸⁸ Manfred Nowak, “What Practices Constitute Torture?” *Human Rights Quarterly* 28 (2006), p. 821, quoting from A. Boulesbaa, *The UN Convention on Torture and the Prospects for Enforcement* (Martinus Nijhoff Publishers, 1999).

V. Recommendations

To the National Department of Health

- Revise through a transparent and participatory process the current maternal health monitoring indicators ensuring that they track adverse pregnancy outcomes and ensure that emergency obstetric care indicators are in accordance with “United Nations Process Indicators” for availability and utilization of obstetric services.
- Require all provinces to conduct needs assessments of emergency obstetric care through a transparent and participatory process, and ensure that indicators are disaggregated on a range of basis—such as education status, income, race, location, and age to eliminate discrimination as well as to ensure that vulnerable communities are benefiting from healthcare programs.
- Ensure the proposed office of ombudsperson for health has a monitoring role to ensure health facilities use patients’ complaints to address systemic problems that contribute to maternal mortality
- Include in the proposed initiative to expand the number and role of community care givers, community education on patients’ rights and complaint mechanisms, as well as monitoring of maternal deaths and morbidities in communities.
- Begin a transparent and participatory process of conducting and afterwards implementing a regular demographic and health survey.
- Appoint a full-time special officer to oversee the implementation of the recommendations of the Confidential Enquiries into Maternal Deaths reports.

To the National and Eastern Cape Departments of Health

- Ensure that investigations into patient complaints include the following essential features:
 - Examination not only of the conduct of individual or frontline health workers, but also of failings in oversight and management by health facility administrators and managers.
 - Responses to complaints that not only provide remedies to individual patients or take corrective action with individual health care providers but include systemic reforms to avoid similar problems reoccurring.
- Develop and implement national and provincial structures for regular feedback on patient complaints and their underlying causes. Such a structure should ensure the participation of nurses and other frontline health workers.

- Develop and implement a system for reviewing complaint mechanisms, on a regular basis, to ensure their effectiveness.
- Ensure that patients who are unsatisfied with responses to their complaints at health facilities know that they can access other avenues for pursuing a remedy, such as through courts, professional bodies, or the proposed ombudsperson for health.
- Consistently and forcefully condemn, at the highest level, physical, verbal, and other abuse of patients, including women seeking maternal health services.
- Sanction health workers who abuse patients, and in cases where the abuse constitutes a criminal offence, ensure that prosecutors pursue criminal penalties.
- Investigate allegations of health workers demanding bribes for services, and discipline or dismiss workers found to have solicited bribes.

To the Eastern Cape Department of Health

On Patients' Rights

- Develop and implement community outreach programs to educate health care users about patients' rights. Ensure that such programs reach poor, rural and illiterate women, as well migrants.
- Work with nongovernmental organizations and community representatives, (particularly those on health committees) on developing public service announcements explaining patients' rights and complaint mechanisms. Ensure that such announcements reach poor, rural, and illiterate populations, as well as marginalized groups such as migrants, in appropriate languages.
- Improve patient education on rights and complaint procedures at health facilities, for example by having audio or video recordings in all the official languages of the province that can be played to patients. In facilities that serve large populations of migrants, translate these messages into languages understood by migrant communities and hire interpreters to assist patients to navigate health care, understand their rights, and lodge complaints.
- Set up help desks in facilities to assist patients who wish to complain, as required by the provincial Complaints Policy Guidelines.

On Complaint Procedures

- Develop simple guidelines (in the form of a poster or similar communication tools) on how patients can submit complaints, and require that they be clearly and strategically posted in health facilities. The guidelines should explain the complaint procedures and authorities, including: timelines; the authorities

(including name, address, and contact details) responsible for addressing complaints; available remedies; appeal procedures; and other avenues for redress if patients are dissatisfied with the a facility’s response to a complaint. These posters should be available in languages reflecting the populations using the health facilities.

- Develop and implement mechanisms to involve health care workers in the analysis of complaints by health care users, and devise strategies to address systemic shortcoming identified.
- Revise the standard complaint form to include contact information for quality assurance officials, and disseminate it to all public health facilities.
- Instruct all health facilities and district authorities to record verbal complaints, investigate them, and include outcomes of such investigations in monthly complaints reports.
- Develop realistic and clear timelines for opening suggestion boxes and disseminate to facilities. Develop a monitoring system to ensure this is happening.
- Instruct all health facilities to ensure that complaint forms and pens for writing complaints are available, and sanction facilities that do not comply.
- Instruct all health facilities to display contact information for the call center.
- Instruct all community health centers and clinics to establish health committees and all hospitals to establish boards, and involve them in complaint processes as required by the National Health Act. Provide oversight to ensure that health committees and boards are fulfilling their duties.
- Disseminate the Complaints Policy Guidelines to all health facilities.
- Appoint more quality assurance officers and provide thorough and ongoing training to them, and improve feedback between facilities and offices providing oversight.
- Develop and implement district-level emergency help lines. Such help lines should be accessible to vulnerable communities, especially rural women with little or no formal education, and migrant women; and have the power to receive complaints around the clock and provide immediate interventions to avert preventable maternal deaths or injuries.

On Migrants

- Consider recruiting foreign national or multilingual healthcare workers to staff facilities in migrant-heavy areas.
- Consider developing a network of community-based interpreters among members of the main migrant communities.

To the South African Human Rights Commission

- Conduct a public inquiry into the abuse of women in health facilities during pregnancy, delivery, and after birth and lack of accountability. Such an inquiry should examine not only the conduct of frontline health workers but also administrators, managers, and district and provincial health officials.

To the South African Parliament

- Adopt the Health Amendment Act Bill to establish the office of a health Ombudsperson to deal with patient complaints, and to ensure health facilities' compliance with norms and standards.
- Establish a joint committee to monitor government implementation of strategies to reduce maternal mortality.
- Ratify the International Covenant on Economic, Social and Cultural Rights and its Optional Protocol.

To South Africa's International Partners

- Donor governments and international agencies should advance the recommendations in this report in their dialogues with the South African government and within their assistance programs.

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“Stop Making Excuses”

Accountability for Maternal Health Care in South Africa

South Africa’s health care system faces many challenges—including a high burden of disease particularly HIV/AIDS, financial mismanagement, and poor pay for health workers. In addition, maternity patients face verbal and physical abuse. The situation has driven away many from seeking care, left psychological scars, and delayed diagnosis and treatment. Between 1998 and 2007, South Africa’s maternal mortality ratio (MMR) quadrupled.

Underlying these problems are shortcomings in accountability and oversight mechanisms that authorities use to monitor health care system performance, identify failings and needs, and make timely interventions. Such mechanisms exist, they are simply not implemented.

Focusing on the Eastern Cape, this report examines accountability frameworks the government uses to monitor health system policies, practices, and performance. It finds the government is not addressing recurrent health system failures that contribute to poor maternal health outcomes, and is failing to provide oversight and accountability to ensure existing reproductive and sexual health-related policies are implemented that could improve maternal health care and overcome abuses.

South Africa has many building blocks needed for a functioning health system, which mean it has potential to be a leader among African countries in tackling maternal mortality. Its government has also made a genuine commitment to address these problems, including through initiatives to strengthen primary health care and improve financial access to care. But these steps can only be effective if oversight and accountability mechanisms are in place and actively applied.

“*Stop Making Excuses*” calls on South African authorities to do more to identify barriers to care and make necessary adjustments to strengthen the health system. The national and Eastern Cape governments should improve maternal health data, inform patients of their rights and options for lodging complaints, and improve complaint procedures.

A sonar scan is performed on a pregnant woman in South Africa.

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