

Eliminating abusive ‘care’

A criminal law response to obstetric violence in South Africa

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This article examines the disrespectful, abusive and violent maternity care that many South African people face. It identifies this conduct as a human rights violation and argues that intentional abusive maternity care should be labelled as obstetric violence, a specific form of gender-based violence, and that it should be criminalised. This approach reflects a nascent global trend to act against obstetric violence, and draws inspiration from statutory crimes introduced in Venezuela and Mexico. Building on the Latin American experience, the article proposes how the current legal conception of obstetric violence should be further developed to suit the unique position of pregnant people in South Africa.

This article is inspired by recent legal developments in Latin America. In Venezuela, the Organic Law on the Right of Women to a Life Free from Violence (2007) recognises obstetric violence as a form of violence that health personnel inflict on pregnant and birthing people, and it imposes criminal liability for such conduct.¹ Soon after the introduction of this law Mexico followed with similar laws.² The laws prohibiting obstetric violence draw attention to the broader social inequalities faced by women and girls and which lead to unacceptable practices in their medical care while pregnant and birthing. The purpose of these laws is to curb abusive and dehumanising obstetric care and ensure accountability when certain standards of care are not maintained during pregnancy and birth. Curbing abusive and disrespectful treatment helps ensure healthy pregnancies and pregnancy outcomes.

The article serves a two-fold purpose. Firstly, it seeks to introduce the concept of obstetric violence into the broader South African discussion on gender-based violence. It considers the origin and scope of obstetric violence, as developed through Latin American social movements and legal instruments. Going further, the article reveals how the term is being used by a body of commentators and activists beyond Latin America to describe a list of inappropriate practices that constitute obstetric violence. Secondly, the article draws on reports of abusive treatment of pregnant people at public health-care facilities in South Africa and argues that a criminal law response to violence against pregnant people in South Africa is necessary. Conduct identified as obstetric violence in foreign jurisdictions mirrors conduct in the South African health-care system. The article argues that criminalising obstetric violence in South African is an appropriate legal response, which should explicitly prohibit abusive obstetric care, drawing on a woman-centred perspective.

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Developing a specific legal response towards obstetric violence is necessary, for several reasons: South Africa is not expected to meet its Millennium Development Goal of reducing maternal morbidity and mortality,³ and poor quality obstetric care is considered to be one of the causes of maternal mortality and morbidity rates.⁴ In response to this, stakeholders are calling for health workers responsible for abusive obstetric care to be held accountable.⁵ It has been recognised that tackling obstetric violence requires a coherent approach, involving professional associations, governmental, non-governmental and grassroots organisations, communities and families.⁶ Yet the law, as an instrument that protects human rights and ensures accountability, is not recognised as having a role to play in curbing abusive and violent obstetric care.

What is obstetric violence?

The term ‘obstetric violence’ first appeared in Latin America during the 2000s. According to Sánchez, activism against obstetric violence in Latin America emerged from a long history of global activism to ensure respectful childbirth.⁷ She ascribes the recognition of obstetric violence to international acknowledgement of the efforts of the women’s health movement over time,⁸ notably by the World Health Organization, which initiated a drive to reduce unnecessary medical interventions during the birth process.⁹

Efforts to respond to and prevent obstetric violence are rooted in the humanised birth movement, which focuses on de-medicalising birth, arguing that ‘birth is a normal event in which women should be in charge and medical interventions should be used only when necessary’.¹⁰

In Spain, the movement to humanise birth employed the term ‘obstetric violence’ as an umbrella concept to describe facility-based obstetric care that is over-medicalised and harmful to birthing women.¹¹ However, in Mexico the concept also includes violence during birth, and thus broadens the scope of the term.¹²

According to Dixon, while the humanised birth movement primarily focused on changing medical protocols, the movement against obstetric violence

identifies certain protocols as violence and ‘not just less-than-ideal practices carried out by unknowing but well-meaning providers’ (see below for examples of such practices).¹³

The move to recognise and respond to obstetric violence encourages a change in thinking from only considering the medical necessity of a procedure to seeing *unnecessary* medical intervention as potentially dangerous.¹⁴ Going further, the movement locates this form of violence in broader concerns about women’s social inequalities based on gender, race and class. That is, ‘how women are treated in labor and birth ... mirrors how they are treated in society in general’.¹⁵ When certain obstetric practices are identified and framed as harmful violations, it demands legal accountability from individual perpetrators and state institutions that allow the conduct to persist.¹⁶

Spanish activists view obstetric violence as a form of gender-based violence. Their work assists to conceptualise the ‘malaise that many women feel after childbirth, even though society tells them that everything is alright and all that is important is that the baby is alive’.¹⁷ The concept of obstetric violence gives expression to women’s bad birthing experiences as a specific form of violence, and it validates the pain women might feel after a negative experience.¹⁸ The concept is also viewed as a transformative tool that can be used to question and change women’s lived realities.¹⁹ Activists reportedly view obstetric violence as a useful term to describe and raise awareness about the abuses women face when birthing: ‘This is a question of violence, serious and aggressive, that women and children pay for with their bodies and health.’²⁰

Despite the fact that legislation prohibiting obstetric violence is limited to Latin American countries, the use of ‘obstetric violence’ as a concept is being applied elsewhere in the world.²¹ The term is used to describe a wide range of conduct, including verbal abuse, humiliation, shouting, scolding, threatening, and crude and aggressive attacks on women’s sexuality, which are all intentionally employed to assert authority and cast shame on women.²² Performing procedures without consent, with coerced consent, or enforcing procedures by an order of

court is also deemed obstetric violence by National Advocates for Pregnant Women.²³

Procedures that have been identified as forms of obstetric violence are those that are imposed on women as routine (without having any scientific foundation) and without informed consent. These include unnecessary episiotomies or performing episiotomies after delivery solely for the purpose of training; manual revision of women's uterine cavities without pain relief;²⁴ inserting long-term birth control mechanisms directly after birth; collective vaginal examinations for training purposes; tying women's legs to the delivery table; health-care providers' failing to introduce themselves prior to treating women; and forced sterilisations.²⁵

Coercive practices that are identified as obstetric violence include over-emphasising foetal risk when a health-care intervention is for the benefit of a pregnant woman, while understating maternal risk when the health-care intervention is for the benefit for the foetus; using social authority to silence women's dissent to certain procedures; lying to women about the progression of labour in order to encourage Caesarean section delivery; and overriding women's refusal of medical intervention and forcing interventions with or without court sanction.²⁶ Procedures that are performed without consent and forced upon women may involve forceful physical control over the body of a pregnant woman, use of restraints, and further interventions such as sedation.²⁷

Other forms of physical violence that have been labelled as obstetric violence include slapping; humiliating pregnant women by forcing them to clean the delivery room after birth; performing clitoridectomies²⁸ and virginity inspections²⁹ where consent is socially coerced;³⁰ and deliberate refusal of pain relief.³¹

Medical neglect, in the form of unattended birth at a health facility, is also identified as a form of violence inflicted on birthing women.³² Pires Lucas d'Oliveira, Diniz and Schraiber identify a number of reasons for neglect that include the attending facility lacking the resources to provide adequate care (in which case structural violence comes to the fore); staff acting unprofessionally; and staff intentionally

neglecting women as a method of punishment for non-compliance with obstetric care protocols.³³

There are many reasons for disrespectful and abusive care. Jewkes and Penn-Kekana state that structural gender inequality, which 'systematically devalues women and girls', fosters an environment that allows for the infliction of violence.³⁴ Systematic devaluation permits poor allocation of resources and effectively disempowers women and girls.³⁵ Honikman, Fawcus and Meintjies state that patients are abused because of a lack of professional support for healthcare providers, hierarchical work relationships, excessive workloads, and poor infrastructure and staffing levels.³⁶

This discussion demonstrates that the term 'obstetric violence' is rooted in the notion that the way birthing women are treated in health-care facilities correlates with their broader unequal social and economic standing and constitutes a form of gender-based violence. It gives expression to women's physical experiences of abusive, dehumanising or violent 'care' and to the wrongs suffered by women despite surviving birth and having a live born child. Furthermore, research (as discussed above) demonstrates that the term 'obstetric violence' is being used to describe a wide range of inappropriate obstetric care, which spans basic verbal abuse to serious and intentional instances of physical assault.

Responses to obstetric violence

At a global level, Millennium Development Goal 5 and now Sustainable Development Goal (SDG) 3 to reduce maternal mortality rates provide a context for addressing abusive and disrespectful maternity care.³⁷ SDG 3 is supported by the Respectful Maternity Care Charter³⁸ and guidelines issued by the International Federation of Gynecology and Obstetrics, International Confederation of Midwives, White Ribbon Alliance, International Pediatric Association and the World Health Organization (FIGO Guidelines).³⁹ The Charter and Guidelines set out the rights of patients and provide strategies to improve quality of care at a health-care system level. These are essentially a 'health system approach'⁴⁰ to addressing inappropriate obstetric care and as such they do not provide for a *legal* response or position.

The FIGO Guidelines suggest that ‘ongoing accountability’ can be expected with its proper implementation.⁴¹ In this respect, Dickens and Cook explain that in ‘law, professional guidelines may serve as a shield to defend practitioners who comply with them, and as a sword with which to attack those who fail or refuse to follow them’.⁴² However, guidelines are not law and may have limited reach; also, as Dickens and Cook point out, legal responses to guidelines may differ from court to court and in different jurisdictions.⁴³

Nevertheless, these and similar health-care guidelines, protocols or charters can be used to inform the content of statutory crimes or other legal responses. In this respect Venezuela and certain states in Mexico have criminalised obstetric violence. As will be seen below, the statutory provisions correlate with the health system approach, but the statutes obviously go further by attaching legal consequences.

Article 15 of the Venezuelan Organic Law on the Right of Women to a Life Free from Violence recognises obstetric violence as one of 19 forms of violence against women. It defines obstetric violence as the

appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women.⁴⁴

Article 51 recognises the following conduct as obstetric violence:

- Untimely and ineffective attention to obstetric emergencies
- Forcing women to give birth in a supine position with legs raised, when the means to perform a vertical delivery are available
- Impeding early attachment of neonates with their mothers without a medical cause
- Altering the natural process of low-risk deliveries by using acceleration techniques without voluntary, expressed and informed consent of women

- Performing deliveries via Caesarean section delivery when natural childbirth is possible and without obtaining voluntary, expressed, and informed consent from women

Contravention of these provisions can lead to the imposition of a fine, and disciplinary proceedings by the relevant professional body.

The Mexican states of Durango, Veracruz, Guanajuato and Chiapas have legislation prohibiting obstetric violence.⁴⁵ In Veracruz, obstetric violence includes coercive practices such as ‘bullying and psychological or offensive pressure’, which inhibit women’s free decision-making about motherhood.⁴⁶ Where a person is found to be in contravention of obstetric violence provisions, that person may face up to six years’ imprisonment and fines amounting to 300 days of their salary.⁴⁷

It was not possible to determine whether obstetric violence provisions are successfully implemented in Venezuela and Mexico, because there is no English language literature available about this. However, it would appear that there is no Venezuelan case law applying obstetric violence legislation, which suggests that the legislation is not being used to support pregnant people’s rights.⁴⁸ Reasons for this could not be found.

Research by Prof. Magally Huggins Castaneda suggests that, aside from the fact that implementation measures are very expensive (in that specialist courts must be established), state authorities are reportedly incompetent and ineffective when receiving complaints.⁴⁹ The National Institute for Women in Venezuela recognises the legislation as being progressive⁵⁰ but ultimately it seems that there is no established commitment to address the issue, which is exacerbated by a lack of mobilisation and enforcement mechanisms to implement the enacted statutory provisions.

Violence during pregnancy in South Africa

There are a number of publications from the public health-care sector that describe current reproductive health-care practices in South Africa as a violation of the notion of ‘care’. These practices (described below) have been identified as contributing to the

increase in maternal mortality and morbidity rates.⁵¹ In a 2009 article, Chopra et al. questioned whether the apartheid-scarred South African health-care system would be able to reduce maternal and neonatal mortality rates, and found that despite making progress in increasing access to maternal health-care, this did not necessarily improve health outcomes for women and children in South Africa.⁵² While women and girls are successfully being steered towards facility-based care, the care they receive there may be disrespectful, abusive and violent.

During 2010 and 2011 Human Rights Watch (HRW) visited a number of health-care facilities providing maternal health services in the Eastern Cape in order to determine how patients experience maternity care.⁵³ After interviewing patients, medical staff, health officials and experts, HRW reported that nurses believed that violent and abusive control and authority were necessary to achieve healthy births and ensure maternal survival.⁵⁴

Patterns of abusive, violent and disrespectful care

Abuse in obstetric care is deep-rooted and has been described as ritualised, sanctioned, normalised and institutionalised.⁵⁵ A senior midwife in South Africa was reported as stating that 'she did not believe there was a midwife in the country who had never hit a patient and explained that they were taught how to do so during training'.⁵⁶

While most reports on substandard and abusive treatment focus on labouring and birthing women, there have been reports of abusive treatment in prenatal care and termination of pregnancy services. In 2014 Amnesty International reported on a number of coercive practices that were widespread in KwaZulu-Natal and Mpumalanga, such as forced HIV testing of pregnant women and girls, and the disclosure of HIV and pregnancy status without consent.⁵⁷ The same report noted that many women and girls also faced verbal abuse and crude remarks concerning female sexuality from nursing staff.⁵⁸ Staff were said to be dismissive and rude when patients reported prenatal concerns and at times patients were scolded when they called a clinic for advice.⁵⁹ Public admonishment is a prominent feature of prenatal care; teenagers are scolded for deviant

behaviour, others for being 'dirty', and at times patients are collectively scolded in order to prevent future wrongdoing.⁶⁰

Women who fail to attend antenatal care and later present for care while in labour face deliberate abuse as a form of punishment for non-compliance with obstetric protocols.⁶¹ This includes neglect to varying degrees, verbal abuse and scolding, and not receiving labour and birth care timeously, or receiving no care at all.⁶² Jewkes et al. describe one patient as having explained that 'we are supposed to accept it [abuse] because that is beneficial to us ... If a person can be cheeky to the nurses and go home (refusing to attend again), she would be digging her own grave not the nurses'.⁶³

Women and girls also face physical abuse while labouring and/or birthing. This includes being slapped and pinched; being stabbed with scissors; rough handling; being hit with instruments such as a ruler; being 'hit between the buttocks'; being denied pain medication when medically indicated, such as when performing episiotomies⁶⁴ or after Caesarean section deliveries; suffering painful internal examinations; women's legs being forced closed while the baby is emerging from the birth canal; women's legs being forced open; women being forced to walk from one ward to the next during birth and/or soon after delivery; women being forced to clean up after themselves or collect supplies from cupboards during labour and/or after delivery; procedures on women being performed without consultation or consent;⁶⁵ and women being told that if they refuse a Caesarean section delivery no one will help if complications arise later.⁶⁶

Numerous reports indicate that women and girls also face neglect at various stages of labour and delivery. At times there is very little monitoring of patients in labour; calls for assistance are left unanswered either because of resource shortages or intentional staff conduct (watching television, sleeping, talking, having tea or a meal); patients deliver without knowledge of what to expect and at times on their own; and questions about complications, procedures, labour progress and general care are left unanswered.⁶⁷ At times women have been told not to

ask questions, or requests are met with hostility and further threats of violence.⁶⁸

HRW highlighted extreme cases of neglect that resulted in death, and reported that women were left for hours holding stillborn babies.⁶⁹ In cases where women do deliver without a midwife present, they face further abuse, or are accused of trying to 'kill the baby'.⁷⁰ Kruger and Schoombee, and HRW indicate that some of the reasons for neglect include punishment for being disobedient; avoidance of HIV positive women; a refusal to treat migrant, non-South African citizens or refugee patients; or that patients are perceived to be undeserving (such as the poor, single or unmarried patients, and black patients).⁷¹

Further, labouring and birthing patients face verbal abuse, which includes sarcasm, scolding, being shouted at and ridiculed, being called derogatory names and being identified as being 'dirty', 'stupid', 'arrogant' and 'lazy'. Patients also face crude and inappropriate references to female sexuality.⁷²

Most of the conduct described here can rightly be labelled a form of obstetric violence. These practices ultimately violate patients' right to access reproductive health-care, bodily and psychological integrity, privacy, dignity, equality and, at times, their right to life.⁷³ It is evident that human rights are being violated at an individual (intentional abuse) and structural level ('structural disrespect' being insufficient allocation of resources, poor infrastructure and training).⁷⁴ Jewkes and Penn-Kekana emphasise that while developing interventions to improve mistreatment of pregnant and birthing people more generally (such as the Better Births Initiative⁷⁵ and Compassionate Birth Project⁷⁶) it is still necessary to ensure individual accountability in cases of intentional abuse.⁷⁷

Principles of criminal law

Many of the acts described above already constitute criminal acts as defined in South African law, and are prohibited. Performing any procedure, regardless of how trivial, without informed consent or with coerced consent may constitute criminal assault. Snyman defines the crime of assault as an unlawful and intentional act (or omission) that impairs another person's bodily integrity, or inspires a belief that such impairment will immediately take

place.⁷⁸ Thus, even the *threat* of imminent assault is sufficient to constitute the crime of assault.⁷⁹ Assault is clearly taking place when women and girls are slapped, pinched, stabbed or handled in a physically aggressive manner, or when they face threats of abuse or neglect.⁸⁰

Going further, the crime of *crimen injuria* is also implicated. It is defined as the unlawful, intentional and serious violation of another's dignity or privacy.⁸¹ A number of acts described above might amount to *crimen injuria*, such as when health status is intentionally disclosed without consent, being shouted at, being publicly degraded and called names, or being refused treatment based on social or health status.

Moreover, negligent treatment that results in death can amount to the crime of culpable homicide. Culpable homicide is defined as the unlawful and negligent killing of another person.⁸² The crime of murder may be implicated where women are intentionally neglected or mistreated and death ensues, or attempted murder where death would have likely ensued but did not.⁸³ While it can be argued that health-care providers do not have the direct intention to murder their patients, they may still be held liable on the basis of *dolus eventualis*.⁸⁴ *Dolus eventualis* is a form of intention and concerns an unlawful action or result that is not a person's main aim, but where he or she subjectively foresees the possibility that in striving for his or her main aim, the unlawful act or result may be caused and he or she reconciles him or herself to this possibility.

Despite well-established criminal law principles prohibiting the conduct described in the reports and publications considered above, no case law has been sourced where perpetrators have been held liable. In fact, those reporting and publishing on substandard health-care of pregnant and birthing people do not readily identify intentional abusive and disrespectful care as criminal conduct and a form of gender-based violence. Furthermore, there has been no collective legal effort to bring the state (Department of Health) to account either.

Reasons for inactivity may lie in the fact that disrespectful, abusive and violent maternity care is invisible, or possibly not viewed as serious enough

to prompt a criminal investigation, especially in cases where a woman and her baby have survived birth.

Further, these common law crimes might not be seen as adequate mechanisms to remedy the distinct harms experienced at the hands of medical practitioners during pregnancy and birth. This might be the case because the harm is taking place in a medical 'care' and life-giving context, and as long as a pregnant person and baby survive birth, medical care could be considered to have been sufficient. The people who are abused and violated, while possibly feeling wronged and hurt, may not identify those wrongs and harms as criminal, or, even if they do, may think that there are no mechanisms available to remedy the specific wrongs and harms caused. Moreover, it might be difficult to report cases to the police, given that the South African Police Service also forms part of the state, and women and girls may fear further prejudice when attempting to report a case. Jewkes et al. suggest that patients fear victimisation and therefore do not report abusive nurses.⁸⁵

Most practices identified in this article are viewed as abusive, disrespectful and/or violent more generally, but those practices have never been identified as criminal. This might be a consequence of these harms never having reached the attention of legal scholars or practitioners. It is submitted that intentionally abusive, disrespectful and violent 'care' should be labelled as obstetric violence and explicitly established as criminal conduct through the introduction of a women-centred statutory crime. The very unique harm and gendered context of this form of violence requires the development of a statutory response as a mechanism that acknowledges and enforces pregnant people's rights. It must address the vulnerabilities that pregnant people face in the context of maternity care and instil a sense of accountability.

While this article advances a criminal law response to obstetric violence, it is recognised that merely introducing a statutory crime in this context may not bring about a normative change and thus more is needed. According to Freedman and Kruk, disrespectful and abusive treatment 'is a signal of a health system in crisis – a crisis of quality and

accountability'.⁸⁶ Improving quality of care requires additional interventions such as improving training, sensitisation to and education campaigns on patients' rights, improving working conditions and staff support, improving internal reporting processes and improving broader gender equalities.⁸⁷ A statutory crime will merely serve as one response out of a number of required responses.

Responding to obstetric violence in South Africa

Explicitly criminalising obstetric violence via statutory law reform should receive increased and meaningful consideration in South Africa. The global movement against obstetric violence provides helpful parameters for what such legislation should encompass. However, if the aim is to develop a South African response to obstetric violence, a number of weaknesses in the current conception of obstetric violence must be considered and addressed.

First, obstetric violence is a very wide, all-inclusive term. While this is helpful for purposes of mobilising civil society organisations, if obstetric violence is to be used to describe a crime, a narrower construction of the term will be required. More specifically, it should be limited to intentional individual conduct. The statutory crime should take its cue from the above described common law crimes but be developed in a way that renders the statutory crime sensitive to the specific context of pregnancy and birth.

Second, the focus of current obstetric violence law in Latin America tends to be on women. This approach appears to exclude girls and intersex persons (who do not self-identify as female or women) from the scope of consideration. Consequently, it fails to respond to the intersection of sex, age and gender that might perpetuate the experience of violence at the hands of health-care providers. By primarily focusing on women and not 'pregnant people', these efforts themselves re-enforce gender roles and 'other' those who are pregnant but do not self-identify as female or women. Arguably, protection only accrues to those who conform to social notions of womanhood.

Third, there is a persistent focus on childbirth. This fails to take into account reproductive health-

care beyond childbirth. According to the Beijing Declaration and Platform for Action, reproductive health-care is 'a constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems'.⁸⁸ Further, 'reproductive health' concerns a state of complete physical, mental and social well-being in all matters relating to the reproductive system, its functions and processes.⁸⁹ Reproductive health therefore entails a wide range of concerns: a safe sex life; the capability to reproduce and the freedom to decide if, when and how often to do so; access to safe, effective, affordable and acceptable family planning and other methods of fertility regulation; and appropriate healthcare that enables 'women' to safely progress through pregnancy and childbirth. Here, childbirth is only one of many care needs. By focusing on childbirth, people in need of respectful termination of pregnancy services are excluded, so too are those who face forced or coercive contraception and/or prenatal care prior to childbirth. As long as obstetric care is implicated in the broad scope of reproductive health-care, the possibility of violent and intentional infringement of rights exists and the crime should be all-encompassing.

Fourth, obstetric violence legislation mainly focuses on individual wrongdoers and not the structural violence that facilitates systematic human rights violations within the realms of obstetric care. Commenting on Venezuela's Organic Law on the Right of Women to a Life Free from Violence, D'Gregorio points out that providing emergency obstetric care might be difficult to achieve in overcrowded public hospitals that are resource deficient and lack suitable infrastructure.⁹⁰ He rightfully argues that the state has the responsibility to solve these concerns, but the legislation holds health personnel 'responsible for a situation that is an institutional responsibility, not a personal one'.⁹¹

Going beyond the limited scope of emergency care, Freedman and Kruk argue that disrespectful and abusive care 'is not the phenomenon of a few bad apples but is inflicted by health systems as a whole, especially when care environments digress from accepted standards of care'.⁹² Sánchez places these concerns in a broader gendered context. She argues

that obstetric violence persists because of embedded patriarchal values, which use women's reproduction and sexuality as a means to keep women in a subordinate position and maintain traditional views of women's gender roles.⁹³ Thus, the entire system of obstetric violence is facilitated by the individuals *and* the state and is founded on the devalued position of women and girls in society. With this view in place, it is argued that the judiciary is also implicated since there is increasing jurisprudence of court-ordered medical treatment of pregnant and birthing people.⁹⁴

Consequently, any statutory crime developed in response to obstetric violence should be adequately linked to broader efforts that specifically denounce the appropriation of pregnant people's bodies by individuals, civil society groups, the judiciary and the state. Legislation needs to be explicitly positioned to advance substantive equality; between pregnant people and civil society, between different pregnant and birthing people, between providers and pregnant people, between the state and pregnant people, and between the courts and pregnant people. It must enforce a shift in power relations and maintain accountability on an individual and collective level.

Fifth, most of the discourse on obstetric violence falls within the realm of public provision of obstetric care. This gives the impression that pregnant people's rights are less likely to be violated while receiving private obstetric care. This is not the case. Lutomski et al. found that pregnant people face a higher risk of obstetric intervention in private facilities than in public facilities for reasons that are not clinically indicated, such as obstetric preferences, fear of litigation and maternal preferences.⁹⁵ On the face of it, maternal preference may appear to remove the presence of obstetric violence, but it is now well established that coercive tactics by providers are regularly employed in order to sway pregnant people into accepting certain procedures or processes over others.⁹⁶ These coercive practices result in coerced consent, which constitutes obstetric violence and should be identified and labelled as criminal, and a human rights violation.

Going beyond facility-based care, it might be necessary to contemplate including traditional obstetric care provided by traditional health-care providers. Including traditional healers and birth

attendants is important in a South African context because they are frequently consulted for purposes of termination, and pregnancy services and care during pregnancy and birth.⁹⁷ Traditional healers and birth attendants are the first health-care choice for many South Africans.⁹⁸ While no reports can be sourced on violent traditional health-care providers, it is an area that will need further research and consideration.

Sixth, 'obstetric violence' emerged from a movement that focused on de-medicalising childbirth. This approach needs to be further developed. It fails to acknowledge that medical interventions are beneficial and can be life-saving in appropriate circumstances. It further fails to recognise that pregnant people are increasingly electing medical interventions as expressions of patient autonomy.⁹⁹ By focusing primarily on de-medicalising childbirth, the obstetric violence discourse adopted by activists may inadvertently fail to effectively sensitise South African medical practice and hospital protocol to patients' rights while within the realms of medicalised births and prenatal care.

Conclusion

This article demonstrates that violence against pregnant people in South Africa includes obstetric care that is characterised as abusive, disrespectful and violent. Discussions of gender-based violence must be sensitive to the abusive medical care pregnant people face and its specificities must be properly considered when developing a way forward.

This article suggests that 'obstetric violence' is an important concept for raising and addressing violent and abusive care. The term encapsulates conduct that violates autonomy, privacy, physical and psychological security and integrity, dignity and equality. It is conduct that takes place without consent or with coerced consent. Obstetric violence concerns unnecessary medical interventions that are imposed on people as routine, which, without consent, amounts to embarrassing and degrading treatment. It is conduct that removes pregnant people as active participants of their pregnancies, treats them disrespectfully and in a one-size-fits-all manner. It is an empowering tool because the term gives expression to the hurt felt and the wrong imposed.

It mobilises thinking about how to characterise harmful 'care' and provides a legal mechanism to vindicate those who have been hurt. While a number of shortcomings to the current obstetric violence discourse have been identified in this article, this should be seen as an opportunity to develop the concept further when considering how to formulate a statutory crime in South Africa.

It is hoped that this article will serve as a springboard for further discussions on how to respond to violence against pregnant and birthing people receiving obstetric care and the feasibility of adopting legislation prohibiting obstetric violence. Further, it reveals that the scope of possible victims of obstetric violence is much broader than the current discourse provides for, and aims to encourage research into the intersection of race, class, sex and gender within the realms of care during pregnancy and birth.



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Notes

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