



Birth with dignity: addressing obstetric violence in South Africa

Building respect, consent
and accountability in
maternity services

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Written by Phylcia Oppelt (Project Lead: Change Ideas)

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Executive summary

Too many women in South Africa experience childbirth not as a moment of care - but of trauma.

This is because of obstetric violence: the coercion, mistreatment, neglect and abuse of women during pregnancy, childbirth and the postnatal period. It happens when women are subjected to non-consensual procedures and unwanted touching.

Certain groups of women are particularly affected: For black, working-class, migrant, adolescent or HIV-positive women, these harms are not rare – they're routine.



Childbirth is a profound life experience for any women. The feelings, emotions and memories become deeply imprinted in their subsequent sense of dignity and agency. It is often a stressful time for clinicians too, especially when they must respond urgently to protect the life of the child and the mother. In these situations, signed consent is not always possible.

However, new evidence from South Africa's largest study of obstetric violence to date – the 2025 Embrace Birthing Survey: The Extent and Nature of Obstetric Violence in South Africa, conducted in KwaZulu-Natal and Gauteng – indicates 60% of the women surveyed had experienced at least one form of harm during labour or birth, with higher rates among black women, adolescents, migrants and those who gave birth in public hospitals.¹ Adolescent girls face the additional risks of moral judgment and neglect. Supporting evidence from litigation, clinical investigations and survivor testimonies reveals deeply embedded patterns of harm.

Childbirth involves unavoidable physical contact. The concern is not touch itself but whether it is explained, consented to, and carried out respectfully. In the 2025 Embrace survey, over one-third of women reported procedures without explanation or permission, and many felt unable to ask questions or voice discomfort, indicating that the experience of violation is closely tied to communication and autonomy rather than clinical necessity.²

The roots of obstetric violence in South Africa are systemic: Collapsing infrastructure, chronic staff shortages, legal ambiguity, poor oversight and enduring racialised inequality all play a part. Maternity staff, particularly nurses and midwives, often work under impossible conditions without the necessary training or support to provide respectful, rights-based care.^{3,4}

Despite decades of research, institutional responses remain weak. National laws and policies don't explicitly define or prohibit obstetric violence, and redress mechanisms are limited. Survivors frequently encounter stigma and struggle to access justice or support.

Globally, obstetric violence is increasingly recognised as a form of gender-based violence (GBV), with growing calls for legal and health system reform. Several countries – particularly in Latin America and parts of Europe – now offer examples of relevant legislation, monitoring and survivor-led accountability.^{5,6}

This brief proposes coordinated reforms across six core areas: legal clarity, health system accountability, mental health integration, provider support, survivor-centred redress and robust data systems.

Introduction

In South Africa, many women giving birth in a public facility are yelled at, smacked, left alone while in labour, physically restrained or subjected to procedures without consent.

These experiences are not isolated. They reflect a wider pattern of obstetric violence, defined as the mistreatment, neglect, coercion and abuse of women during pregnancy, childbirth and the postnatal period.^{7,8}

Obstetric violence is deeply rooted in the legacy of racialised inequality and institutional violence and neglect in South Africa's healthcare sector. Maternity wards, particularly those in public facilities, often reflect wider social power imbalances between provider and patient, between adolescent girl and adult nurse, between citizen and migrant and between care and control. While it occurs across all settings, women who are young, black, working-class, migrant (i.e. without documentation) or HIV-positive are most at risk.^{9,10,11}

New research confirms that obstetric harm is widespread. The Embrace 2025 Birthing Survey found that 60% of respondents had experienced at least one form of obstetric violence, with rates in under-resourced facilities and among historically marginalised populations significantly higher.¹² Qualitative accounts of forced sterilisations, coerced consent, neglect and systemic denial of dignity and choice support these findings.

Importantly, these incidents aren't simply a matter of individual misconduct. It's the product of structural failures, including underfunded health systems, gaps in training, weak accountability mechanisms and outdated legal frameworks. Also, it's not only patients who are affected: Health workers themselves report moral injury, burnout and frustration with collapsing institutions.^{13,14}

International bodies – including the World Health Organization (WHO), United Nations (UN) human rights mechanisms and the African Union (AU) – recognise obstetric violence as a violation of human rights and a form of GBV. These frameworks emphasise the importance of dignity, informed consent and accountability in maternity care.^{15,16} Yet South Africa has not fully integrated these standards into its national policies, laws or health system protocols, creating a gap between global norms and lived experiences.

This policy brief draws on both South African and global evidence to describe the forms, drivers and impacts of obstetric violence. It presents new data, contextual insights and survivor voices and offers concrete recommendations for legislative, clinical and institutional change.

Ending obstetric violence is not only a legal and moral imperative; it's also essential for improving maternal outcomes and restoring dignity and trust in maternity care.

Forms and impacts of obstetric violence

Obstetric violence takes many forms – from overt physical abuse to more subtle but similarly harmful violations of autonomy, dignity and consent. These forms often overlap, compounding both the emotional and physical harm caused. These are the most frequently documented forms:

Verbal and emotional abuse

Verbal mistreatment includes being shouted at, mocked, insulted or humiliated during childbirth. Common examples include women being blamed for “non-cooperation”, threatened with being left alone or scolded for expressing pain. A qualitative study in Durban found that patients were regularly shouted at, mocked or accused of being difficult – particularly younger mothers and those in visible distress.¹⁷

Even though these interactions are less visible than physical abuse, they create a climate of fear, shame and emotional trauma.¹⁸

The National Integrated Maternal and Perinatal Care Guidelines for South Africa explicitly condemn verbal abuse. The document cites phrases such as “You opened your legs to get pregnant, why don’t you open your legs now?” as examples of unacceptable, degrading language.¹⁹

Neglect and denial of care

Many women are left alone for long periods, ignored when they call for help or denied basic clinical care. Examples include not being provided with pain relief, being refused a companion or being forced to give birth on the floor or without assistance. Although these incidents are often rationalised as a consequence of staff shortages or work overload, the effects are profound and sometimes life-threatening.²⁰ Participants in the Durban study describe being left alone, ignored or mocked for seeking help, which reinforces patterns of abandonment.²¹

Young mothers are often actively avoided by staff during labour. This isolation deepens their feelings of fear and abandonment.²²

The Maternal and Perinatal Care Guidelines emphasise that no woman should be turned away or left unattended. It mandates timely triage and continuous support, especially during active labour.²³

Non-consensual care

Administering care without informed consent is a core feature of obstetric violence. This includes coerced or forced medical interventions such as sterilisation, abortion, induction, caesarean section or episiotomy. Many women describe undergoing these procedures without an explanation of what it involves, without being asked if they consent or given the opportunity to refuse care, or under duress. Repeated, painful vaginal examinations performed without consent are also widely reported.^{24,25}

The Maternal and Perinatal Care Guidelines reaffirm the legal and ethical obligation to obtain informed consent outside moments of distress or active labour. It also mandates that consent be communicated and documented in the patient’s preferred language.²⁶

Personal experiences from the 2025 Embrace Birthing Survey:²⁷

“I felt angry to the point that I made the decision not to have children anymore.”

Anonymous, Gauteng

“I had to wrap my baby with dirty linen due to the staff refusing to give me my bag.”

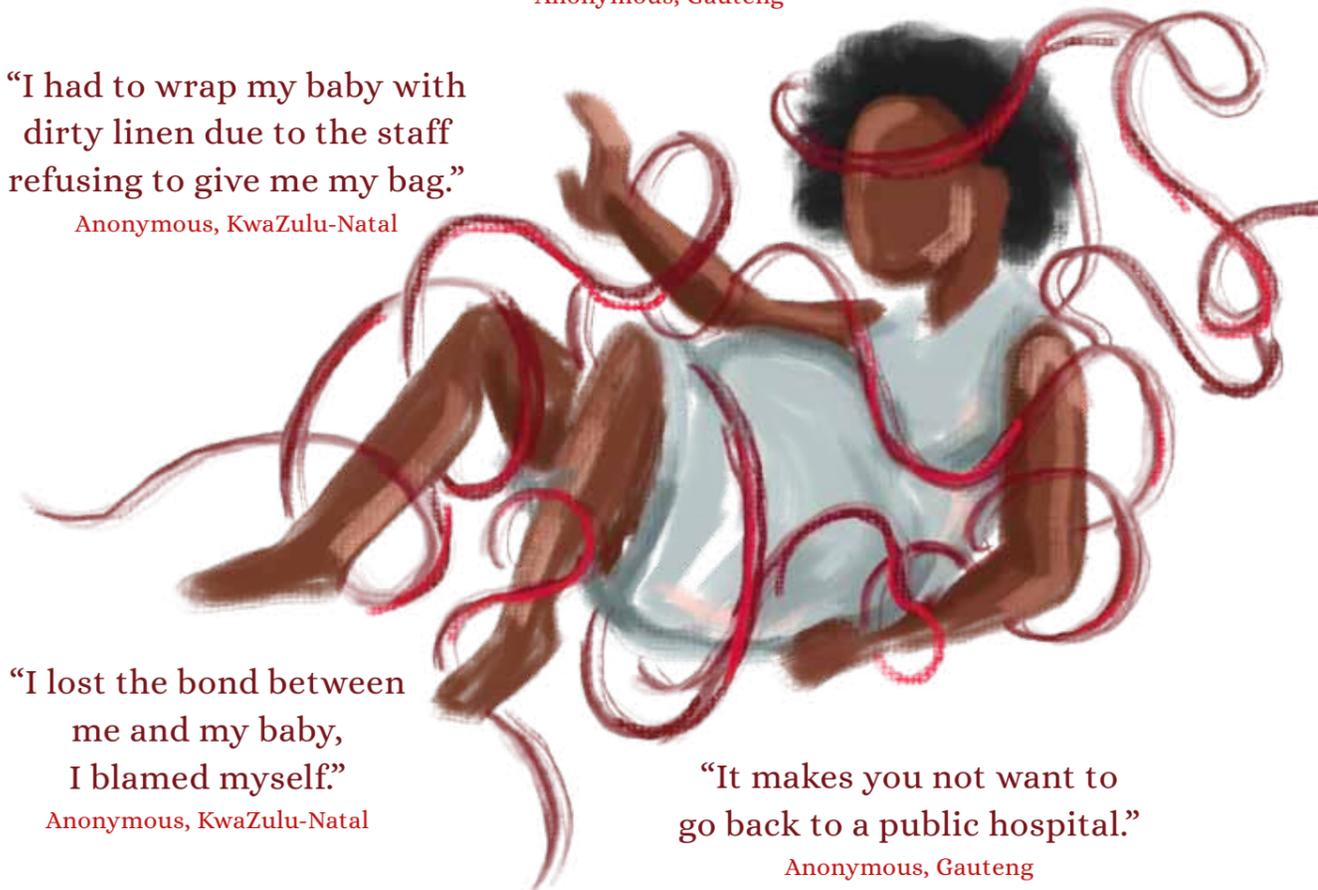
Anonymous, KwaZulu-Natal

“I lost the bond between me and my baby, I blamed myself.”

Anonymous, KwaZulu-Natal

“It makes you not want to go back to a public hospital.”

Anonymous, Gauteng



Physical abuse and coercion

Women report being slapped, pinched, pushed or physically restrained during labour and delivery. Excessive force – such as fundal pressure applied on the abdomen without medical indication – is deemed both dangerous and traumatising. In some cases, women are tied down during procedures or physically prevented from moving, denied food or water or forced to lie on their backs for extended periods despite clinical guidance to the contrary.²⁸

Violation of dignity and privacy

Patients describe undergoing examinations or giving birth without curtains or partitions, while others had their private health information disclosed without consent. Refusing women a birth companion or making decisions on their behalf without involving them further strips away their dignity.²⁹

The Maternal and Perinatal Care Guidelines mandate that all examinations be conducted in private settings and that birth companions be permitted at all times, unless there are clear clinical or safety concerns.³⁰

Distinct patterns of obstetric violence faced by adolescent mothers

Across public health facilities in South Africa, Ethiopia and Kenya, 27% of adolescents reported mistreatment during childbirth – a significantly higher rate than among adult women.³¹ Stigma, lack of consent, poor privacy and judgmental attitudes are common in the treatment of adolescents. As a result, many young mothers delay antenatal care due to fear, shame or poor provider treatment, and they are often excluded from decision-making during labour.³² The fact that adolescents' levels of health literacy, education and employment are generally much lower than those of adult women further limits their ability to claim their rights or navigate the system. When abused, they are therefore less likely to report it or to seek redress.³³

Verbal abuse is common. Adolescent mothers report being scolded, insulted or mocked for their age and pregnancy status. In one Tshwane facility, adolescents were told, “You wanted to be a mother – deal with it”, and some were too afraid to call for assistance due to ongoing verbal mistreatment.³⁴

The Maternal and Perinatal Care Guidelines call for adolescent-friendly services and warn against the common mistreatment of young women. It emphasises the need for sensitive, non-judgmental care that protects confidentiality and reduces stigma.³⁵

Summary:

These cases aren't isolated incidents.

They're part of an alarming trend that reflects systemic failures in health governance, clinical training and institutional culture. The cumulative impact on maternal health, mental well-being and trust in the healthcare system is profound – and avoidable. The Maternal and Perinatal Care Guidelines offer a concrete, state-endorsed standard to prevent and redress these harms. However, without adequate resources and support for implementation, the guidelines are ineffective.

Evidence of obstetric violence in South Africa

Obstetric violence is highly prevalent in South Africa. According to the 2025 Embrace Birthing Survey, 60% of respondents reported experiencing at least one form of obstetric violence during childbirth, including verbal abuse, neglect and non-consensual care.³⁶ These findings echo those of the 2024 survey (Counting What Matters), which highlighted deep dissatisfaction with communication and consent practices and a lack of respect for patient dignity.³⁷

Multiple studies and legal inquiries – such as the ones mentioned below – have documented patterns of abuse, negligence and coerced consent within South Africa’s maternity system. In a 2020 inquiry by the Commission for Gender Equality, more than 48 women – many of whom are living with HIV – testified about forced or coerced sterilisation while seeking care at public facilities.³⁸ Legal advocacy organisations have since pursued compensation and systemic reform, citing violations of constitutional rights and medical ethics.³⁹

First-hand accounts also reveal the extent of emotional and psychological harm caused by obstetric violence. Women have described being scolded during labour, denied pain relief and left to deliver their baby on the floor by themselves.^{40,41} One woman stated, “They treated me like a thing, not a person. No one explained what they were doing. I just lay there and cried.”⁴²

A growing body of research has identified adolescent girls as particularly vulnerable to abuse in maternity settings. In studies conducted in Tshwane and the Eastern Cape, adolescent mothers describe feeling judged, ignored and deliberately mistreated by staff who saw them as “too young” to deserve compassion.^{43,44}

Institutional data supports these survivor accounts. Section27’s 2023 litigation against the Gauteng Department of Health included testimonies from multiple women who were subjected to verbal abuse, denied care and humiliated during delivery. The judgment reaffirmed that such treatment violates rights to dignity, equality and healthcare.⁴⁵

Summary:

The evidence is unequivocal: Obstetric violence is widespread, deeply embedded and structurally reinforced within South Africa’s maternal health system.



Systemic drivers of obstetric violence

Obstetric violence doesn't arise in isolation. It's rooted in longstanding health system failures and structural conditions that compromise the delivery of respectful, safe and dignified maternal care.

One of the most visible drivers is the collapse of infrastructure and chronic overcrowding in public health facilities. The Rahima Moosa Mother and Child Hospital (RMMCH) investigation report describes scenes of women sleeping on floors, unattended deliveries as well as midwives and doctors working under extreme pressure in understaffed wards.⁴⁶ Such an environment fosters clinical neglect and normalises mistreatment as routine.

“RMMCH was found to be in violation of this Constitutional mandate by:

- a. Allowing healthcare professionals to continue to work in an unsafe environment.
- b. Expecting pregnant women to sit on plastic chairs while admitted to the hospital for delivery of their babies.
- c. Sitting on plastic chairs with post-delivery stitches.
- d. Acquiescing that pregnant women regularly sleep on the hospital floor in Ward 15 is unethical and disrespectful.”⁴⁷

– Office of the Health Ombud's findings

As the RMMCH report points out, health workers face intense resource shortages and unsafe working conditions. Many are overburdened, underpaid and lack the supervision, mentoring and/or time they need to provide compassionate care. Studies report that demoralised health workers who lack support may become desensitised to patients' suffering or adopt controlling behaviours to manage risk and time.^{48,49}

A critical gap in the system is the failure to implement national guidelines. Even though the Maternal and Perinatal Care Guidelines promote informed consent, companionship and respectful communication, there's little evidence that these standards are widely taught or enforced in clinical practice.⁵⁰ A South African Medical Research Council study confirms that even where antenatal guidelines exist, implementation is often weak due to gaps in training, staff shortages and poor accountability.⁵¹ This disjuncture between policy and practice undermines answerability and perpetuates abuse.

Fragmented accountability systems remain a key hurdle. Facility-level complaint mechanisms are often inaccessible, intimidating or ineffective. Many patients are unaware of their rights or fear retaliation if they speak out against mistreatment. Women describe being shouted at or ignored

when they cried out or questioned care, which discouraged them from speaking up. Many also thought that it was pointless to object because they believed their complaints would not be taken seriously or acted upon.⁵² Even in high-profile cases, disciplinary processes are slow and rarely result in institutional change.⁵³

Poor communication reinforces the choice to stay silent. Procedures are seldom explained, and nurses often speak harshly, leaving women feeling intimidated and reluctant to ask questions.⁵⁴ Over time, this contributes to a “culture of silence” in which mistreatment becomes normalised, and women feel they must simply endure care in overstretched facilities.⁵⁵

Another structural factor reinforcing the pattern of abuse is the divide between the public and private sectors. Only 15.5% of South Africans have medical aid coverage, meaning the vast majority rely on an already strained public health system.⁵⁶ Patients at public maternity wards tend to experience higher rates of abuse due to high patient loads, staff stress and inadequate oversight.⁵⁷ This is in line with international studies, which confirm that the poorest and least-educated women experience the highest rates of abuse in public systems.^{58,59}

While private facilities offer more personalised care, they're not immune to obstetric violence. In these settings, it often takes the form of over-medicalisation, where women are exposed to interventions that aren't always clinically necessary, such as caesarean sections and discretionary admissions.⁶⁰ The Health Market Inquiry found that private-sector admission rates for procedures like caesarean section in South Africa exceed international benchmarks and reflect a broader pattern of over-servicing.⁶¹

These patterns are linked to commercial incentives within the private health system, where fee-for-service reimbursement and hospital business models reward higher volumes of procedures. The Inquiry notes that when providers are paid per service, demand tends to be supplier-induced, leading to more interventions being recommended than are medically necessary.⁶² In maternity care, this translates into pressure to conform to hospital schedules, planned deliveries for provider convenience or preference for surgical birth over supported vaginal delivery.⁶³

Summary:

Without addressing the systemic drivers of obstetric violence, it won't be possible to achieve and sustain respectful care – even if sound national policies are in place.

Power, race and class

Obstetric violence is deeply embedded in power imbalances within society and the health system. Historical patterns of racialised abuse continue to shape clinical interactions. Women who are black, working-class, adolescent, migrant or living with HIV are consequently disproportionately subjected to neglect, coercion and silence.^{64,65,66,67,68} Migrant women often face language barriers, fear of arrest and denial of care. Adolescents report being treated with hostility or moral judgment. Women with disabilities also face distinct risks, namely physical inaccessibility and degrading assumptions.⁶⁹

“Forced sterilization and abortion are medical treatments practiced without informed consent across the globe. They are carried out by health professionals for multiple reasons, for example as being somehow in the so-called best interest of the woman, or based on the belief that certain groups of women from minority groups, such as Roma women, indigenous women, women with disabilities and women living with HIV, are not “worthy” of procreation, are incapable of making responsible decisions regarding contraception, are not fit to be “good mothers” or that their offspring are not desirable.”⁷⁰

– UN Report of the Special Rapporteur

Adolescent mothers face a higher risk of mistreatment because of intersecting vulnerabilities. A study at a Tshwane public hospital revealed that adolescent girls in labour were frequently shamed, ignored or subjected to demeaning and demoralising language, pointing to age-based discrimination in public health facilities. These dynamics are reinforced by the young women’s low levels of health literacy, education and social support, which reduce their ability to navigate the health system or claim their rights.⁷¹

At the same time, healthcare workers – especially nurses and midwives – describe working under severe constraints that limit their ability to provide respectful, person-centred care. Many report experiencing moral distress when they feel unable to act in line with their professional and ethical values due to staff shortages, resource constraints and rigid hierarchies.^{72,73} These pressures operate within gendered and classed health systems: Nurses and midwives – historically female-dominated professions – often have less decision-making power and status, leaving them caught between institutional demands and patients’ needs.

Summary:

Obstetric violence is both a reflection and a reinforcer of structural inequality in South Africa’s health system. Addressing it requires confronting how race, class, age, gender and legal status shape clinical power – and redressing the systemic injustices that enable it.

Legal and human rights context

“The State party is responsible for failing to adequately regulate and monitor public and private health services, thereby allowing violations of women’s human rights to occur in medical settings without consequence.”⁷⁴

– Decision of the UN Committee on the Elimination of Discrimination against Women (CEDAW)

South Africa’s Constitution guarantees the rights to dignity, equality, bodily integrity and access to healthcare. However, for many birthing women – especially those who are black, poor, adolescent or migrant – these rights aren’t realised in practice.

Current local legislation does not explicitly define or prohibit obstetric violence. The Sterilisation Act lacks protections against coercive or non-consensual procedures, and neither the National Health Act nor the Nursing Act creates binding standards for respectful, rights-based care or trauma-informed practice.

International frameworks increasingly treat obstetric violence as a form of GBV. The Maputo Protocol (ratified by South Africa) obliges states to protect reproductive rights and dignity in healthcare settings.⁷⁵ The 2025 African Union Convention on Ending Violence Against Women and Girls (AUCEVAWG) – Africa’s first binding treaty to address reproductive health violence – calls on states to prohibit obstetric violence, provide survivor redress and strengthen oversight.⁷⁶ UN bodies have similarly urged states to adopt laws that explicitly define obstetric violence, mandate informed consent and ensure accountability.^{77,78} South African civil society submitted a 2024 report to the AU calling for obstetric violence to be addressed through legislative and institutional reform.⁷⁹

In 2023, a Gauteng court ruled against the provincial health department for rights violations during pregnancy and childbirth.⁸⁰ Generally, however, many legal actors lack training on obstetric violence, and few rulings have addressed its systemic nature. Survivors rarely find redress. In 2025, the Parliamentary Portfolio Committee on Health proposed legislative amendments to address the issue directly.⁸¹ It furthermore expressed concern about the lack of action taken by the relevant government departments, the absence of rehabilitation and mental health support and the lack of accountability among those responsible.⁸²

The Maternal and Perinatal Care Guidelines confirm that respectful care – including consent, privacy and non-discrimination – is both a clinical and legal obligation. Hospitals and CEOs are instructed to provide staff with access to the guidelines and document any resource-based constraints.⁸³

Summary:

Legal recognition, judicial training and legislative reform are essential to prevent obstetric violence and hold institutions accountable. However, obstetric violence is currently not explicitly recognised in law, leaving women without legal remedies. It’s recommended that the Minister of Justice engage with the South African Law Reform Commission to define obstetric violence as a distinct legal harm, framed as a violation of dignity, equality, bodily integrity and access to healthcare. In addition, the commission should develop binding legislation that imposes enforceable obligations on healthcare providers, establishes accessible reporting and redress mechanisms and aligns with constitutional and international standards. To ensure it’s implemented effectively, the legislation must be supported by broad stakeholder consultation and public advocacy.



Mental health consequences

Obstetric violence inflicts lasting psychological harm. Studies confirm strong links between such violence and postpartum depression, post-traumatic stress disorder and anxiety.^{84,85,86} These outcomes are compounded by the absence of routine mental health screening and/or support during and after childbirth.

Women who experience obstetric mistreatment often delay or avoid returning to health facilities due to distrust in the system. This amplifies the negative impact on maternal and neonatal outcomes.⁸⁷

Adolescent mothers describe labour and delivery as traumatising and emotionally scarring. They often express fear, shame and reluctance to engage with healthcare services again. Without social support, these emotional wounds increase the risk of postpartum depression and long-term disengagement from care.^{88,89,90}

The inclusion of a dedicated chapter on maternal mental health in the updated Maternal and Perinatal Care Guidelines marks a positive step and recognises the importance of mental well-being during pregnancy and postpartum. However, the guidance is non-binding and doesn't mandate routine mental health screening, counselling or referral, which means there's a risk of inconsistent implementation across facilities. To effectively protect maternal health and well-being, there's an urgent need to mandate routine mental health screening, particularly for high-risk groups such as adolescents, women with a history of intimate partner violence and those who have suffered prior birth trauma and obstetric violence.

Summary:

Maternal mental health is compromised by obstetric violence; psychosocial support must therefore become a core component of maternity care.

Global practices and lessons

Many countries have taken steps to recognise and address obstetric violence in their laws and policies. In Latin America, Mexico and Venezuela have enacted legislation defining obstetric violence as a form of violence against women, with survivor-led reporting and redress mechanisms.^{91,92}

Australia's Select Committee on Birth Trauma and Spain's legal rulings demonstrate growing recognition of obstetric harm in these countries.^{93,94} The AU has also formally integrated obstetric violations into its sexual and reproductive health protocols.⁹⁵

In the US, a Centers for Disease Control and Prevention (CDC) study found widespread mistreatment of women, especially women of colour. Forty-five per cent feared mistreatment if they spoke up, and nearly one in three black, Hispanic or multiracial mothers reported feeling mistreated.⁹⁶

Scoping reviews and comparative studies confirm that change must be systemic. Models that have proven effective combine national legislation, professional ethics reform, facility-level accountability and budgetary investment.⁹⁷

The WHO's Respectful Maternity Care Charter offers a clear roadmap. Its emphasis on dignity, informed consent, privacy and provider support aligns with international human rights standards and national guidelines.^{98,99}

Summary:

South Africa can draw on global lessons to shape an integrated, legally enforceable response to obstetric violence.



Economic costs of obstetric violence

While data quantifying the full economic burden of obstetric violence is limited, existing research highlights the hidden and indirect costs to the health system, the state and society. Mistreatment during childbirth leads to rising litigation, increased demand for mental health services, reduced uptake of healthcare services and missed opportunities for preventive care.

“... findings from the Commission for Gender Equality, which investigated 15 hospitals in KwaZulu-Natal and Gauteng and confirmed a systemic pattern of violations, as well as the national HIV Stigma Index, where 7.4 percent of 6 000 women surveyed reported coerced or forced sterilisation, suggesting that between 350 000 and 400 000 women may be affected.”¹⁰⁰

– Parliamentary Portfolio Committee on Health

Litigation and compensation payouts are increasing, particularly for claims of coerced consent, stillbirth and mistreatment.¹⁰¹ Untreated trauma reduces productivity, disrupts maternal-infant bonding and increases reliance on already overstretched mental health services.¹⁰²

Disrespectful systems erode trust, leading to inefficiencies and reducing health-seeking behaviour, particularly among historically marginalised populations.¹⁰³

Summary:

Investing in respectful maternity care and survivor support services is not only an ethical imperative – it's also fiscally sound health policy.

Litigation and redress

Despite several court victories, justice for survivors remains slow, limited and inaccessible. Resource barriers, legal complexity and limited awareness often constrain domestic remedies.

Regional and international bodies – including the African Commission on Human and Peoples’ Rights and the CEDAW – provide alternative avenues for redress, particularly in systemic cases of reproductive rights violations.¹⁰⁵

Survivors consistently call for more than compensation. They want acknowledgement, apologies, guarantees of non-repetition and health systems that protect dignity and autonomies.¹⁰⁶

Legal professionals and health rights advocates are increasingly pursuing obstetric violence litigation as a tool to drive systemic reform, establish precedent and amplify survivor testimony.^{107,108}



Summary:

Redress must be survivor-centred, timely and transformative – not merely punitive.

Recommendations

Obstetric violence isn't inevitable.

It results from structural neglect, legal gaps and institutional silence. South Africa can end it – with political will, community mobilisation and decisive reform.

Multi-Level Response Framework



This section proposes coordinated actions across six priority areas:

A Legal reform

- Amend the National Health Act and Sterilisation Act to include explicit protections against obstetric violence and to mandate informed, voluntary consent for all procedures.
- Introduce binding, maternity-specific regulations that establish clear minimum norms and standards for respectful maternity care in all health facilities. These regulations should define a core threshold of care that cannot be compromised, regardless of institutional constraints, staff shortages or resource limitations.
- Develop national legislation that defines and prohibits obstetric violence and that's aligned with the Constitution and international obligations.
- Ensure obstetric violence is recognised in GBV strategies and maternal health policies.
- Assign responsibility to the National Department of Health and the Department of Justice and Constitutional Development to initiate and monitor legislative changes.

B Health system accountability

- Implement the Maternal and Perinatal Care Guidelines as the binding standard for respectful, rights-based maternity care, with clear accountability protocols for health managers.
- Make the integration of obstetric violence reporting systems into health information platforms mandatory.
- Strengthen the oversight role of provincial health departments and hospital boards.
- Mandate routine facility audits and link accountability mechanisms to the Office of Health Standards Compliance.
- Support the expansion of midwife-led obstetric units and community-based maternal care as advocated by the International Confederation of Midwives and the Maternal and Perinatal Guidelines.

C Mental health integration

- Embed routine screening for postpartum mental health in maternity care.
- Recruit and train counsellors and community health workers to provide trauma-informed support.
- Ensure referral pathways from maternity wards to mental health services are operational.

D Provider support and training

- Incorporate obstetric violence prevention, ethics and respectful care into both pre-service curricula and continuing education for midwives and nurses.
- Hold nursing schools and the Department of Higher Education and Training accountable for curriculum reform.
- Improve working conditions to reduce burnout, including adequate staffing, supervision and mental health support.
- Integrate respectful, adolescent-responsive care into pre-service and in-service provider training.
- Develop communication protocols that specifically address youth-centred care, including stigma reduction and trauma-informed support.
- Ensure antenatal training protocols – including respectful communication, informed consent and adolescent-responsive care – are standardised and routinely monitored across provinces.

E Survivor-centred redress

- Establish complaint mechanisms at the facility, district and national levels that are accessible, anonymous and trauma-informed.
- Offer non-judicial remedies such as apologies, truth-telling processes and support groups.
- Allocate resources for survivor-led initiatives, peer support and legal assistance.

F Data collection and reporting

- Integrate obstetric violence indicators into national health surveillance tools.
- Fund periodic prevalence and qualitative studies that are disaggregated by age, race, disability and migration status.
- Report publicly on complaints, disciplinary actions and facility-level reforms.

Summary:

Maternal mental health is compromised by obstetric violence; psychosocial support must therefore become a core component of maternity care.



Conclusion

Obstetric violence undermines the health system's constitutional obligation to provide respectful, equitable and evidence based care. While its causes are systemic – from under-resourced facilities to legal and institutional gaps – its consequences are deeply personal: diminished trust, preventable harm and long-term disengagement from care.

South Africa has the tools to act.

National guidelines already set out clear standards. Constitutional and international obligations provide a legal foundation. The 2025 Embrace Birthing Survey results and survivor accounts offer evidence and indicate urgency. What remains to be done is coordinated, accountable and sustained implementation.

Preventing obstetric violence isn't an aspirational goal; it's a measurable standard of quality, a test of public accountability and a necessary condition for health system integrity. Respectful maternity care must become the norm – not the exception.

Bibliography

1. Embrace. 2025. 2025 Birthing Survey: The Extent and Nature of Obstetric Violence in South Africa.
2. Ibid.
3. Rucell, J.Z. 2017. *Obstetric Violence & Colonial Conditioning in South Africa's Reproductive Health System* (PhD thesis, University of Leeds). White Rose eTheses Online. oai:etheses.whiterose.ac.uk:20747
4. Dutton, J. 2022. What drives obstetric violence amongst nurses and midwives throughout the continuum of maternal health care in governmental hospitals and antenatal clinics in urban Western Cape. (PhD thesis, University of the Western Cape). UWCScholar. <https://uwcscholar.uwc.ac.za/items/1407f3fd-5c73-47f7-bdba-74dec2342ad3>
5. World Health Organization. 2015. The prevention and elimination of disrespect and abuse during facility-based childbirth. <https://iris.who.int/server/api/core/bitstreams/a287bfd1-97c0-4af6-ba57-a4469fd3ed8/content>
6. African Union. 2003. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (adopted 11 July 2003, entered force 25 November 2005). https://au.int/sites/default/files/treaties/37077-treaty-charter_on_rights_of_women_in_africa.pdf
7. Jewkes, R. and Penn-Kekana, L. 2015. Mistreatment of Women in Childbirth: Time for Action on This Important Dimension of Violence against Women. *PLOS Medicine* 12(6), e1001849. <https://doi.org/10.1371/journal.pmed.1001849>
8. Swemmer, S. et al. 2022. Obstetric Violence Know Your Rights Handbook and Pilot Project. Centre for Applied Legal Studies. <https://doi.org/10.13140/RG.2.2.33349.52962>
9. Oosthuizen, S.J. et al. 2017. It does matter where you come from: mothers' experiences of childbirth in midwife obstetric units, Tshwane, South Africa. *Reproductive Health* 14(1), 151. <https://doi.org/10.1186/S12978-017-0411-5>
10. Rucell, J.Z. 2017. *Obstetric Violence & Colonial Conditioning*.
11. Collins, E.C. et al. 2025. Maternity Care Providers Perspectives and Experiences of Obstetric Violence in Low-, Middle- and High-Income Countries: An Integrative Review. *Journal of Advanced Nursing*. <https://doi.org/10.1111/jan.70055>
12. Embrace. 2025. 2025 Birthing Survey.
13. Collins, E.C. et al. 2025. Maternity Care Providers Perspectives.
14. Bohren, M.A. et al. 2024. Towards a better tomorrow: addressing intersectional gender power relations to eradicate inequities in maternal health. *eClinicalMedicine* 67, 102180. [https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370\(23\)00357-7/fulltext](https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(23)00357-7/fulltext)
15. United Nations. 2019. Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence. General Assembly. <https://docs.un.org/en/A/74/137>
16. African Union. 2003. Protocol to the African Charter.
17. Mapumulo, S. et al. 2021. Health workers' disrespectful and abusive behaviour towards women during labour and delivery: A qualitative study in Durban, South Africa. *PLOS ONE* 16(12), e0261204. <https://doi.org/10.1371/journal.pone.0261204>
18. Human Rights Watch. 2024. Addressing 'Obstetric Violence' in Africa: Abuse in Health Care System Amounts to Violence Against Women. Questions and Answers on Obstetric Violence. <https://www.hrw.org/news/2024/11/13/addressing-obstetric-violence-africa#:~:text=These%20acts%20include%20non,viole%3B%20verbal%20abuse%20and%20sexist>
19. Department of Health. 2024. National Integrated Maternal and Perinatal Care Guidelines for South Africa. Fifth Edition. https://knowledgehub.health.gov.za/system/files/elibdownloads/2024-10/Integrated%20Maternal%20and%20Perinatal%20Care%20Guideline_23_10_2024_0.pdf
20. Human Rights Watch. 2024. Addressing 'Obstetric Violence' in Africa.
21. Mapumulo, S. et al. 2021. Health workers' behaviour towards women.
22. Oosthuizen, S.J. et al. 2017. Mothers' experiences of childbirth.
23. Department of Health. 2024. Maternal and Perinatal Care Guidelines.
24. Human Rights Watch. 2024. Addressing 'Obstetric Violence' in Africa.
25. Özer, E., Çetinkaya Sen, Y. and Canli, S. 2025. Evaluation of the prevalence of obstetric violence during child birth: A Meta-analysis study. *Aggression and Violent Behavior* 83, 102067. <https://doi.org/10.1016/j.avb.2025.102067>
26. Department of Health. 2024. Maternal and Perinatal Care Guidelines.
27. Embrace. 2025. 2025 Birthing Survey.
28. Human Rights Watch. 2024. Addressing 'Obstetric Violence' in Africa.
29. Office of the Health Ombud. 2023. Investigation report into allegations against Rahima Moosa Mother and Child Hospital (RMMCH). <https://healthombud.org.za/wp-content/uploads/2023/03/Investigation-Report-into-allegations-against-Rahima-Moosa-Mother-and-Child.pdf>
30. Department of Health. 2024. Maternal and Perinatal Care Guidelines.
31. Amboko, B. et al. 2025. Characterizing the cascades of care experienced by pregnant adolescents in three African countries; Ethiopia, Kenya and South Africa: A Cohort Study. medRxiv. <https://doi.org/10.1101/2025.05.16.25327748>
32. Oosthuizen, S.J. et al. 2017. Mothers' experiences of childbirth.
33. Ibid.
34. Ibid.
35. Department of Health. 2024. Maternal and Perinatal Care Guidelines.
36. Embrace. 2025. 2025 Birthing Survey.
37. Embrace. 2024. Counting What Matters: Birth Experiences Survey Results. https://www.embrace.org.za/wp-content/uploads/2024/02/Count-Our-Births_Survey-Results-Feb-2024.pdf
38. Commission for Gender Equality. 2020. Investigation report on the forced sterilisation of women living with HIV/AIDS in South Africa (Complaint Ref No: 414/03/2015/KZN). <https://cge.org.za/wp-content/uploads/2021/01/forced-sterilisation-of-women-living-with-hiv-and-aids-in-south-africa.pdf>
39. Centre for Applied Legal Studies et al. 2024. Submission to the African Union Commission (AUC) and the Gender Is My Agenda Campaign (GIMAC) on Obstetric Violence in Africa for Consideration and Inclusion in the Africa Union Convention on Ending Violence Against Women and Girls. https://www.hrw.org/sites/default/files/media_2024/11/Submission_Q%20and%20A%20on%20Obstertric%20violence.pdf
40. Swemmer, S. 2022. *Obstetric Violence Know Your Rights Handbook*.
41. Gauteng Division of the High Court. 2023. Migrant Health Court Order. Section 27 v Gauteng Department of Health and others. Case No: 22/19304. <https://section27.org.za/wp-content/uploads/2023/04/section-27-and-others-vs-MEC-for-health-Gauteng-and-others-case-no-19304-22-Court-Order-Default-Judgment-14-April-2023-Sutherland-DJP.pdf>
42. Parliamentary Portfolio Committee on Health. 2025a. HPCSA operational processes and complaint-management mechanisms; Update on the forced sterilisation of HIV-positive women. <https://pmg.org.za/committee-meeting/42136/>
43. Oosthuizen, S.J. et al. 2017. Mothers' experiences of childbirth.
44. Amboko, B. et al. 2025. Care experienced by pregnant adolescents.
45. Gauteng Division of the High Court. 2023. Migrant Health Court Order.
46. Office of the Health Ombud. 2023. Investigation report against RMMCH.
47. Ibid.
48. Collins, E.C. et al. 2025. Maternity Care Providers Perspectives.
49. Dutton, J. 2022. Obstetric violence amongst nurses and midwives.
50. Department of Health. 2024. Maternal and Perinatal Care Guidelines.
51. Hlongwane, T.M. et al. 2021. Implementing antenatal care recommendations, South Africa. *Bulletin of the World Health Organization* 99, p. 220. <https://doi.org/10.2471/BLT.20.278945>
52. Mapumulo, S. et al. 2021. Health workers' behaviour.
53. Skoko, E. 2022. Maternal gift economy framework for addressing obstetric violence. (con)textos: revista d'antropologia i investigació social 10, pp. 35-52. <https://dialnet.unirioja.es/servlet/articulo?codigo=8393864>
54. Ibid.
55. Ibid.
56. Statistics South Africa. 2025. General Household Survey 2024. <https://www.statssa.gov.za/publications/P0318/P03182024.pdf>
57. Competition Commission of South Africa. 2019. Health Market Inquiry: Final Findings and Recommendations Report. <https://www.compcom.co.za/wp-content/uploads/2020/01/Final-Findings-and-recommendations-report-Health-Market-Inquiry.pdf>
58. Skoko, E. 2022. Maternal gift economy framework.
59. Azzam, Q.A. et al. 2023. Obstetric Violence among Pregnant Jordanian Women: An Observational Study between the Private and Public Hospitals in Jordan. *Healthcare* 11(5), 654. <https://doi.org/10.3390/healthcare11050654>
60. Ibid.
61. Ibid.
62. Ibid.
63. Ibid.
64. Chadwick, R. 2017. Ambiguous subjects: Obstetric violence, assemblage and South African birth narratives. *Feminism & Psychology* 27(4), pp. 489-509. <https://doi.org/10.1177/0959353517692607>
65. Pickles, C.M.S. 2018. Sounding the Alarm: Government of the Republic of Namibia v LM and Women's Rights during Childbirth in South Africa. *Potchefstroomse Elektroniese Regsblad/Potchefstroom Electronic Law Journal* 21, 1-34. <https://dx.doi.org/10.17159/1727-3781/2018/v21i0a4303>
66. Amboko, B. et al. 2025. Care experienced by pregnant adolescents.
67. Ibid.
68. Rucell, J.Z. 2017. *Obstetric Violence and Colonial Conditioning*.
69. Collins, E.C. et al. 2025. Maternity Care Providers Perspectives.
70. United Nations. 2019. Report on violence against women.
71. Oosthuizen, S.J. et al. 2017. Mothers' experiences of childbirth.
72. Collins, E.C. et al. 2025. Maternity Care Providers Perspectives.
73. Bohren, M.A. et al. 2024. Addressing intersectional gender power relations.
74. United Nations. 2022. Committee on the Elimination of Discrimination against Women (CEDAW). Views adopted by the Committee under article 7 (3) of the Optional Protocol, concerning communication No. 149/2019. CEDAW/C/82/D/149/2019. <https://digitallibrary.un.org/record/3988079?ln=en>

75. African Union. 2003. Protocol to the African Charter.
76. African Union. 2024. The African Union Convention on Ending Violence Against Women and Girls. <https://au.int/en/aucevawg>
77. United Nations. 2022. Views adopted by the CEDAW.
78. United Nations. 2019. Report on violence against women.
79. Centre for Applied Legal Studies et al. 2024. Submission on Obstetric Violence in Africa.
80. Gauteng Division of the High Court. 2023. Migrant Health Court Order.
81. Parliamentary Portfolio Committee on Health. 2025a. Forced sterilisation of HIV-positive women.
82. Parliamentary Portfolio Committee on Health. 2025b. Committee on Health Expresses Concern Over Report on Forced Sterilisation of Impoverished HIV Positive Women. Media statement, 27 November. <https://www.parliament.gov.za/press-releases/media-statement-committee-health-expresses-concern-over-report-forced-sterilisation-impoverished-hiv-positive-women>
83. Department of Health. 2024. Maternal and Perinatal Care Guidelines.
84. Silva-Fernandez, C.S. et al. 2023. Factors Associated with Obstetric Violence Implicated in the Development of Postpartum Depression and Post-Traumatic Stress Disorder: a Systematic Review. *Nursing Reports* 13(4), pp. 1 553–1 576. <https://doi.org/10.3390/nursrep13040130>
85. Kohan, S., Mena-Tudela, D. and Youseflu, S. 2025. The impact of obstetric violence on postpartum quality of life through psychological pathways. *Scientific Reports* 15, 4 799. <https://www.nature.com/articles/s41598-025-88708-8>
86. Mengesha, M.B. et al. 2025. Obstetric violence across the maternal care continuum and its impact on women's perinatal mental health in low-and middle-income countries: a systematic review and meta-analysis protocol. *BMJ Open* 15, e105355. <https://doi.org/10.1136/bmjopen-2025-105355>
87. Ibid.
88. Oosthuizen, S.J. et al. 2017. Mothers' experiences of childbirth.
89. World Health Organization. 2018. WHO recommendations: Intrapartum care for a positive childbirth experience. Licence: CC BY-NC-SA 3.0 IGO. <https://iris.who.int/server/api/core/bitstreams/ba043cf7-cba4-484d-bf7e-ec79c4102d54/content>
90. World Health Organization. 2022. Improving the quality of care for maternal, newborn and child health: Implementation guide for national, district and facility levels. Licence: CC BY-NC-SA 3.0 IGO. <https://iris.who.int/server/api/core/bitstreams/74956bbf-0666-4a0e-8490-0f752d514b31/content>
91. Smith-Oka, V., Rubin, S.E. and Dixon, L.Z. 2022. Obstetric Violence in Their Own Words: How Women in Mexico and South Africa Expect, Experience, and Respond to Violence. *Violence Against Women* 28(11), pp. 2 700–2 721. <https://doi.org/10.1177/10778012211037375>
92. Sadler, M. et al. 2016. Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence. *Reproductive Health Matters* 24(47), pp. 47–55. <https://doi.org/10.1016/j.rhm.2016.04.002>
93. New South Wales. Parliament. 2024. Birth trauma (Report no. 1). Legislative Council. Select Committee on Birth Trauma. <https://www.parliament.nsw.gov.au/lcdocs/inquiries/2965/FINAL%20Birth%20Trauma%20Report%20-%2029%20April%202024.pdf>
94. United Nations. 2022. Views adopted by the CEDAW.
95. African Union. 2024. Ending Violence Against Women and Girls.
96. Mohamoud, Y.A. et al. 2023. Vital Signs: Maternity Care Experiences – United States, April 2023. *MMWR (Morbidity and Mortality Weekly Report)* 72(35), pp. 961–967. <https://www.cdc.gov/mmwr/volumes/72/wr/mm7235e1.htm>
97. Arcilla, J.T. et al. 2025. Racialized migrant women's discrimination in maternal care: a scoping review. *International Journal for Equity in Health* 24(1), 16. <https://doi.org/10.1186/s12939-025-02384-8>
98. World Health Organization. 2018. Recommendations: Intrapartum care.
99. World Health Organization. 2022. Improving the quality of care.
100. Parliamentary Portfolio Committee on Health. 2025a. Forced sterilisation of HIV-positive women.
101. Swemmer, S. 2022. Obstetric Violence Know Your Rights Handbook.
102. Silva-Fernandez, C.S. et al. 2023. Obstetric Violence and Postpartum Depression.
103. Skoko, E. 2022. Maternal gift economy framework.
104. Swemmer, S. 2024. No Time for Justice? Obstetric Violence, Damages Claims and Prescription Periods in South African Law. *New Area Studies* 4(2). <https://doi.org/10.37975/NAS.70>
105. Pickles, C. 2025. Emerging Human Rights Standards on Obstetric Violence and Abuse During Childbirth. *International Journal of Gynaecology & Obstetrics*, 170(1), 508-514. <https://doi.org/10.1002/ijgo.70174>
106. Swemmer, S. 2024. Damages Claims and Prescription Periods.
107. Ibid.
108. United Nations. 2022. Views adopted by the CEDAW.
109. Embrace. 2025. 2025 Birthing Survey.

What is Change Ideas?

DGMT's Change Ideas is a new initiative that makes cost-effective and scalable policies accessible to the public and politicians. These policies, drawn from years of implementation experience, research, and embeddedness in South African civil society, offer opportunities to get South Africa out of the inequality trap. Change Ideas aims to empower you with comprehensive policy briefs, research findings, and expert perspectives on 10 key opportunities identified as pivotal for fostering sustainable change.





Douglas Murray House 1 Wodin Rd Claremont 7700
PO Box 23893 Claremont 7735
+27 (0)21 670 9840
info@changeideas.co.za
www.dgmt.co.za

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