

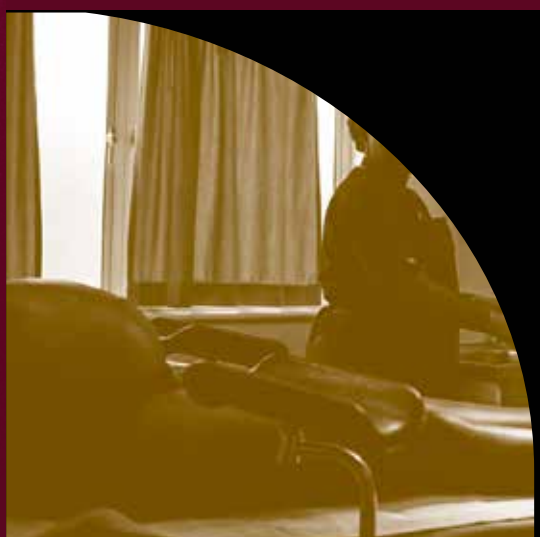




THE EXTENT AND NATURE OF OBSTETRIC VIOLENCE IN SOUTH AFRICA

2025 BIRTHING SURVEY

Findings Report



embrace

The Movement for Mothers

THE EXTENT AND NATURE OF OBSTETRIC VIOLENCE IN SOUTH AFRICA

2025 BIRTHING SURVEY

Findings Report

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ACRONYMS

ACRONYM	MEANING
CAPI	Computer-Assisted Personal Interviewing
CEDAW	United Nations Committee on the Elimination of Discrimination Against Women
CSE	Comprehensive Sexuality Education
DP	Distress Protocol
DGMT	D G Murray Trust
GBV	Gender-based Violence
GP	Gauteng Province
HSRC	Human Sciences Research Council
ICPD	International Conference on Population and Development
IRR	Inter-Rater Reliability
KZN	KwaZulu-Natal
MMR	Maternal Mortality Ratio
OV	Obstetric Violence
POPIA	Protection of Personal Information Act
PTSD	Post-Traumatic Stress Disorder
SDG	Sustainable Development Goals
SSA	Social Surveys Africa
SAL	Small Area Level (census)
UHC	Universal Health Coverage
WHO	World Health Organisation

1. EXECUTIVE SUMMARY

1.1 Study Aim

This report presents the findings of the Obstetric Violence Prevalence Study conducted by Social Surveys Africa on behalf of Embrace and DG Murray Trust. The study aimed to fill existing knowledge gaps, raise awareness, inform policy development, and guide interventions aimed at preventing and addressing obstetric violence in South Africa, ultimately striving towards the realisation of reproductive justice for all women.

1.2 Methodology

The study employed a quantitative methodology, utilising household interviews. The Community Tapestry typology was used to sample 24 areas in six municipalities in the Gauteng and KwaZulu-Natal provinces, South Africa. The typology ensured representativeness across regions, with data collected from 845 respondents.

1.3 Prevalence of Obstetric Violence

Over the past ten years (2015–2025), 60% of those who have given birth in KwaZulu-Natal and Gauteng have experienced some form of obstetric violence (OV) – representing 1.79 million people. Of those, 864 297 of those were in Gauteng and 923 130 were in KwaZulu-Natal. The prevalence of obstetric violence is significantly higher in KZN with 63% of birthing individuals in that province having been abused as compared to 58% in Gauteng. Comparing these trends across African countries shows that obstetric violence is not simply about individual misconduct, but rather a systemic issue rooted in gender inequality, poor accountability, and weak health systems.

1.4 Types of Abuse

1.4.1 Physical abuse and Non-consented Care

Reports of physical violence and medical negligence were extensive. A quarter of abused respondents had procedures undertaken without their consent (e.g., C-sections, sterilisation); others were pressured into procedures, often in private facilities. Approximately one in seven (14%) were slapped/pinched/humiliated, and one in ten (10%) said their newborn was mistreated or injured.

1.4.2 Verbal Abuse

Nearly three in five respondents experienced disrespect/belittling, and two in five were shouted at or insulted — eroding trust and mental well-being.

1.4.3 Emotional Abuse

Emotional harm was pervasive and undermined trust, confidence, and future health-seeking behaviour, which contravened rights to dignity, autonomy, and non-discrimination.

1.5 Awareness of Abuse

Mistreatment has become so normalised that two-thirds of those abused did not recognise their treatment as abuse.

1.6 Profile of Those who Experienced Obstetric Violence

Age, marital status, education, employment status, personal income and deprivation according to the poverty index were all indicators of increased propensity of abuse. Those in government facilities were more likely to be abused than those in private facilities.

1.7 Procedures Undertaken Without Explanation or Consent

The practice of undertaking procedures without consent was extensive, with a third of respondents indicating that they had undergone procedures without an explanation of what the procedure involved or giving their consent. These procedures included episiotomies, C-sections, internal examinations, performing a "husband stitch", and in 3% of cases, sterilisation. This practice has become so normalised that many of the respondents didn't know it was wrong for healthcare providers not to ask a patient's consent before undertaking a procedure. A maternal education campaign is desperately needed to inform women about their rights.

1.8 Individuals Responsible for Abuse

Nurses and midwives, as the primary caregivers in overstretched public health systems, were most often identified as involved in obstetric abuse, with 92% of women reporting that nurses or midwives abused them. This is driven by high workloads, poor staffing, burnout, hierarchical cultures, limited respectful maternity care (RMC) training, and social prejudice. Solutions include integrating RMC into training, strengthening accountability, improving working conditions, transforming institutional culture, and empowering patients.

Although occurring less often (14%), abuse by doctors involved coerced consent, unnecessary interventions, and violations of reproductive autonomy, rooted in medical paternalism, unchecked authority, time pressures, inadequate rights-based training, and social prejudice. Addressing this requires curriculum reform, independent oversight, stronger legal protections, and leadership-driven cultural change in line with 2024 national guidelines.

1.9 Perceived Prejudice Resulting in Abuse

Obstetric violence is not random — it is patterned along lines of social and structural vulnerability. Women perceived as young, poor, uninformed, different, or powerless are more likely to be mistreated. Age and number of previous deliveries were seen as the most likely influences of abuse.

1.10 Conditions Experienced During the Birthing Process

Although most patients understood what information was provided, there were clear information gaps, with staff failing either to explain procedures or to seek permission for procedures undertaken. Other conditions experienced during the birthing process suggest overcontrolling care ,which undermined patient rights and autonomy. Six in ten respondents were denied pain relief, and many faced restrictions on movement or birthing position — practices contrary to evidence-based recommendations for improved outcomes.

1.11 Birthing Environment of Those who Experienced Abuse

While most respondents reported good physical conditions during childbirth — clean rooms (87%), access to food and water (84%), comfortable temperatures (79%), and clean toilets (70%) — relational and dignity-based care was lacking. Nearly one-third felt unsafe, 40% lacked privacy curtains, 11% experienced breaches of confidentiality, and only 25% were allowed a preferred birth companion, contrary to World Health Organization (WHO) recommendations. A quarter were asked to clean up after delivery, reflecting neglect and dehumanisation despite adequate infrastructure.

1.12 Care Given On or Before Discharge

Postnatal care showed major gaps in patient-centred and respectful maternity care. Most women were discharged without the opportunity to discuss concerns or preferences, 60% lacked information on maternal danger signs, and over half were not told about newborn warning signs. While 94% of newborns were examined before discharge, only 74% of mothers received checks. Reproductive autonomy was compromised, with 36% of respondents forced to take contraception and 42% denied choice of method.

1.13 Reporting of Abuse

Reporting of obstetric violence was found to be extremely low, with nine in ten patients not reporting their abuse and two-thirds being unaware that their treatment constituted abuse. Barriers include unclear or unsafe reporting channels, fear of retaliation, trauma, shame, family discouragement, and cultural normalisation of mistreatment. Effective accountability requires clear, confidential complaint systems, protection from retaliation, community education, emotional support for survivors, and measures such as facility-based ombudsperson offices and trained birth companions to monitor care and deter abuse.

1.14 Impact of Abuse

Obstetric violence causes deep and lasting harm. Results showed that survivors often avoid healthcare facilities (55%) and delay or forgo future pregnancies (46%), which undermines maternal and child health outcomes. High rates of undiagnosed depression, trauma, and anxiety are reported, alongside physical recovery complications, sexual health impacts, and impaired mother–infant bonding. Some infants suffer injury, disability or even death, and rare but severe maternal harms point to critical failures in patient safety. These findings highlight the urgent need for trust-building in healthcare, integrated mental health support, robust accountability systems, and the enforcement of respectful maternity care standards.

1.15 Recommendations

The report calls for urgent, multi-level action to end obstetric violence in South Africa. This includes fully implementing the 2024 National Integrated Maternal and Perinatal Care Guidelines, with an emphasis on dignity, informed consent, and privacy; establishing patient-rights and ombudsperson offices in all facilities; and ensuring that those responsible for abuse are held accountable. Strengthening the health system requires increased funding, recruitment and retention of skilled maternity staff, improved supervision, and continuous training in respectful, trauma-informed care. Empowering women and communities through rights education, guaranteed birth companions, and community advocacy is critical. Finally, improved data systems and targeted research are needed to track respectful care, monitor patient experiences, and test innovative, patient-centred models of maternity care.

2. BACKGROUND

The International Conference on Population and Development (ICPD) reframed sexual and reproductive health as a matter of human rights and social justice, placing dignity, autonomy, and well-being at the centre of global health policy (ICPD, 1994; UNFPA, 2004). In 2019, global leaders renewed commitments to eliminate preventable maternal deaths, ensure universal access to family planning, integrate sexual and reproductive health into universal health coverage and end harmful practices, including violence, in maternity care. These goals align with the Sustainable Development Goals on health, gender equality, and reproductive rights.

Despite these commitments, abuse and mistreatment of pregnant women and mothers — known globally as obstetric violence — remain widespread. First identified in South America in 2007, obstetric violence refers to harmful, disrespectful, and degrading treatment during childbirth, often rooted in power imbalances between patients and providers (Chadwick, 2016; Morales et al., 2018; Williams, 2018). WHO (2015) affirms that all individuals have the right to respectful,dignified care, yet seven forms of obstetric violence are consistently documented: physical abuse, non-consensual care, breaches of confidentiality, non-dignified care, discrimination, abandonment, and detention for inability to pay (Bowser & Hill, 2010).

In South Africa, obstetric violence occurs within a legacy of apartheid-era inequities, under-resourced health facilities, and entrenched gender and power hierarchies. While the Constitution and progressive reproductive health policies guarantee the rights to dignity, health, and non-discrimination, studiesreveal ongoing verbal abuse, neglect, non-consensual procedures, discrimination, and physical violence in both public and private facilities (Jewkes & Penn-Kekana, 2015). The public sector — where 90–95% of births occur (Stats SA, 2022) — is characterised by overcrowding, staff shortages, and infrastructure deficits. These factors place significant strain on health workers but do not excuse mistreatment.

Although countries in Latin America and Spain recognise obstetric violence as gender-based violence, and Venezuela criminalises it (Dixon, 2015; Smith-Oka, 2015), the term is seldom used in South Africa and remains absent from most policies. While the state has taken strong action on gender-based violence more broadly, including introducing the National Council on Gender-based Violence and Femicide Bill, there is little targeted effort to address obstetric violence or ensure accountability for perpetrators, leaving a significant gap in the protection of maternal rights.

2.1 Policy Gap and experiences of Obstetric Violence in South Africa:

South Africa already has the legal basis and policy guidance to address obstetric violence — through constitutional rights, the National Health Act, the Patients' Rights Charter, 2024 maternity guidelines, and the Sterilisation Act No. 44 of 1998. The main policy requirement now is enforcement: integrating strategies for preventing obstetric violence into those targeting gender-based violence, mandating respectful maternity care audits, establishing strong complaint mechanisms, and ensuring accountability for breaches.

2.2 Lack of Prevalence Data

One of the most critical gaps is the absence of large-scale, empirical data on the prevalence of obstetric violence in South African health facilities. While qualitative studies and anecdotal reports suggest that mistreatment during childbirth is not uncommon (Bohren et al., 2015; Jewkes & Penn-Kekana, 2015), there is no national or provincial surveillance system dedicated to measuring obstetric violence. This lack of robust data hinders policymakers' ability to design targeted interventions and monitor progress. The provision of empirical evidence to support advocacy efforts and policy reform initiatives aimed at addressing obstetric violence in the South African maternal healthcare system is essential. This includes generating data-driven insights to mobilise stakeholders, collaborate with government agencies, healthcare institutions, and civil society organisations to advance the rights of women towards the provision of dignified maternal healthcare services.

2.3 Limited Understanding of Long-Term Impact

The psychological and physical consequences of obstetric violence are also poorly documented in the South African context. Although international research has linked mistreatment during childbirth to post-traumatic stress disorder (PTSD), postpartum depression, reduced trust in health systems, and avoidance of future facility-based deliveries (Bohren et al., 2015; Moray, 2018), these outcomes are not systematically tracked in South Africa. Without this evidence, the long-term costs of obstetric violence to maternal and public health remain invisible in policy discussions.

2.4 Policy and Legal Framework Deficiencies

Unlike some Latin American countries, such as Venezuela and Argentina, which have formally recognised obstetric violence as a distinct category of violence in their legal systems (Dixon, 2015; Smith-Oka, 2015), South Africa lacks a clear legal definition. Existing health and gender policies do not explicitly address the issue, making legal recourse for survivors difficult. The absence of formal recognition in policy and law means that advocacy efforts are often diluted, and health workers who commit abuse during childbirth are rarely held accountable through disciplinary or legal processes (Chadwick, 2016).

2.5 Regional and Socio-Economic Disparities

Little is known about how experiences of obstetric violence differ across regions and among socio-economic groups. Given South Africa's deeply unequal health system — shaped by apartheid legacies and characterised by disparities between rural and urban, and public and private health services (Stats SA, 2022) — it is likely that obstetric violence is more prevalent among poorer, black individuals giving birth in under-resourced public facilities. However, there is insufficient research to map these disparities, limiting the ability to implement equity-focused interventions. The survey therefore aimed to explore provincial disparities by including KwaZulu-Natal and Gauteng in the sample. We selected KwaZulu-Natal and Gauteng owing to marked systemic failings evidenced in key health-system indicators. Data from the 2022 District Health Barometer (Health Systems Trust 2023) show high in-facility maternal mortality ratios (measured per 100 000 deliveries) in several KwaZulu-Natal districts (e.g. uMgungundlovu: 132.7; Ugu: 87.3; King Cetshwayo: 116.8), as well as in Gauteng's Sedibeng district (78.0). While some of these districts show maternal mortality ratios far above the national rate of 101 per 100,000, those slightly lower than the national rate are still unacceptably high. Historical studies (2002–2006) similarly highlight KwaZulu-Natal and Gauteng as being two provinces with high numbers of maternal deaths, in stark contrast to the Western Cape's much lower maternal mortality ratio.

In addition, both provinces have been the focus of high-profile media and human-rights investigations that revealed widespread obstetric abuse in public facilities — ranging from physical and verbal mistreatment to refusal of timely care.

3. OBJECTIVES

01 Assessing Prevalence

02 Identify Forms and Context

03 Examine Impact

04 Inform Advocacy and Policy Reform

05 Contribute to Transformative Change

3.1 Assessing Prevalence

The primary objective of the study was to determine the prevalence of obstetric violence in the maternal healthcare systems in two provinces: Gauteng and KwaZulu-Natal. This involved systematically documenting and quantifying instances of mistreatment, abuse, and violations experienced by women during the childbirth process.

3.2 Identify Forms and Contexts

Various forms of obstetric violence were recorded, including but not limited to physical aggression, verbal abuse, violations of privacy, and lack of informed consent. In addition, the study explored the contextual factors contributing to obstetric violence within the South African healthcare system and forms of discrimination such as age, gender, race, religion, health status, economic status, marital status, sexual orientation, disability, nationality or documentation status, healthcare infrastructure deficiencies, and cultural norms surrounding childbirth.

3.3 Examining Impact

The study also sought to understand the impact of obstetric violence on maternal health outcomes, including its association with birth trauma, postnatal depression, and PTSD. This involves assessing the physical, emotional, and psychological consequences experienced by individuals who have been subjected to obstetric violence during childbirth.

3.4 Informing Advocacy and Policy Reform

Empirical evidence as gathered in this survey can support advocacy efforts and policy reform initiatives aimed at addressing obstetric violence within the South African maternal healthcare system. This includes generating data-driven insights to mobilise stakeholders, collaborate with government agencies, healthcare institutions and civil society organisations, and advance the rights of women towards the provision of dignified maternal healthcare services. Implementation of policies is critical, particularly in the South African context, where too often good policies are only partially or never implemented.

3.5 Contributing to Transformative Change

Data as obtained in this survey can help to catalyse transformative change in the provision of maternal care in South Africa by recognising and amplifying the voices of women, raising awareness about the extent of obstetric violence, and advocating for interventions that prioritise respectful and empowering childbirth experiences for all individuals involved.

Through these research objectives, the study aimed to fill existing knowledge gap in order to raise awareness, inform policy development, and guide interventions aimed at preventing and addressing obstetric violence in South Africa, ultimately striving towards the realisation of reproductive justice for all individuals.

4. METHODOLOGY

4.1 Sampling Approach

The fieldwork was conducted between April and July 2025. Owing to the sensitive nature of the survey, Social Surveys Africa obtained ethical clearance from the Human Sciences Research Council's ethics committee.

A random stratified sample was used, which involved 845 face-to-face interviews conducted with women between 16 and 45 years of age. The survey was conducted in Gauteng and KwaZulu-Natal across all races and nationalities. All respondents had given birth in South Africa in the past 10 years (2015–2025).

Social Surveys' Community Tapestry was used as the sample frame for the study. This framework is a statistically derived typology that provides a spatially nuanced mapping of community characteristics, categorising all South African communities into 16 main 'types' based on three dimensions: infrastructure, socio-economic standing, and inequality. Since it represents every community in the country, the Community Tapestry serves as an ideal sampling frame, allowing results to be weighted back to the provincial level. The sample was stratified by province and by type of municipality.

COMMUNITY TAPESTRY SEGMENTATION

Typology of communities allowed us to take three sets of indicators into account:
- Infrastructure
- Socio-economic level
- Gini coefficient (as an indication of inequality)

This provides us with a national data frame providing a more granular perspective at community level.

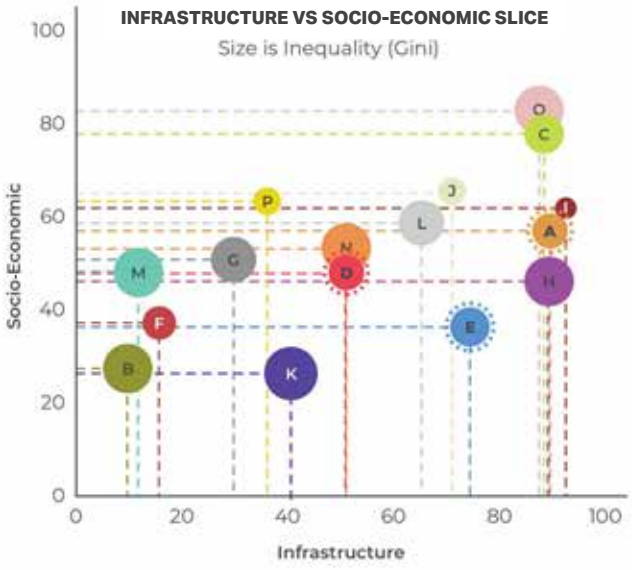


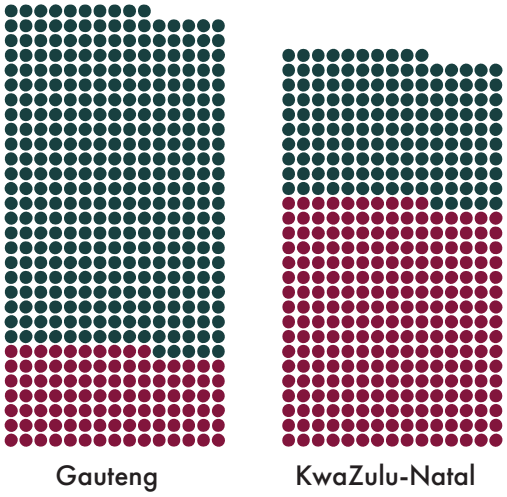
Figure 1: Community Tapestry Segmentation

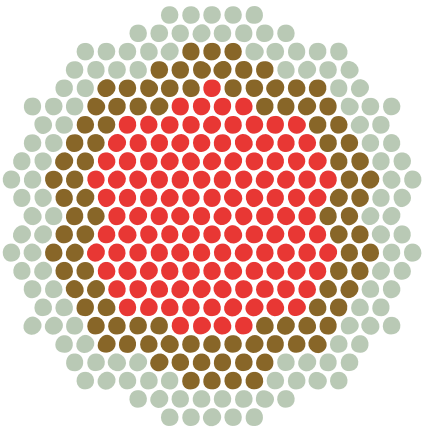
Below is the breakdown of the number of interviews and clusters per municipality. Thirty households were randomly selected in each cluster.

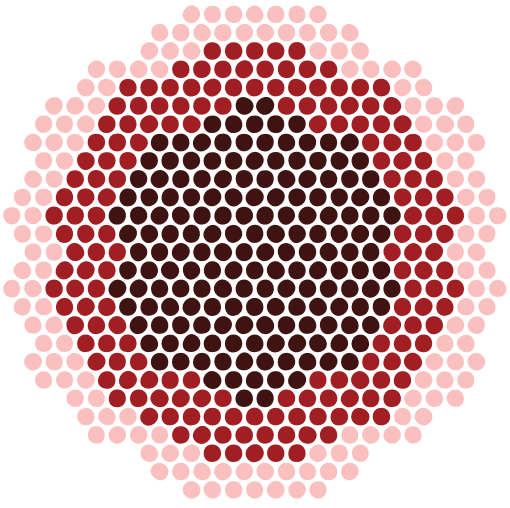
Table 1: Sample breakdown

GAUTENG			
TYPE OF MUNICIPALITY	SAMPLED MUNICIPALITY	TOTAL SURVEYS	NUMBER OF CLUSTERS
Metro	City of Johannesburg (JHB)	173	5
Metro	Ekurhuleni	174	5
District	Sedibeng	100	3

KWAZULU-NATAL			
TYPE OF MUNICIPALITY	SAMPLED MUNICIPALITY	TOTAL SURVEYS	NUMBER OF CLUSTERS
Metro	eThekwini	150	5
District	iLembe	124	4
District	Harry Gwala	124	4







4.2 Fieldworker Recruitment, Training, and Pilot Study

Social Surveys Africa recruited 20 skilled fieldworkers from a pool of 30 trained over four days. Training covered technical use of the Kobo Collect tool, unbiased data collection practices, and strategies for managing field challenges, with inter-rater reliability assessments and simulated exercises ensuring only high-performing candidates were selected. Given the sensitivity of the study on obstetric violence, a dedicated trauma training day equipped fieldworkers to recognise and respond appropriately to participant distress, follow a distress protocol, and maintain ethical standards, while also supporting their own well-being through regular debriefing. A two-day pilot tested the survey instrument's flow, clarity, and duration, as well as fieldworker technique. Feedback from the pilot and from Embrace partner organisations informed final refinements to the tool, ensuring clarity, feasibility, and sensitivity before full-scale fieldwork began.

4.3 Data Collection

The data was collected in Gauteng, specifically Ekurhuleni (7 areas) and Sedibeng (5 areas) and in KwaZulu-Natal in Ethekwini (6 areas) and Harry Gwala (6 areas) local municipalities. Data was collected in 24 areas of the selected municipalities. Respondents were fairly equally distributed, with 52.9% from Gauteng and 47.1% from KwaZulu-Natal. The field team consulted community leaders and counsellors to gain access to each area before fieldwork started.

4.4 Sample Profile

The sample is fairly evenly split between the two provinces, providing regional comparability and insights into geographic disparities in maternity care, with 447 respondents from Gauteng and 398 from KwaZulu-Natal.

Almost two-thirds of the sample were single/not living with a partner, which may impact their support structures during childbirth and influence experiences of obstetric care. Interestingly, only 16% were married and a further 20% were living with a partner.

Most respondents participating in the study were black (85%) and only 6% or less were from any of the other race groups. It should be noted that it was significantly more difficult to reach wealthier respondents due to high walls, gated communities and a lack of willingness to participate. This still-existent shadow of apartheid contributed to the lower proportions of white, asian and coloured respondents.

Less than half the sample had not finished high school, although 17% did have a tertiary qualification.

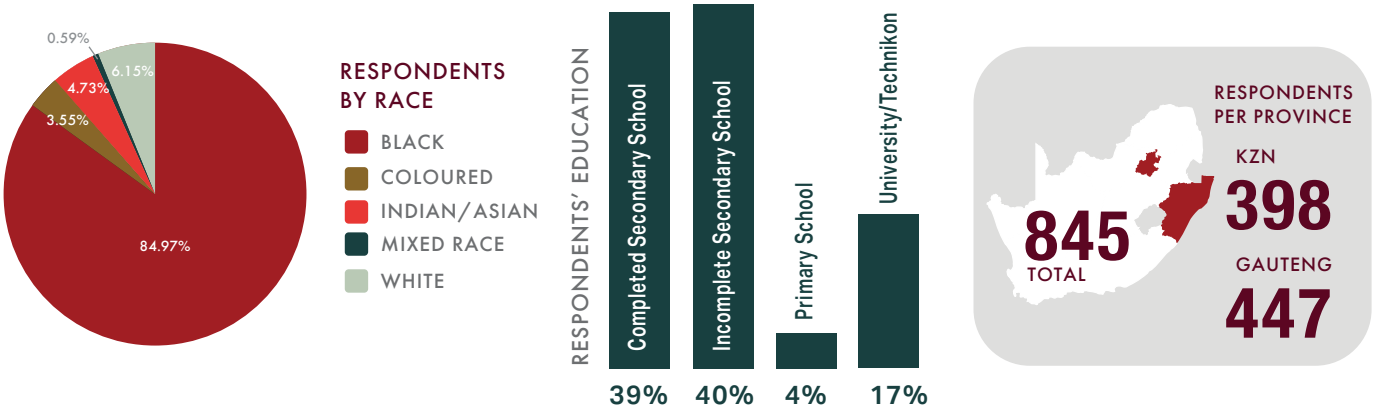


Figure 2: Sample Profile Achieved

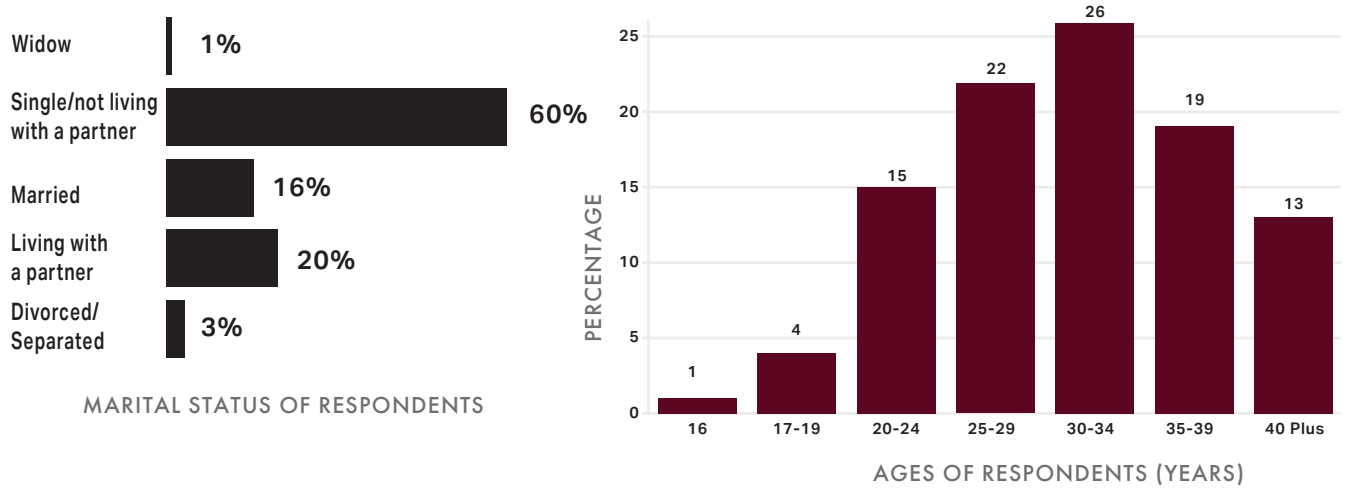


Figure 2 Continued: Sample Profile Achieved

5. SURVEY RESULTS

5.1 Prevalence of Obstetric Violence

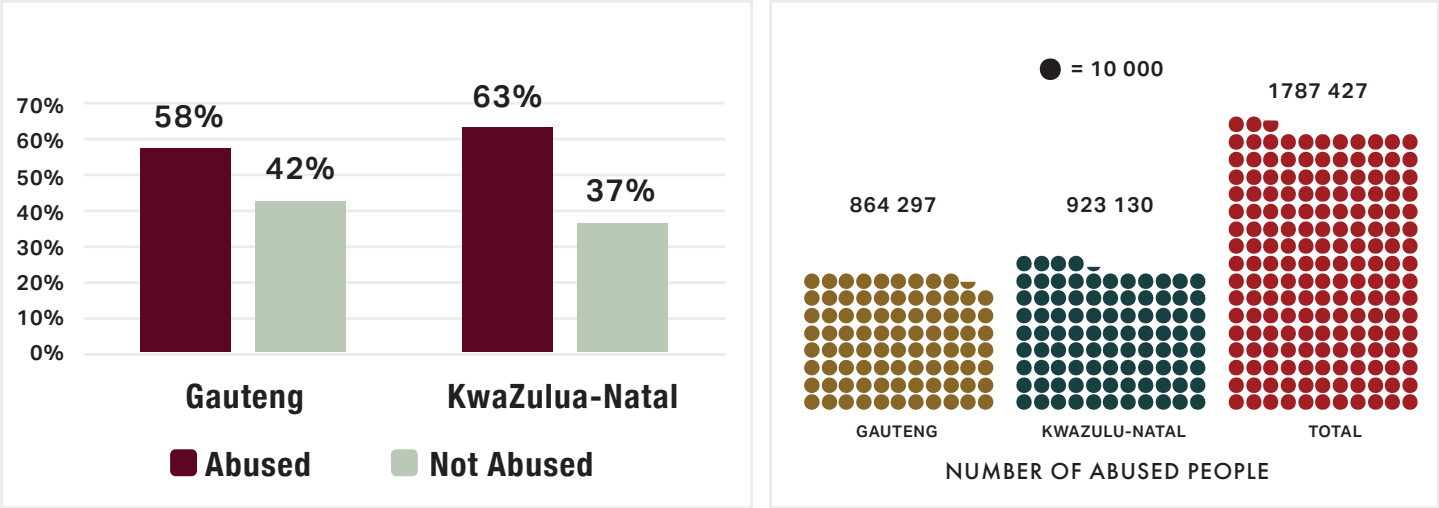


Figure 3: Total OV Prevalence in South Africa

60% of those who have given birth in KwaZulu-Natal and Gauteng in the past ten years in South Africa have experienced some form of obstetric violence.

1.79 MILLION

The 1.79 million abused individuals represent a public health and human rights crisis. The normalisation of obstetric violence at these levels signals deep-rooted structural, cultural, and institutional failings in maternal healthcare.

KwaZulu-Natal's higher prevalence may be linked to:

- greater resource constraints in facilities
- lower health system oversight in rural areas
- stronger persistence of hierarchical, authoritarian care models

Earlier reports have noted specific coercive practices in KwaZulu-Natal, such as forced HIV testing of pregnant women, verbal abuse, and humiliating treatment in prenatal care and childbirth services (Human Rights Watch & Amnesty International, 2021). Cultural and systemic factors contribute to obstetric violence, where abusive behaviour is often normalised and justified to discipline labouring women perceived as uncooperative or disobedient. There is a connection between social and medical power dynamics, gender, race, and class in the perpetuation of this violence (Chadwick, 2017).

"I was seriously afraid for my baby's life after what happened. The nurses almost burnt my baby alive with that baby incubator heater...I was asked not to report it to the doctor when he arrives, I felt like I was being shut down."

"I got really scared when the nurse hit me in my face and shouted at me; I was afraid to ask her questions. Even though I wanted more children I won't have anymore because of the treatment I received."

The results from this survey and others elsewhere in the world illustrate that **obstetric violence is increasingly being documented across African countries**, revealing troubling patterns of abuse, neglect, and systemic failure in maternal health services for women. The significance of these African comparisons lies in their exposure of widespread structural inequalities, especially in under-resourced public health systems. Obstetric violence in African contexts, including in South Africa, is often exacerbated by high patient loads, limited staff, and power hierarchies, where individuals are expected to be passive and unquestioning of healthcare providers. The results of this study show that obstetric violence is not simply about individual misconduct, but rather a systemic issue rooted in gender inequality, poor accountability, and weak health systems being in place. Obstetric violence is a **human rights issue** and a **public health concern** that should be addressed at all costs.

Recognising this shared experience across borders strengthens the call for South African and regional policy reforms, accountability mechanisms, and rights-based approaches to maternal healthcare. There is still a long way to go, however, and although obstetric violence is internationally recognised as a serious violation of women's human rights and a form of gender-based violence, South African law currently lacks explicit legal recognition and remedies for this issue, limiting access to justice for survivors (Van der Merwe, M. 2023)

"I waited in the passage outside the theatre for five hours. The doctors just ignored me and my requests for pain medication, which really made me very anxious. I ended up having high blood pressure, and the doctor diagnosed me with PTSD because of the whole incident and mistreatment."

5.1.1 Types of Obstetric Violence

Figure 4 shows the range of obstetric violence reported by individuals in KwaZulu-Natal and Gauteng, painting a concerning picture of mistreatment during childbirth in these two provinces.

Reports of physical violence and medical negligence were extensive. A quarter of the respondents who were abused had had procedures done to them without their consent, including C-sections and sterilisation. Others were pressured into procedures they did not want. This was an occurrence that frequently happened in private facilities. The finding that 14% of women who experienced abuse were slapped, pinched, or humiliated is troubling and illustrates direct human rights violation.

One in ten respondents reported that their newborns were mistreated or injured, a serious indicator of unsafe obstetric practices.

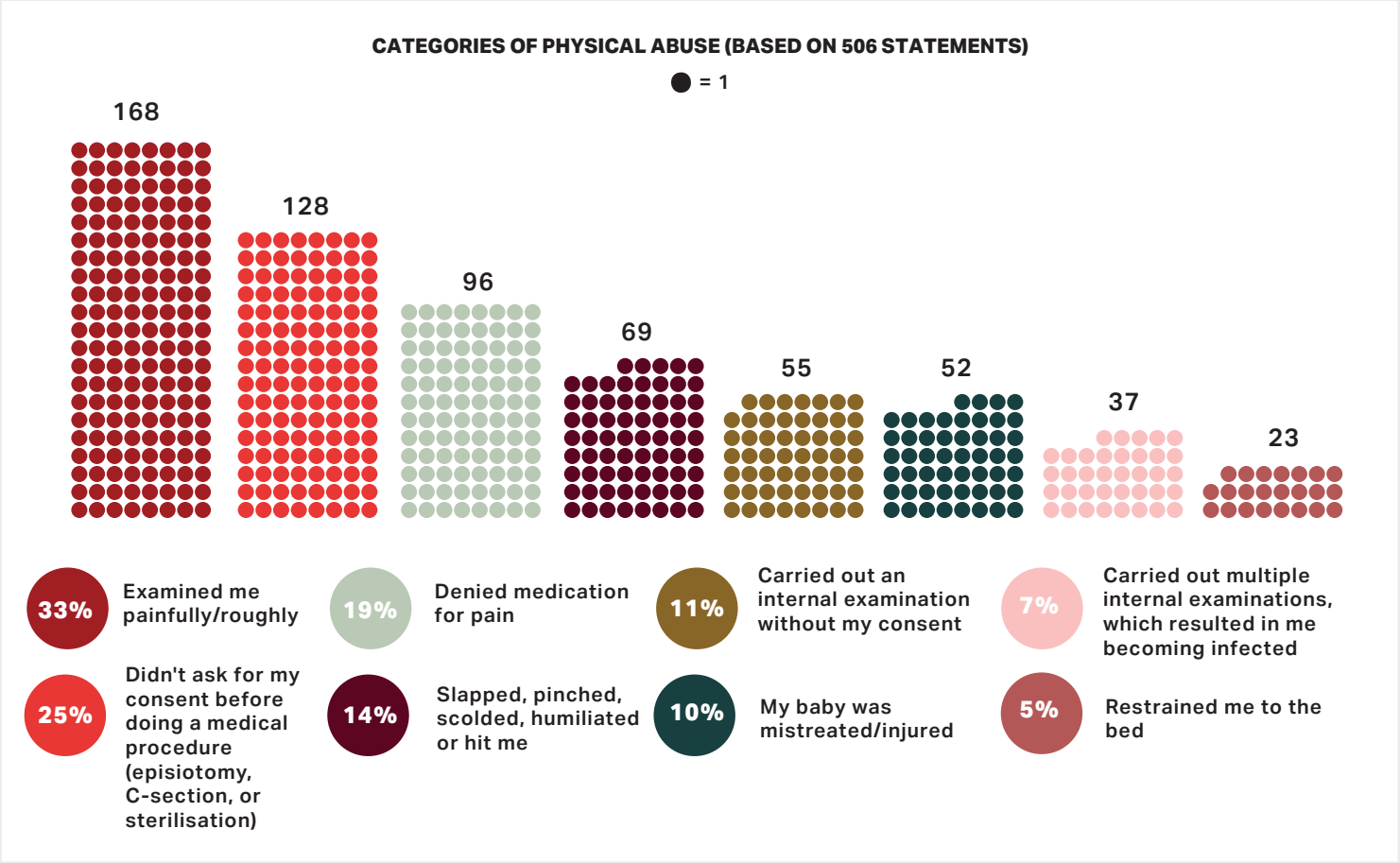


Figure 4: Types of Physical Abuse Experienced by Birthing Individuals

These findings paint a disturbing picture of physical mistreatment and systemic abuse during childbirth, underscoring the urgent need for:

o legal safeguards on informed consent
o mandatory respectful maternity care training
o independent accountability mechanisms in health facilities.

Widespread physical abuse was seen in both Gauteng and KwaZulu-Natal. Distinct provincial challenges are noted:

o Direct physical mistreatment was notably higher in KwaZulu-Natal. For example, women in KwaZulu-Natal were almost twice as likely to report being slapped, pinched, scolded, or hit (17% vs 10% in Gauteng). Similarly, denial of pain medication was more common in KwaZulu-Natal (21% vs 17%). These findings suggest harsher interpersonal treatment and weaker pain management protocols in KwaZulu-Natal facilities.

o Procedural violations (exams and procedures without consent) were consistently high in both provinces (rough examinations: 33% in Gauteng vs 34% in KwaZulu-Natal; procedures without consent: 25% in Gauteng vs 26% in KwaZulu-Natal). The near identical prevalence underscores that systemic disregard for consent is likely a wider problem and, not confined to one province.

"It was a painful experience for me; I'd rather die than go back to that hospital. I even tried to escape the hospital because of the painful experience and the things they did to me. When I tried to escape, security took me back to the hospital where they shouted at me for escaping. There was this doctor who said I'm a dustbin and she cannot keep a dustbin in her hospital. They put a balloon to open my womb, but it left me in pain and bleeding, which is why I even tried to escape."

o Infant mistreatment was also similar in Gauteng and in KwaZulu-Natal (11% in Gauteng vs 10% in KwaZulu-Natal), pointing to a risk of newborn neglect or injury in both provinces.

o Other categories, such as multiple examinations leading to infection (7% in Gauteng vs 8% in KwaZulu-Natal) and restraint to the bed (4% in Gauteng vs 5% in KwaZulu-Natal) were reported at low but concerning levels in both provinces.

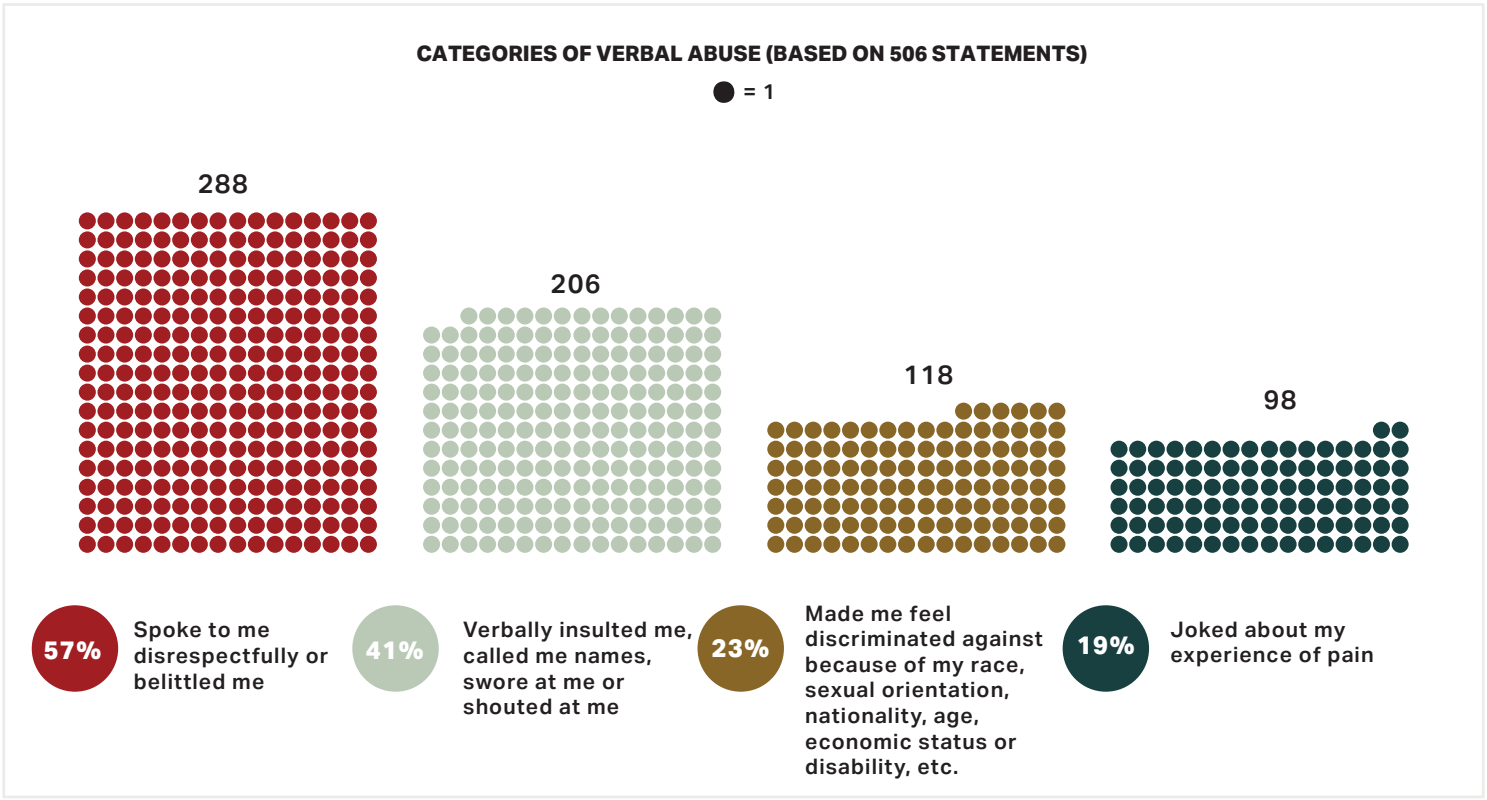


Figure 5: Types of Verbal Abuse Experienced by Birthing Individuals

"I had a negative experience; I felt humiliated and disrespected by the staff, who shouted at me and called me names throughout labour and postpartum."

Nearly three in five individuals experienced disrespect or belittling comments, and over two in five were shouted at or insulted. Verbal abuse is a critical dimension of obstetric violence, often invisible but deeply damaging to maternal mental health and trust in the healthcare system. Disrespect often thrives in overstretched environments where providers are overwhelmed and unsupported. Factors such as shortages of staff, beds, medication and equipment, as well as overworked and burned-out providers, combined with poor privacy, all contribute to a situation where women must face the consequences.

As shown in Figure 6, verbal abuse is pervasive across both provinces, with disrespectful and belittling speech being the dominant pattern.

More instances of discrimination and mocking of pain were noted in Gauteng, suggesting intersectional vulnerabilities (linked to identity and socio-economic status).

A slightly higher prevalence of direct verbal insults was seen in KwaZulu-Natal compared with Gauteng, pointing to hostile or aggressive communication from providers.

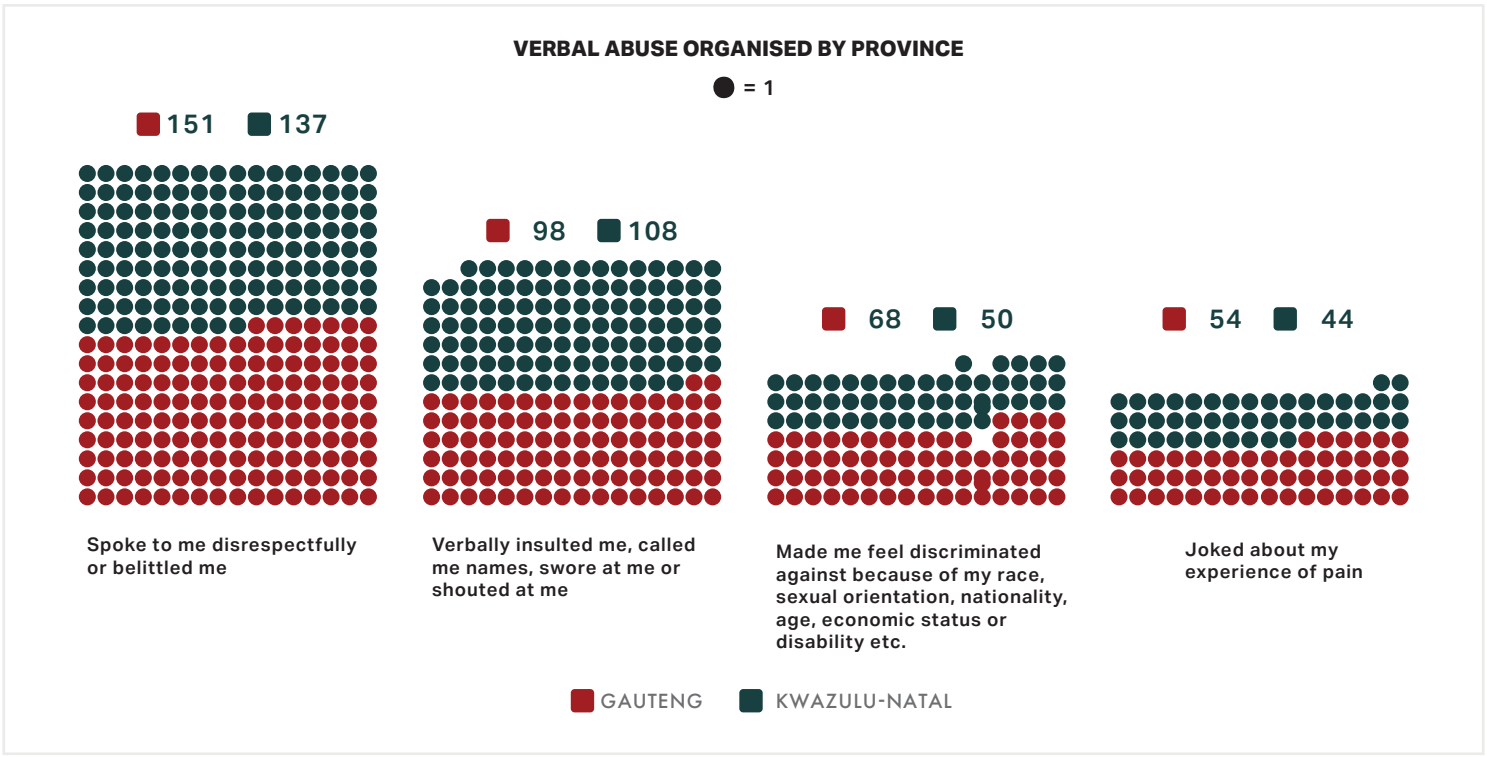


Figure 6: Types of Verbal Abuse, Organised per Province

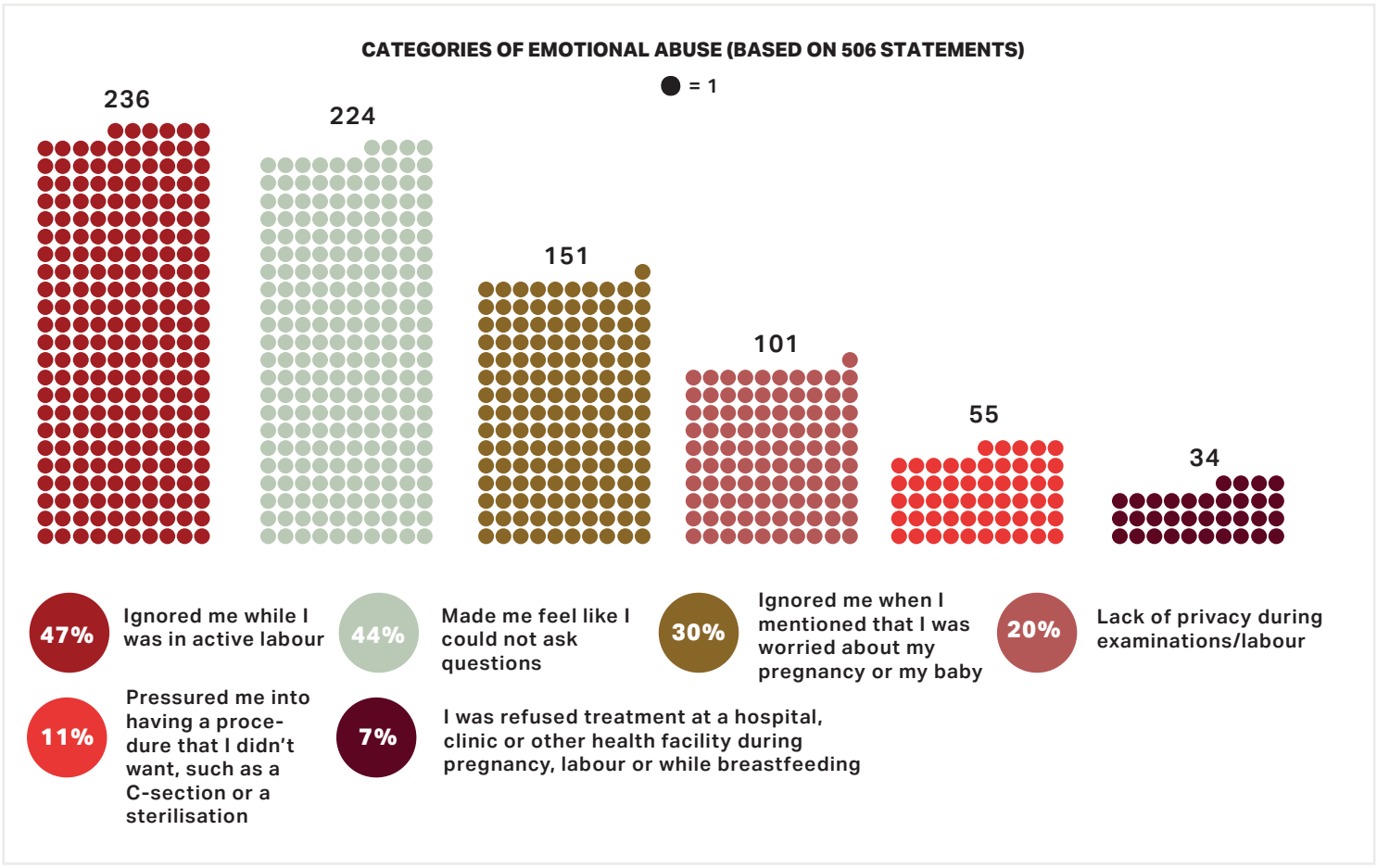


Figure 7: Types of Emotional Abuse Experienced by Birthing Individuals

The data underscores that emotional abuse is pervasive yet often overlooked, despite being psychologically devastating. Emotional abuse during childbirth undermines:

- o trust in the health system
- o women's confidence and mental health
- o health-seeking behaviour in future pregnancies.

"It affected me very badly, and it really damaged me emotionally, physically, mentally and psychologically; and it took away my sexual pleasure."

Emotional abuse also violates international human rights standards, including the right to dignity, autonomy, and non-discrimination in healthcare. Dube (2024) talks about discriminatory attitudes and harmful gender stereotypes in relation to women's decision-making competence, their societal roles, and motherhood and how these attitudes foster disrespect and emotional cruelty towards birthing women. Other factors contributing to emotional abuse include dysfunctional power dynamics in healthcare settings, where hierarchical and paternalistic medical authorities allow health workers to exert control and punish people who do not comply with instructions (University of Cape Town, 2023).

There are some clear provincial differences in patients' experience of obstetric violence, with higher levels of dismissive and neglectful emotional abuse (ignored in labour, silenced, concerns disregarded) consistently noted in KwaZulu-Natal.

Gauteng shows slightly more problems with privacy, which may reflect systemic and infrastructure challenges in busy urban facilities.

Both provinces share systemic issues such as coercion into unwanted procedures, although the levels are equal.

5.1.2 Awareness of Obstetric Violence

The abuse has become so prevalent in health facilities in South Africa that it has become the norm, with two-thirds of respondents not knowing that the treatment they received was abuse.

To address these violations, there is an urgent need for ystemic reforms, which include: training healthcare workers on respectful maternity care; enforcing legal and professional accountability for abuse and enforcing staff penalties; improving staffing and infrastructure, especially in high-burden provinces like KwaZulu-Natal; and ensuring that patient voices are heard, respected, and protected, particularly during one of the most vulnerable moments in a person's life.

"I didn't know they had to ask my permission before doing those procedures to me."

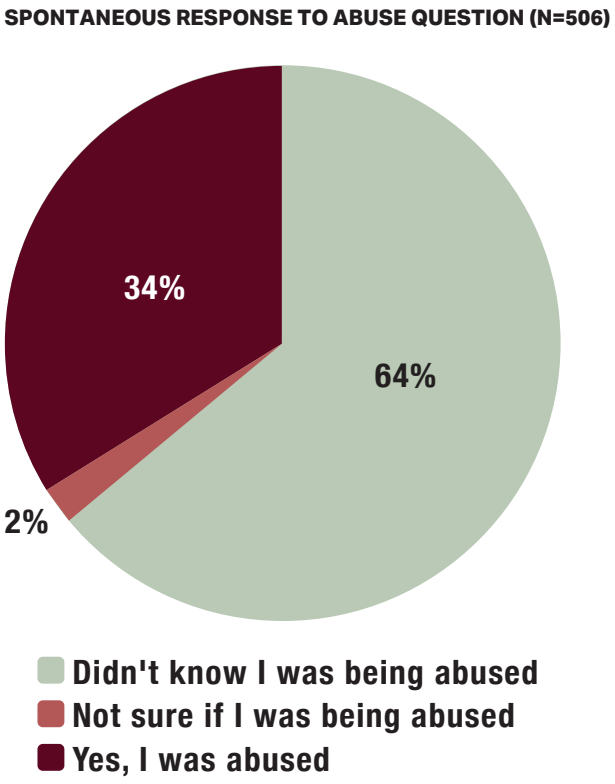


Figure 8: Awareness of Abuse

5.1.3 Profile of those who Experienced Obstetric Violence

Table 2 shows indicators of increased probability of abuse by province:

Table 2: Indicators of Increased Likelihood of Abuse

INDICATOR	GAUTENG	KWAZULU-NATAL	TOTAL
Age – 16-25 years	41%	51%	46%
Marital Status – Single, not living with partner	57%	69%	63%
Education – Any secondary school	76%	85%	79%
Personal Income (current) – <R800 pm	73%	76%	71%
Facility – Government Hospital	87%	94%	88%
Facility – Private Hospital	5%	4%	7%
Poverty Index - Deprived	41%	52%	45%

Obstetric violence in South Africa is shaped by intersecting demographic and socio-economic risk factors that differ by province. The indicators in the table point to higher vulnerability in specific population groups in Gauteng and KwaZulu-Natal, and these insights align with peer-reviewed research and policy documents (Bohren et al., 2020; Chadwick, 2017; Medical Brief, 2022; Department of Health, 2024; UWC, 2024; WLCE, 2019).

Socio-Demographic Risk Factors

Research strongly emphasises that young age (16–25 years), single marital status, and low level of education are linked to increased risk of obstetric violence — particularly in under-resourced settings as seen from higher percentages in these groups shown in the table (Bohren et al., 2020; UWC, 2024). Adolescents and single mothers often have reduced social support, face greater discrimination, and possess less power to contest abusive treatment (UWC, 2024).

Socio-economic Status and Facility Type

Low household income (<R800 pm) is a clear marker of risk, seen more frequently in KwaZulu-Natal (76%) than Gauteng (73%). Poverty amplifies vulnerability due to limited options, poor access to information, and reduced capacity to seek accountability (Chadwick, 2017). Similarly, dependence on government hospitals is greater among abused populations in both provinces, although it is higher in KwaZulu-Natal. Overburdened public hospitals are often associated with increased reports of violence, stemming from staff shortages, resource constraints, and poor accountability mechanisms (Medical Brief, 2022).

5.1.4 Poverty Index

To further understand obstetric violence in South Africa, we developed a Poverty Index based on the assumption that more vulnerable women, less likely to speak out for themselves, would be more likely to be abused. The results of this analysis are detailed below.

The poverty index is made up of the following indicators:

- Education
- Employment status
- Individual and household income
- Household situation
- Hunger
- Access to medical treatment

In KwaZulu-Natal, those who were described as being deprived were significantly more likely to be abused. This is likely due to the deeply entrenched cultural factors at play in KwaZulu-Natal, as described earlier.

5.1.5 Profile of Abuse by Facility

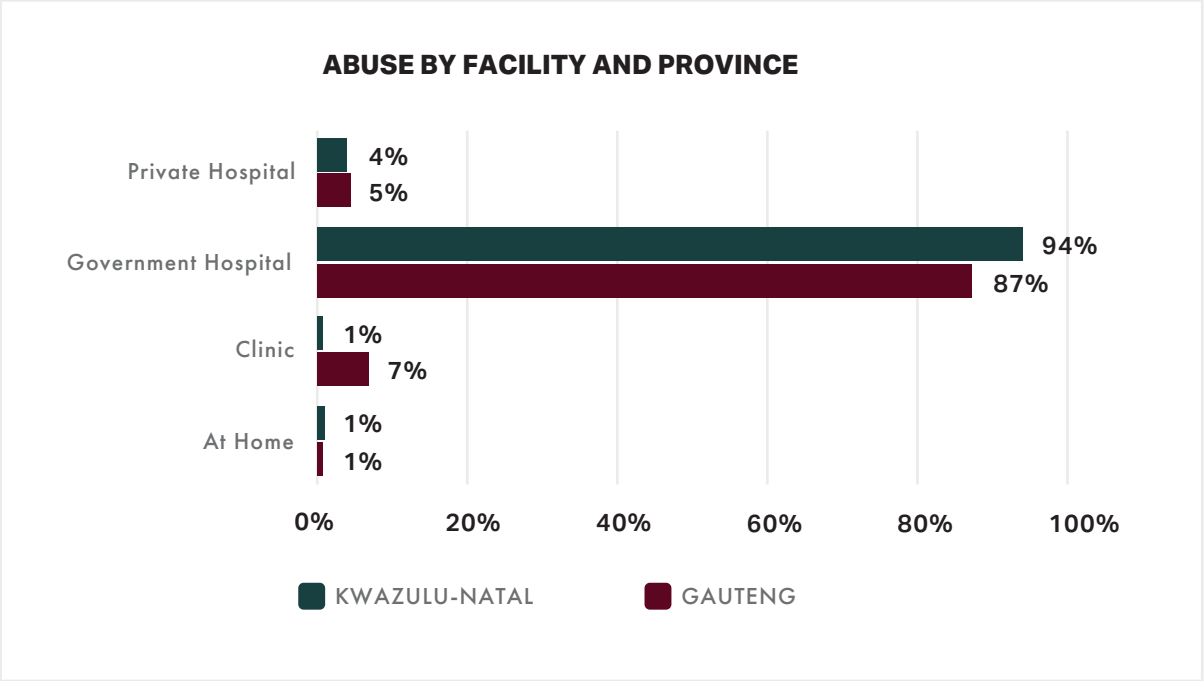


Figure 9: The Prevalence of Abuse by Facility and Province

The graph illustrates that obstetric abuse is widespread in government hospitals — where the majority of South Africans give birth. (It was. however, not possible to determine whether the prevalence of abuse is greater in government hospitals due this question being asked of abused individuals about the facility they attended and therefore no comparison with the total sample is available, although the literature would indicate that this is the case.) Clear provincial differences are evident: in KwaZulu-Natal, an exceptionally high occurence of abuse cases (94%) were reported in government hospitals, compared with 87% in Gauteng. Although Statistics South Africa does not provide a direct breakdown of deliveries in public and private hospitals, the fact that 92% of all births occur in health facilities strongly suggests that these figures reflect extensive abuse within government services. This finding is consistent with national and international evidence showing that abuse is disproportionately concentrated in public facilities, where systemic pressures such as high patient loads, staff shortages, and weak accountability foster mistreatment (Bohren et al., 2015; Human Rights Watch, 2011; Jewkes & Penn-Kekana, 2015). While both provinces face systemic challenges in public healthcare, the higher prevalence in KwaZulu-Natal points to deeper structural weaknesses, including staff shortages, overcrowding, and limited accountability mechanisms.

In contrast, private hospitals, where considerably fewer individuals give birth, account for only 4% of abuse cases in KwaZulu-Natal and 5% in Gauteng, reflecting far lower prevalence and highlighting the sharp disparities between public and private maternity care.

Clinics show a divergence: in Gauteng, 7% of abuse was reported in clinics, compared with just 1% in KwaZulu-Natal. This may reflect the greater reliance on clinic-based childbirth services in Gauteng's urban and peri-urban contexts, whereas deliveries in KwaZulu-Natal are more concentrated in hospitals.

The following provides a facility-level comparison of the types of obstetric abuse most likely to be experienced by women in the different types of facilities:

Clinic
- o My baby was mistreated/injured.
- o Joked about my experience of pain.
- o They didn't ask for my consent before they did a medical. procedure such as an episiotomy, C-section, or sterilisation.
- o Ignored me when I mentioned that I was worried about my pregnancy or my baby.
- o Verbally insulted me, called me names, swore at me or shouted at me.

Government Hospital
- o Spoke to me disrespectfully or belittled me.
- o Ignored me while I was in active labour.
- o Verbally insulted me, called me names, swore at me or shouted at me.
- o Made me feel like I could not ask questions.

Private Hospital
- o Pressured me into having a procedure that I didn't want, such as a C-section or sterilisation.

(All other forms of abuse were considerably lower in private hospitals.)

"It affected me to a point that I don't want to give birth at a government facility again."

"It made me hate government clinics. They were so rude, and the mistreatment made me blame myself for not having medical aid."

"The experience led to anger issues and made me resent the health facility where I was mistreated."

5.1.6 Procedures Undertaken Without Explanation or Consent

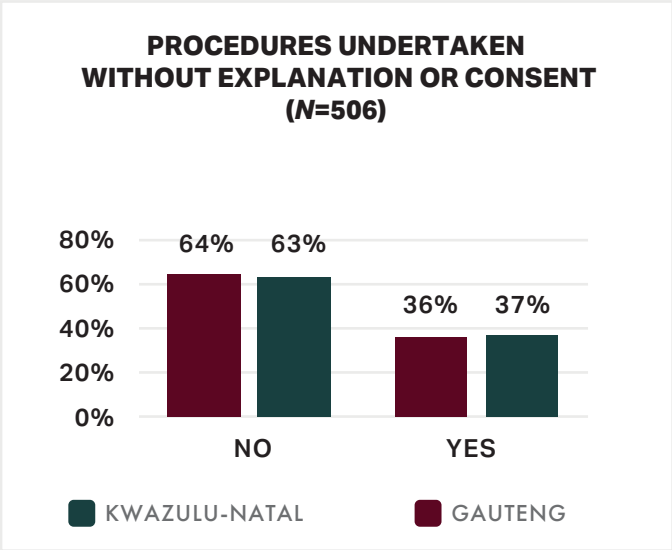


Figure 10: Extent of Procedures Undertaken Without Explanation or Consent

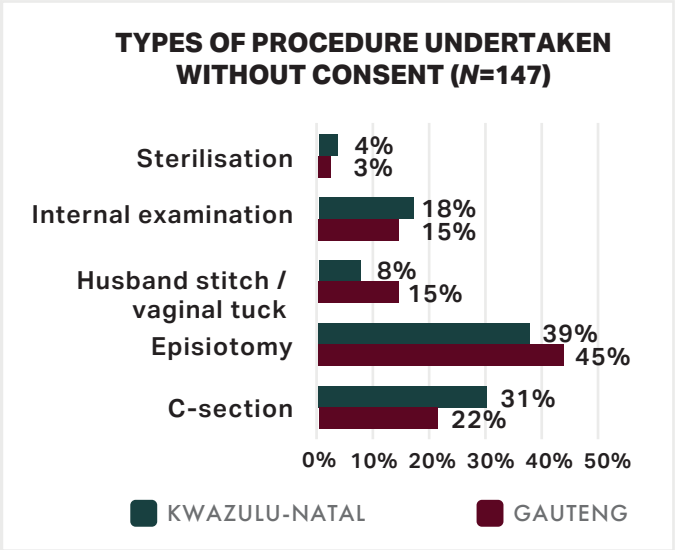


Figure 11: Types of Procedure Undertaken Without Explanation or Consent

It is shocking that, in both province, close to four in ten individuals who were abused were not given an explanation or asked for their consent before a procedure was undertaken. The most common procedure done without consent was an episiotomy (42%). This suggests that episiotomies may be routinely performed without patient involvement, likely due to outdated protocols or time pressure. These procedures were more likely to have been undertaken without consent in Gauteng (45%) as than in KwaZulu-Natal (39%).

C-sections were the second most common at 27%, indicating a troubling pattern of coercive or rushed surgical decisions. C-sections were more frequently undertaken in KwaZulu-Natal than in Gauteng.

"I thought it was normal to take decisions on my behalf as health care workers; I didn't know that I was being mistreated"

The prevalence of internal exams (16%) and "husband stitches" (12%) — a controversial and unethical practice — shows that intimate, invasive procedures are being done without explanation or consent, further compounding trauma. The prevalence of performing a "husband stitch" without consent was higher in Gauteng (15%) than in KwaZulu-Natal (8%). While sterilisation (3%) appears rare, it is especially concerning when undertaken without consent, raising red flags about reproductive rights violations.

"It negatively impacted my life. They didn't inform me about the procedures; as a result I am now unable to make choices."

High prevalence of non-consensual obstetric procedures in both provinces demonstrates systemic disregard for informed consent, a fundamental patient right.

Higher levels of episiotomies and "husband stitch" procedures were noted in Gauteng, whereas more non-consensual C-sections were reported in KwaZulu-Natal.

5.1.7 Time Since Giving Birth

Table 3: Time Since Giving Birth *N*=506

TIME SINCE GIVING BIRTH	GAUTENG (*N*=254)	KWAZULU-NATAL (*N*=252)	TOTAL (*N*=506)
0–5 years ago	75%	65%	70%
6–10 years ago	25%	35%	30%

Abuse appears to have increased considerably in the past five years compared with levels seen six to ten years ago. This may be attributed, in part, to recall bias, with respondents who gave birth more than five years ago possibly not remembering well. However, the difference is sufficiently large to suggest that abuse has become considerably worse in the past five years, with notably higher levels reported in Gauteng than in KwaZulu-Natal. This may, in part, be due to worsening conditions in government hospitals and increased overcrowding.

5.1.8 Type of Birth and Experience of Obstetric Violence

Figure 12 describes the types of birth among abused individuals. The results indicate that the majority of those who reported abuse had a standard vaginal delivery (65%), while 22% had an emergency C-section. These figures may indicate that women undergoing unplanned or routine deliveries are more vulnerable to neglect, disrespect, or coercive practices, possibly due to the fast-paced nature of labour wards or provider bias (Bohren et al., 2015). In emergencies, time pressure may result in fewer consent processes, increasing perceptions of mistreatment.

Approximately one in ten (11%) of the respondents who reported abuse had an elective C-section. These results may signify that elective c-sections are planned, which may afford better preparation, informed consent, and continuity of care in healthcare facilities. This aligns with research by Freedman et al. (2014), which showed that planned births allow for more respectful and controlled interactions between patients and healthcare providers. Planned births (e.g., elective C-sections) are often handled in more controlled environments, possibly with more senior staff and better planning, whereas emergency or routine vaginal deliveries may involve rushed decisions, limited privacy, and less individualised care, thus increasing the likelihood of mistreatment (Kruk et al., 2014). There were no significant differences between Gauteng and KwaZulu-Natal in terms of abuse by the type of birth.

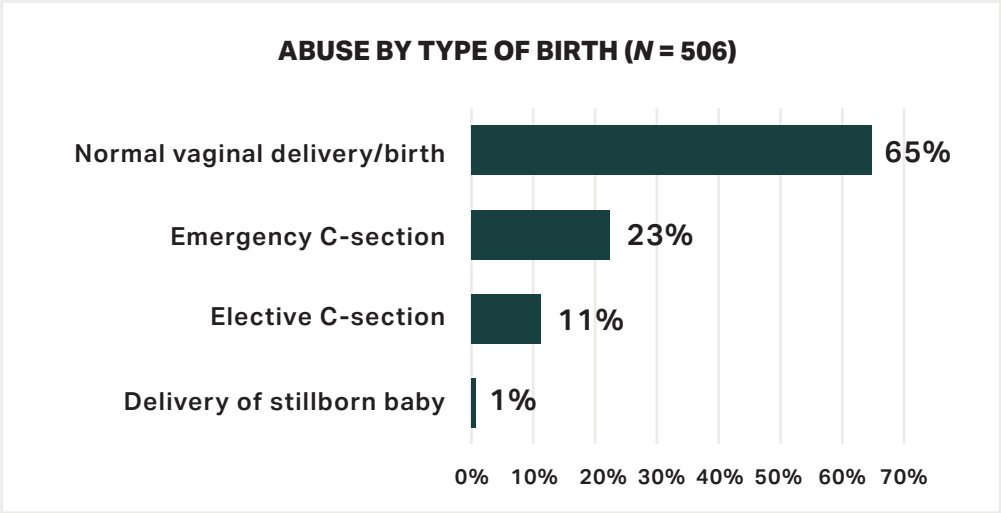


Figure 12: Abuse by Type of Birth

5.2 Individuals Responsible for Abuse

5.2.1 Type of Healthcare Professional Responsible for Abuse

Nurses were overwhelmingly identified as the primary perpetrators of abuse, accounting for three-quarters (75%) of reported cases. Midwives (17%) and doctors (14%) also contributed, but to a lesser extent. Because many patients don't know the difference between nurses and midwives and tend to use the terms interchangeably, these two categories have been collapsed into a single category.

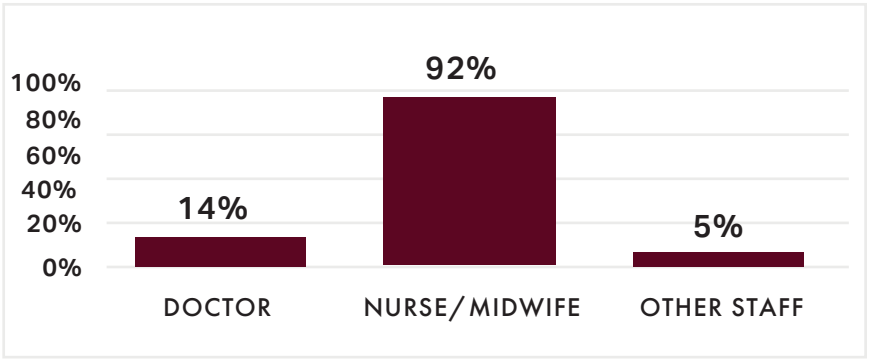


Figure 13: Health Professionals Responsible for Abuse

The prevalence of abuse by nurses and midwives is the same for both KwaZulu-Natal and Gauteng.

5.2.2 Contextual Factors that Contribute to Abuse by Nurses and Midwives

The findings of this study clearly show that nurses and midwives are the most frequently reported perpetrators of obstetric abuse, but this result must be understood within a systemic and contextual framework. Nurses and midwives operate in overburdened, under-supported environments where disrespectful care may be both a coping mechanism and a reflection of larger institutional dysfunction. The solution is not punishment but transformation — of training, systems, and culture — towards a dignified, rights-based model of maternal care.

In many public and resource-constrained settings, especially in South Africa and similar African contexts, nurses are the primary point of care during labour, particularly in clinics and district hospitals. Their high level of patient contact increases the likelihood that abusive interactions are attributed to them (Bohren et al., 2015). It is also worth noting that primary healthcare serves as the initial point of contact with the health system for the majority of individuals accessing public healthcare services, unless complications arise during pregnancy that necessitate referral to higher levels of care (secondary or tertiary facilities). Nurses and midwives constitute the principal providers of maternal healthcare within the primary healthcare setting.

Chronic understaffing in public health facilities often leads to high patient-to-provider ratios, overwhelming nurses and midwives. Burnout, compassion fatigue, and emotional detachment become common symptoms, which in turn contribute to verbal abuse, neglect, and rough treatment (Jewkes et al., 2018).

Nurses and midwives also often operate in stressful, highly hierarchical environments, where they may face disrespect from senior doctors and administrators. Abuse can become normalised as a way to assert control or cope with powerlessness within the system
(Freedman et al., 2014).

Most health training curricula still do not sufficiently emphasise respectful maternity care, patient rights, or trauma-informed approaches. Without proper values-based education, some providers resort to authoritarian or punitive care models.

Providers may internalise social judgements about race, age, marital status, or socio-economic status of women, especially young or unmarried individuals. Abuse then becomes a form of moral policing rather than a reflection of clinical practice (Sando et al., 2016).

5.2.3 Recommendations

01 MANDATORY TRAINING ON RESPECTFUL MATERNITY CARE (RMC)

- Integrate RMC principles into nursing and midwifery curricula and make them part of continuous professional development.
- Training should include informed consent, communication, cultural competence, and patient rights.

02 STRENGTHEN ACCOUNTABILITY SYSTEMS

- Establish clear reporting, complaint, and disciplinary mechanisms for obstetric violence within facilities.
- Set up anonymous reporting platforms and ensure whistleblower protection.

03 IMPROVE WORKING CONDITIONS AND MENTAL HEALTH SUPPORT

- Address chronic staff shortages, particularly in high-volume public hospitals.
- Provide regular debriefing, psychosocial support, and supervision to prevent burnout.

04 TRANSFORM INSTITUTIONAL CULTURE

- Shift from top-down hierarchies to collaborative care models, where nurses and midwives feel valued and supported.
- Promote team-based care with shared accountability and regular feedback.

05 PATIENT EMPOWERMENT AND ADVOCACY

- Educate women about their rights to respectful care during antenatal visits and community outreach.
- Involve community health committees and patient advocates to monitor care quality.

5.2.4 Contextual Factors that Contribute to Abuse by Doctors

Obstetric violence perpetrated by doctors — though statistically less frequent than by nurses in many settings —remains a significant issue. When doctors are responsible, the nature of the abuse is often more clinical, procedural, and institutional in nature, involving coerced consent, unnecessary medical interventions, or violation of reproductive autonomy.

"It was bad because the doctor made sexual advances and kept touching me in places I don't like."

Doctors often sit at the top of a rigid clinical hierarchy and may exercise unchecked authority, particularly over young, poor, or less educated patients. Medical paternalism persists: patients are seen as passive recipients of care rather than autonomous decision-makers.

Studies show that this hierarchical model discourages shared decision-making, enabling coercive or non-consensual practices (Freedman et al., 2014: Sadler et al., 2016).

In both the public and private sector, doctors may favour interventions such as C-sections, episiotomies, or inductions — sometimes for convenience, fear of litigation, or profit (in private settings). This practice contributes to routine performance of procedures without adequate explanation or informed consent, a core element of obstetric violence (Bohren et al., 2015; WHO, 2018).

In high-volume settings, doctors may prioritise clinical speed over patient interaction, especially in labour wards. Consent processes and emotional engagement are often skipped under the justification of clinical urgency, even when time would permit proper discussion.

Traditional medical education in South Africa emphasises clinical outcomes over patient-centred care. Doctors may receive minimal exposure to rights-based frameworks, respectful maternity care, or trauma-informed practice (Jewkes et al., 2018).

Some doctors bring personal moral judgements into the clinical space, particularly about:

- o teenage pregnancy
- o unmarried women
- o women from lower socio-economic groups or migrant backgrounds.

These biases may manifest as verbal abuse, denial of pain relief, or withholding of information (Human Rights Watch, 2011).

In many settings, doctors are less likely to be disciplined or reported for abuse compared to nurses or midwives. Their actions may be protected by institutional loyalty or professional boards, especially in cases of coerced sterilisation or surgical abuse (Amnesty International, 2017).

Doctors in KwaZulu-Natal were more often indicated in cases of obstetric abuse (17%) than in Gauteng (12%), possibly due to systemic pressures. KwaZulu-Natal faces severe staff shortages and high patient loads, with many facilities relying on junior or foreign-trained doctors in short-term posts, which weakens accountability (Department of Health, 2020; Magcaba et al., 2022; Reid, 2017). Rural hospitals also struggle with resource gaps and poor referral systems, which create stressful environments that heighten risks of neglect and mistreatment (Bhardwaj et al., 2020). By contrast, Gauteng's better-resourced, specialist-rich system with stronger oversight reduces these risks.

5.2.5 Recommendations

01 CURRICULUM REFORM

- o Integrate respectful maternity care, ethics, and patient rights into medical school and residency training.
- o Include communication skills, consent practices, and gender sensitivity as core competencies.

02 INDEPENDENT OVERSIGHT MECHANISMS

- o Establish ombudspersons or patient-rights units within hospitals, with the power to investigate misconduct by senior clinicians.
- o Enable anonymous and safe patient reporting, particularly for procedural abuses.

03 LEGAL PROTECTIONS AND POLICY ALIGNMENT

- o Strengthen laws that explicitly prohibit obstetric violence, including forced or non-consensual procedures.
- o Enforce the 2024 National Integrated Maternal and Perinatal Care Guidelines, which mandate informed consent and respectful care.

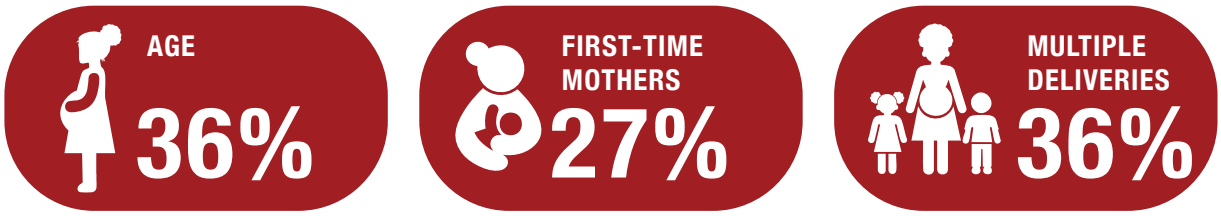
04 CULTURAL CHANGE IN CLINICAL LEADERSHIP

- o Promote mentorship and leadership accountability, where senior doctors model respectful care for junior staff.
- o Encourage patient-centred care audits to balance clinical outcome metrics with measures of respectful care.

5.2.6 Type of Prejudice Experienced

Obstetric violence is not random — it is patterned along lines of social and structural vulnerability. Individuals perceived as young, poor, uninformed, different, or powerless are more likely to be mistreated.

This aligns with global literature that identifies obstetric violence as not just a health issue but a reproductive justice issue, shaped by gender, class, race, and power relations (Jewkes et al., 2018; Sadler et al., 2016).



Age

Younger individuals, especially adolescents, are often stereotyped as "irresponsible" or "undeserving", and are more likely to be scolded, ignored, or shamed by healthcare providers. This reflects moralistic or judgemental attitudes within the health system, consistent with findings across Africa and globally (e.g. Bohren et al., 2015).

First-time Mothers

First-time mothers may lack familiarity with procedures and thus appear "naïve" or "needy" to overburdened providers.

They are especially vulnerable to verbal abuse and non-consensual interventions because they may not know what to expect or how to assert themselves.

Individuals who Have Had Multiple Deliveries

Mistreatment may be due to assumptions about overpopulation, lack of family planning, or devaluation of reproductive agency.

5.3 Conditions Experienced

5.3.1 Conditions Experienced During the Birthing Process

Figure 14 reflects self-reported experiences of birthing individuals and highlights several indicators of obstetric violence and disrespectful maternity care. The results suggest systemic failures in informed consent, respectful communication, and patient autonomy. Although it would appear that, for the most part, language was accessible and birthing individuals understood the information provided, effective communication or respectful care are not guaranteed if other aspects of consent and understanding are lacking.

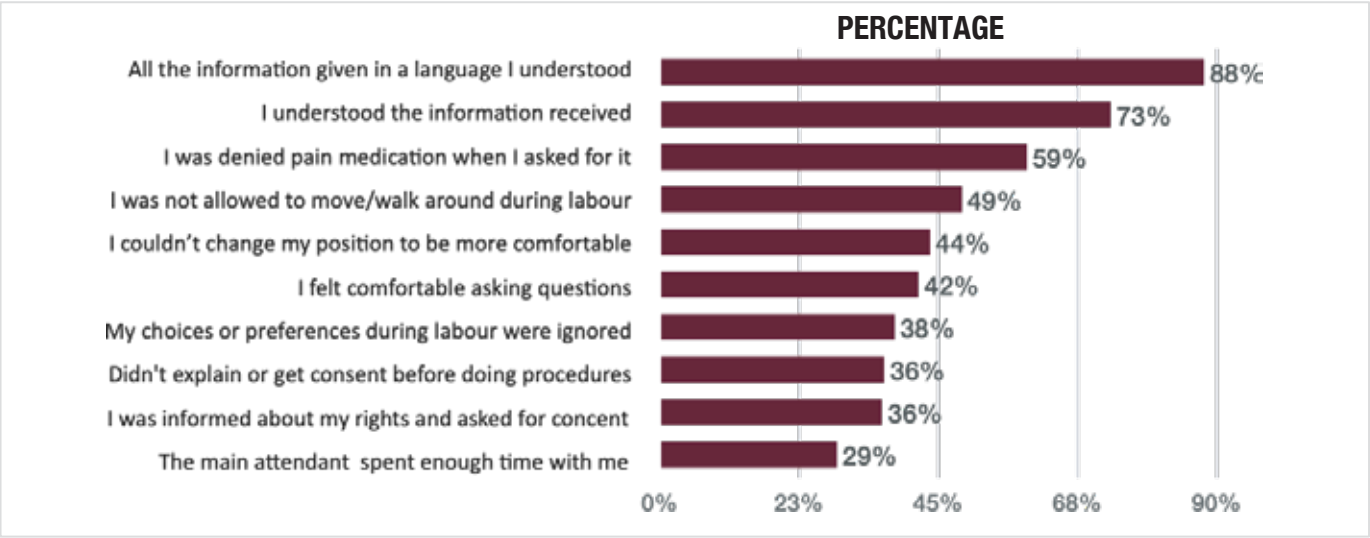


Figure 14: Conditions Experienced During the Birthing Process

Six out of ten respondents indicated that they were denied pain medication, which can be linked to provider control, judgement, or discrimination. This type of control is also seen from reports of individuals not being allowed to walk around during labour or change their position. Evidence suggests that the freedom to move and choose positions during labour improves outcomes during the birthing process (Bohren et al., 2017; WHO, 2018).

"Not being able to ask questions when I wanted to made me feel like I was going to lose my baby because I didn't understand why she was connected to pipes or in the NICU."

"I thought it was normal to take decisions on my behalf as healthcare workers; I didn't know that I was being mistreated."

Birthing individuals reported mixed experiences regarding consent and getting information about their rights, with equal proportions indicating that medical staff either did not explain procedures or seek consent, or did inform them of their rights and obtain permission.

There were no significant differences between the provinces in terms of the birthing conditions of abused individuals.

5.3.2 Environment During the Delivery

Figure 15 presents a nuanced picture of the co-existence of acceptable physical conditions with interpersonal mistreatment during childbirth. Circled numbers indicate particularly notable findings.

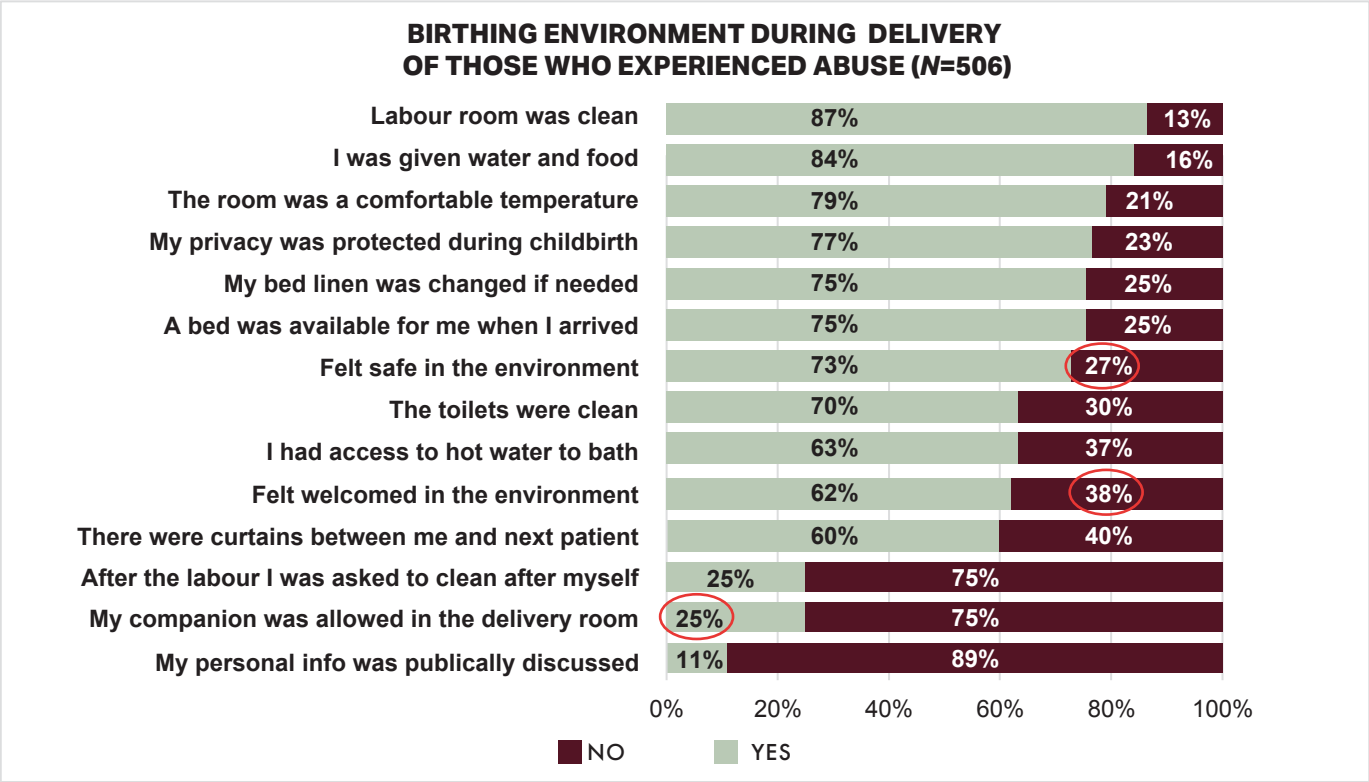


Figure 15: Birthing Environment During Delivery of Those Experiencing Abuse

A high proportion of respondents who experienced abuse reported positive environmental conditions with, noting clean rooms (87%), access to food and water (84%), comfortable temperature (79%), and clean toilets (70%). These indicators suggest that basic infrastructure and hygiene were generally well maintained even in contexts where abuse occurred.

Despite clean environments, relational and dignity-based aspects were weak, with only 62% of those who experience abuse feeling welcomed and 73% feeling safe — implying that nearly one in three individuals felt unsafe during childbirth. Only 60% had curtains for privacy from other patients, indicating possible visual exposure and loss of dignity — an often-reported form of obstetric violence (Freedman et al., 2014).

Other privacy breaches were also noted, with 11% saying their personal information was publicly discussed, which is an ethical and legal violation.

Alarmingly low scores were recorded for being allowed a preferred companion during delivery (only 25% said yes). WHO recommends labour companionship as essential for respectful maternity care. Abuse may be substantially reduced if the presence of labour companions with training in monitoring of care is encouraged in the labour ward.

Being asked to clean up after giving birth is a form of neglect and degradation (25% said yes). This reflects the dehumanisation and lack of postnatal support that typify disrespectful care environments (Stanton & Gogoi, 2022).

Gauteng patients reported better facility-related conditions (privacy, cleanliness, temperature), while KwaZulu-Natal patients reported better basic care and interpersonal environment (provision of food/water, feeling welcomed). Critical gaps, particularly in companion support and bed linen changes, were seen in both provinces, reflecting systemic weaknesses in patient-centred obstetric care.

5.3.3 Care Given On or Before Discharge

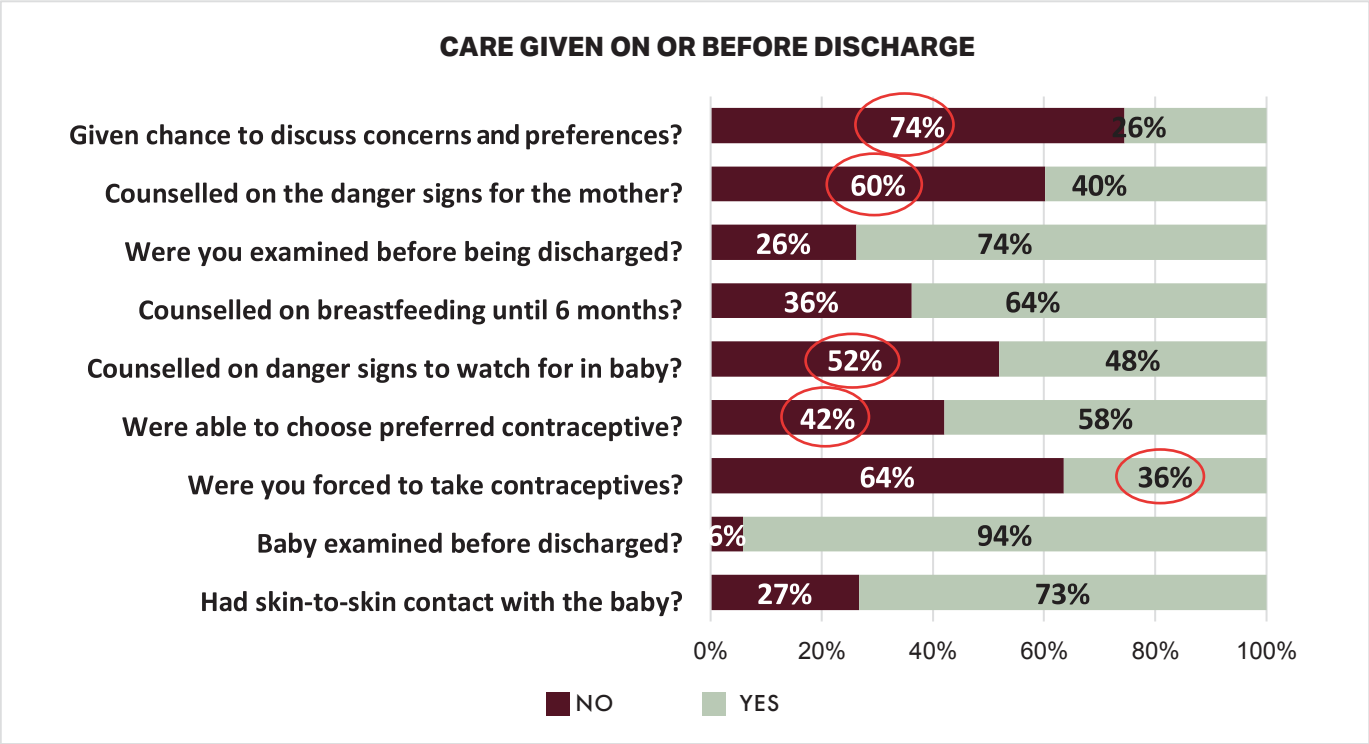


Figure 16: Care Given On or Before Discharge

Figure 16 shows the proportion of birthing individuals who reported receiving specific types of care and counselling on or before discharge after childbirth. The results highlight both strengths and significant gaps in postnatal care, with implications for maternal and newborn health, as well as for respectful maternity care. Circled numbers indicate particularly notable findings.

Most patients were not given the opportunity to discuss concerns and preferences before discharge, a serious gap in patient-centred care and shared decision-making. Six in ten of individuals who had just given birth were sent home without critical knowledge about recognising complications from giving birth, and just over half were discharged without knowing what danger signs to look for in their newborn.

"It was a bad experience because I was afraid to take my baby for check-ups because of the treatment I received in that facility"

Approximately three-quarters (74%) of mothers and 94% of newborns were examined before discharge — suggesting newborn checks are prioritised over maternal checks, despite both being important for early detection of complications.

The autonomy and reproductive rights of individuals were also compromised, with 36% of individuals forced to take contraception and 42% not given a choice as to what contraception they would prefer.

5.4 Reporting of Abuse

Findings highlight deep structural, psychological, and cultural barriers to reporting obstetric violence, with nine out of every ten patients who were abused not reporting their treatment. This is exacerbated by the finding that the kind of treatment in these facilities has become so normalised that two-thirds of the respondents didn't know that the mistreatment was abusive.

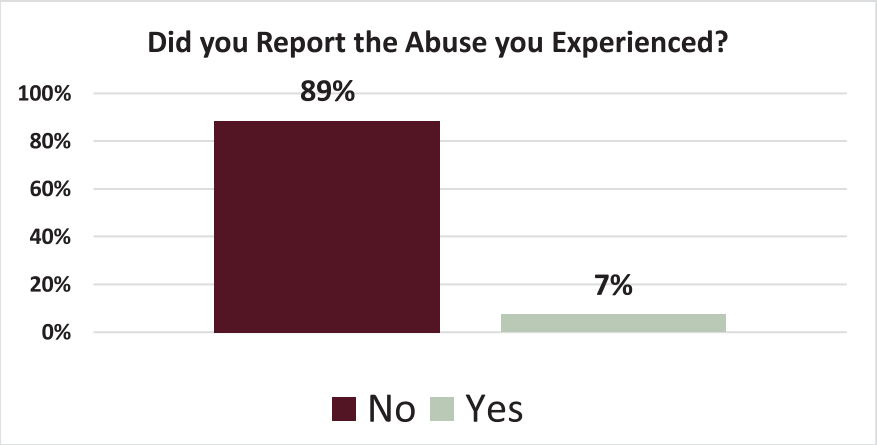


Figure 17: Proportion of Birthing Individuals who Reported Abuse (*N*=506)

There are extensive barriers that contribute to individuals not reporting the abuse experienced:

- **Structural barriers:** Lack of clear reporting channels and fear of retaliation from healthcare providers.
- **Psychological barriers:** Trauma, shame, self-blame, and emotional exhaustion.
- **Social and cultural barriers:** Family discouragement, normalisation of mistreatment, and discrimination.

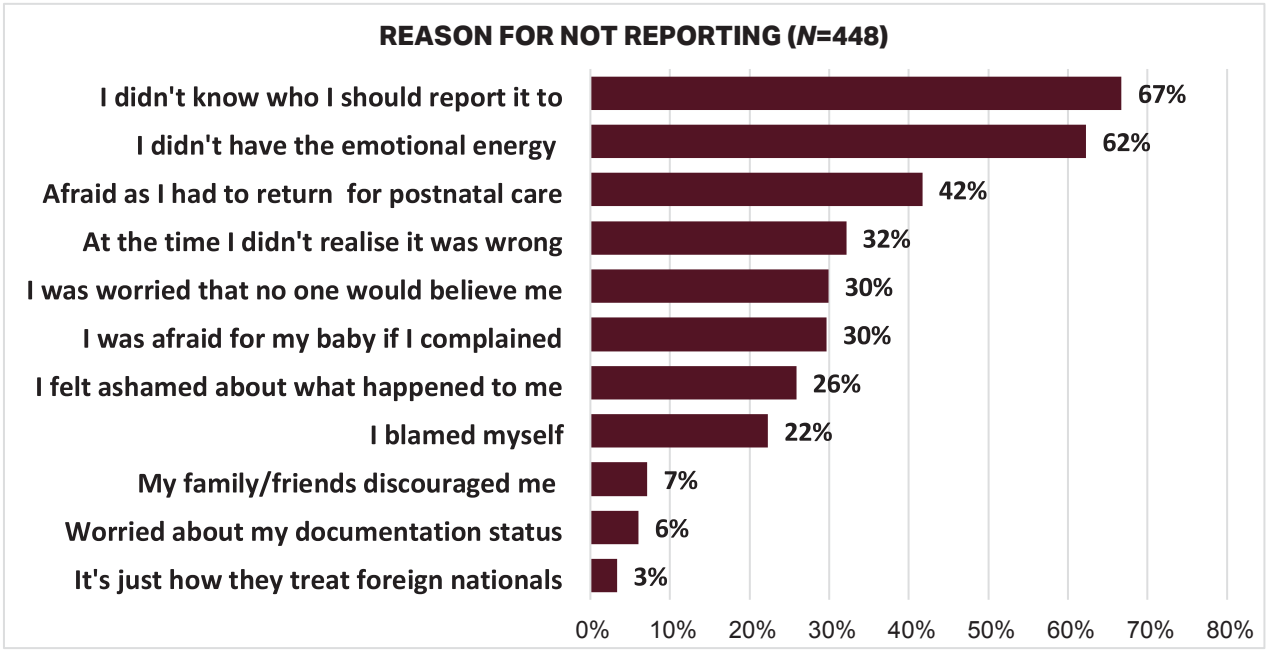


Figure 18: Reasons for birthing individuals not reporting abuse

This pattern suggests that even if reporting mechanisms exist, they are inaccessible, unsafe, or mistrusted. For accountability to work, women need:

- clear, safe, and confidential complaint systems
- protection from retaliation
- community education so that obstetric violence is recognised as unacceptable
- support services to help individuals overcome the emotional burden of reporting.

"I'm not in the right state of mind, I lost my child because of what they did. I'm still in pain, even when I want to cry, I don't know who to cry to."

The establishment of ombudsperson offices, which can inform women upon admission to the facility about the channels for reporting abuse, would greatly improve the current lack of reporting. Furthermore, allowing preferred birthing companions, who are trained to monitor the care provided during the birthing process to accompany patients would also improve reporting and hopefully deter healthcare providers from abusing their patients.

Individuals in KwaZulu-Natal reported stronger fears of retaliation affecting their newborns, but slightly less emotional and social barriers compared with those in Gauteng.

In Gauteng, women more often cited emotional exhaustion, shame, and normalisation of abuse as barriers to reporting. They were also more likely to identify systemic gaps (unclear reporting channels) and family discouragement.

In both provinces, fear, lack of knowledge, and emotional/psychological barriers were the dominant reasons for non-reporting, reflecting systemic failures in providing safe, accessible, and trusted complaint mechanisms.

5.5 Impact of Abuse

5.5.1 Physical, Emotional and Psychological Ramifications of Abuse

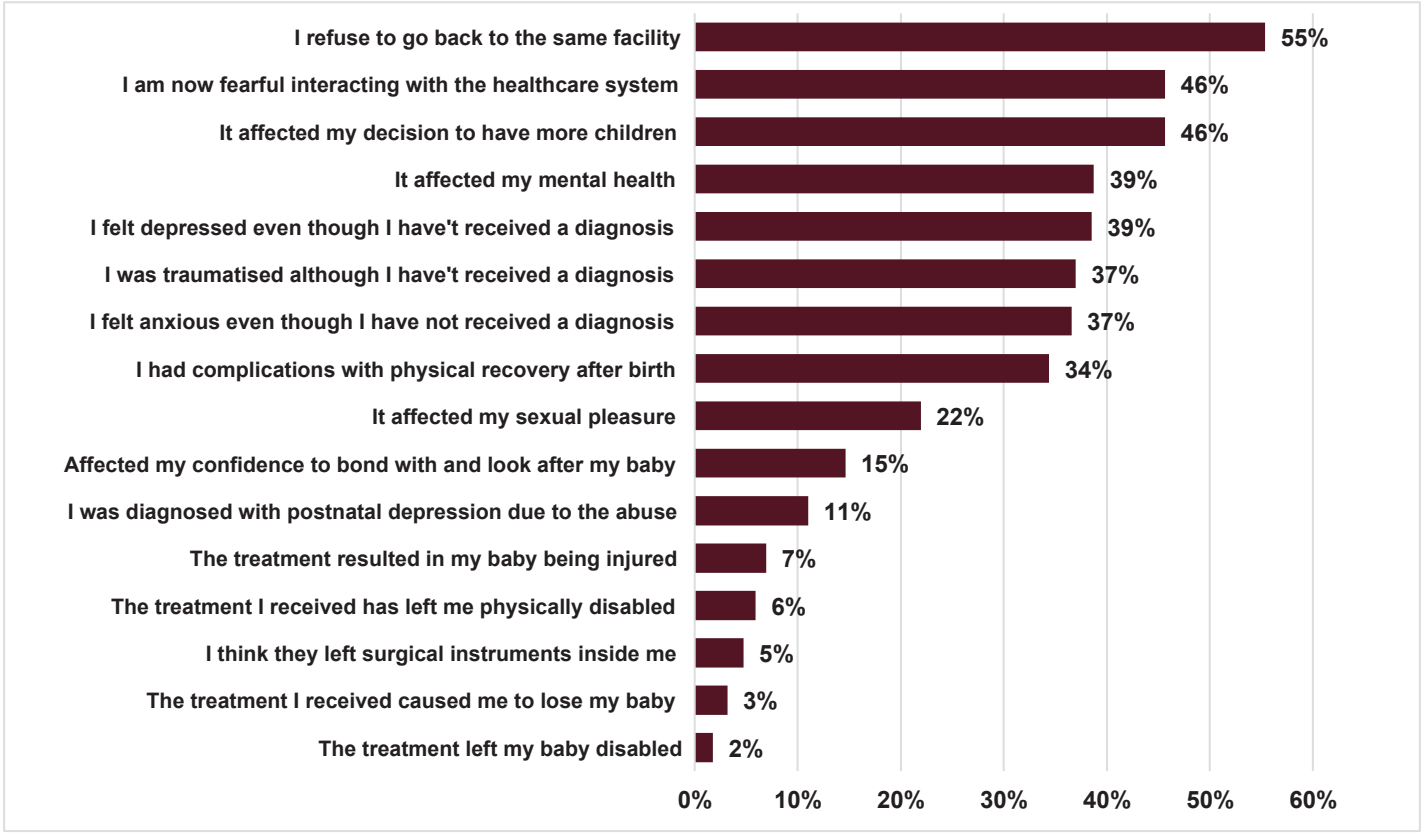


Figure 19: Longer-Term Impact of Abuse (*N*=506)

The impact of the abuse was considerable and in many instances lasting, affecting life decisions such as not having more children.

Avoidance of Facilities and the Healthcare System

Of the respondents who experienced abuse, 55% said they refuse to return to the same facility where the abuse occurred, and 46% were fearful of interacting with the healthcare system, having lost their trust in the system. This aligns with global evidence that mistreatment during childbirth erodes trust in health systems, leading to avoidance of facility-based care in future pregnancies (Bohren et al., 2015; Freedman et al., 2014). In South Africa, this avoidance can contribute to higher rates of home births without skilled attendants, increasing maternal and neonatal risks.

Reproductive Decision-Making

Almost half (46%) of respondents reported that the abuse affected their decision to have more children. Undermining an individual's future reproductive choices and violating their reproductive agency, i.e. fear of repeated abuse, impact their choices about family size and timing and contravenes Article 16(1)(e) of the Convention on the Elimination of Discrimination Against Women (CEDAW): *the right to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights (United Nations, 1979).*

These results are similar to findings from studies in Kenya and Nigeria, where obstetric violence discouraged women from future pregnancies or facility-based deliveries (Asefa & Bekele, 2015).

Mental Health Impacts

High rates of psychological effects were noted:
- Mental health affected — **39%**
- Depression without diagnosis — **39%**
- Trauma symptoms without PTSD diagnosis — **37%**
- Anxiety without diagnosis — **37%**

These figures suggest a significant burden of undiagnosed perinatal mental disorders, consistent with South African research showing under-diagnosis of postpartum depression and trauma (Tomlinson et al., 2014). Untreated maternal mental health issues can impair maternal–infant bonding, child development, and overall family well-being (Stein et al., 2014).

Physical Recovery and Sexual Health

A third (34%) of individuals who experienced abuse reported complications with physical recovery, and 22% reported impacts on sexual pleasure. This echoes evidence from literature showing physical harm from neglect, unnecessary interventions, or inadequate postnatal care (WHO, 2018). Sexual dysfunction is a known but under-reported outcome of traumatic childbirth experiences (Ayers, 2016).

"My self-confidence has been completely destroyed. I am even disabled in my genitals, I have lost my identity, and I am still heartbroken because I don't know what will happen when I meet a man."

Impaired Bonding and Parenting

Approximately 15% of those who experienced abuse felt reduced confidence to bond with or care for their infant; 11% were diagnosed with postnatal depression linked to abuse. The link between obstetric violence and impaired maternal–infant attachment is supported by research indicating that trauma and postnatal depression negatively influence caregiving behaviours (Beck, 2015).

Harm to Infants

One of the saddest impacts of obstetric violence is the abuse perpetrated against newborns, with 7% of those reporting abuse noting that their infant was injured; 2% reported the newborn became disabled and 3% lost their newborn. These outcomes illustrate that obstetric violence is not solely a maternal health issue but also a child rights concern.

Rare but Severe Incidents

Surgical instruments being left behind after the procedure was suspected in 5% of cases and 6% of cases noted being left physically disabled. While lower in prevalence, these reflect extreme breaches of medical ethics and patient safety, pointing to systemic gaps in clinical governance and accountability.

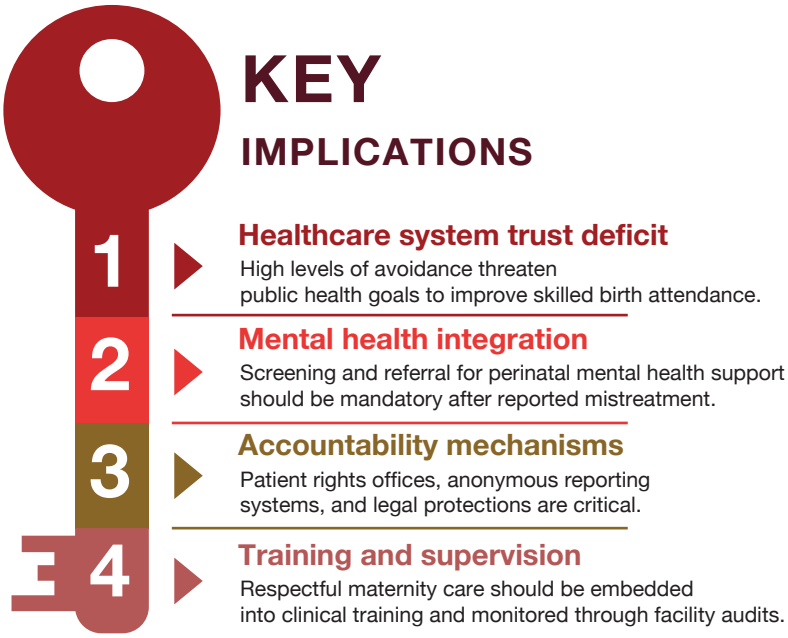


Figure 20: Key Implications

Provincial Analysis

The findings reveal clear provincial differences in the consequences of obstetric abuse. In Gauteng, psychological harm was more pronounced, with high levels of anxiety (43%), trauma (41%) and mistrust of the health system (53% fearful of care, 59% unwilling to return). These outcomes reflect global evidence that mistreatment erodes confidence in facilities and deters future use (Bohren et al., 2015; Freedman et al., 2014). In KwaZulu-Natal, physical consequences were more prominent, with 8% of individuals left disabled compared with 4% in Gauteng, alongside higher rates of complications and reports of surgical errors, consistent with persistent maternal health challenges in the province (Health Systems Trust, 2022). Reproductive and social impacts were significant across both provinces: nearly half the sample reported the abuse influenced their decision to have more children, while 22% said it affected sexual pleasure and 15% noted it adversely affected their bonding with their newborns (Asefa & Bekele, 2015; Human Rights Watch, 2011; Okafor et al., 2015).

In short, reports from Gauteng reflect stronger psychological impacts and mistrust, while those from KwaZulu-Natal show more severe physical sequelae. These findings highlight the need for both psychosocial and structural interventions.

6. RECOMMENDATIONS

Obstetric violence is not just a clinical issue but also a human rights crisis. Addressing it requires systemic change through coordinated action at multiple levels. The following multi-level response framework is recommended.

MULTI-LEVEL RESPONSE FRAMEWORK

Community:
Empower patients and the public through awareness campaigns and active participation in advocacy.

Monitoring:
Collect data, conduct research, and establish accountability mechanisms to track progress and gaps.

Structural:
Laws, funding, and system-wide policies must be developed and implemented to protect birthing people and ensure accountability.

Interpersonal:
Training, communication, and respectful care practices should be embedded in all maternity services.

Figure 21: Response Framework

6.1 Institutionalise Respectful Maternity Care

- Fully implement the 2024 National Integrated Maternal and Perinatal Care Guidelines. Certain factors currently constrain the implementation of these guidelines, including a lack of staff, space, equipment, and budget. The most important part of the guidelines is a clear emphasis on dignity, autonomy, informed consent, and support for birth companions.
- Strengthen laws that explicitly prohibit obstetric violence, including performing forced or non-cosensual procedures.
- Develop local protocols emphasising dignity, informed consent, and privacy. These need to be implemented and monitored in all facillities.
- Track respectful care by means of clinical audits.
- Establish ombudsperson and patient-rights offices in health facilities. Considering the extremely low reporting results found, it is critical that these offices are established and that patients are given the details of the relevant office upon admission.
- Enforce legal standards: by amending legislation to explicitly prohibit obstetric violence.

6.2 Strengthen Health System and Workforce

- o Increase funding for maternal and newborn care.
- o Recruit and retain midwives and obstetric nurses by focusing on key aspects, including dignity, informed consent, the use of essential equipment like incubators, and obtaining permission for birth companions.
- o Improve supervision and ensure fair workload distribution.
- o Provide continuous training on consent, trauma-informed care, and cultural competence.
- o Adopt the CEDAW recommendations on obstetric violence.

6.3 Empower Women and Communities

- o Guarantee the patients' right to birth companions in all facilities.
- o Educate companions to monitor and report on quality of care and ensure they are aware of the reporting protocols and the details of the ombudsperson.
- o Run public education campaigns on patient rights. This should continue through to admission, where women are given material that informs them of their rights.
- o Involve men and community leaders in respectful care advocacy.

6.4 Data and Research

- o Integrate obstetric violence metrics into health information systems.
- o Conduct anonymous patient-experience surveys.
- o Disaggregate data by age, race, income, and migrant status.
- o Fund pilot projects such as midwife-led care, communication tools, and respectful maternity care training.

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DGMT is a South African foundation built on endowments from Douglas and Eleanor Murray. As a public innovator through strategic investment, DGMT is committed to developing South Africa's potential. To this end, DGMT has identified 10 opportunities to escape the inequality trap and build a thriving society. These opportunities span early childhood development, innovation amongst civil society organisations, youth development, preventing nutritional stunting and promoting literacy. DGMT currently distributes about R200 million per year, and leverages and manages a similar amount of funding through joint ventures with other investors.

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This report reflects the findings of the first-ever quantitative study on the prevalence of obstetric violence in South Africa.

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