SUBMISSION TO THE PARLIAMENTARY PORTFOLIO COMMITTEE FOR JUSTICE & CORRECTIONAL SERVICES

on

State Liability Amendment Bill [B16-2018]

SUBMITTED BY

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TO: Dr. Motshekga, and Portfolio Committee members

INTRODUCTION

1. This submission has been vetted and is supported by researchers activists with expertise in the fields of reproductive health, and gender-based violence.

- **Dr. Rucel**l is a postdoctoral fellow at the University of Cape Town who has extensive experience investigating the causes and drivers of obstetric violence in South Africa, with special attention to the governance and management of reproductive health services.
- **Dr. Pickles** is a postdoctoral fellow at Oxford University whose expertise is in the law and obstetric violence. She has published extensively on pregnancy and birth and the law in South Africa.
- **Dr. Towriss** is a Senior Lecturer at University of Cape Town. Her focus is on population health with a concentration of reproductive health. She has published on maternal health services with focuses on HIV+ women and contraception.
- **Brenda Madumise, Law and Policy Committee, #TheTotalShutdown (TTS)** is a social justice movement fighting against the scourage of gender based violence (GBV) in South Africa. TTS is a predominantly social media based constituentcy with an online following of more than 100,000 womxn from all backgrounds, it also boasts support offline from womxn who were activated in communities, including but not limited to, townships and rural areas.
- **Keitumetse Fatimata Moutloatse, Founder & President, Black Womxn Caucus** is an NGO based in Gauteng led by womxn who educate and empower womxn and gender-non-conforming people in churches schools and corporations with the aim to increase safety and end gender-based violence and femicide.
- **Marion Stevens, Director, Sexual and Reproductive Justice Coalition** is a South African NPO organised as a voluntary association with 170 members who have signed on to our statement of intent which addresses marginalised areas of sexual and reproductive justice. Find more details :www.srjc.org.za

We the signatories of this submission ("We") welcome the opportunity to make a submission on the B16-2018 ("the Bill").

We aim to put forward why we understand the Bill will not address the root cause of the crisis in obstetric care, and why it is an inadequate approach to reduce Department of Health expenditure. We recommend the portfolio committee reject the Bill in its entirety given the significant concerns we raise. We welcome the opportunity to make an oral submission as well.

ABUSE OF WOMEN & POOR QUALITY OF SRH

2. For over twenty years Sexual Reproductive Health Rights, SRHR– the protections of people's right to have a satisfying and safe sex life, and the freedom and safety to decide if, when, and how often to have children –has been protected in law in South Africa.[1] Despite this state responsibility, pregnant girls and women seeking maternal health services consistently face abuse. Research over the last twenty years has consistently shown that the health system perpetuates both physical and psychological forms of violence toward pregnant girls and women in South Africa.[2] [3],[4],[5],[6],[7],[8],[9] This evidence has also been confirmed by South African obstetricians, gynaecologists[10],[11],[12] and nurses[13] as well as global health experts.[14] Additionally, the statement and testimonies by women in the recent Total Shut Down movement, #TTS demonstrate the national scope of this problem.[15]

The physical forms of violence girls and women have been found to face during childbirth include: *assault,* and *coercive* and *unnecessary medical procedures*. Forms of assault include: slapping, pulling and applying pressure

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[1] South Africa. 1996. Constitution of the Republic of South Africa, Act. 108 of 1996.

[2] Jewkes, R., Abrahams, N. and Mvo, Z. 1998. Why do nurses abuse patients? Reflections from South African obstetric services. *Social Science & Medicine*. **47**(11), pp.1781–95.

[3] Kruger, L., and Schoombee, C. 2010. The other side of caring: Abuse in a South African maternity ward. *Journal of Reproductive and Infant Psychology, 28*, pp.84– 101.

[4] HRW Human Rights Watch. 2011. *Stop making excuses: accountability for maternal health-care in South Africa*. [Online]. [Accessed 10 November 2012]. Available from: www.hrw.org/sites/default/files/reports/sawrd0811webwcover.pdf

[5] Essack, Z. and Strode, A. 2012. "I feel like half a woman all the time": The impacts of coerced and forced sterilisations on HIV-positive women in South Africa. *Agenda*. **26**(2), pp.24-34.

[6] Strode, A. Mthembu, S., Essack, Z. 2012. "She made up a choice for me': 22 HIV-positive women's experiences of involuntary sterilisation in two South African Provinces. *Reproductive Health Matters*. **20**(39S), pp. 61-69.

[7] Chadwick R., 2013. "The right to dignity in childbirth? Public sector birth stories". Report to National Research Foundation, South Africa.

[8] Strode, A. Mthembu, S., Essack, Z. 2012. "She made up a choice for me': 22 HIV-positive women's experiences of involuntary sterilisation in two South African Provinces. *Reproductive Health Matters*. **20**(39S), pp. 61-69.

[9] Chadwick, R.J., Cooper, D. and Harries, J. 2014. 'Narratives of Distress about Birth in South Africa public Maternal settings: A qualitative study'. *Midwifery.* **30**, pp.862- 868.

[10] Farrell, E. and Pattison, R.C. 2004. Out of the Mouths of Babes–Innocent reporting of harmful labour ward practices. *South African Medical Journal.* **94**(11), pp.896-897.

[11] Mets, D.J. 2005. Out of the mouths of babes – innocent reporting of harmful labour ward practices. *South African Medical Journal*. **95**(5), pp. 284-286.

[12] Honikman, S., Fawcus, S. and Meintjes I. 2015. Abuse in South African maternity settings is a disgrace: potential solutions to the problem. *South African Medical Journal.* **105**(4), pp.284–286.

[13] Hastings-Tolsma, M., Nolte, A.G.W, Temane, A. 2018. Birth Stories from South Africa: Voices unheard. *Women and Birth*. **31,** pp. e42-e50.

[14] Chopra, M., David, E., Pattinson, R., Fonn, S. and Lawn, J.E. 2009. Saving the lives of South Africa's mothers, babies, and children: can the health system deliver?. *The Lancet.* **374**(9692), pp.835-845.

[15] See for example the 2 July 2018 thread on member Aliki Doula Livanis post in '#TheTotalShutDown: Intersectional Women' s Movement Against GBV Facebook' closed group.

to the fundus during active labour.[16] Coercive and unnecessary medical procedures include: C-sections, routine episiotomy,[17] vaginal exams (which women describe as sexual assault)[18] and the delivery of pain medication,[19] contraception (especially sterilisation and the delivery of the 3-month injectable).[20] The psychological form reported in this body of evidence range from neglect to verbal assaults. Neglect here refers to girls and women in active labour being turned away from healthcare facilities, as well as girls and women not being attended to by labour ward staff.

South Africa has a consistently high rate of maternal mortality and this is preventable.[21] The National Committee for Confidential Enquiry into Maternal Deaths, NCCEMD details some health system factors that can address this high cost of life. The NCCEMD's assessment finds 40% of maternal deaths are due to poor health system factors.[22] Moreover, 21% of neonatal mortality, including stillbirth is preventable, and is caused by poor health system factors.[23] These factors include health professionals lacking adequate knowledge and training in fetal distress and hypertension.[24]
Increasingly, women and their families are turning to litigation to gain remedies for the poor maternal and neonatal birth outcomes they endure (including for disabilities such as cerebral palsy) resulting from the poor quality of care delivered by the public health system.[25],[26] Furthermore, some scholars single-out the relationship between the abuse received through reproductive health services and poor obstetric outcomes (including South

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[16] The fundus is the base or upper part of the uterus, which protrudes during pregnancy. Applying pressure to this organ during pregnancy is not part of evidence-based practice.
[17] Episiotomy refers to an incision into the vulva (aka vagina). Clinical guidance advises a restriction of this practice. See WHO, 2015. WHO recommendations for prevention and treatment of maternal peripartum infections: evidence base. Geneva: WHO.

[18] This occurs during cervical checks to determine dilation in childbirth. #TTS movement women especially report this by gynaecologists during examinations for suspected miscarriage, and post-abortion.
[19] This includes both the denial of drugs, as well as coercive delivery of pain medication.
[20] References 5 and 6 detail coercive and forced sterilisation, and more recently a Human Sciences Research Council, HRSC study's unintended findings revealed 498 respondents reported forced sterilisation. See: Cloete, A., Simbayi, L., Zuma, K., Jooste, S., & Wabiri, N. (2015). The people living with HIV stigma index: South Africa 2014, Summary Report. *HSRC, 05*, 1–26. Conversely women who have chosen sterilization have also reported being denied access the procedure.
[21] HRC Human Rights Council. 2012. *Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality*. *Report of OHCHR*. UN Doc. A/HRC/21/22. (2 July) Geneva: UN.
[22] Republic of South Africa, Department of Health. Saving mothers 2011-2013: sixth report on confidential enquiries into maternal deaths in South Africa. Short Report. [Accessed 1 September 2014]. Available from: http://www.kznhealth.gov.za/mcwh/Maternal/Saving- Mothers-2011-2013-short-report.pdf. 2014.
[23] Chopra, M., David, E., Pattinson, R., Fonn, S. and Lawn, J.E. 2009. Saving the lives of South Africa's mothers, babies, and children: can the health system deliver?. *The Lancet.* **374**(9692), pp.835-845.
[24] Ibid.
[25] Bass, D. 2015. Medico-Legal Services, Western Cape Health Department: Report on activities and priorities. April, Cape Town: Department of Health.
[26] Motsoaledi, A. 2017. White Paper on National Health Insurance for South Africa: Toward Universal Health Coverage. Department of Health Republic of South Africa.

Africa's high rate of maternal mortality).[27] One could argue the scale of the Department's of Health agreements to settle and provide financial compensation to women and their families for obstetric malpractice claims deemed –indefensible– also confirms this relationship.[28]

SITUATING OBSTETRIC MALPRACTICE CLAIMS

3. The Bill concerns medical negligence claims, and especially claims relating to obstetric malpractice. However, it does not raise the context of poor and abusive services that contribute to the scale of – indefensible – obstetric malpractice claims. We argue that such an approach is inadequate, as the context driving the indefensible obstetric malpractice claims is relevant for legislative approaches to this problem. In-fact, the specific relevance of the context of poor quality and abusive treatment to malpractice quantum is evidenced by case law on obstetric malpractice. For instance, a review of existing case law up until 2017 (cases arising from obstetric claims that were not offered settlements, but rather were litigated) demonstrated:

> "Lack of adequate monitoring and poor record-keeping features prominently, as does failure to comply with guidelines. The role of midwives is central to the process of legal recompense, in that they often fail to detect foetal distress, and don't seem to act with appropriate urgency. Case law demonstrates that midwives are found to ignore the concerns of patients being admitted, and this works against them".[29]

It is also important to consider the abuse of women in childbirth that features in existing case law, for instance in Madida v MEC KZN 2016 para 57-58. In this case a midwife at a secondary or tertiary hospital applied pressure to the fundus, the women's abdomen during active labour. The case noted that this was dangerous for both the mother and foetus, and decided in favour of the mother as a result of the newborn developing the lifelong disability of cerebral palsy.[30] These examples and explicated context allow us to conclude that some of the women and families turning to litigation are doing so to gain justice and remedial support to address violations of their SRHR rights.

The crisis in the quality of obstetric services is further evidenced by an overview provided by the National Department of Health's Advocate, Montsho, concerning claims January – July 2017. The total claims for medical malpractice in this period were 7,889, of which obstetric related cases were

[27] Chopra, M., David, E., Pattinson, R., Fonn, S. and Lawn, J.E. 2009. Saving the lives of South Africa's mothers, babies, and children: can the health system deliver?. *The Lancet.* **374**(9692), pp.835-845.

[28] Mantsho, M.J. 2017. Steps taken by the department of health to address issues of medico litigation in South Africa. National Treasury Meeting. 17 July.

[29] Rucell, J. (2017). Obstetric Violence & Colonial Conditioning in South Africa's Reproductive Health System. Doctoral Thesis, University of Leeds.

[30] *Madida v MEC KZN* (2016) JDR 0477.

4,063, and the total number of cerebral palsy cases was 3,089.[31] This overview demonstrates that the overwhelming majority of cases are settled out of court, an action we presume results from the Department's medico-legal teams determining indefensible claims.

CORRUPTION vs OBSTETRIC MALPRACTICE SETTLEMENTS

4. The Minister of Health, as well as Provincial Medico-Legal departments have acknowledged there is a crisis in reproductive health resulting in significant obstetric malpractice.[32],[33],[34] However, while SRHR are legally protected and this crisis is now recognized the proposed Bill does not consider or address the root cause of the problem. Nor does the Bill adequately prioritise an intervention into the primary factors causing the loss of monies by the Department of Health.

The Bill's approach is based on the notion that public healthcare services are increasingly becoming compromised as a result of the monies paid out for indefensible claims.[35] This argument neglects two important factors. Firstly, that public funding continues to entrench inequality by disproportionately subsiding the private health sector, despite it only servicing 20% of the population [36] , [37] Secondly, that monies lost to corruption or 'irregular expenditure' exceeds those paid out to women and their families who have successfully litigated their cases to remedy trauma, and increased death and disabilities they suffer.

To demonstrate the latter we draw on evidence from available data from the provincial Health Department with the best clinical outcomes – the Western Cape.[38],[39] A comparison shows corruption and mismanagement in 2013 and 2014 (totaled R168, 991,000) which also exceeded the material compensation the Department paid to women and their families for indefensible obstetric malpractice in the same years (R24,094,147 ZAR).[40],[41],[42] This comparison is

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[31] Mantsho, M.J. 2017. Steps taken by the department of health to address issues of medico litigation in South Africa. National Treasury Meeting. 17 July.

[32] Motsoaledi, A. 2016. Minister of Health Speech, Health Department Budget Vote 2016/17. 10 May, South African Parliament, Cape Town, South Africa.

[33] Motsoaledi, A. 2017. White Paper on National Health Insurance for South Africa: Toward Universal Health Coverage. Department of Health Republic of South Africa.

[34] Presence C. 2017. Motsoaledi: NHI is coming, whether you like it or not. *Independent Online.* [Online]. 16 May. Available from:https://www.iol.co.za/news/politics/motsoaledi-nhi-is-coming-whether-you-like-it-or-not-9171470

[35] South African Law Reform Commission. 2017. Project 141 Medico-Legal Claims. Issue Paper 33. Pretoria: SALRC.

[36] Presence C. 2017. Motsoaledi: NHI is coming, whether you like it or not. *Independent Online.* [Online]. 16 May. [Accessed 20 May 2016]. Available from: https://www.iol.co.za/news/politics/motsoaledi-nhi-is-coming-whether-you-like-it-or-not-9171470

[37] National Planning Commission. 2011. 'Diagnostic Overview'. NPC: South African Government. Accessed 2 August 2017 http://www.gov.za/sites/ www.gov.za/files/npc_diagnostic_overview.pdf

[38] Padarath, A., King, J., Mackie, E., Casciola, J., 2016. *South African Health Review 2016.* Durban: Health Systems Trust.

[39] Evidence from Mantsho, M.J. 2017. (Referenced in fn 44), also demonstrates the Western Cape has fewer total cerebral palsy claims than all of South Africa (54.6% vs 74%).

[40] Western Cape Government Health 2013. *Annual Report 2012-2013*. Cape Town: Western Cape Department of Health.

especially important, not only because the Western Cape has the best clinical outcomes[43] but also because when compared to the other provinces payouts for obstetric malpractice claims average more in the Western Cape.[44] These contextualizing factors cause us to conclude the monies lost to corruption in other provinces would more greatly exceed settlements paid out for obstetric malpractice.

CONCLUSION

5. This submission has raised several significant concerns about the Bill's approach to addressing the loss of expenditure by the Department of Health.

- Firstly, we provided evidence of the poor quality and abusive context driving obstetric malpractices.
- Secondly, we demonstrated through public health literature as well as the government's own evaluations that significant proportions of maternal and neonatal mortality are preventable, and are linked to health system factors.
- Thirdly, we showed that existing case law also finds there is a link between poor obstetric outcomes, including neonatal disability can be linked to abusive and poor quality obstetric services.
- Finally, we provided evidence that the Bill does not consider or propose to address the more significant drain on Department of Health expenditure – namely mismanagement and corruption. We conclude that the Bill in effect will place the burden of the health system's poor quality of obstetric services and the consequences of corruption on poor women and their families. Additionally, we find that by limiting lump sum payments the Bill also creates barriers for poor women and their family's access to justice. The Bill would do so as such claimants rely on legal representatives that require contingency fees, which this Bill aims to limit.

It is on the basis of this reasoning and significant concerns that we urge the committee to reject the Bill in its entirety.

SIGNATORIES

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[41] Western Cape Government Health 2015. *Annual Report 2014-2015, PR293/2015*. Cape Town: Western Cape Department of Health.
[42] Bass, D. 2015. Medico-Legal Services, Western Cape Health Department: Report on activities and priorities. April, Cape Town: Department of Health.
[43] Padarath, A., King, J., Mackie, E., Casciola, J., 2016. *South African Health Review 2016.* Durban: Health Systems Trust.
[44] Mantsho, M.J. 2017. Steps taken by the department of health to address issues of medico litigation in South Africa. National Treasury Meeting. 17 July.

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