Obstetric Violence & Colonial Conditioning

in South Africa's Reproductive Health System

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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I dedicate this work to the praxises of decolonisation.

I also dedicate this work to my father whose introduction to sexism and racism rooted my moral compass. Additionally, without his generosity toward me, this degree and therefore contribution to decolonial praxis would not have been.

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Thirdly, this work, as with any contribution to knowledge is not one completed singularly, but rather is a product of scholarship, mentorship, support, and dedication to the production of knowledge. Thus, I have found support from people whose prior work this dissertation aims to contribute to, and build on, as well as from those who have more directly shaped my ability to research and author this work. In the latter regard I give thanks to my broad supervisory team, which over the expanse of this project has included six scholars. Firstly, to Professor Gordon Crawford and Dr. Lars Waldorf for selecting me to be one of your students, and to be a recipient of the Economic and Social Research Council grant that initially framed and supported this work. Secondly, I appreciate Dr. Alex Beresford who stepped in as my primary supervisor at both a late and middle stage of my dissertations development. Without your commitment to propelling me forward this work would look very different than it does now, thank you. I am indebted to Professor Sue Fawcus, my

Abstract

My dissertation outlines the relationship between obstetric violence, and colonial era conditioning. Examining South Africa's post-1994 public health system, I argue societal norms, political-economic arrangements, health systems, and their policies, have established structural violence which generates and spreads a continuum of violent practices within reproductive health services. The rationalisation and obfuscation of violence against Black women throughout the colonial and apartheid periods, including coercive contraception protocols, indexes more than simply gender-based violence in health services. I propose a theoretical underpinning: *obstetric structural violence* to explain what I argue is a particular type of violence against women. I interrogate the systematic violation of sexual and reproductive health rights enacted by health systems, resulting in: 1) non-consensual constraint of reproductive autonomy, 2) preventable maternal and neonatal disability, 3) mortality. Part 1 analyses the colonial conditioning that led to health services becoming constitutive of racial, and gendered structural violence. Examining the political-economy of the democratic period, Part 2, demonstrates how constant reform and limited power undermine low-level managers capacity to ensure the functioning of accountability, thereby propagating obstetric violence. Drawing on extensive qualitative fieldwork within seven primary–tertiary hospitals, I describe how routine, as well as episodic, physical and psychological forms of direct obstetric violence are pervasive. I argue these outcomes prove the connection between obstetric violence, adverse health, and obstetric malpractice, a fact often absent from related literature. Lastly, I argue the resultant case law and individual awards from obstetric malpractice for incurred patient harms, encourages the invisibility of obstetric, and obstetric structural violence.

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Note on Terminology

Racial and ethnic labelling remains a contentious issue and practice. Still, using such labels is necessary to situate contexts and people within them, therefore a note on terminology is necessary to clearly set forth my usages and their intended referents. In this dissertation I have used South African as an inclusive term to denote people of all races who are nationals of South Africa. African is used as an inclusive term referring to the diversity of peoples of the continent. I have followed current usage in employing Black to refer to all those racially discriminated against during the periods of colonialism and apartheid. In summary this label inclusively refers to those who were legally categorized as coloured, Indian, and black African under apartheid. When it has been useful to draw attention to specific groupings, I have followed South African historian Yvette Abrahams using the term Khoekhoe to inclusively refer to southern African first peoples, whom "a non-African anthropology has defined as hunter-gatherers, and those defined as herders" (2000: 52); and black has been used to specify coloured, Cape Malays, and Khoekhoe people; 'coloured' has been used to refer to individuals of 'mixed race'.

1 | Introduction

1.0. Research Problem

This chapter sets the scene for the dissertation by introducing the problem of violence against women in maternity, situating my case study, approach to this research and contribution to literature.

Recent activism and research has led to global attention on the particular problem of "disrespect and abuse" of girls and women in "facility-based childbirth" (World Health Organisation, WHO 2015). Citing data from low-income, as well as high-income countries, the WHO determined that these injuries, carried out by health facilities, affect girls and women during maternity, especially childbirth, and are manifested in physical, psychological, and medical forms. This pattern of adverse treatment was described by WHO as:

> "outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilisation), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-

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threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay" (Ibid).

Recent literature on this social problem spans diverse geographical spaces, low-income and high-income countries, and academic fields, ranging from obstetrics and gynaecology (Farrell and Pattison 2004), to midwifery (Nyman et al 2017; Watson and Downe 2017), from public health (d'Oliveira et al 2002; Freedman and Kruk 2014), and anthropology (Dixon 2015), to law (Centre for Reproductive Rights, CRR and Federation of Women Lawyers–Kenya, FIKA 2007; Pickles 2015). Research in these areas employs both applied quantitative (Kruk et al 2014; Okafor et al 2015) and qualitative methods (Schroll et al 2013; Bohren et al 2014). This diversity of discipline and context, as well as the focus of research encompassing patient and staff experience, and health systems functioning, has resulted in multiple contrasting discourses and labelling of the problem including: disrespect and abuse, childbirth abuse, birth rape, and obstetric violence, to name but a few (Chadwick 2014). For reasons explained in Chapter 2, I find the term "obstetric violence" to be most useful. Despite this scholarship creating multiple and contested conceptualisations of the problem, existing evidence has begun to shape a consensus on the forms this violence takes and what populations are at greatest risk, as the aforementioned WHO statement reflects.

Additionally, and similar to other adversities, there is growing consensus that this problem particularly effects individuals, and specific communities whose freedom and capabilities have been constrained by social historical orders. Particularly highlighted markers that increase risk of adverse treatment

include: those discriminated against because of their age, race, economic and disease statuses, amongst other characteristics (WHO 2015).

Extant literature concerning the adverse treatment of girls and women during maternity and childbirth has identified that, in addition to taking various forms, this problem operates at different levels within health systems including: the individual relational level occurring between patients and health professionals; taking direct physical and psychological forms (d'Oliveira et al 2002; Kruger and Schoombee 2010; Chadwick et al 2014; de Silva et al 2014; Smith-Oka 2015; Okafor et al 2015); the service delivery level relating to diagnosis and medical interventions; taking the form of unnecessary and/or unconsented medical procedures e.g. caesarean-sections, routine episiotomies, administering of especially long-term and permanent contraception (Farrell and Pattinson 2004; Bowser and Hill 2010; Sanchez 2014; Nyman et al 2017); and the operational or structural level of health systems and the professions of medicine, including the forms of insufficient staffing, inadequate supply chains, punitive policies, and hierarchical training (CRR, FIKA 2007; Sanchez 2014: 50; Freedman et al 2014; Freedman and Kruk 2014; Dixon 2015; Sandler et al 2016: 51).

The aim of this dissertation is to analyse how, and why obstetric violence is generated and spread. Recognising that health systems are products of their environments – responding to and reproducing the socio-political ideologies within their local and global environments – I take a historically situated approach to understand this problem. Using the case study of South Africa's public maternal health services, I examine the relationship between obstetric violence and the socio-political conditioning that has shaped maternal health

services from their commencement, until now. While this dissertation specifically looks at violence in the context of maternal health services, I do so drawing on a framework of literature that concerns violence within the broader practice of reproductive health. I especially do so because my evidence shows the administration of contraception within maternal health services has been and is routinely coercive. Throughout the dissertation I seek to make my unique contribution to the diversity of academic literature engaged in debates about this global problem, by proposing a theoretical underpinning to explain what I argue is *a particular type of violence against women*. I advance the thesis that, it is the cumulative enforcement of discriminatory social norms and political-economic arrangements overtime which has led to obstetric violence becoming built into the behaviours and practices of public maternal health services in South Africa.

1.1   Research Context

The health service originated through South Africa's centuries of colonial governance. In this context white male doctors "(licensing regulations generally excluded women, workers, and Black [people] from the profession)" played a central role (Lund 2003: 91). This group of medical professionals were "also frequently involved in the administration of the colonies due to their education and social standing," even taking the position of Prime Minister, and Colonial Secretary (Ibid). This situation of governance ensured the service was predicated on colonial body politics, which rested on the notion that white people exclusively, held the right to control Black people, specifically their bodies (Marks

1994; Scheper-Hughes 2004: 264-265). Thus, medical professionals and their institutions played a key role in establishing colonial rule. For example, "[p]ublic health policies extended the power of the colonial state over the indigenous population, intervening in everything from housing to personal habits" (Paul Weindling, quoted in Slack 1992: 14).

In this era, public health policy and health provision dominated, and was based on protecting colonists at the expense of the Black population (Lund 2003: 92). For instance, the spread of bubonic plague northward from Cape Town in 1900, gave the first legal grounds for the state to take legal rights from Black people and remove them to peripheral locations (Lund 2003: 93). The Colony used this medical reasoning to justify "reliev[ing] the city of its burden of uncivilised, low-paid, slum-bound, disease-ridden black labourers", thereby setting a precedent for the later containment of Black labouring classes in permanently removed locations (Swanson 1977: 393). This recounting of the utilisation of biomedicine as a mode of control, discarding and devaluing of Black people, is accurately summarised in Jean Comaroff's analysis of the colonial period that, the practice of medicine, ultimately became a means of controlling Black people and their minds, and thus an instrument of imperialism (1993).

From the implementation of official apartheid rule in 1948, until the achievement of democracy in 1994 the WHO asserted, "racist ideology …guide[d] all health action" (1983: 6). During this period, health services were designed and manipulated as a tool of "separate development." When health resources were made available to Black people they were often in the form of

dehumanising services and maltreatment (WHO 1983; de Beer 1984; Marks 1994; Scheper-Hughes 2004; Hassim et al 2007; Coovadia et al 2009; Posel 2011: 322). The policies of separate development meant health services, as well as the authorities overseeing them, were racially demarcated. Hospitals, and when this was not possible, wards, were divided by "race." The goal was that medical services provide disparate care based on racial discrimination. To ensure this hierarchy, healthcare, like most social services was managed through an authoritarian rules-based culture (Marks 1994: 14). The governance of healthcare was divided through the assignment of different Departments of Health designated to each "race." These were further split among fourteen different health authorities assigned to the racially exclusive residential areas to which people were confined (Hassim et al 2007: 12). Apartheid meant, the Black population was deprived not only of adequate medical leadership and care, but also that the health care workforce was strictly stratified further by gender, and strictly organised through a hierarchical racialised management from top to bottom. Notably then, apartheid's system of separate development impacted occupational structures within health services by, "creating a system of professional segmentation with little interaction, communication and trust between the different [administrative and professional] pillars" (Froestad 2005: 174). The health service, at the point of democratic transition in 1994, like so much of South Africa's architecture, required an administrative justice process of "rationalisation" aimed to restructure the fragmented services and orient the resources toward providing for the entire population equally (Klaaren 2007).

"Apartheid health" as it was often referred to, was based on a belief in inequality, rather than the state's desire, or responsibility, to ensure the well-being

of all South Africans (Truth and Reconciliation Commission, TRC 4: 5 ¶ 28). This approach affected not only the everyday workings of the healthcare environment, but also the development and course of the medical professions of nursing and doctoring. Maintaining the colonial ideology that only white men could be in the superior position of controlling bodies, shaped the position of Black medical professionals, under apartheid. However, to maintain this control, different strategies were used for the differently gendered and powered professions of nursing and doctoring. Each of which, as we shall see, has had specific outcomes for health care environments that impact the social patterns, dynamics of power, and therefore processes of reform. Significantly, during World War II a gender-based exception was made to the on-going exclusion of Black people from training as health professionals. War time demands found reasons to make an exception for Black women, after years of their struggling demanding acceptance to train as health professionals, were allowed to train (albeit through intentionally inferior curricular), and be employed, as nurses (Marks 1994).

This exception arose in part because Black women were subordinated and therefore seen as able to be "groomed" to be tools to "moralise and save the sick" (Coovadia et al 2009: 829). The inclusion of Black women into medical training led to a significant growth and expansion of the number of Black nurses within the extremely stratified and hierarchical ranks of the profession.[1] The law maintained the subordination of Black nurses who retained lower sala-

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[1] Black nurses were largely included in the lower ranks of nursing, which are organised through these formalised levels: staff, auxiliary, assistant, school and probation nurses.

ries than their white counterparts until the late 1980s, excluded them from treating white patients, and from having authority over white nurses until the 1970s (Marks 1994: 156, 165). The subordinated position and intention of disciplining and grooming Black patients, has been argued to have led to the ranks of Black nurses, gaining reputations for "rudeness, arbitrary acts of unkindness, physical assault and neglect," which importantly have been "widely reported particularly in sexual and reproductive health services" (Coovadia et al 2009: 829). This context of the medical professions' racialised and gendered development and manipulation and exclusion of Black people is important, as it explains key elements of the historical patterns of racial and gendered inequality within health care services at the point of South Africa's late twentieth century political transition.

This inclusion marked a new type of employment open to Black women (formerly, conventional occupations for Black women were restricted to: farming, domestic work, and teaching). The inclusion of Black women into nursing, including the specialist field of midwifery, had positive long-term economic and social impact for this demographic, and the population more generally. As one of the only professions accessible to Black women until the late twentieth century, Black nurses have been proud of their pioneering role in proving that the European concept of Black inferiority was fallacious (Foster 2003: 2). Despite this, the continued racialised deprivation of health resources meant that by 1972, the Black majority only had access to two per cent of all medics in the areas to which they were confined (Digby 2005: 445). The historic exclusion of Black people from medical professions partially explains the continued demo-

graphic inequality—especially at the highest medical ranks (Coovadia et al 2009: 829; Chopra et al 2009: 1027)—and persisting inadequate human resource capacity within the higher medical professions today (Bateman 2013).[2]

This section has concentrated on key historical socio-political elements that have shaped South Africa's health services and policies. Specifically, it provided an overview of how South Africa's colonial, and apartheid era's, shaped public health policy, the medical professions, and how these impacted Black women and the population generally. The next section similarly demonstrates the outcomes of this period of desperate healthcare at the point of South Africa's political transition. It also offers a general review of the maternal health services functioning in the democratic era, and lays out my approach to this research.

Apartheid's Impact on Maternal health

It has been argued apartheid was particularly harsh to Black South African women and children… Under-resourced health services, environmental risks, and precarious food security characterised the lives of many during this period. By …1994, infant mortality was ten times higher in the black population than in the white population (infant mortality rate 130 vs 13 per 1000 live births), rates of stunt-

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[2] The outcomes of this exclusion can still be seen today, for one by the lack of senior South African Black doctors. In a profession where it takes seven years of training to qualify as a doctor, and an added twelve years to specialize, reaching a racial parity will take some time.

ing were much higher in black children than in white children (28·4% vs 1·1%)… and large and mostly uncounted numbers of maternal deaths were occurring from septic abortions; these examples indicate some of the ways in which women and children bore the brunt of the effects of apartheid on health (Chopra et al 2009: 835)

These figures of disparate mortality are one way to express and understand the magnitude of inequality in reproductive freedom resulting from apartheid. Violence that attacks the womb, the central location of the reproduction of persons, is a violence that is not easily redeemed. Especially when it has been built into health services through complex deprivation, toxic environments, and repeated biomedical malpractice, as the above quotation from Chopra and his colleagues show. Medical analysts had expected the period of democracy and its good "health policies and programs [to]…have resulted in substantial improvements in health, and the achievement of the MDGs [Millennium Development Goals]".[3] [4] The new government's approach to safeguarding the Black population's reproductive capacity, caused analysts to be especially hopeful about the achievement of MDG Goal 5: "Improving Maternal Health: tar-

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[3] Policy improvements include significant advancements for women: 1,300 new primary healthcare facilities were built, user fees were removed for maternal and child health at the primary and district levels in the public sector, abortion was legalised, and child support and care dependency grants were introduced [for the majority population] (Chopra *et al* 2009: 835).

[4] The Millennium Development Goals (MDGs) are eight international development goals that all United Nations member states agreed to achieve between 1990 and 2015.

get three quarters reduction of maternal mortality ratio per 100,000 livebirths" (Chopra et al 2009b: 1023-24).

A selection of news headlines since South Africa's democracy articulate a history of problems in maternal health in particular: "Department 'to blame' for child's traumatic birth" (Peters 2012); "Maternal Mortality Under Scrutiny" (Odhiambo 2012); "Bara Baby Crisis" (Thom 2012); "Alarm Over Baby Deaths in Khayelitsha" (Hassan 2011); "Nightmare Birth at Hospital" (Venter 2011); "E Cape Hiding Information on Baby Deaths, Says DA" (Staff Reporter 2008); and, "Newborns Share Cardboard Boxes at Bara" (Flanagan 2007). This news media coverage especially of neo-natal disability and mortality, highlights the continuity of poor social determinants of health, and the challenges arising from limited staffing, and increased access and availability of maternal health services. Confirming this evidence is a string of academic literature documenting the trend of abusive practices within reproductive health services, including maternal health (Tint et al 1996; Oskowitz 1997; Jewkes et al 1998; Wood and Jewkes 2006; HRW 2011; Harris et al 2013). For example, psychological forms of abuse based on moral judgements of women's sexuality were reported by patients seeking care within maternity services, specifically Jewkes and her colleagues found pregnant patients to be scolded for being, "dirty," as well as other insults referencing their age, and access to income (Jewkes et al 1998: 1785-1787).

By 2015 South Africa did not meet the MDG target of reducing the maternal mortality ratio to 38 per 100,000 (Statistics South Africa, SSA 2015). Im-

portantly, though there is some uncertainty regarding MMR estimates in South Africa; it is suggested for example, that during the MDG period, the rate of maternal mortality fluctuated (Chadwick et al 2014; see Bradshaw and Dorrington 2012 for an in-depth analysis). However, by some estimates the rate of maternal mortality during this period has been suggested to be high for South Africa, considering its middle-income country status, and even when compared to estimates for low-income country contexts (Chadwick et al 2014: 862). Most importantly, research as well as initiatives such as the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD), have determined that many of these deaths are preventable. For instance, Chopra and his colleagues reported in 2009 that national audits found between a quarter, and half of maternal deaths, showed an "avoidable health-system factor contributed to mortality" (Chopra et al 2009: 835). The study concluded that the "weak and underdeveloped public health-care delivery system, struggling to overcome poor administrative management, low morale, lack of funding, and brain drain," was a major cause for the reversal of initial gains made toward MDG 5 (Chopra et al 2009b: 1023). Even more relevant, they concluded that the primary causes of the majority of these deaths, were directly related to the actions of healthcare providers, and not merely the system's lack of material resources (Chopra et al 2009: 836, my emphasis), although these two factors are inextricably related (Freedman and Kruk 2014). The most recent NCCEMD report (2011-2013) found that "40 percent of maternal deaths were preventable, with the primary causes linked to healthcare system challenges" (Cooper et al 2016: 82).

Empirical studies researching the quality of public healthcare services from various angles, have been increasing the evidence that South Africa has a poor track record. Patients reported they are "rarely treated with respect and dignity" within the public healthcare system (Harris et al 2011: s115-s116). Another study confirmed that public healthcare professionals report "not [to] trust their patients" because they don't utilise services accurately, or that they do not deserve services (Gilson 2003: 1460). A study of health services in the Western Cape metro district, found discrimination based on language in several facilities (Deumert 2010). An investigation of Eastern Cape maternal health care services found routine abuse toward pregnant women by health workers has been a factor in the deterioration of women's health, and loss of their children (Human Rights Watch: HRW 2011). This wide-range of findings reveals a pattern of adverse social norms reflected in public health care, has survived the democratic transition, and the beginning of health service reform in South Africa. By showing how and why violent patterns are spread in reproductive health care, an added purpose for this research is to contribute to understanding how best health system interventions can be designed to address the root causes so obstetric violence can be prevented.

1.2 Research Questions and Aim

The aim of my research to is to understand what sustains obstetric violence. To investigate this, the dissertation answers the question:

How, and why, is obstetric violence generated and propagated in South Africa?

This broad question is answered by building on the following set of sub-questions, which are examined throughout the following chapters.

1. How, and why, were health services enabled to be tools of conquest, and how was maternal health particularly influenced by these characteristics of colonial, and apartheid governance?

2. How do the political and economic arrangements of the democratic period, relate to obstetric violence?

3. What are the forms and scope of obstetric violence in contemporary South Africa, and how do they inform what we know about this type of violence?

4. What relationship do internal health system accountability procedures, and external legal accountability mechanisms have with obstetric violence?

1.3 Analytical Approach

As I will detail with more precision in Chapter 2, this section foregrounds my advancement of current conceptualisations of obstetric violence, which is my main contribution to literature. My approach builds on four key analytical frameworks, which I apply and bring together in my work. The four frame-

works drawn upon are: 1) structural violence, 2) everyday violence, 3) obstetric violence, and 4) literature theorising constraints on reproductive freedom.

Most notable for my approach are conceptualisations of "structural violence" (Farmer 2004; Gupta 2012; Anderson 2015), and "everyday violence" (Klienman 2000; Scheper-Hughes and Bourgois 2004). While everyday violence has been used to explain direct, visible and often physical violence, structural violence has been applied to expound settings where economic, political and legal structures cause extreme inequality, resulting in indirect violence that constrains the capabilities of individuals and whole groups, such that they are not able to reach their potential, including life expectancy (Galtung 1969: 168-169; Gilligan 1997; Farmer 2004: 305; Gupta 2012: 20; Anderson 2015: 3). In this way scholars have shown that structural violence, which shapes inequality and is built into structures of power, is constitutive of direct episodic violence (Scheper-Hughes and Bourgois 2004: 1-2). Contemporary scholars continue to apply the theory to explain the ways in which discrimination engenders unequal power. For example, Emma-Louise Anderson has used "gender as structural violence" in her scholarship to reference women's disproportionate risk of HIV (2015: 8).

Reproductive rights movements and scholarship from Latin America and Spain, have increasingly described the pathologisation of women in maternity, routine unnecessary and coercive medical interventions, and dehumanising treatment in maternal health services as "obstetric violence." This includes several countries establishing obstetric violence as a legal concept punishable by

law (Sanchez 2014: 50-59). More broadly, literature analysing this global social problem, proposes that it operates at different levels, especially the individual relational level of care (d'Oliveira et al 2002; Kruger and Schoombee 2010; Chadwick et al 2014; de Silva et al 2014; Smith-Oka 2015; Okafor et al 2015); the service delivery level relating to diagnosis and medical interventions (Farrell and Pattinson 2004; Sanchez 2014); and increasingly, at the structural level of health systems and the professions of medicine (CRR, FIKA 2007; Freedman et al 2014; Freedman and Kruk 2014; Dixon 2015; Sandler et al 2016), including the ways in which health professionals are affected (Honikman et al 2015).

Lastly, my analytical approach draws on the lens established by the scholarship overlapping violence, and reproductive health. This scholarship has been concerned with the roots of injustice with regards to reproductive health and has been carried out, not exclusively, but principally by feminist women of colour (see especially Davis 1983; Roberts 1997; Qadeer 1998, 2005; Silliman and Bhattacharjee 2002; Rao 2004; Silliman, Fried, Ross and Guiterrez 2016; and Ross and Solinger 2017). This literature has successfully theorised how structures of power curtail reproductive freedom, and emphasise the constraint of women's capability to have children safely and with dignity (Ross and Solinger 2017: 55-56). This analytical lens is complementary to that on structural violence, as it underscores how the economic resources individuals and whole groups possess, structures their reproductive options, especially the reproductive rights available to girls and women. This view often takes an "intersectional" approach, drawing on Kimberle´ Crenshaw's seminal theorisation, to explain how gender is structured through race and class, to explain how people are oppressed through multiple social markers simultaneously (1993). Scholars do so in order to foreground the fact that individuals and whole groups' socio-

economic and political contexts, are critical factors in establishing control over one's body, sexuality, and in exercising reproductive liberty.

Drawing on these four analytical lenses and the findings from this research has led me to advance existing analyses of the direct, and structural ways obstetric violence constrains women and girls reproductive freedoms. Firstly, I define obstetric violence as physical, psychological violence and/or unnecessary or coerced medical interventions carried out within health systems. This approach entails viewing obstetric violence as a particular type of violence against women based on four factors: 1) it endangers a pregnant woman as well as her foetus or new born; 2) it has a direct impact on her kin; 3) when certain forms are applied systemically it can impact the reproductive health of entire groups; and 4) it is carried out by health systems and/or policy.

Secondly, I advance the thesis that this global phenomenon occurring across race, class and cultural differences is obstetric structural violence, by which I mean the socio-political causes of the systematic violation of sexual and reproductive health rights carried out by health systems, and/or policy resulting in the constraint of individuals' and in some circumstances whole groups capability to have children safely and with dignity, and preventable maternal and neonatal disability, morbidity and mortality. I argue obstetric structural violence is the cause of direct obstetric violence.

Thirdly, I posit obstetric structural violence is generated and propagated through a continuum of violence:

Figure 1: The Continuum of Violence in Maternal Health

Social Norms

Political Economy

Race

Obstetric
Structural Violence

Gender

Class

Health Systems & Policies
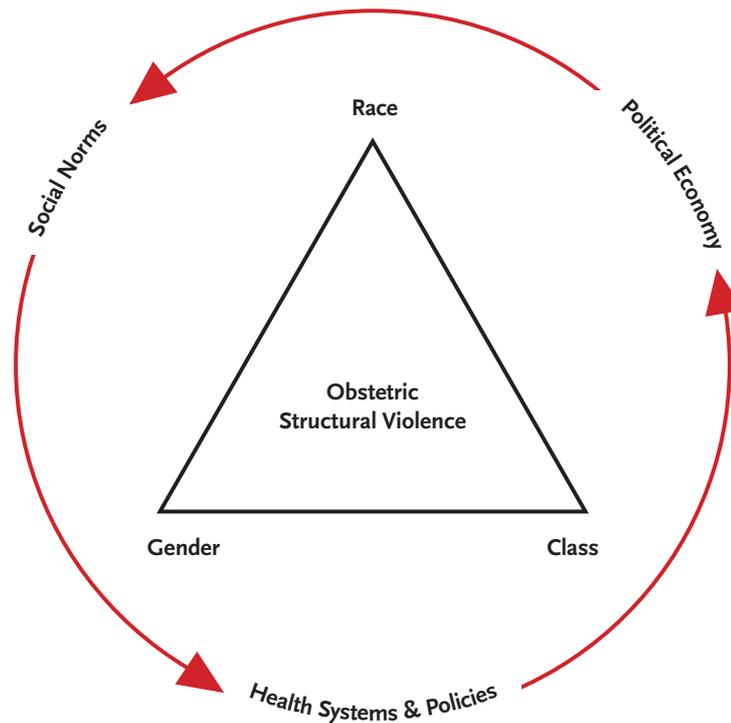
(Authors Own).

Building on the work of Cockburn (2004), Scheper-Hughes and Bourgois (2004) I use the notion of a "continuum of violence" to emphasise that obstetric structural violence operates and interacts along a continuum, and drawing from other forms of violence against women. Acknowledging this continuum places emphasis on how both direct and structural forces constrain safety and dignity at the time of maternity, and are shaped by the intersecting social markers which have gained stability in the ways power is unequally distributed

(Crenshaw 1993). Finally, applying the conceptualisation of a continuum of violence also aims to draw attention to the nuanced ways nurses can simultaneously be targets, and perpetrators of violence within health systems. This nuance and the ways in which it contributes to obstetric violence is examined in Chapters 4 and 5.

This situated approach takes seriously that health systems do not exist in vacuums, and rather are products of their socio-political environments, reflecting and reinforcing the dominant processes of their societies (van der Geest and Finkler 2004: 1996). My argument is that, taken together, social norms, political-economic arrangements, and health systems and the policies shaping them, drive multiple and overlapping practices and behaviours that generate and sustain a continuum of violence within maternal health services. I advance this thesis on the basis of the evidence from the case study of South Africa. I demonstrate that racial gendered structural violence established within colonial health services and medical professions, coupled with social norms that objectify, exploit, and inaccurately portray Black women's sexuality, fosters negative moral judgements and values about pregnancy and childbearing. The persistent constraint of resources, including the power dynamics shaping the social interactions of patients, health professionals and managers, adds to these foundations in the contemporary period. Such antagonisms exacerbate the spread of violence within maternity care services, leaving patients, health professionals, and managers, to challenge, mediate, and adapt to this continuum. Consequently, the limited space afforded to health professionals, and clinic and facility managers, often results in their actions being co-opted by the continuum of violence they ostensibly aim to mitigate.

1.4. Obstetric Violence and Obstetric Malpractice

An additional novelty of my research design is my exploration of the relationship between obstetric violence and obstetric malpractice conceptually and in practice. Both are prevalent globally. Obstetric malpractice is known broadly to shape the provision of maternal healthcare (for example through high insurance and costs of care, and the un-necessary and high reliance on caesarean section in many geographies (WHO 2015; Chadwick 2016: 424). Others raise high rates of C-section are a form of obstetric violence (Sanchez 2014). In agreement with Sadler and her colleagues (2016) I posit this demonstrates the existence of a form of obstetric structural violence. Yet the two concepts have rarely been considered together (Diaz-Tello 2016). I have included an exploration of the relationship between obstetric violence and obstetric malpractice because acknowledgement of obstetric violence as a problem of global concern, and the high-rates of obstetric malpractice globally evidence the need for interrogation. Encouraging this relevance is my review of public health literature on obstetric violence which taking an epidemiological approach is often reluctant to confirm a causal association between obstetric violence and adverse maternal and neonatal outcomes. This is most prominently evidenced in the careful wording of the WHO 2015 statement: "Such practices [disrespect and abuse of women in childbirth] may have direct adverse consequences for both the mother and infant". Despite medical professionals being expert witnesses in obstetric malpractice cases, testifying that negligence has resulted in lifelong disabilities for instance see: Molefe v MEC 2015 JDR 0449, I found

Chopra and his colleagues are a rare exception. In the case of South Africa they argue:

> "30% of maternal deaths had a modifiable factor related to administrator action…58% of maternal deaths had a modifiable factor related to health-care provider action at the primary facility level; 49% at secondary level; and 30% at tertiary level… 8% of stillbirths and early neonatal deaths had an avoidable factor directly related to administrator action…22% of all modifiable factors in child deaths were related to administrator action…[and] 53% of all modifiable factors in child deaths were related to health-care provider action" (2009: 836).

In Latin America it has been established that at least in some national settings the law is ill equip to consider, provide and pass judgement on obstetric violence (D'Gregorio 2010). I have included an exploration of the relationship between obstetric violence and obstetric malpractice to highlight the disjuncture between these two field's conclusions regarding causes of harm. My examination reveals there are connections and differences between the two concepts, and sometimes this has to do with the way negligence is conceptualised in law, while in others they are distinguished because of the form obstetric violence takes.

1.5 Methodological Design

1.5.0 Methodological Approach

How, and why women are violated during pregnancy and childbirth by health systems has been shown to relate to a number of health systems factors, for example availability of and management of resources (Browser and Hill 2010). The persistence of reproductive injustice has also been found to relate to discrimination, and inequality (Solinger and Ross 2017). Inequality is structured and legitimated over time. Paul Farmer has argued the analyses of forms of persistent violence require methodological designs that take into consideration historical, political, and economic trends and changes (2004: 309). This approach is relevant for studying the development of a complex system, such as maternal health services. Health systems have been found to reflect and reinforce societies' dominant social and cultural processes (van der Geest and Finkler 2004), and as societal values change over time these factors re-shape patient/provider relations (Gilson 2003: 1461). Thus, to understand the cause and drivers of this particular violence against women found in health care it is necessary for my research to apply an historical approach and examine how political and social changes impact patterns of health care practices.

Following this literature on structural violence and health systems, to answer the question: How, and why, is obstetric violence generated and propagated in South Africa? I designed a mixed-method qualitative approach rooted in an empirical situated case. A case approach was taken to explore the contemporary empirical environment as it allows for multiple methods to be ap-

plied to examine the circumstances, dynamics and complexity of social and cultural processes (Yin 2009). To facilitate a historically broad and empirically situated approach my design includes four layers: Firstly, I broadly examine the historical development of South Africa's approach to public health through the formation and implementation of policies, and changing macro socio-political conditions. Secondly, I consider the positioning of Black women by the colonial, apartheid, and democratic governments and how this has particularly influenced reproductive health care. Thirdly, I empirically interrogate contemporary maternal health care services in the Cape Town metro district. Fourthly, I empirically examine a provincial policy intervention aimed at curbing obstetric violence, and extant national case law on obstetric malpractice.

The first two layers of my approach enabled me to answer the question: How, and why, were health services enabled to be tools of conquest, and how was maternal health particularly influenced by these characteristics of colonial, and apartheid governance? To do so I primarily relied on historical material, for instance archival documents including policies, as well as historical literature. The interviews with nurses at the field sites were also informative. Interviews included questions about participant's professional training and employment history. This data was especially useful to understand the roles of apartheid and the early democratic period on reproductive health.

As noted above, my empirical investigation concentrated on the sites of service delivery. This location has been shown to yield data that is critical for the analyses of the broader health care systems in which they are organised (Gilson

2003; Blaauw 2003; Levin 2004; Scott et al 2014). For example, Gilson's research has demonstrated that applying the method of observation in clinical settings enables triangulation of information about relations of power amongst staff (2003). Observing interactions between nurses, midwives, doctors, and managers revealed how the power differential between ranks encouraged obedience amongst those in lower ranking positions. This is not something that would have been clearly discernible without using this method. Observation was able to show how language and patterns of information sharing were used to reinforce the level by which, nurse managers for example, participated. Additionally, the collection of grey literature as well as observation in facilities and during the policy development and implementation process revealed the hierarchical structuring of information sharing, decision-making and power. This data builds on Scott and her colleagues work in the Western Cape which showed how misconceptions between layers of health service managers can result in conflict as (2014).

To further situate these power dynamics I link the first two layers of my approach with the third and fourth. I do so by considering the ways social determinants shape maternal health service functioning, as well as the lives of the low-income staff and families reliant on the public health system. I have taken this approach following the conclusions of women of colour feminists, who have long argued that in order to understand constraints to reproductive freedom, the socio-political context in which it takes place must necessarily be taken into account (Davis 1983; Roberts 1997; Qadeer 1998, 2005; Rao 2004; Silliman, Fried, Ross and Guiterrez 2016; and Ross and Solinger 2017).

Designing this research through a historical and situated social determinants approach allowed me to review my collective empirical and secondary data to answer the question: How do the political and economic arrangements of the democratic period, relate to obstetric violence? This undertaking adds to the relevance, and originality of my dissertation's contribution to the nascent literature examining obstetric violence in South Africa (Farrell and Pattinson 2004; Strode, Mthembu, Essack 2012; Chadwick 2014; Chadwick et al 2014; Pickles 2015; Chadwick 2017). This research has established the empirical evidence demonstrating that obstetric violence is prevalent in a number of forms. My research confirms and expands on this. It does so through my analysis of the links between patterns of reproductive injustice and the policy contexts in which they have emerged, and are being sustained. In this way the fourth layer of my approach: the examination of the governance of the health system contributes to the South African literature which has analysed obstetric violence with regard to the management of maternal health care services (Jewkes et al 1998; Kruger and Schoombee 2010; Human Rights Watch HRW 2011; Harris et al 2013; Honikman et al 2015). Part of the novelty of this study is my analysis of the relationship between obstetric violence and internal state, and external legal accountability mechanisms. This contribution is foremost made through my review of extant national case law which establishes the basis for my argument that there is a connection between obstetric malpractice and obstetric violence.

Adapted Participatory Action Research

With in this case study approach, I specifically adapted the Participatory Action Research approach to explore a provincial policy intervention aimed at curbing obstetric violence. Participatory Action Research (PAR) is a methodological approach developed in the mid-twentieth century to enable research to go beyond investigation and contribute to direct social changes. PAR is distinguishable in several ways. Firstly, PAR is an applied approach. One of its aims is to shift the position of power established through the common practice of research. To do so the approach emphasises a fully democratic, collaborative application (Walter 2009: 151-154). Typically when applying PAR research participants are actively involved in the design, facilitation, analysis, and application of the research through an iterative participatory process (Ibid). When this approach is applied in its full vision the researcher or primary investigator takes the role of a coach (Whyte 1991). Thus, the research question or topic of examination is derived from the research participants themselves. The inquiry is aimed at solving a problem that the participants are engaged in, and that impacts their lives (Kindon, Pain, Kesby 2008: 90-95). In this way PAR aims to produce knowledge and actions that are directly useful to the group of participants engaged in the research. Additionally researchers who apply a PAR approach fully will engage in a long term process repeating the research cycle indefinitely – identifying the problem, planning and applying how to address it, participants observing this process and its outcomes and analysing and reflecting upon them – to resolve the research problem (Walter 2009: 154).

Ethical review required that I gain a local supervisor and additional institutional approvals before conducting fieldwork in the hospital system (see the section on Ethics and Integrity below for full details on ethical review). To es-

tablish these relationships and gain insight into the health system I conducted a literature review focused on South African-based scholars and practitioners working on "human rights and health" "sexual and reproductive health" "health systems" and "maternal health", this informed a stakeholder analysis which focused on the position, interest, interrelations and networks of scholars. Following Varvasovsky and Brugha a stakeholder analysis was applied to identify relevant actors, and to facilitate the implementation of, in this case, a research project (2000: 239). Through this I was able to gain insight into local networks of key informants as well as the policy intervention I would eventually study. Once initial leads were made from this list, 'snowballing techniques' – chain referrals– from one contact to their colleagues was used to generate a list (Biernacki and Waldorf 1981: 141). The list comprised of experts to interview and scholars to contact who could fill the required additional mentorship role. This process allowed me to eventually approach several academics with the prospect of supporting my application for local ethical clearance. See section Ethics and Integrity for a full description of my ethical clearances and the process it entailed.

Additionally, this process, and initial meetings I learned that a couple of months prior to my entering the field clinical heads of departments, unit managers, and policy makers were engaged in a formal provincial Department of Health task team which developed a policy and "Patient-Centred Maternity Care" Code of Conduct, PCMC, which was aimed at addressing obstetric violence (Honikman et al 2015). The existing task team context, was a perfect opportunity to engage in the research project. The team was already committed to addressing the research problem, producing knowledge about the drivers of

abuse in maternity care, and aimed at introducing solutions in hospitals. This context lent itself to applying a PAR approach to research the government's intervention. Furthermore, PAR has increasingly been applied within health research (de Koning 1996; Minkler and Wallenstein 2003). The Department preferred this more collaborative approach, which is a way local researchers had been carrying out health policy and health systems research (Scott et al 2014).[5]

My application of PAR was applied through participant observation of the policy implementation process (attending all of the eleven meetings convened by the team), and carrying out complementary work as part of the task team's monitoring and evaluation, M&E working group.[6] My work in this capacity centred on coordinating the data needed from various DoH departments to inform the task team. Additionally, I supported the creation of M&E tools used by unit managers to assess policy implementation progress, and an exit survey given to patients to assess the quality of care upon their discharge from post-natal wards. Thus, some of the research participants in the policy intervention were initially contacted from the snowball sampling but most were not selected by the research project. Rather they were part of an existing group assigned and tasked by the Department of Health to develop an intervention into

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[5] Local government, universities and provincial government have been applying similar participatory approaches to research through the District Innovation, Action and Learning for Health Systems Development (DIALHS) project, and the Collaboration for health systems analysis and innovation (CHESAI).

[6] My use of this approach was guided by my field research mentor, Professor Sue Fawcus. This mentorship was formal, and was required through the study's local ethical approval requirement, which was approved by the University of Cape Town. Professor Fawcus, was a task team member, and the Chair of its monitoring and evaluation Working Group.

abuses in maternity care that they were already concerned about. Applying PAR required me to operate from two specific positions: as a researcher, and concerned participant. Doing so allowed me to continually challenged myself to study my own practice, and reflect on the insights others shared while studying the behaviours, practices and interests of the Department and its staff.

At its heart the PAR approach establishes a "collective, self reflective inquiry that researchers and participants undertake, so they can understand and improve upon the practices in which they participate and the situations in which they find themselves" (Baum, MacDougall and Smith 2006: 854). I adapted this approach to make it feasible within my research context. Firstly, by using it only with regards to my research into the provincial Department of Health's intervention, and not during my observations in the clinics and hospitals. I chose not to apply PAR in the clinical settings as the busy, patient needs driven environment did not allow for such a participatory, reflective–driven process. Though sometimes the distinction of these boundaries blurred, as clinical managers participated in the policy working group, and district and hospital policy implementation meetings and trainings were at times held within hospitals with a wider group of clinical staff. Task team members were consulted about the design, and approach to my broader field research, (including data collection within the varied hospital settings). In this way the task team was brought into the research process and partnered with me to consider what information was necessary for my research, and their policy intervention. This was conducted through the course of the task team meetings and its convening's. In these meetings the team collectively reflected on the design and application of the policy intervention, sharing information and insights. For the re-

search, this allowed for a participatory iterative process of knowledge production about the different understandings participants held and the prioritisation of types of solutions to the research problem. For example, at one stage nurse managers raised constraints of resources as a driver of staff transgressions, while heads of departments emphasised policies and training were lacking to inform maternity unit's of their responsibilities, and I raised the influence of the social and political context which framed what is an appropriate delivery of care.

A key outcome of this process was the research project gaining necessary familiarity, buy-in and trust from senior departmental staff and relevant managers which supported the empirical research done within the hospital settings. Finally, by using a PAR approach I was able to learn experientially how the departmental policymakers broadly interacted with staff, experts and approached intervening in this particular form of violence against women.

Another way I adapted the PAR approach was the ways data was analysed. Some data that I apply in the dissertation was collected and analysed through the policy task team, however the majority of data I collected and used for the study was collected outside of the task team and analysis was not done through the team and in a participatory process. Data collected, analysed and acted upon as part of the policy development and implementation process included: a partial analysis of necessary clinic equipment, stock inventory lists, an assessment of clinical infrastructure and barriers to confidentiality and the development of health professional and patient educative and monitoring and evalua-

tion tools. All other data collected and analysed for this study was conducted solely by myself, the primary investigator.

Finally, my application of the PAR approach, and my participation in the task team through it created the opportunity for action. Firstly, the task team allowed me to cultivate a way to inform and discuss my preliminary findings with the Department of Health. I presented my findings at several stages to the DoH and the hospital managers who were involved in the task team and the broader staff groups involved in the implementation of the policy. This included mid-level management whose role is to support maternity care on a sub-district level. My presentations included a final formal reflective feedback session which helped to inform the task team's actions after I left the field. At this final presentation I questioned the policy intervention approach which was more centred on solutions and frameworks than questioning the cause of obstetric violence. I suggested the lack of attention to the reasons for the on-set of the pattern of abuse seemed to drive the language the task team used to contextualise the problem for staff. Finally, I raised how this language and the pressure put on unit managers and midwives was shown to alienate and block the effectiveness of the solutions the department envisioned. As mentioned above such iterative reflective feedback and resultant actions is typical aspect of a PAR approach.

Provincial Case Selection

While obstetric violence is widely reported across South Africa's public health services, as evidenced in the previous section, I chose to examine the Western Cape maternal health service to answer my research questions. The Western Cape was decided upon for several reasons. Firstly, the health service and its bureaucracy had a comparatively more developed capacity at the point of South Africa's transition than other provinces (Gilson et al 2017: 60). One aspect enabling this strength of the provincial health service (and that continues to bolster the service today), was that three universities in the provincial metro use the public service hospitals as training facilities for nurses and doctors. Secondly, in 1994 the geographic region which became the Western Cape province was more socio-economically advantaged than other regions. Resultantly the Western Cape had better health indicators, e.g. the infant mortality rate was 1.5 times lower than the national average (Western Cape Government cited in Gilson et al 2017: 60). A major reason for selecting the Western Cape has been that the provincial health system has remained one of the two top funded systems when compared to the nine other provinces (Health Services Trust 2008 cited in Coovadia et al 2009: 826). Thirdly, and most importantly, despite the Western Cape having sustained a well-established clinical record and having comparatively stronger health system resources (in relation to the rest of South Africa, and the continent), research has continued to show that women experience abuse when seeking maternal healthcare (Jewkes et al 1998; Kruger and Schoombee 2010; Chadwick 2014; Chadwick et al 2014).

Existing global evidence demonstrates that poorly resourced health systems are a major factor driving obstetric violence (Bohren et al 2015). As the empirical case is a relatively well-organised, resourced and performing health system, the findings of this examination add further knowledge about what the keys factors causing and spreading this violence are when deprivation is not the main barrier.

Already explained above, in 2012 instances of physical and psychological abuses occurring throughout the Metro District Health Services (MDHS) of Cape Town were brought to the attention of the Chief Directors of the Western Cape Department of Health, WCDoH (Vivian et al 2011).[7] As a result, the Department committed to developing a policy and Code of Conduct to address this on-going problem, the implementation of which commenced in 2013 (Honikman et al 2015). For these reasons, I determined that the Cape Town Metro District was especially relevant to understanding the role of interventions and accountability mechanisms in propagating obstetric violence.

1.5.1 Data Collection, Sources and Methods

Data Collection

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[7] Personal interview 23 February 2013, and correspondences 19 February 2013 with Professor, Eleanor Grant.

The main field research took place over a period of eight months (April – December 2013). During this time I gained the majority of the primary sources of data analysed for this research. Additional data collection of secondary sources and follow-up interviews were conducted periodically from October 2014 – October 2017.

A complex process of ethical approval guided my methodological approach to fieldwork. In addition to securing ethical clearance from my home university ethical clearance was also required from a local (in-country) university, which, as mentioned above also required me to work with a local academic to oversee my field research and ethical clearance application (HREC 2013). Moreover, once this was obtained, I was required to gain clearance by the Provincial Department of Health before being able to approach clinical Heads of Departments and CEOs of hospitals who would then be the final determiners of whether or not the study could enter a clinic and hospital (Western Cape Health Research Committee 2010).

This complex process of ethical approval guided the locating and soliciting of field research sites, as well as initial interviewees (which was described above in the section Adapted PAR). These ethical requirements guided the process of selecting field research sites which is standard practice for health system research in South Africa. Hospital sites are chosen in consultation with provincial Department's of Health in order for the Department to monitor and control the balance of research occurring within their system (Western Cape Health Research Committee 2010). The facilities chosen as field sites for my

study were all participating in the pilot implementation of the Patient-Centred Maternity Care, policy intervention. It was chosen to investigate participating clinics in order to interrogate the government intervention, and to build on the existing relationships and trust established through my participation in the task team. The selection of the field site locations is further discussed in the following Limitations section.

Sources

The primary sites of data collection included the Western Cape Department of Health offices, and seven hospitals within the Metro District Health Services (MDHS) of Cape Town. Four hospitals were responsible for primary care, two for secondary care, and one for tertiary care, totalling seven. The primary care Maternity Obstetric Units (MOUs), are well distributed as each are from one of the MDHS's four sub-districts. They are all based in townships, and all supporting low-income and poor Black communities. The remaining higher level health care services are situated in residential urban areas and serve a low-income, poor and racially mixed populations.

I have drawn on several secondary sources to close gaps in my primary empirical dataset, corroborate my findings, and to balance them as my access to the facility based sites was uneven (this is discussed in detail in the Depth of Participation and Limitations sections below). The first of these secondary sources is the personal archive of a Professor (identified by the pseudonym "Eleanor Grant"), documenting reports of obstetric violence for accountability purposes. The archive primarily contains accounts of obstetric violence report-

ed to the Professor by interning medical students, and correspondence with WCDoH top-level Directors, Clinical Heads of Departments and administrators about specific cases. As with all participants in the study, when noting data from this source I have provided ethnically representative pseudonyms, both to establish the diversity of my participants, and also to ensure their anonymity. Added to this, is an archive of testimonies relating to obstetric violence provided by patients and their families to the Western Cape Women's Working Group of the Treatment Action Campaign, (a national social movement and NGO). This latter archive also includes correspondence with legal advocates who examined several of the testimonies with the aim of consideration of legal claims. This archive was provided to me by the chair of the working group.

Also to cooperate my empirical findings, and especially to situate my data within a national geographic spread of evidence of obstetric violence I reviewed extant case law on legal malpractice. To source obstetric malpractice case law I used the Jutastat database, as well as a relevant malpractice lawyer's record of existing case law. To search Jutastat, I used the key words "medical negligence" which initially raised 164 possible cases. This field was narrowed by adding the key word "birth," which provided 51 possible cases. Of these, 14 were relevant to my study. One additional case was found on the less reliable SAFLII database, which was not available on Jutastat. The lawyer's records produced an additional 8 cases. Most legal claims in this area of medical negligence are settled out of court. Knowing this and to bolster these two sources, I obtained a third source of legal records. This source comprises internal reports, and a review of statistics on obstetric malpractice cases authored by National, and Provincial Departments of Health. These sources were obtained through

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Department of Health staff. These three sets of secondary sources were utilised to determine that obstetric violence is occurring throughout the country in the public health system in a range of forms. They were also especially useful to determine the actions the National Department of Health as well as the WC Department of Health are taking to address this problem. The candid archive of correspondence between responsible managers showed the lack of diligence on the part of provincial administrators to follow-up on reports of consistent abuse. The archive was also shed light on the measures responsible administrators thought appropriate to address on-going concerns. Additionally the extant case law, and internal lawyers assessments and governmental reports showed the criteria used by lawyers to bring about cases against the state for obstetric malpractice, and the judges opines revealed the weight of evidences they used to determine if punitive and/or remedial measures were to be sanctioned.

Depth of Participation

The broadness of observation and engagement of participants for the implementation of the empirical component of the study was based on which actors and structures of the health system could provide the most reliable information about the main research question: How, and why, is obstetric violence generated and propagated in South Africa? The actors and sites engaged were prioritised further based on there ability to inform answers to two of the secondary research questions: What are the forms and scope of obstetric violence in contemporary South Africa, and how do they inform what we know about this type of violence?; and What relationship do internal health system accountability procedures, and external legal accountability mechanisms have with obstetric violence?

This additional criteria was used to further determine who involved in the governance, management and delivery of services should be prioritised as informants: 1) the distribution of authority over service delivery; 2) influence on direct service 3) the study's access to informants. The understanding of the distribution of authority that informed this prioritisation was based on initial mapping of staff components informed from the task team and existing evidence, for example organograms produced by the department (WC DoH 2010). The influence on direct service was determined based on the time spent directly with patients, and access to staff was based on ethical approvals and the level of participation staff offered the study. This led me to primarily observe and engage directors of the Provincial Department of Health, clinical and administrative managers, hospital CEOs, clinical heads of departments, doctors (including students and specifically registrars overseeing secondary and tertiary care), district directors, mid-level support managers, and midwives and nurses at every facility.

The process of analysis along with staff numbers per clinic also influenced the broadness of the participant sample. For example, at the primary level clinics were staffed by between 10 and 17 staff. The broadness of the study aimed to interview more than half of staff members in each professional grouping (midwife, nursing assistants and staff nurses) and all managers. Additionally, the iterative process of analysis which was carried out during the fieldwork period (explained in detail in the below Analysis section) allowed for an assessment of the 'saturation of data.' Saturation of data is a technique used to assess

the prevalence of themes repeatedly arising in datasets (Charmaz 2008: 167). The ideal way to apply this technique is to analyse existing data during the collection process and to continue to do so until data collected begins to reveal repetition to the point that the researcher is confident further collection will not reveal any new information, however the authors acknowledge doing so in the field is generally not an option due to time, the prominence of purposive deductive research models and other constraints (Guest, Bunce, Johnson 2006). Guest, Bunce and Johnson note that a range of sample sizes have been determined to achieve a saturation of qualitative data in health sciences research where non-probabilistic sample sizes are concerned (2006: 61). The authors review of literature found the recommended range varies between 5 - 50 participants (Ibid). My sample went beyond this range. Upon reflection on the initial analysis, saturation was reached with regards to metathemes relating to the research questions after the analysis of twelve narratives. However, the connections amongst metathemes and microthemes, and especially the nuances sought about social relations of power required the analysis of a broader sample size and analytical refinement. This was gained from analysing 38 interviews at this level of microtheme, and brought me confidence that only follow-up interviews were necessary after the completion of the main data collection period.

The extent of access to the seven hospitals included as field sites differed greatly. Therefore, participation in the study could not be established evenly at the facilities. This resulted from hospital CEOs and clinical managers granting differing levels of access to their management processes and service delivery wards. This is discussed in detail in the Limitations section below. Three of the

four MOUs were established as primary sites. This entailed non-participant observation in the ante-natal, labour, and post-natal wards, and participation through interviews with nurses and managers based at these sites. In addition the study explored the management practices of these primary sites as well as two Secondary and one Tertiary hospital including the support they provided to the corresponding primary MOU sites. In practice, this meant non-participant observation was carried out within wards in one Secondary facility, and one Tertiary facility. Clinical and managerial staff were engaged in interviews at all Secondary and Tertiary facilities and non-participant observation was carried out at several clinical and administrative meetings which concentrated on overseeing quality care at the primary and tertiary levels.

Finally, I spent time in five of the townships served by the MOUs, and engaged the leadership of one community-based Health Committee supporting one of the participating Primary care hospital's. Patients and their families accessing maternal health services at each of the participating seven hospitals were briefly engaged. The choice of limiting engagement with this group of participants is elaborated on in the Limitations section below.

In practice this meant introducing the study to patients by providing them information sheets, and orally explaining why the research study was in the clinic and the opportunity they had to engage with the study. Potential participants were assured that they could choose not to participate or withdraw at any stage without any negative repercussions, that the interview and observation notes would remain confidential, that their names and identities would be pro-

tected throughout the research project and that pseudonyms would be used in the thesis and any, articles or presentations based on the research. An information sheet and consent form was given to each potential interviewee and their signature was obtained to indicate consent to participate in the study. Consent forms were provided in English, Afrikaans and isiXhosa. This introduction was carried out by myself to all staff in pre-organised meetings at the start of accessing a unit. Staff were given the opportunity to raise questions and concerns, and only after several days in the service did interviewing commence. Introducing patients to the study took a similar approach. This introduction was carried out by the unit manager at the primary level on a daily basis, and by myself at the bed-side in secondary and tertiary labour and post-natal wards. Patients and family members engaged by the study were then asked if they wanted to share any reflections and complaints they had about the service through short conversations while they were idle in the hospital. In practice this meant less than one hundred and twenty patients and family members were engaged through brief conversations in waiting areas and at bedsides. These conversations centred on: basic demographic details, attendance at the clinics, how familiar they were with the structures and entitlements of care and feedback and complaints mechanisms, and how they perceived the services provided. When participants raised a lack of understanding information was given to them about basic services, and feedback mechanisms. When issues of dissatisfaction were raised direct questions were asked with regard to, for example, issues of abuse, discrimination, and denial of care. In these instances participants were given the opportunity to explain their experiences fully in the moment, and or follow-up interviews were attempted. Most patients were poorly informed of the care available to them at clinics, and that which they

were entitled to, those who raised dissatisfaction, and were willing to share their experiences did so in brief within clinics. The tables below organised by staff component provide an overview of the total number of hours of observation, and participants formally engaged through interviews or focus groups.

Table 1. Range & Number of Participants

No. of People	Data Source	Method
6	Operational Managers	Interviews
4	Middle Management	Interviews
10	Sr. DoH Officials (incl. Chief Directors)	Interviews
7	Sr. Hospital Managers; CEOs	Interviews
11	Midwives	Interviews
8	Doctors	Interviews
8	Nurses	Interviews
5	Patients & Family Members	Interviews
6	Experts (Public Health, NGO)	Interviews
4	Civil Society Advocates	Interviews
Total	67	

Table 2. Range & Number of Participants

No.	Data Source	Method
112 hrs	Maternal Health Services	Observation
5	WC DoH Policy Meetings (April 8, May 23, June 27, July 16, Sept. 23 2013)	Participant Observation
5	Monitoring & Evaluation Working Group, PCMC task team	Participant Observation
9	Hospital Management Meetings	Observation
7	PCMC Hospital implementation Meetings	Participant Observation
6	Trainings for midwives (led by NGOs and DoH)	Observation
1	Health Committee (Community)	Focus Group
5	Midwifes/Nurses	Focus Groups

The two tables above, list the breadth of health professionals, administrators and expert actors who participated in the study and the range of methods used to engage them. The selection of this sampling was reviewed and determined through an iterative process of data review after field-work had commenced at both facility based and DoH sites. The criteria used to further prioritise the sample of participants included: 1) maternity ward staff components covering both day, night and weekend shifts, 2) maternity staff representatives of different age, ethnic and gender groups, 3) clinic, facility and district management, 4) administrators engaged in oversight of women's health policy, 5) those named (either by interviewees or in official proceedings) as a staff member who has engaged in abuse, 6) managers named with regards to oversight of abuse cases, 7) willingness to participate.

In total I conducted semi-structured interviews with 67 managers, senior officials, midwives, doctors, nurses, patients, patient's family members, civil society advocates, and public health experts. Interviews introduced a number of themes relating to the research topic, for example: health professional history (including training, and employment), workplace environment; cooperation, decision-making, and communication; workplace and social stressors; past and present abuses they were involved in or aware of; institutional structure, especially relating to governance, management, and accountability; and, implementation of policy interventions. Initial interviews with staff members usually began with a general question, "Tell me about your entry into midwifery?", or "Tell me about your experience managing maternal health services?" I had a

set of questions to pursue if that became necessary but most interviews occurred as conversations where I asked spontaneous questions that developed spontaneously from what the participant narrated. The fluid and open-ended structure of interviews allows for participants to narrate their perceptions and experiences. This method is best suited to elicit narrative's which can later be analysed using a narrative and thematic analysis (Riessman 2008). This method gave me a familiarisation with their positions and enabled me to direct the interview questions toward the most relevant information. See Appendix 1, which provides a sample question guide as well as that which guided non-participant observation, and the information and consent forms used to inform and recruit participants. The aim of these conversations was to gain an understanding of the prominent maternal health system issues, how they were perceived, actions participants take in relation to them, and what was understood to be necessary to address them.

In addition, six focus groups with community members, and nurses were undertaken. This method was used to gain insight into shared understandings of important factors, for example, grievances lodged, stock outs of equipment and trainings. It is important to note that the focus groups were not structured or organised formally but rather originated at the request of participants during observation periods within services (excluding one with a community Health Committee). These were undertaken when participants requested a group discussion, because this was easier during a ward shift than interviews in a room away from their demands of care. Non-participant observation took place within clinical settings, and participant observation occurred at DoH offices during the provincial Department of Health's development and implementa-

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tion of the Patient Centred Maternity Code of practice, PCMC. Six trainings relevant to the topic as well as the policy implementation process and conducted for nurses in facilities by the Department were also observed. Observing these allowed for insights about the ways the Department framed the problem, engaged staff, and the reception of nurses to these attempts to disseminate information, and encourage learning and adherence to these explicit regulations.

1.5.2 Methods

A mixed-method qualitative approach was applied as the best way to gain an in-depth understanding of the reasons obstetric violence is caused and spread with in the health system. The empirical research of this study primarily employed semi-structured in-depth interviews, and non-participant and participant observation (as described under the Methodological Approach section above). Additionally, and also mentioned above, on a few occasions, focus groups were used when participants requested, and when the busy healthcare environment best suited group conversations. The majority of non-participant observation occurred in labour, ante-natal and post-natal wards during day and night shifts, including on weekends, and often lasted between 4 and 5 hours per hospital visit. I engaged research assistants to support this aspect of the data collection process. Two assistants provided support for non-participant observation in antenatal, labour and postnatal maternity wards from August – October 2013. We carried out observations together, which supported an iterative learning and data collection process. Both assistants understood Afrikaans and isiXhosa, the two dominant languages spoken in addition to English. Including assistants who had these skills and local cultural and institutional familiarity assisted me to understand complexities of the service delivery, especially

when local language and nuance was used in the labour ward that would otherwise have been missed without this support. Payment to my research assistants was approved and paid through my Economic and Social Research Council, UK fieldwork support grant —¬inline with local standards of remuneration. All observation field-note data was collected in English requiring no further translation, see Appendix 1 for a sample of the training guide and collection sheets used for the approach I took to applying this method.

I also observed several managerial, community and clinical oversight meetings. Utilising these qualitative methods in the service and health system governance environments (along with my review of extant national case law on obstetric malpractice) especially enabled me to answer the research question: What are the forms and scope of obstetric violence in contemporary South Africa, and how do they inform what we know about this type of violence?

1.6 Analysis

All formal interviews were documented using short hand notes during or directly after interviews. Similarly a tally of basic information discussed was written down after every conversation with a patient. Participants who were formally interviewed were asked if they would accept the conversation being recorded. On 65 occasions participants agreed and indicated their consent on the formal release form. Non-participant observation guides were used to capture impressions from sessions (see Appendix 1 for an example). Attention was paid to the flow of work, presence of staff and patients, interactions amongst staff, with patients, and managers. These and additional blank sheets were used

to capture brief narrative, document birth experiences, and researcher reflections. Participant observation was documented through formal meeting notes of the DoH task team, as well as the researcher's notes, at times formal written reviews of meetings, trainings and presentations were also compiled. As explained by Charmaz's description of qualitative inquiry and grounded theory, portions of the analysis process were carried out during the main period of data collection in order to inform the collection process and minimize preconceived ideas about the research problem and data itself (2008: 155).

The aim of this research was to determine the causes and drivers of obstetric violence. Extant literature has suggested this violence, similar to other forms of violence against women is a product of gender discrimination (Jewkes and Penn-Kekana 2015), that is compounded by racial, and other forms of discrimination (HRW 2011; Bowser and Hill 2010). As such, my interpretation of data required an analysis of power using an intersectional approach. Following Cho, Crenshaw and McCall's suggestions for intersectional analysis all of the data's content was reviewed with consideration firstly to the ways social relations were raised, and particularly how structures of power constituted subjects (2013). Attention was paid to the "interplay of multiple social dynamics and power relations" rather than analysis that simply considers individual subject's positions themselves (Cho, Crenshaw and McCall 2013: 807). This analysis of the data resulted in the identification of 38 key interviews, along with dozens of field notes from observations. These interviews were then transcribed for further thematic analysis.

These key interviews, as well as narratives from observation notes were then collated by professional level this included: nurses, midwives, doctors, CEOs, specialist doctors, operational managers, clinical managers, mid-level managers,

district directors, chief directors, patients and experts. Collation by professional category was carried out to situate the ways social relations were raised with regards to different positions set by the social order of the professions, and health system's hierarchy. The grounded theory method was drawn on to inductively categorise narratives into meta and micro layered themes. This allowed for the analysis to identify and organise particular sections of information through qualitative coding. This resulted in a set of metathemes that emerged from the narratives, for example "background," "apartheid", "township environment", "social violence", "institutional culture", "description of patients", "accountability", "management", and "intervention." Once organised thematically the relevant narratives could be compared with regard to staff component and other standpoints to identify and consider correlations of patterns, again with consideration of social relations.

Microthemes were developed from the narratives to identify participant's representations of social relations. And how their perceptions related to conceptualisations. With regards to obstetric violence codes included: "describing humiliation"; "defining sexual assault", "detailing cases of stillbirth", "explaining fear of punishment", "describing forced contraception", "explaining neglect during labour", "explaining lack of care", "describing sepsis", "explaining unnecessary mortality due to asphyxia", "describing humiliation". With regards to what leads professionals to abuse codes included: "carrying triple responsibilities", "disappearing colleagues", "disappearing managers", "feeling forced to work", "lack of accountability", "feeling disrespected", "detailing being left behind", "detailing the deafness of management", "being unable to function", "explaining hopelessness", "externalising issues of stock and equipment", "need for whole system change", "explaining staff are hungry", "explaining

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institutional racism", "describing poor people should not have children", and "describing patients inability to follow instructions." The aim of having more active and detailed codes using the language from the narratives was to allow for "emergent theories" to develop from the data set (Charmaz 2008: 157). Once this second layer of coding was complete they were grouped and then interpreted with comparison to professional level. This enabled me to consider perceptions of power relations from the standpoint of professionals with differing levels of authority within the health system. Once patterns began to emerge with regards to social relations themes and emergent theories were then interpreted in relation to theoretical concepts established through the literature review.

In practice my process of analysis and conceptual development for instance, to clarify what obstetric violence comprises, entailed drawing out and linking participants perceptions and comparing the emerging theories with existing definitions and lists of actions found in literature on obstetric violence, and literature theorising constraints on reproductive freedom. These initial conceptualisations were then further compared to the forms of abuse identified through patient testimonies (from the Western Cape Women's Working Group, the Treatment Action Campaign); reports of obstetric violence witnessed by medical students (from Professor Eleanor Grant's archive), and finally those documented through extant case law. This process was iterative and cyclic revisited throughout the initial and later data collection and writing processes.

1.7 Reflexivity

1.7.0 Scope and Generalisability

This research project has been ambitious in its aim to determine the causes and drivers of obstetric violence in South Africa. The findings and conclusions derived from the data collected from my four-tiered methodological approach vary in genralisability and must be considered in their context. The study's design in the first and second instance considered the positioning of Black women, and this influenced the development of reproductive health policies and services in the Cape Colony during colonialism, apartheid, and through the transition to democracy. The key finding from this analysis is that certain forms of obstetric violence were sanctioned in the provision of reproductive health care, and the cumulative enforcement of services and policies rooted in racial and gendered discrimination led to patterns in public health services that violated Black girls and women in maternity. This conclusion – that discriminatory social, political and economic policies cumulated overtime are key structural drivers that reinforced at least four detectable patterns of violence in complex ways – were found to be reasonably significant in the case of the Cape Colony up until the late 20th century. Given that we know the legal and political structures governing South Africa during colonialism and apartheid were meticulously entrenched in their regimen of enforcement and control it is reasonable to argue that this conclusion is generalisable to South Africa.

The study's empirical interrogation of contemporary maternal health care services used the case of the Cape Town Metro District, which examined ser-

vice delivery at all three levels of care. Examination of the data found that there are various forms of physical and psychological obstetric violence practiced at the interpersonal, diagnostic, operational and structural levels of maternal health services (some routine, and others episodic); invidious discourses honed during colonialism and apartheid about Black girls and women's relating to pregnancy continue to fuel obstetric violence; .and finally that disparate distribution of national funding of the public health system and the lack of transportation and security at the primary care level constrains health professionals from providing adequate care to pregnant women, especially with regard to attending to all women presenting in active-labour. These conclusions were found to be reasonably significant for the case study, thus not generalizable causal findings. That said, these conclusions must be considered in their context, given that the Western Cape Province is wealthy and historically the clinically highest performing health system in South Africa (and perhaps all of Africa), then it is reasonable to assume that the problems occurring in this case setting are also occurring in the other eight South African provinces or in relative and lower performing contexts in Africa.

Finally, the fourth tier of the methodological approach examined health system structures and polices, the functioning and distribution of oversight and accountability, and existing national case law and medical obstetric settlements. This interrogation resulted in several findings and conclusions. A key issue found in the Western Cape province exacerbating accountability and weakening low-level management is the constant change the system has been under for decades. This has fed concentrations of power at the top of the health system, and a lack of transparency and confusion about governing systems in the

Western Cape. Both have undermined low-level managers authority, resulting in demoralisation. These findings are reasonably genralisable for the province, but would require comparative study to claim national significance. The national data examined importantly found that most metro-district governance is often in contradistinction to national law, and though law mandates community governance and oversight of health services, most often these structures are weak or non-existent, where only two provinces have a semblance of active community oversight bodies. The review of extant national case law on obstetric malpractice confirmed that this is a national problem resulting in punitive financial compensation. An analysis of the monies mandated to be paid to litigants by the state in the Western Cape cases (the province with the second highest number of cases) as compared to monies lost to corruption found that the latter was much higher. As the Western Cape province has been noted in auditor general reports to have relatively good performance in relation to corruption it is reasonable to argue the trend of more money being lost to corruption annually as compared to indefensible obstetric malpractice litigation is a trend generalisable nationally. Finally, the review of national case law found that it is common for health professionals to fail to keep necessary records, and follow national best practice guidelines concerning maternity care. Though the courts have often accepted practices of obstetric violence as evidence in cases trying the state for neonatal damages courts power was found to be limited to prescribing remedies that would effect health system governance. While it is presumptive to say limitations of courts legal authority is widely generalisable in this area there is a growing body of evidence in Latin America, Spain and the United States demonstrating this.

1.7.1 Limitations

While my training, skillset and methodological approach provided the necessary tools that led to answers to the research questions limitations exist at several levels. Firstly, my positionality offered some particular challenges. Being an outsider to the system, the local cultures and languages (medical and linguistic) was a major limitation. The barriers presented by this unfamiliarity prolonged the study and necessitated a reliance on local research assistants during the primary facility-based data collection period. Furthermore, the sensitive and personal nature of the topic required establishing trust and confidence in order to solicit frank and genuine responses (especially because the presumption is that patients and health care staff are punished for raising complaints). After a couple weeks on-site it was clear the facility environment was more conducive to navigating this requirement across my constraints (racial, class, linguistic, nationality and cultural differences) with staff than with patients. This was especially true as patients were time was erratic within the service environment when compared to staff whose time was consistent which allowed for building trust. These challenges informed the decision to concentrate on gaining a broadness with one participant group (health system staff) and to conduct short consultations with patients and interviews when patients requested them, and or had a depth of relevant experiences.

The ways in which the selection of hospital sites was determined as well as the granting and denial of access to hospital locations can be argued to be a limitation of the study. Firstly, as mentioned in the above Adapted PAR section, part of the general requirement to access health facilities in South Africa by researchers is that approvals must be granted by local Department's of

Health (WC DoH 2010). As part of this procedure informed consent of CEO's of facilities, and heads of departments or clinic managers are also required (*Ibid*). These administrators have the discretion to deny access to research studies even when all other approvals have been gained.

As per these regulations the hospital site selection was conducted in consultation with the Department of Health. In this case the sites were chosen to correlate to the hospitals participating in a policy intervention. This posed a certain limitation, as the sites of empirical investigation were not able to be independently selected. After gaining the letters of approval from the Provincial Department of Health for the selected hospital sites I approached the relevant CEOs, heads of departments and clinic managers. Further, challenges to access occurred at this stage. One of the nine institutions I was approved to approach for access declined. Informally I was told my study was denied access out of the Executive's interest to protect their institution from an examination of such a controversial topic. In another instance, I was afforded partial access whereby the clinic manager agreed and encouraged the study however the CEO refused to consider the request for their informed consent (did not respond to my repeated inquiries and told the clinic manager in a meeting that they would not approve the request). After the majority of fieldwork data collection took place this obstacle was overcome as a result of changes in management. Lastly, a conflict of interest (when institutions or a person has incompatible interests to more than one party, for example relationships through employment, consultative, and board membership) was raised which resulted in limiting my access to two of the remaining eight facilities I had gained full

approval to study.[8] Further, these limitations and the ways they constrained access to facilities were negotiated by deciding to prioritise the empirical sites where I had the most comparable access, leading me to designate four primary sites and three additional sites. The distribution and balance of data collection amongst these sites was detailed in the above Depth of Participation section.

Furthering the limitations to access that arose from the formal regulation of research, were the challenges I faced in engaging middle management, and the lower rung of top level managing directors. While I had been introduced to some of these persons on several occasions, and I attempted to gain access to these staff components for several years, in most cases access to interviewing these directors was denied. Presumably these layers of staff were weary of lending insights to a study interrogating the transgressions of their employees, and what actions they have taken in response to on-going transgressions and legal cases. On the one hand, I was able to obtain contact information and access to the top-level chief directors, and permission to access internal grey literature. However, where one branch of the system was open, I found this level to be almost completely shut down. This made triangulation of results difficult, as much of the data about the follow-up of procedures and disciplinary processes occurred at the middle management level. Thus, the outcomes and procedures of disciplinary process was often only accessible on a word-of-mouth basis through interviews. These limitations of the empirical research were negotiated

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[8] It is important to note that this conflict of interest was note related to me as the primary researcher but to someone else engaged in the PAR aspect of the research. Do to the ethical constraints of anonymity I am not able to describe this conflict further. The important point here is that it resulted in a limitation of access.

through secondary datasets obtained from reliable sources (discussed in detail in the above section Sources).

Finally, limitations with regard to the actionable utility –or– powers of my empirical dataset arose from the routine requirement imposed by ethics committees for researchers 'complicity' in employing a methodological strategy of anonymisation in research involving people. In the case of my ethical approval's this included anonymising the research locations and ensuring confidentiality of all informants. Confidentiality and anonymisation are different, however, their processes are connected in that confidentiality entails "not disclosing to other parties opinions or information gathered in the research process" (Clark 2006: 4). I understand the requirement of anonymisation for my study to have resulted in a limitation as it caused an inability to name the hospitals and professionals engaged in obstetric violence, which allows for evasions of accountability.

Furthermore, it limited my ability to document and use specific information relating to obstetric violence and accountability. For example, routine neglect of services in terms of stock outs of goods and equipment (for example, long-term (over two years) stock outs of essential sterile equipment); several accusations and observations of likely corruption; numerous accounts of dysfunctional accountability mechanisms (including Sub-District Directors seemingly not following up on several reports of obstetric violence, including reports leading to foetal/neonatal mortalities); the disclosure of facilities where forms of obstetric violence have been observed routinely, and of public servants who have been identified by participants to have repeatedly abused women during

childbirth in primary and secondary facilities. Several examples of the forms of obstetric violence I am unable to report on due to these 'ethical' constraints with specifying information include: *routine* denial of pain medication during active labour; the administration of progesterone-only Long-Acting Reversible Contraceptives with lack of informed consent, and at times coercively; abuse of women during childbirth (for example, unnecessary, and un-anesthetized episiotomies,[9] and those administered without sterile surgical sutures,[10] unnecessary repeated manual vaginal dilation during the second phase of labour, reported as "almost like sexually assaulting the patient").[11] These practices during childbirth cause additional pain, restrict the power of women, and may contribute to risks of maternal and neonatal health. Had blanket anonymity not been required, my study may have offered considerable data about where obstetric violence is taking place to responsible authorities. Additionally, it could report to authorities about multiple levels of management responsible for the failure of oversight relating to the perpetuation of obstetric violence.[12]

1.8 Ethics and Integrity

I obtained ethical approvals from several university and governmental bodies before empirical research commenced in 2013, namely the School of Politics and International Studies, University of Leeds, including the university-wide ethics committee (Ref. No. AREA 12-013), and from the Department of

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9 Personal interview, MOU Unit Manager, Midwife, Asanda Mlandu, 26 October 2016, interview conducted with the participation of the Operations Manager.
10 Observation notes, MOU, 30 September, 7, 14 October 2013.
11 Personal interview, medical student, secondary hospital internship, Thomas Russell, 30 November 2013.
12 I have written on the limitations posed by ethical review requirements extensively elsewhere see Rucell 2018.

Obstetrics and Genecology at the University of Cape Town (UCT), and the university-wide Human Research Ethics Committee, UCT (No. HREC 290/2013). Additionally, I received approval (Ref. RP093/2013) from the Western Cape Provincial Department of Health's Research Unit, and acceptance from each of the seven participating hospitals.

I approached both observation and interviews with patients, managers and staff from the point of view that it was the responsibility of the facilities, to provide essential services to the public. Therefore, as a researcher, first and foremost, I had to be aware not to impinge on the vital work of this public service. Further, this research is about a sensitive topic, it is about harm accrued, and enacted in a public service workplace. The research was partially carried out through interviews with public servants who worked closely with one another. Therefore, who participated and at what level of participation, might easily have been discernible especially amongst staff members. This research context demanded special attention to maintaining the integrity of the research purpose of support staff, managers and healthcare systems, to create healthy and safe environments to work, and provide the best quality services to all patients. This required me, as the primary investigator to draw on my skills as a transparent and open communicator while not showing bias toward any one authority, or role player. This also required that I maintain the confidentiality of the data collected from participants. Confidentiality has been maintained through conducting communications between myself and informants, through confidential and private emailing, telephone, and personal verbal means. Further, informed consent has been applied for personal interviews as well as focus groups. In the latter case, this was achieved by reminding partici-

pants that their participation in-group sessions must remain confidential within the group. Additionally, this level of integrity and transparency was necessary to potentially mitigate and challenge any suspicions that could arise, that this research might be used for anything other than my stated purpose.

Maintaining such ethical integrity called for regular reflection on the professional role I played, and how to best act in order to maintain such integrity with informants and authorising officials with whom I had built relationships and engaged in research. This included developing a careful selection process for the two research assistants with whom I partnered, to assist with facility-based non-participant observations.

1.9 Structure of Dissertation

Chapter 1, "Introduction," sets the scene for the dissertation by fore-grounding the problem of facility-based violence against women in maternity, situating the case study, approach to this research, and my contribution to literature. Chapter 2, "Review of Literature on Violences," develops my theoretical approach by reviewing scholarship on reproductive health, and on violence of different types and forms, including scholarship that overlaps these two topics. Specifically, this chapter develops the theoretical approach of my research and advances current conceptualisations of obstetric violence. Chapter 3, "Foundations of Obstetric Violence in South Africa," takes seriously the premise from South African feminist scholarship (Abrahams 2000; Baderoon 2014 and Gqola 2015), that colonial violence, and particularly the period of slavery

in the Cape Colony, has been a constitutive element of South Africa and that this context is essential for understanding contemporary violence against women. By doing so, this chapter interrogates secondary data to establish the roots of contemporary obstetric violence in light of colonial and apartheid conditioning. Chapter 4, "The Political Economy of the Social Determinants of Reproductive Health," situates the problem of obstetric violence within the current crisis of South Africa's public health system. Particularly, it examines the neoliberal arrangements causing persisting material constraints for the majority population, including a disparate distribution of health resources. Chapter 5, "Direct and Structural Obstetric Violence," examines how the public health system reproduces violence. Firstly, it examines patients and health professionals' routine experiences of this system, as well as how resource constraints, and poor managerial systems and practices, impact patients and staff and in turn how these contexts shape attitudes and behaviours. Secondly, I analyse the different forms obstetric violence often takes in South Africa, and how this relates to constraints in resources, power, and discrimination. Chapter 6 presents my examination of the functioning of accountability mechanisms relating to obstetric violence. This covers an analysis of the Department of Health's internal administrative rules and procedures, existing case law concerning obstetric malpractice, and PCMC a Western Cape Provincial policy intervention aimed at curbing obstetric violence. I situate these mechanisms within the landscape of redress, the authorities, and hierarchy of health system governance. This shows how in practice, public officials at different levels of authority apply the mechanisms available to them. By doing so, I contribute an evidence-base of the specific behavioural incentives and disincentives arising from health system policy, rules and procedures, and legal accountability mechanisms on obstetric

violence. Chapter 7, "Conclusion," provides an overview and synthesis of the findings of this study, and foregrounds my contribution to knowledge on obstetric violence, offers policy recommendations, and the applicability of the conclusions of this investigation.

2   Review of Literature on Violence

2.0 Introduction

This chapter develops the dissertation's analytical approach which builds on literature which theorises different types and forms of violence, and especially on literature that concerns reproductive health and violence. It comprises two sections. In section one I consider the literature on violence by reviewing and evaluating conceptualisations of modes of violence, namely the "structural violences" that are built into structures of power (Galtung 1969; Farmer 2004; Anderson 2015), and the "everyday violences" which are direct and episodic (Kleinman 2000; Scheper-Hughes and Bourgois 2004). This theoretical basis has been applied to examine the direct and indirect harms found within maternal health services by doing so I contribute to furthering understandings about the types of violence shown in maternal health services and develop a stronger case for the constitutive relationship between "structural," and "everyday violences." Moreover, the review considers the ways that historic orders of race, class and gender shaping unequal distributions of power can inform conceptualisations of obstetric violence. To expand

on how violence operates through social structures marked by race and gender the chapter applies philosopher Maria Lugones' formulation of the "modern/colonial gender system" which illustrates how these subjugating structures of power interact (2008). This review shows the importance of distinguishing different types and forms of violence. Supporting (Sandler et al (2016) and Chadwick's (2017) positions I contend that structural violence provides a conceptual basis to examine how patterns of harm have become built into the behaviours and practices of maternal health services. This foundational literature is applied in the second section which reviews the multi-disciplinary contestation of how to conceptualise the prevalence of the harm of women and girls in maternity and childbirth. Combining these theoretical foundations demonstrates the analytical importance of distinguishing the different types of obstetric violence implicated within maternal health services.

In conclusion my review strengthens the argument made through legislation in several Latin American countries that obstetric violence is a type of violence against women (Sanchez 2015). I further this argument by positing obstetric violence is a particular type of violence against women that takes both direct, and structural forms, which following Anderson (2015) leads me to introduce the concept, 'obstetric structural violence.' The Chapter presents my analytical premise and contribution to this disparate literature, namely an explanation of the connections between obstetric and structural violences, a definitional distinction of obstetric violence, and by arguing how the concepts inform one another I provide an explanation for how they are applied in the dissertation.

2.1 Theories of Violence

Academic literature tends to categorize different forms of violence based on motive, consequence, and actors. While scholars use a variety of typologies to explain violence there is agreement on distinctions of political, structural, symbolic13 and everyday violences (Pearce 2007a: 53). Theorists employ these classifications to offer a nuanced perspective on the spectrum of lived experiences of violence during conflict, societal transitions, and in times of peace (Scheper-Hughes and Bourgois 2004). This dissertation attempts to understand the sustained violences in a paradoxical setting (maternal healthcare services), occurring in a so-called 'post-transition' context (South Africa). Interestingly, the concept structural violence is most widely applied by contemporary scholars of public health, medical sciences and medical anthropology whose primary research concerns persisting violences in low-resourced contexts. Most notably, these scholars include Gilligan 1997, 2000; Farmer 2004, 2005; Scheper-Hughes and Bourgois 2004. This view of violence contrasts the common understanding that violence is always direct, visible, and has an attributable perpetrator, and cause. These scholars have established theories of violence to distinguish episodic from structured persistent forms

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13 Bourdieu and Wacquant conceptualized the term 'symbolic violence' to refer to violence internalized by a person and carried out upon themselves. They explain this occurs by the "exercising" of unequal social relations as 'symbolic violence' internally by a person (or group) to the degree that they can themselves "structure what determines them" to be inadequate, deserving of violence, marginally located or expendable (2004: 272).

of violence and to better explain provocations of death by continuous patterns that stabilise social and material realities of inequality.

The theory of "structural violence" was first developed by Johan Galtung to distinguish between "*direct*" (physical) and "*indirect*" (low life expectancy) forms of violence (1969: 168-169, emphasis retained). Theorists of violence argue a circumstance of great inequality is a "*structurally violent*" *context* (Henkeman *et al* 2016: 5, my emphasis). Thus, structural violence is most often applied to explain extreme poverty and inequalities of class. A structurally violent context signifies a setting where social structures (including economic, political, and legal) cause inequality such that individuals and whole groups' capabilities (including psychological, physical well-being and or life expectancy) are diminished to the point of them becoming unable to reach their potential (Anderson 2015: 3; see also Gilligan 1997; Farmer 2004: 305; Gupta 2012: 20). Farmer (2005), along with Gilligan (2000) for example, apply the theory to examine how poverty and acute diseases have been sustained by various economic and political hegemonies. Thus, structural violence refers to both the production of exclusion from basic "entitlements" or put it another way, the "rights" to those basic entitlements (e.g. food and water), as well as exclusion from "forms of recognition" (citizenship, healthcare and education) (Gupta 2012: 20). The concept is relevant for researching persistent inequality, for instance the preventable rates of maternal mortality and morbidity (Farmer 2005: 44). Part of my thesis is that applying this concept to the globally prevalent abuse of women in maternity by health systems is also relevant.

2.1.2 Structural Violence

Given the high level of inequality within South Africa, and specifically the country's health services, which as discussed earlier denotes a structurally violent context, I apply this concept in conjunction with everyday violences. I do so especially to analyse the stable and changing interactions between various forms of violence and different structures of domination influencing the sustainability of violence within maternal health services (Wacquant 2004: 322). As was explained in the introduction to this chapter the concept structural violence is employed by scholars who aim to bring better focus to the cumulative social and political forces that over time, acutely diminish the life chances of some, while multiplying the chances of others. For example, structural violence has been applied to explain South Africa's racist system of apartheid (Scheper-Hughes 1998: 127), as well as the violences that persist beyond its legal dismantling (Gready *et al* 2010: 1, Ross 2010: 211; Henkeman *et al* 2016: 8-9), including violence within the South African health system (Scheper-Hughes 2004a: 264; Harris *et al* 2014; Pickles 2015: 7).

Using the theory of structural violence also becomes important for analysing local health system environments as Gilligan (2000), Bourgois and Scheper-Hughes (2004), and Gready *et al* (2010) have identified structural violence to be the main cause of everyday violence. I argue these related theories are useful for situating violence within maternal

health services in the broader context of reproductive politics and inequality that this 'exceptional' problem occurs within. Lukes argues while power is deeply embedded in societal structures, its functioning can be understood by observing "whose interests are furthered by the dominant ideas of the current system and whose interests are harmed" (cited in Anderson 2015: 7). How scholars define structural violence is critical as some definitions have shown shortcomings to the concept's analytical utility. Scheper-Hughes and Bourgois' comprehensive synopsis of the theory provides a useful example:

Structural violence is violence that is permissible, even encouraged. It refers to the [often] invisible social machinery of inequality that reproduces social relations of exclusion and marginalization via ideologies, stigmas, and dangerous discourses… attendant to race, class, sex, and other invidious characteristics. Structural violence "naturalizes" poverty, sickness, hunger, and premature death, erasing their social and political origins so that they are taken for granted and no one is held accountable except *the poor themselves*. Structural violence also refers to the ease with which humans are capable of reducing the socially vulnerable (even those from their own class and community) into expendable non-persons, thus allowing the license—even the duty—to kill them (2004: 13, my emphasis).

This description illustrates the confusion the theory can create between causes and symptoms. On one hand, structural violence is de-

scribed as the cause of consistent violence through "invisible social machinery" (e.g. exploitative working conditions) and on the other it is recognized as a "naturalizing" symptom. Still, at other times it is described as its outcome, "poverty, sickness and hunger" (*Ibid*). These conflations are an understandable challenge as the theory attempts to describe forms of violence that have become pervasive and often stable through European colonialism. Scheper-Hughes and Bourgois' definition poses a risk as it begins to identify every oppressive cause, symptom and outcome as falling into this category. Gilligan has dealt with this risk by defining the concept more precisely as, "the increased rates of death and disability suffered by those who occupy the bottom rungs of society" (2000: 192).

These arguments make clear that analytical tools aimed at understanding violence must differentiate between the multiple forces that apply varied forms of violence to dominate. Secondly, strategies for violence prevention require tracing the changing links between forms of violence, and power. As Gready and his colleagues remind us, the political nature of structural violence facilitates a questioning of the role of the state in the reproduction and escalation of such violences (2010: 2). Moreover, using the concept to collapse the various forms of violence (e.g. political, gender, symbolic) within their structural patterns to simplify the role of the state and the complexity of the forms of violence, risks producing a reductionist understanding of how a *status quo* is maintained.

Such reductionism weakens efforts to prevent violence. Analysts must be careful to identify the distinctions between the different forms of violence to draw out the causes, meanings, experiences and consequences especially of structural violence. Illuminating the structural forms violence takes can help to develop understanding about how adverse systems build and rebuild themselves through neutralizing and absorbing opposition and reform. To avoid the problems of conflation discussed above, my dissertation relies on the three distinguishing features of structural violence Gilligan identifies: (1) "lethal effects operating continuously" (as opposed to sporadically, such as murder or episodically, such as riots); (2) acting "more or less independently from individual acts;" and (3) normally invisible, "because it may appear to have had other (natural or violent) causes" (2000: 192).

Farmer characterized structural violence as ostensibly being "nobody's fault" (2004: 307), further emphasizing what Galtung called the "indirect" nature of structures (1969: 170). Farmer's characterization has been challenged, most notably by Wacquant who points out that "responsibility" for historical and contemporary political forces, which enable structural violence is not only apparent, but can be "clearly assigned" (2004: 322). He further raises the violence enacted through wielded from a common example; Trans-Atlantic slavery has most certainly been apparent especially to those who suffered directly (*Ibid*). Wacquant also points out that the concept tends to conflate "full-fledged domination with mere social disparity" (2004: 322). Maintaining this distinction is important, as Pearce reminds us that violence is 'multi-causal,' and while

structures of domination (e.g. slavery) and inequality (e.g. racial hierarchy) are mutually constitutive they are also distinct, and varied in type, power, and scale (2007: 45). Since these critiques, contemporary theorists have moved away from strict adherence to the idea that responsibility for structures of violence cannot be traced. Indeed, Farmer has also asserted through his scholarship as well as through his humanitarian activism that a task of research is to "identify the forces conspiring to promote suffering" (2004a: 288). Still, Galtung's idea of an apparent invisibility of structural forces continues to gain purchase. Writing more recently, Gupta, maintains victims of structural violence are those "injured by the inequity of social arrangements" and thus easily identifiable, however "it is hard to identify a perpetrator" (2012: 21). In relation to this aspect, I find myself in the middle of the two poles of debate. I posit single actors responsible for structurally violent outcomes are often concealable because of the widespread impunity and scale of suffering. This is further discussed in the second half of this chapter by raising "naturalizing arguments" used to justify violence relating to reproduction. Gupta, while recognizing the "analytical perils" of identifying structural inequalities as violence finds "overwhelming" reasoning to do so, namely that such a label "retains a focus on violence: it keeps one's attention on its impact on mortality", and I add, morbidity (2012: 21).

Following Gilligan's approach of defining structural violence by its outcomes, the definition I apply here is: *the unequal distribution of disability, mortality and morbidity relating to reproduction and maternity*. I arrive at this definition as it provides an analytical framework with which to discern the

causes and outcomes relating to social, economic, political, and legal structures. Furthermore, what percentage of this total number relates to 'indirect maternal mortality' (i.e. chronic illness such as HIV/AIDS), and still what percentage of this total number can be argued? I ask similar questions relating to neo-natal disability and mortality. These questions are examined in Chapters 4-6.

2.1.3. Everyday Violences

Theorists have developed concepts to describe everyday, common forms of violence, which are practiced in intra/interpersonal as well as public, and private spheres. For instance, to articulate ordinary and routine expressions of violence that degrade local worlds Scheper-Hughes and Bourgois use "violence of everyday life" (2004: 5) and Kleinman uses the plural form, "violences of everyday life" (2000: 227). Furthermore, by applying the concept of everyday violence, the normalization of violence within street-level bureaucracies becomes more readable. Scholars have used this concept to examine the routine cultural processes of local worlds where the 'normalization' of everyday violence occurs. Bourgois (2004) and Kleinman (2000) find that routine cultural processes conjoin with symbolic and structural violences to facilitate the pervasiveness of social inequalities. Kleinman argues, that hierarchy and inequality are "fundamental to social organization" (2000: 238). This view is supported by Anderson who argues, a "challenge in advancing gender social justice is that, where structural violence permeates the societal structures, it is obscured from view and the policy response is itself embedded within it"

(2015: 7). Violent ordering structures are not only replicated through the "routinization" and acceptance of social cultural processes, but also shape individual lives, and in the case of violence do so in "all-too-often twisted, bent and even broken" ways (*Ibid*). Bourgois defines everyday violence as, "daily practices and expressions of violence on a micro-interactional level" which "focus on the individual lived experience that normalizes petty brutalities and terror at the community level and creates a common sense or ethos of violence" (2004: 426). I prefer Kleinman's pluralisation of the term as it reinforces the complexity that there can be several forms of routine violence taking place.

Literature describing the violent interpersonal behaviour between health professionals and maternity patients demonstrates the relevance of the concept of everyday violences to this problem (Jewkes and Penn-Kekana 2015). The common direct forms of violence - slapping, beating, and various kinds of verbal and psychological abuse - are well documented in the literature in this area (Browser and Hill 2010; Bohren *et al* 2015 provide extensive reviews of the existing literature). Rather than detail these here I will provide an overview of two key examples in South Africa arising from 'unnecessary medicalization'. This is another form of violence highlighted among practices "that are imposed on women as *routine* (without having any scientific foundation) and without informed consent" (Pickles 2015: 7, my emphasis). These include "unnecessary" surgical procedures including, "episiotomies or performing episiotomies after delivery solely for the purpose of training" (*Ibid*). Furthermore, episiotomies are considered, "costly and either unnecessary or harmful for

normal births" the procedure entails a "surgical incision to enlarge the vaginal opening" (Mirsky and van der Gaag 2001: 28-29). Evidence concerning episiotomies from my dataset is discussed in Chapter 5 and 6. Rates of episiotomy remain high globally despite clinical guidance to restrict the practice (WHO 2015: 30) this is especially the case in so-called developing countries where often the procedure has been found to be administered to most labouring women (Graham *et al* 2005; Mirsky and van der Gaag 2001: 34; Maduma-Butshe 1998). These examples show how, in some cases, the medicalization of childbirth has normalized everyday violences. Additionally, they raise a gap in existing research on the distinctions between the forms violence takes in maternal health systems in the Global South, versus the Global North. In South Africa, this most often translates to distinctions between the public and private health systems.

Another form of everyday violence is "inserting long-term birth control mechanisms directly after birth" (Pickles 2015: 7). This example is worth noting as coercive consent defined as lack of consent, lack of informed consent and limited choice presented is widely known to be *routine* practice in the administration of contraception in the public health system in South Africa (Towriss 2016). Additionally worrying, is that often the contraception administered can be defined as 'risky' meaning contraceptives with high levels of progesterone which are known to cause serious side effects, and which have been found to increase the risk of contracting HIV (Sathyamala 2000; WHO 2016; FHI360 2016). Further compounding this form of everyday violence is that one could argue

that it has become structural. Research shows that often the coercive administration of a progesterone contraceptive has been *standard* practice in maternal health services for Black women in South Africa since the apartheid state began directly funding its population control program in the 1970s (see Brown 1987: 266-268; Kaufman 1996: 30; Towriss 2017). The concepts and definitions of everyday violences, therefore clearly apply to the literature on reproductive health as well as the specific literature examining forms of violence found within maternal health systems. As a result of expressions of violence within reproductive health taking multiple forms I have chosen to include everyday violences as an analytic tool to distinguish the cause and outcome of violences.

I have chosen to therefore apply 'everyday violences' referred here to mean: sporadic intra and interpersonal practices and expressions of violence in reproductive health services. As will be discussed below my use of the direct obstetric violence is often used to supplant everyday violence. This includes physical and psychological abuse including in forms of sexual humiliation, fear of retaliation, unnecessary medical procedures, medical neglect, the deliberate refusal of pain relief, and theft.

This specific, yet broad definition encourages analytical questions about the routine practices and behaviours of health professionals, as well as policymakers and administrators that cause everyday violence and instil obedience and fear among patients and health professionals. An example of everyday violence carried out by health professionals toward

patients and their families is their coercive administration of unnecessary medical procedures discussed above. An example carried out by policy makers and administrators is the routine dismissive attitude with which complaints about deprivation of resources is met, which then instils fear of retaliation in staff.

2.1.4. Race, Class and Gender Constitutive of, and Constituting Violence

The constitutive relationship between indirect and direct forms of violence, has helped me to understand the relationship of structural continuities of resource deprivation arising from South Africa's legacy of colonialism and apartheid and direct forms of obstetric violence found in contemporary maternal health services. This section presents definitions of structural and everyday violences to be applied to this research. Specifically, I argue that gender divisions, gendered discrimination, as well as the idea of "race" are constitutive, and constituting of structural violence in South Africa (this follows especially the work of Anglin 1998, Gilligan 2000 225-239; and in the context of women's health Harris et al 2011; Anderson 2015; Pickles 2015).

Lugones' argument is that, "the coloniality of power" genders people (2008: 3-4). Lugones posits female and woman are separate categories, where females are categorised and reduced to women who are made ineligible as producers of knowledge, and leadership, and reduced to labour-

ing objects for sexual and economic exploitation. In this matrix of power the idea of race is central, providing a system of "universal social classification" into which all people categorised (Lugones 2008: 2). Thus, gender and race are understood as constituted by, and constituting operations of power, which I argue along with class influence the care women receive at their time of reproduction. Anderson maintains, the fact that these categories of difference are socially constructed - neither fixed, nor universal but rather are culturally and historically situated - is not the issue (2015: 5). It is not that people are diverse, that they can be read differently depending on where they are located, or that individuals are gendered.

Lugones clearly explains the consequences of the idea of race which Maldonado-Torres argues has "achieved stability up to the present" causing the reality of "different forms of racism" structuring locals across the modern world (2008: 217). The logic and structure established on the idea of race referred to here determined "conquered people" in the colonies to be inferior to Europeans and has now come to naturalise the "very constitution of people" into a stratified species (Ibid). The other key social category concerning this study is that of gender. "The idea of "gender" is defined here as "the social construction of concepts that define …maleness and femaleness as mutually exclusive beings opposed to each other (Mangena 2008: 255). Mangena goes on to explain, "[s]uch beings have their labour (productive, reproductive, mental, and emotional) loaded with values that get measured in terms of men-superior and women-inferior. This determines the unequal relations between men and

women in social organisation and development" (Ibid). Similar to the idea of race that was produced during European colonialism and that has gained stability since, some scholars also note that these widely-shared categorisations of gender result from gender being imposed through European colonisation, and are produced and stabilised through "modern" organizations of "power" (Quijano 2000 cited in Lugones 2009: 2; for an evaluation in an African context see Oyěwùmí 1997; 2010).

In the site of this study, South Africa's maternal health services, as in many other health systems, racialized and gendered women enact direct violence upon poor pregnant patients from their own social groups. The theoretical framework on violence constructed in this chapter is applied throughout the dissertation to explain the linkages between obstetric violence, and persisting resource inequality, and poor social determinants of health.

The Relationship of Social Markers to Structural Violence

From when it was first coined theorists of structural violence, including Galtung (1969: 171), have identified historic orders of social stratification (e.g. race, gender, class) which unevenly distribute power to be characteristics that constitute, and are constitutive of structural violence. As noted above class inequality resulting in disparate life expectancy has been most notably explained by structural violence (Farmer 2004, 2005). However, examples of the use of the idea of "gendered structural vio-

lence" are also found in literature (Anderson 2015). Anderson identifies gendered structural violence to be how "gender structures…justify men's domination over women across class, race and cultural differences" (2015: 5). Similarly, Gupta argues, a key feature of structural violence resulting from the pervasive imposition of social stratifications is that it "perpetuat[es] a social order in which such extreme suffering is not only tolerated but also taken as normal" (2012: 21). Furthermore, there is a consensus in the literature on violence that social impositions of gender and race are forms of structural violence, and that these arise from inequalities caused by the hierarchies of power inculcated onto these markers, and thus onto the very constitution of people (see Anglin 1998; Gilligan 2000: 225-239; Scheper-Hughes and Bourgois 2004; Farmer 2005: 8; Anderson 2015).

2.2. Conceptions of Violence in Reproductive Health

The body of literature overlapping violence and reproductive health that my approach draws on has successfully theorised how structures of power curtail reproductive freedom, and emphasised the relevance of this analysis for the context of having children safely and with dignity (Ross and Solinger 2017: 55-56). This theorisation has been concerned with the roots of injustice with regards to reproductive health and has been carried out, not exclusively but principally by women of colour feminists see Davis 1983; Brown 1987; Hartmann 1987; Petchesky 1990; Roberts 1997; Qadeer 1998, 2005; Gordon 2002; Briggs 2002; Silliman and Bhattacharjee 2002; Rao 2004; Silliman, Fried, Ross and Guiterrez

2016; and Ross and Solinger 2017. This body of literature underscores the economic resources individuals and whole groups possess structure's their reproductive options, indeed the reproductive rights available to girls and women. This scholarship often takes an "intersectional" approach drawing on Kimberle´ Crenshaw's theorisation to describe how gender is structured through race and class to show how people are oppressed through multiple social markers simultaneously (1993). Authors do so to foreground the socio-economic and political context individuals, and whole groups live in is central to the capability to have control over the body, including sexuality, and exercise reproductive liberty. This critical work, challenges the mainstream paradigm that centres reproductive freedom on individual women's choices. Specifically, these scholars have demonstrated state regulations subject reproduction to: population management, disciplining of individuals as well as whole groups, along with exercise of control over sexuality, and gender see Davis 1983; Brown 1987; Hartmann 1987; Petchesky 1990; Roberts 1997; Qadeer 1998, 2005; Gordon 2002; Briggs 2002; Silliman and Bhattacharjee 2002; Rao 2004; and Silliman, Fried, Ross and Guiterrez 2016.

Firstly, "Obstetric" refers to childbirth, which relates to women's context at the late stage of maternity and childbirth being of: "not-one-but-not-two" (Pickles 2014: 21-22).[14] Secondly, "Obstetric" denotes that

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14 The concept "not-one/not-two" is applied originally, as well as in this dissertation to recognise the intertwined relationship that exists between pregnant women and foetuses during pregnancy, and only in so far as this recognition advances women's rights (Pickles 2014: 21-22).

violence against women in the context of maternity and especially child-birth effects a woman, and her foetus; her social context, her family, and kin. Obstetric therefore exposes the social meanings of this type of violence against women. Thirdly, I argue it is important to harness the term "violence" as it accurately describes the forms this harm takes, and keeps attention on its impact on disability, mortality and morbidity. Fourthly, I argue the attention on violence is necessary for one, because millions of women die annually as a result of "preventable," risks of maternity which are uncontested "violations of human rights" (Human Rights Council 2016 ¶1). Moreover, the consistent extreme un-equal distribution of this mortality (WHO 2014) exemplifies a structural form of violence.

It does so by examining the labels scholars have given to this problem, and the meanings ascribed to them. Additionally, it engages literature that discusses the forms and scope of this problem and expands on conclusions made by public health scholars by engaging discourses in development studies on approaches to women's health. The section moves on by exploring the causes outlined in this literature, which centres on two key areas relating to this problem, namely social and institutional factors facilitating violence in maternity settings. By grappling with these debates, the chapter refines the understanding of what reproductive health, reproductive rights and violence in this area are understood to encompass. Thus, identifying existing gaps in the field and how the dissertation is able to fill them. In this way, my work identifies that violence does not only impact patients seeking maternity health services, but also the health professionals working in the area of reproductive health.

Finally, the review highlights the importance of examining both the structural as well as the direct expressions of violence in maternity settings, to better understand the complexity of factors that make up and sustain this global problem.

International law "holds that the right to health requires health services that are available, accessible, acceptable and of good quality" (Freedman et al 2014: 915). Despite many approved intergovernmental interpretations and guidance documents applying this right to reproductive health and specifically childbirth, what some scholars label "disrespectful and abusive treatment" during labour and delivery continue in many parts of the world (Ibid). WHO itself acknowledged a gap in existing ability to measure quality in its 2016 standards for improving quality of maternal and neonatal care. The report states that, "there is currently no substantive guidance, although it is the key to ensuring the quality of care" (WHO 2016: 1). WHO contends a part of this problem is that despite the existing guidelines and descriptions of maternal health and reproductive health care a "universally accepted definition of quality care" is "not found in the literature" (WHO 2016: 14). The Beijing Declaration and Platform for Action defines reproductive health care as "a constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems" (1995 ¶ 94). Additionally, reproductive health is understood to include sexual health, and is described more broadly as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (*Ibid*). I apply these broad views of repro-

ductive health care and use the term 'reproduction' to encompass the whole process namely, conception, pregnancy, delivery, and the first 1,000 post-partum days of child and mother's lives.

2.2.1. Contested Labels and Meanings

Violence in reproductive health care settings has been documented in all regions of the globe for over three decades (Jewkes and Penn-Kekana 2015: 1). However, it was only in the 2000s that global health institutions singled out this social problem. The World Health Organization only recently labelled "disrespect and abuse during facility-based childbirth" a global challenge (WHO 2014). Research has shown that this abuse can occur at any time during pregnancy (Honikman, Fawcus, Meintjes 2015; Janevic *et al* 2011; Bowser and Hill 2010; Pires *et al* 2002). However, it is most common when women are particularly vulnerable during childbirth (Chadwick, Cooper, Harries 2014; D'Ambruoso, Farrell, Pattison 2004; McMahon *et al* 2014; Moyer *et al* 2014).

Public Health literature has largely considered this problem an issue of 'quality care' (Freedman and Kruk 2014: e42). This point of view stems from the conceptual framework built on the international law which established the 'Right to Health', and more specifically follows the Committee on Economic, Social and Cultural Rights, CESCR guide that health services must be *available*, *accessible*, *acceptable* and of *good quality*

(CESCR 2000: ¶ 12).[15] Additionally, this follows General Comment 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) that states, "All individuals and groups should be able to enjoy equal access to the same range, quality and standard of sexual and reproductive health facilities, information, goods and services, and to exercise their rights to sexual and reproductive health without experiencing any discrimination" (¶ 22). Until recently, 'quality care' had been outlined as, "culturally acceptable, health facilities, goods and services… [that are] scientifically and medically appropriate" (CESCR 2000: ¶ 12). Thus, it was hardly distinguishable from acceptability. Following this, poor quality services, even those leading to harm have often been viewed as resulting from 'non evidence-based' practices, in other words practices that are not based on reliable research.

Despite the existence of international law, and official guidance about how to apply these rights, defining what 'quality care' comprises in maternity care settings, and how to assess health professionals' behaviour, is lacking. Evidence of the lack of tools to measure quality care have been raised in the literature. The recent research on several countries in Africa and Asia's long-term efforts to strengthen health systems by Van Lerberghe et al as a way of improving maternal health, has done just that; they conclude, "metrics to assess trends over time in compassionate and

15 Acceptability has been understood as relating to patients' perception of the service, and there if it is acceptable to them or not and why. This is often investigated in relation to patients' health seeking practices.

respectful care do not currently exist" (2014: 1217). Therefore, while this is viewed as a problem of quality care by Public Health and Human Rights disciplines they have developed few indicators about how to measure quality care in reproductive health services, namely, if it is occurring, or if it has been sustainable, let alone implemented in an equitable manner. As a result, the WHO responded by re-evaluating quality of care and establishing a framework. The current definition of quality care resulting from these efforts is, "the extent to which health care services provided to individuals and patient populations improve desired health outcomes" (WHO 2016: 14). To achieve this, the WHO has recently begun to develop new framework to set standards and enable the measurement of quality of care (*Ibid*).

Still, rights organizations investigating this area, for instance the Centre for Reproductive Rights (CCR) and the Federation of Women Lawyers in Kenya (FIDA 2007) reporting on Kenya, and Human Rights Watch (HRW 2011) reporting on South Africa, have made progressive use of rights frameworks. Both apply human rights legal strategies, and specifically right to health and quality care frameworks to identify "violations" for physical and verbal "abuses" and urge governments and inter-governmental agencies to promote accountability for these legal obligations (*Ibid*). The analysis of maternal health services in Kenya argues serious rights violations are caused by economic barriers in the form of lack of funding for public health systems and user fees including deposits, as well as "humiliating" physical and verbal abuses including intimidation and detention that "endanger" women and infants' lives (CCR,

and FIDA 2007: 7-8). Similarly, the investigation of maternal health services in South Africa posits "abuses by health workers and substandard care… put [mothers] and their newborns at high risk of death or injury" (HRW 2011: 1). Although the concept of quality of care has been found to be lacking in analytic rigor to measure and implement high quality standards, the application of these concepts and labels by rights organizations through their investigations, reporting, lobbying and litigation demonstrates that these concepts are useful to identify violations and contextualize both individual violations, as well as systemic failures as part of state obligations to protect human rights. This evidence demonstrates there has been some utility by way of political and judicial mechanisms to bolster accountability through rights groups' advocacy about everyday and structural violences in maternity care by using international law and other guidance regulations relating to this concept. How WHO's 2016 revisions will be applied may determine the potential of its broader utility, for example in relation to the implementation of direct service.

Although the rights-based and milder terms: poor quality care, abuse, disrespect, and mistreatment are still found more widely in literature, including at the intergovernmental level (Bohren *et al* 2015: 21), the weaknesses of these frameworks as well as the frequency of reproductive health services negatively impacting women has resulted in the development of a variety of more specific descriptive terms and additional concepts. These include "disrespect and abuse," "mistreatment," "birth rape," and most recently, the concept of "obstetric violence" (Chadwick 2016: 5). Public Health and Development researchers who carried out a

systematic review of literature on the issue determined the phrase "mistreatment of women" was the most appropriate to express the full range of adverse experiences it aims to describe (*Ibid*). The authors argue this broad phrase is more inclusive than others such as "obstetric violence," "dehumanized care," and "disrespect and abuse," which for them are unable to encapsulate the multiple levels this 'mistreatment' operates through (*Ibid*). These scholars argue the "active," "passive," and "health system" or systemic prevalence of 'mistreatment' evidenced in existing literature are not captured by these other terms and concepts (*Ibid*). However, Bohren and colleagues' choice of phrase is not more inclusive than "disrespect," nor is it specific enough to express the particularity of this harm: it effects more than just women, but *human reproduction*, *maternity* and more broadly *obstetric care*. Nor does 'mistreatment' grasp the extent, of the different forms this harm takes, especially when considering the structural violence of maternal and neo-natal mortality and morbidity. Similar weaknesses are found in the work of Public Health and Gender Studies scholars who describe their findings about adverse birth experiences in addition to "mistreatment," as "traumatic birth," and "emotionally distressing birthing environments" (Chadwick, Cooper and Harries 2014: 866-867). These terms are applied to express what is meant by poor quality maternal health care (*Ibid*). While these additional phrases express more clearly the cruelty and potential adverse outcomes, arguably they do not offer more than descriptive cues to understand this problem.

Whereas the more exacting term, 'obstetric violence' has been developed into a concept by women's and reproductive rights movements in South and Central Americas, and Spain (Sanchez 2014: 51). Scholars have argued "it is vital to use the term violence in contexts of structural inequality as "it keeps one's attention on its impact on mortality" (Gupta 2012: 21; see also Anderson 2015: 148). This concept has been further developed through processes establishing it as a legal concept punishable by law in several countries in Latin America beginning in 2007 (Sanchez 2014; D'Gregorio 2010). There are three key problems the movements for humanized childbirth identify as obstetric violence: firstly, the pathologization of pregnant people, which they argue secondly provokes the medicalization of reproduction and the trend of routine, unnecessary medical interventions, and thirdly the dehumanizing treatment, women and girls often encounter during maternity within health facilities (Sanchez 2014: 59). Furthermore, the movements for humanized childbirth perceive these practices as restrictions on the autonomy of women through the limiting of women and girls' control over their maternity (Sanchez 2014: 75). These civil society movements developed the concept of obstetric violence to draw attention to this analysis of the problem and to especially create space within current debates about maternal health that would empower women to challenge the violence they are often subject to within reproductive health systems (Sanchez 2014: 75-77). Building from earlier women's movements analyses they locate this violence in relation to gender divisions of power that perpetuate mechanisms and behaviours which assert, "control over women's reproduction and sexuality" as means of subordination (Sanchez 2014: 21-22). Here

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they are referring to moral judgments which inferiorise people who do not subscribe to non- dominant sexual preferences, for example homosexuality.

Dixon's analysis of what she calls the "unexpected, jarring and provocative" term obstetric violence demonstrates that it has become a useful "socio-political concept" in Mexico (2015: 438, 450). Her research shows this as it finds midwives, rather than rejecting the interpretation that forms of obstetric care can be violent, embraced the concept as a tool to point out the structural forms of this violence (Dixon 2015: 438). Midwives have used the concept to draw attention to the role of "providers and health care systems" in influencing patients "medical choices in birth," along with structural "constellations of gender, power, history and biomedicine" (*Ibid*). By appropriating the concept to describe their analysis of the problem, as well as their relationship to it, health personnel in Mexico have been able to mitigate the accusation placed upon them by the legal interpretation's misattribution of responsibility on individuals for the structural drivers of obstetric violence. Thus, health professionals have been able to use the concept to acknowledge their place in the discussion, rather than allow its exacting assertion to exclude their key experience. This is important because it demonstrates that in practice the concept can express the broad drivers and effects of violence occurring within reproductive health systems. Adding to this is Sanchez' examination of the uses of the concept of obstetric violence by reproductive justice advocates considers its utility for patients and social change. Here advocates report it "legitimat[es] the pain many women"

experience, and assists them "to question" and "transform" their trau-matic experiences in obstetric care (2014: 95). Additionally, the concept locates these practices as particular forms of gender violence, which as-sist to contextualize the relevance of social structures to this problem (*Ibid*). Advocates asserted that by recognizing these experiences are vio-lent, the concept challenges the "blindness" that distorts these acts as non-existent or rather individual aberrations (quoting Jesusa Ricoy, Sanchez 2014: 96).

While advocates, and even some health professionals, have found util-ity in the concept and legal definition some leading Global Health schol-ars and Development experts have raised strong reservations. For in-stance, although obstetric violence has been applied as a legal term since 2007, Freedman and her colleagues writing in 2014 argue "there is no definition of disrespect and abuse that can be used to study its preva-lence or evaluate interventions to address it" in existing literature (2014: 915). Further to their point the authors state "[f]ormal legal definitions do not resolve this definitional problem" (*Ibid*). The authors find that the simple promotion of "abstract standards through advocacy and educa-tion – or even through legal enforcement and punishment – is unlikely to solve the problem of disrespect and abuse" (Freedman *et al* 2014: 916). They contend abstract standards "only acquire meaning over time by careful attention to the lived experience of disrespect and abuse, and to the deeper dynamics of power that underlie it" (*Ibid*). The authors high-light the key point that "health systems are deeply embedded in society's broader social and political dynamics" (Freedman *et al* 2014: 915). Their

point is that any adequate definition and intervention will prioritize the "local drivers of disrespect and abuse" (*Ibid*). In this way, the authors support the development of a definition that considers both the broad normative standards set out by human rights mechanisms, as well as the more limiting norms of locality which inform providers *and* patients perceptions of violations (Freedman *et al* 2014: 915-916). To establish awareness and sensitivity to local perceptions they propose involving all stakeholders relevant to a particular health system in a collaborative definitional consensus building process (Freedman *et al* 2014: 916).

In conclusion, while all the terms applied have limitations, I find obstetric violence to be the most relevant for several reasons. Obstetric violence best speaks to the specific forms everyday violence takes within reproductive health policy, programs and direct services. This violence is unlike other gendered based violences which also target women, as direct physical, psychological and verbal violence experienced by women during maternity and especially childbirth contributes to the violation of the women, as well as the fetus, neonate, or child depending on the type of damages incurred. In relation to the structural forms of violence that impact on reproduction, I do not think these are helpful to be included in the definition of obstetric violence. If both everyday as well as structural forms and consequences of violence are referred to by the same term the term risks becoming analytically unhelpful. To avoid this, I argue obstetric violence should refer to everyday violences. Specifically, that which relates to my use of the term here: common intra and interpersonal practices and expressions of violence which contribute to a climate of vio-

lence in reproductive health services. The structural drivers of obstetric violence and its related causes should be described by a separate term; for this, I suggest "structural violence."

2.3 Conceptualising Obstetric Violence

The various terms and concepts above have been used to describe a range of adverse practices taking place within maternal health services. Most commonly included are physical and psychological abuse, the denial of medical services, and detention of mothers and newborns for lack of payment (WHO 2015). To understand the forms and scope of violence scholars aim to express through the concepts and terms discussed above, it is useful to outline the following typologies. Recently researchers, especially from Public Health and Development Studies have begun to theorize the types of violence experienced in maternal health services. Bowser and Hill (2010) with support from USAID conducted interviews and an extensive review of grey literature covering Africa, and North and South America to develop the first typology to identify the analytically similar experiences of violence in maternal health services (2010). To do so they used a landscape analysis, which resulted in seven categories that describe what they labelled, "disrespectful and abusive birth care:"

Disrespectful and Abusive Birth Care

(a) physical abuse,

| (b) non-consented clinical care, |
| (c) non-confidential care, |
| (d) non-dignified care, |
| (e) discrimination, |
| (f) abandonment of care, and |
| (g) detention in health facilities |

Following this typology, and the few studies that have subsequently applied it, Bohren led an international team of sixteen researchers to conduct a systematic review of qualitative and quantitative literature concerned with what they termed, "mistreatment of women during childbirth in health facilities" (2015: 21). The stated aims of the systematic review were to improve upon Bowser and Hill's analysis by developing an "evidence-based typology" that could contribute toward "consensus at a global level" on "how these occurrences are defined and measured" (2015: 3). Bohren et al propose a typology of eight categories:

Mistreatment of Women During Childbirth in Health Facilities

| (1) physical abuse, |
| (2) sexual abuse, |
| (3) verbal abuse, |
| (4) stigma and discrimination, |
| (5) failure to meet professional standards of care, |

(6) poor rapport between women and providers,
(7) health system conditions and constraint, and
(8) performance of unconsented surgical operations

While these typologies differ they also have broad overlap. Notably, they both make clear the violences that harm one's capability to reproduce safely, include, but go well beyond challenges of access to medical services, including methods to prevent pregnancy. These shifts in understanding and emphasis are important as often Public Health and Development interventions have been found to prioritize access barriers, while turning a "blind-spot" to quality challenges (Freedman and Kruk 2014: e42). Significantly the conclusions of these reviews, largely derived from qualitative and quantitative studies by Development and Public Health scholars are consistent with Critical Feminist theorists that emphasize the key factors mitigating reproductive freedom are: (1) discrimination – based on gender, race and other characteristics – and (2) the economic conditions poor women live with, and those the health systems deliver in (Qadeer 1998; Rao 2004; Harcourt 2009). Importantly, both reviews' findings concur with recent literature by highlighting the two underlying dimensions to the problem, namely direct violence (physical, psychological etc.) through relational forms between patients and health professionals, and structural violence (depravations departing from standards for staffing, infrastructure, equipment etc.) at the health system level, which directly affects staff as well. (Jewkes and Penn-Kekana 2015: 2; Pickles 2014: 7; Freedman and Kruk 2014: e43).

They both do so by raising the crucial structural problems of 'discrimination,' which speaks directly to structural social discrimination based on identity markers such as race, class and gender. Additionally, both refer to barriers caused by neo-liberal economic structures albeit in different and limited ways. Browser and Hill do so by including the specific problem prevalent in a few African countries of detaining post-natal women and girls, often along with their newborns for lack of payment, which results from management, governance and neo-liberal policy approaches that undermine the autonomy and security of women and newborns (CCR and FIDA 2007: 7-8). Abandonment of care can include denial of care, and lack of access that can both refer to barriers caused by neo-liberal economic structures, additionally, non-dignified and non-confidential care can also refer to infrastructural barriers resulting from structural economic drivers. The Bohren typology using the category, health systems conditions and constraints, speaks more generally. Similar to obstetric violence, it provides space for the inclusion of the structural economic constraints impact on staff, as well as patients. Furthermore, by including *unconsented* surgical operations, Bohren and colleagues point to the pattern of forced methods of preventing pregnancy, which potentially have been driven by structural institutional policies and practices. However, both typologies appear to exclude routine unnecessary (without having any medical basis) medical procedures including those without consent, with coerced consent and procedures enforced by order of court, unlike several applications of obstetric violence (Sanchez 2014: 94;

Pickles 2015: 7). Consequently, the structural factors are included in the typologies however they are to a limited extent.

The typologies established by both reviews largely concentrate on the *expression* of the *types of violence* women and girls in maternity experience, this is not surprising as most research and advocacy focuses on the impact of obstetric violence on females in maternity, without inclusion of the structural forces driving it, nor their broader impact, namely, the neglect of the forms of violence experienced by health professionals. This infers a more limited scope of obstetric violence. Furthermore, analysis from this limited view leads to conclusions that there are clear fixed categories of perpetrators (public servants, and health professionals), and victims (women, girls and pregnant people). As we will see in the following section, reviewing scholars understanding of the causes of this violence many implicate health professionals as subject to violence in these contexts as well. Moreover, Freedman and her colleagues' analysis of Browser and Hill's typology puts forward key limitations in existing literature, they find these categories limit analysis as they "describe types of disrespect and abuse… but do not define it in terms of the c*haracteristics* of health-care provider *behaviour*, *facility conditions* or other factors that could be construed as disrespectful and abusive" (Freedman *et al* 2014: 915 my emphasis). Similarly, Bohren et al were not able to go further than describing types of violence predominantly faced by patients, which excludes the impact on health professionals and other health system staff.

This research project emphasizes the structural aspects of violence in reproductive health services, in other words, the "crisis of quality and accountability" and thus contributes to closing these gaps in existing evidence and theory (Freedman and Kruk 2014: e43). Additionally, I argue that an understanding of how the lack of consent to medical interventions contributes to obstetric violence must include the control of *populations* by the widespread and often coercive delivery of contraception, especially long-acting, risky, and permanent forms, as detailed above in the section on everyday violences. This is especially important as from the 1940s to the mid 1990s "tens of millions of poor people… were paid to 'agree' to sterilization" under the auspices of coercive family planning programs and policies which dominated global development's approach to reproductive 'health' (Connelly 2008: xi, emphasis added). Such policies and programs were successfully challenged in 1994 by a global advocacy movement which ushered in a paradigm shift toward "reproductive rights" based on the ideas of 'improving women's lives' and 'empowerment' (Harcourt 2009: 50). However, these decades long global practices not only have generational consequences, some scholars argue the lauded global paradigm shift to improving women's lives has amounted to mere rhetoric (Smith in Briggs *et al* 2013: 11). Smith furthers this argument by critiquing the idea of "choice" noted in the definition of reproductive rights[16], as well as the approach of reproductive rights which she argues

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16 Choice is implied in the context of reproductive rights as people being, "able to have a satisfying and safe sex life and they have the capability to reproduce and the free-

rests in "individualist, consumerist notions of 'free' choice," that "don't take into consideration all the social, economic and political conditions that frame the *so-called choices* that women are *forced* to make" (*Ibid*, my emphasis).

It is important to include in this discussion, the scope of harms concerning reproduction the position of intergovernmental agencies and Development Studies scholars who concentrate on reproductive health policy at local and global levels. For instance, the Office of the High Commissioner on Human Rights (OHCHR) takes the position that "[t]he scale of maternal mortality and morbidity across the world reflects a situation of inequality and discrimination suffered by women throughout their lifetimes, perpetuated by formal laws, policies and harmful social norms and practices" (2010: 10 ¶14). Consistently highest rates of maternal mortality are in sub–Saharan Africa and South Asia (WHO 2014: 1). This means "[p]regnancy, childbirth and their related complications" present the highest level of risk "to the survival, health and well–being of women and their babies" from these regions, which comprise "85%" of maternal deaths worldwide "annually" (*Ibid*). In numerical form this percentage refers to over 200,000 deaths annually (*Ibid*). Additionally, a recent technical guidance report on applying a human rights-based approach to maternal mortality states "between 10 and 15 million

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dom to decide if, when and how often to do so…to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice" (UN Population Fund, Report of the International Conference on Population and Development, ICPD Programme of Action 1994 A/CONF.171/13/Rev1).

more suffer debilitating complications annually" while between "88 to 98 per cent of maternal deaths are *preventable*" (OHCHR 2012: ¶ 3 my emphasis). Mirsky and Van der Gaag contextualize this injustice when stating, "maternal mortality is a stark reminder of the non-fulfilment of women's rights and reducing it cannot be separated from broader structural issues of gender equality" (2001: 14). Based on these conclusions this review argues the majority of maternal mortality and rates of morbidity can be understood as resulting from obstetric violence. Similar to Smith's critique of the 'choice' paradigm, Development scholars and so-called 'Third World' feminists working on reproductive freedom have long argued the problem of high rates of maternal mortality and morbidity are linked to the development community's lack of attention to the interdependence of "socio-economic conditions" and "reproductive health" (Qadeer 1998: 2676).

In conclusion, many fields agree women in maternity health settings experience harm. The variety of forms this harm takes – many of which are understood to be forms of violence in other settings – convincingly shows that the widely used label, 'obstetric violence' is most appropriate to describe this problem. As I have argued above. Moreover, many of the other labels used are not sufficient, as they do not specify that the harm concerns the sphere of reproduction. The clear identification with maternity, through the label obstetric violence therefore specifically locates the experience of this problem, which avoids confusion with other locations of more commonly, described forms of violence, for example domestic violence.

2.3.1. Social Elements

The WHO's recent statement emphasizes those most in danger of obstetric violence are "adolescents, unmarried women, women of low socio-economic status, women from ethnic minorities, migrant women, and women living with HIV" (2015). This makes clear that discrimination is a key factor driving this problem. The key characteristics the WHO lists which make one at risk can arguably be grouped into discrimination based on: (1) nationality, race, ethnicity and (2) moral perceptions. Additionally, as this violence is predominantly directed at women and girls and their sexuality, this discrimination is also based on gender and sexuality. Freedman and her colleagues' reminder that "health systems are deeply embedded in society's broader social and political dynamics" provide a useful direction for analysis (2014: 915). Structural context is especially important as public health advocates note that they have crucial influence on maternal and infant mortality, and rates of fertility (People's Health Movement *et al* 2011: 129).

Adding to this position is Linda Gordon's seminal history of 'reproduction control' which similarly concludes "analysis of the subordination of women, including their resistance and accommodation to it" is essential to understanding the politics of reproduction (2002: 2). This position is also echoed by the Human Rights Council which recently asserted, "[i]n all countries, patterns of maternal mortality and morbidity often reflect power differentials in society and the distribution of power be-

tween men and women. Manifested in poverty and income inequality, gender discrimination in law and practice, and marginalization based on ethnicity, race, caste, national origin and other grounds are social determinants that affect multiple rights" (OHCHR 2012: 5, ¶ 13). Scholars of Public Health and Medicine's review of relevant literature especially including research covering Latin America and Asia similarly concludes, for societies in which violence is highly prevalent at home, in the streets, and in schools, the use of violence in health care can be an extension of routine violence in society (Pires *et al* 2002: 1683). Following from this awareness, this research project considers the links between the routine context of social, political and economic violence in South African society in which the reproductive health services operate, and also constitute, and the violence occurring within these services.

Jewkes and Penn-Kekana who have been studying gendered social violence, as well as violence in maternal health systems in South Africa for almost a decade, offer important insight into the social dynamics linked to this problem. They argue that "parallels" between the particular violence affecting women and girls in maternity and "violence against women more broadly" can easily be made, and infer that the former is a "subset" of the latter (2015: 1). Pires and colleagues similarly argue that the various forms of violence females in maternity face are "similar to the forms of violence in personal relationships… emotional, physical and sexual abuse" (2002: 1681). Jewkes and Penn-Kekana identify the "essential" feature of violence against women is that the violence results from the structural social order of gender i.e. females' "subordinate" position

in society as compared to men (*Ibid*). This structural subordination "systematically devalues the lives of women and girls," which the authors go on to argue "enables the inappropriately low allocation of resources to maternity care that is found in many countries. It also disempowers women and enables the use of violence against them" (*Ibid*).

The parallels they draw on conclude that power relations of "hegemonic dominance" being found between females in maternity and "*some* health professionals" are "strongly" similar to "societal position of dominance of men" (*Ibid*). Jewkes and her colleagues' earliest research in maternity settings has shown that these relations can create the *expectation* that staff will control patients and are entitled to a variety of strategies including direct violence to do so, including punishing perceived disobedience (Jewkes, Abrahams, Mvo 1998, my emphasis). This study argues that nursing training for more than a century in South Africa has been linked to ideas of "civilization and moral superiority," whereby the use of violent punishment is used when patients might be seen to have violated social moral codes (Jewkes, Abrahams, Mvo 1998: 1782). Pires and colleagues similarly found that health professionals deployed abuse with intentionality to assert authority and cast shame on women and girls (2002: 1683). Another parallel points to cycles of violence, namely that female healthcare professionals "who act most harshly" toward patients may do so to "compensate[e]" for lack of perceived power in other parts of their lives, as has been found for "some violent men" (Jewkes and Penn-Kekana 2015: 2). The authors argue this "disempowered" perception results from health professionals' low remuneration, and working in

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what seem to be undervalued environments and institutions as a result of systemic under-resourcing, along with possibly being subjected to "abuse at home" (*Ibid*). Lastly, they highlight that it may not be a coincidence that the large range of harmful diverse acts covered in the above section overlap greatly with the range of abuses associated with domestic forms of violence (*Ibid*). Jewkes and Penn-Kekana's conclusions echo the civil society, and legal assertions in Spain and Latin America that label these abuses obstetric violence, which they also argue is a specific type of violence against women and girls (Sanchez 2014: 38).

Further evidence in line with the WHO's categorization of at risk persons comes from Browser and Hill's review of literature on the topic which found that "prejudice" on behalf of "[health] providers" can lead to "discriminatory behaviour against certain sub-groups of women" (2010: 21). This is important as it reflects on what Scheper-Hughes has linked the structural and everyday violence by analysing how the rote [everyday] acts of public servants in Brazil, turning a 'deaf ear' or acting in 'rapid dispatch' – to follow procedures as if nothing of note has happened – reinforce structures of marginalization (1993: 294-295). Similarly, Anglin applies the concept to point to how the United States has produced violence by withdrawing social supports, encouraging incarceration and by 'legitimizing' certain family forms under the guises of problem solving, social stability and order (1998: 145). Moreover, Bowser and Hill explicitly state that, "racism…based on false stereotypes linked to race" may drive harmful practices in maternal health (*Ibid*). These theories and the recent research they are based upon are especially

aligned with conclusions of a body of seminal critical feminist scholarship, which has examined the intersection of race, class, gender and reproductive health in the Global North and South. While this scholarship studied divergent contexts, it established the understanding that one of the ways that especially females, and whole racialized/caste groups have been structurally subordinated, stigmatized and regulated, is by controlling their sexuality and reproduction (Davis 1983, Hartmann 1995, Qadeer 1998, Gordon 2002). This body of work has shown that often, especially for poor racialized women the ability to reproduce has been portrayed as a disadvantage, a burden, and a cause of their, as well as national poverty, thus concluding that this ability necessitates social control. Feminists have long argued one part of the larger systems of oppression that plays an important role in perpetuating racial, sexual and gendered subordination are the racist and sexist narratives that assert that females "should not be in charge of their own reproductive and sexual destinies" (Silliman, Fried, Ross, Gutiérrez 2004: 14). When females are signified for example as sexually promiscuous, too irresponsible, too poor, stemming from too amoral or backward a culture to be good mothers, to make their own reproductive decisions, these narratives function as justifications for the violence used to offer the discipline and control these females are perceived to require (Silliman, Fried, Ross, Gutiérrez 2004: 15). Characterizing females in this way serves as the rationale for enacting and legitimizing discriminatory policies, programs, and laws (*Ibid*). The expectations, meanings, intentions, and rationalizations that surround a sharp slap and angry word while a woman struggles to push in the final stages of labour demonstrate how health systems re-

inforce the low status females occupy in the societal context in which the system is embedded (Freedman and Kruk 2014: e43). Furthermore, the practice of applying these mythical labels erases ontological status, which reduces women in maternity to having limited value thus enabling their objectification.

Included in this body of work are examinations of reproduction during African-American slavery. Roberts' pioneering work successfully demonstrates that this commodification of Black people included population control, taking the form of heinous and coercive efforts to increase Black women's reproduction (1997). Common methods of coercion by slave-owners included rape and forced marriage to enforce maternity (*Ibid*). Other examples of methods used to control whole groups' sexuality and reproduction include: systematic and widespread forced as well as coerced sterilization and hysterectomies (including immediately post-childbirth), to prevent pregnancy through targeted family planning programs supported by Eugenic and racist ideologies (See Davis 1983 and Briggs 2002 for Puerto Rico; Espino 2000, Smith 2002 and Gutiérrez 2008 for the United States; and Brown 1987 for South African apartheid). Furthermore, Davis' seminal work demonstrates how reproductive health problems are not isolated from the often "miserable social conditions" women of colour live with (1983: 355-365). Her seminal analysis of the differential access to preventative methods women were afforded based on their race and class in the United States clearly demonstrated how reproductive freedom is linked to political economy. Moreover, to use phrasing from Silliman, Fried, Ross, Gutiérrez, this

body of work shows how "coercion" is often "masqueraded as "choice"" by emphasizing that the social context in which individuals are able to consider choices (or not) has been key to whole groups ability to access their reproductive rights (2004: 5). Not only has this body of work clearly established that discrimination has been a key driver of violence concerning reproduction but it also shows that the scope of obstetric violence should be conceptualized broadly, as the 'undermining of fertility.' In other words, obstetric violence concerns harms or restrictions to female, male and even whole groups' rights to have children, how to do so, as well as the right not to. Furthermore, that the ability to control reproduction is especially challenged by racism, poverty, environmental degradation and sexism.

2.3.2. Institutional Elements

The demeaning, and constrained working environments health professionals navigate in order to provide their services in health systems, serves as a catalyst to the structural social drivers that facilitate the violence females are subjected to during maternity. Paradoxically this factor has rarely been highlighted by research and reporting on the topic (for examples of this absence see WHO 2014, Chadwick et al 2014, Sanchez 2014).

However, some analysis has acknowledged this relationship, as well as the important recognition that health professionals and other staff are

also subjected to discriminations by the health systems where they work. For example, Honikman, Fawcus and Meintjes assert that maternity health care professionals in South Africa face poorly funded facilities, lack of mentorship and leadership, demoralization which creates a lack of motivation as well as excessive overtime and ever-burgeoning patient demands which all contribute to poor quality care (2015: 284). They echo Jewkes, Abrahams and Mvo (1998) by raising that "abusive behaviour in this context may result from staff's perceived sense of powerlessness" (Honikman, Fawcus and Meintjes 2015: 284). Pires and colleagues add that the violence of the work environment including "personal danger" can demoralize and traumatize staff leading them to take their frustration out on patients (2002: 1683). Honikman, Fawcus and Meintjes raise the important conclusion that "care" for health professionals themselves is vital to improving the quality care of patients (2015: 284).

Scholarship has also identified that medical neglect, as well as direct violence in maternity service settings result from maternal health facilities extreme lack of resources and equipment which place health professionals in compromised positions that inhibit their ability to deliver adequate quality care (Honikman, Fawcus, Meintjes 2015: 284). Additionally, some research findings demonstrate that the low-quality of the work environment results in alienation of midwives (Sargent and Rawlins 1992). Exacerbating this context is the normalization and acceptance of reproductive health system deficiencies, including health professionals being subject to "degrading and disrespectful working conditions" (Freedman and Kruk 2014: e43). This context often results in staff's professional ideals "suc-

cumb[ing]" to "emotional and physical survival strategies" (Ibid). Jewkes and Penn-Kekana explain how the lack of serious repercussions for harmful acts directly contributes to violence against patients by fuelling a "sense of entitlement" to abuse for health professionals (2015: 1). To build on this finding my research examines what impact the lack of liability on behalf of health system managers for maintaining basic resources necessary to provide quality care has on health professionals. Browser and Hill's review found that researchers cite a major contributing factor to be a systemic lack of accountability and enforcement of professional standards of care (2010: 18). They expand on this arguing lack of both institutional as well as "community accountability" and "implementation" and "enforcement" of compliance with such laws including "redress" may exacerbate obstetric violence (Bowser and Hill 2010: 16-18). Freedman and Kruk's analysis takes this a step further by arguing the presence of obstetric violence represents a breakdown in accountability not only to its users, but also for the healthcare system. They conclude such fractured health systems and locally expressed power dynamics conspiring against both patients and health professionals "signal of a health system in crisis–a crisis of quality and accountability" (2014: e43).

Bowser and Hill raise several factors as part of their theory on what contributes to the widespread violence in reproductive health services. While they acknowledge cumulative economic (i.e. poverty and resource constraints) as well as social (i.e. multiple forms of normalized discrimination) drivers, they also focus on the key institutional drivers relating to governance, and national laws and policies (2010: 3). The authors infer

there are political challenges contributing to this crisis, noting that there is a "strong negative impact" from "disengaged or obstructive leadership" (Browser and Hill 2010: 20). Importantly, they maintain that the widespread emphasis on 'quality care' standards in health system management in most maternal health care settings is translated as the "prioritization" of "evidence-based clinical care" with "little emphasis" on dignified treatment (Ibid). Additionally, Van Lerberghe and colleagues' review of country efforts to strengthen health systems as a way of improving maternal health similarly assert that managing quality requires addressing "respectful woman-centred care" (2014: 1222). Moreover, they charge that until recently this has been a "blind-spot" of policymakers (Ibid). Freedman and Kruk found their "blind-spot" metaphor appropriate as it raises the way this problem has "evaded the attention of the global health community, as well as national and local health authorities, including those governing midwifery and other health professions" (2014: e42).

Moreover, Browser and Hill highlight that leadership at all levels is essential to preventing obstetric violence. They contend that at the "individual facility level" leadership is "critical for enforcing standards of respectful birth care" (2010: 20). At the "regional and district level" leadership is essential for ensuring "local implementation" and oversight of national policy and to promote "innovative approaches" (Ibid). And finally, at the national level leadership is required for "establishing proactive maternal health policy that is linked to implementation and enforcement mechanisms at the highest levels of government" (Ibid). To

date there are few studies analysing the governance and management of maternal health services overtime in South Africa and its effects on the structural and everyday violence relating to reproduction (Cooper et al 2004, Mkhwanazi 2014), none which combine primary research on accountability and enforcement mechanisms at the local and district levels. Therefore, this study will contribute necessary research to this key issue driving obstetric violence.

Included in the literature are approaches at the global level which may contribute to harm in reproductive health. Critical development scholars argue that often what is left out of development thinking are the causal social and economic constraints making maternity a major risk for women's health, for instance poor "livelihood" and "welfare" (Qadeer 1998: 2676). Scholars who evaluated the impact the 1994 global policy shift from population control to reproductive rights had on the political economy of reproductive health found "cuts" to "welfare" and "structural adjustment" went unchallenged, which resulted in "undermining the [new] reproductive health agenda" (Harcourt 2009: 47). Knudsen importantly adds that the reproductive rights agenda "encourag[ed] countries to adopt user fees for health services" (2006: 7). It could be argued that this neo-liberal approach to reproductive health contributes to obstetric violence, through the deprivation of resources put toward women's health, and especially the practice of detaining mothers and newborns that are unable to pay for the cost of maternal health services.

Importantly, population control policies have often been promoted as logical solutions to poverty (Hartmann 1995; Roberts 1997; Knudsen 2006; Connelly 2008; Briggs et al 2013). This framing of the prevention of reproduction as a solution is based on a false association between reproduction and poverty, namely that having few children alone will improve the economic circumstances of individuals, families and whole populations, or nations. Put another way, this idea, which encourages obstetric violence disguises what reproductive freedom actually comprises - the ability to 'freely choose' – which requires economic, social and political power. While coercive population control programmes delivered through reproductive, sexual health and maternal health programs may be a consideration of obstetric violence in the past, this is important to note as some scholars assert the "assumption that the cause of the world's problems is poor people's ability to reproduce has not fundamentally changed" (Smith in Briggs et al 2013: 111). Considering these elements is important for this research study as they raise the complexity of meaning for reproductive freedom beyond individual rights, and demonstrate further how the social and economic context within which health systems are embedded can encourage obstetric violence. In the case of this dangerous notion about solutions to poverty this is especially important precisely because populations of the Global South, are the ones whose choice to have children has often been restricted by family planning programs while these are the same populations that suffer the highest rates of obstetric violence in the form of high rates of maternal mortality and morbidity.

This review has shown that obstetric violence is described as taking various forms, and to operate at different levels within health systems (Bohren et al 2015). These have included four levels, namely: the individual relational level occurring between patients and health professionals taking direct physical and psychological forms, the service delivery level relating to diagnosis and the administration of medical interventions taking the form of unnecessary and/or unconsented to medical procedures (e.g. caesarean-sections, routine episiotomies, administering of especially long-term contraception), and also included in some typologies is the operational level of health systems taking the forms of insufficient staffing, inadequate supply chains, and punitive policies. These findings have led me to distinguish between the direct and structural types of obstetric violence, which is discussed in the following sections.

2.4 Obstetric Structural Violence

With few exceptions, attention to the scope, and meaning these harms have for reproduction has been neglected or understood narrowly. In an effort to go beyond the limitations of current conceptualisations I build on the scholarship of women of colour feminists, who assert the socio-political contexts in which reproduction takes place shapes individual's and at times whole community's control over the process of their reproduction. By taking the social contexts and meanings of reproduction seriously I, put forth why the term "obstetric violence" is the most analytically useful term to explain this type of violence. To do so I

argue that obstetric violence is a particular type of violence against women in at least four ways: (1) it endangers individual pregnant women *as well as* their foetus or newborns; (2) it has a direct impact on her family; (3) it can be applied in a structural form impacting whole groups; and (4) it is carried out by health institutions, and or policy. My analysis that this *particular type* of violence against women takes both direct, and structural forms leads me to introduce a new concept, '*obstetric structural violence.*' By which *I mean* the socio-political causes of the systematic violation of sexual and reproductive health rights carried out by health systems, and/or policy *resulting in* unconsented constraint of reproductive capacity, preventable maternal and neonatal disability, morbidity and mortality. I argue obstetric structural violence is the cause of the more direct, obstetric violence, which I define as physical, psychological violence and/or unnecessary or coerced medical interventions carried out within health systems. The case of South Africa is used to illustrate and contextualise these arguments.

2.5 Conclusion

This chapter has critically reviewed the literature on harms in maternal health settings from several academic fields. It has engaged in the debates about violence, especially on the theories of obstetric violence, structural and everyday violences. This review has found the concepts of structural, everyday violences, and obstetric violence to be the most useful analytical frameworks for this study.

I interpret the definition of structural violence as: the unequal distribution of disability, mortality and morbidity relating to reproduction and maternity. This definition importantly provides an analytical framework with which to discern the causes and outcomes relating to social, economic, political, and legal structures. Furthermore, I refer to everyday violences to mean, common intra and interpersonal practices and expressions of violence which contribute to a climate of violence in reproductive health services. This includes physical and psychological abuse including in forms of sexual, humiliation, fear of retaliation, unnecessary medical procedures, medical neglect, and the deliberate refusal of pain relief. The term obstetric violence has been chosen to refer to the forms of everyday violences (as defined above) carried out on pregnant women in health systems. Obstetric violence speaks best to the specific forms everyday violence takes within reproductive health policy, programs and direct services. I argue that "obstetric violence" appropriately implicates not only the woman but her offspring and kin as victims. This is especially important as obstetric violence often impacts the woman's family, kin and in extreme cases of mass violence, whole population groups. It can be argued that a form of obstetric violence carried out as structural violence raises similar unique outcomes as the routine and mass rape of women in wartime. I consider obstetric violence as structural violence for example in the case of the mass sterilization of generations of Puerto Rican women of reproductive age (See Briggs 2002). For these reasons, I argue that obstetric violence is the most useful of the existing terms. Similar to Anderson (2015) and Gupta's (2012) arguments in relation to their research problems, I argue this because this violation is caused be-

cause of what it is, gender-based violence, it is violence and because it is obstetric in nature as it relates to human reproduction.

In this way structural violence, coupled with everyday and obstetric violences provides strong analytical tools to understand how inequalities shape violence during maternity. For example, by doing so the relationship between violence by maternal health services can more easily be related to interpretations of the well-established inequality in the burden of risk of maternal mortality (see Trends in maternal mortality 1990-2013, WHO 2014). In other words, how women in sub-Saharan Africa and South Asia continue to be at the highest risk of death from maternity, the natural process of human reproduction. Interestingly, this inequality has also been characterized as "fundamentally linked to violations of the human rights" (Office of the High Commissioner on Human Rights (OHCHR) 2010: 27 ¶58). By applying these theories to help situate my study in the broader context of reproductive politics the *concealed forms of violence* that I am concerned with become more visible. For example, how the structurally violent results of extreme deprivation and inequality result in three professional nurses treating two-hundred patients a day, five days a week in under-resourced conditions; and women in labour being routinely turned away from health services or subjected to direct violence within them. These structurally violent and everyday experiences in primary maternity care will be expanded on in Chapter 4 and 5. The problem of record high maternal mortality and morbidity rates, and other reproduction-linked adversities often exist as seemingly "inevitable despite being preventable" (Gupta 2012: 6).

The review found that the primary approach to challenges in maternal health are framed by development and rights discourses as issues of access and quality care, which for the latter has until recently been poorly explained and thus poorly understood. Feminists have long critiqued this approach for neglecting the social determinants of women's health, which they argue are the prime cause for risks to safe maternity. This scholarship emphasizes that it is women's ownership and control of resources, and access to social securities, in addition to health resources that influences their health risks. These also influence females' ability to assert reproductive autonomy. Additionally, the review found that there is an emphasis toward framing the main issue as women's ability to prevent pregnancy, while a major issue that is often left out is women's ability to have safe pregnancy. They argue that by ignoring the context within which women live, the rights framing and solutions have embraced neo-liberal models of health care, and prior to this a population control model, which itself the review found is a form of obstetric violence. Furthermore, it found both these approaches enable access to highly advanced reproductive technologies that do not necessarily facilitate reproductive autonomy, but rather sustain the deplorable social conditions that force women to choose to prevent pregnancies. The emphasis on reproductive rights has highlighted the issues of injustice women face during in maternity, especially most recently with several human rights bodies recognizing high rates of maternal mortality to be violations of human rights, and other forms of obstetric violence. This has proven particularly useful in identifying typologies of obstetric violence occurring within health systems that are both structural and interpersonal.

However, these limitations to the framework do not make it adequate to address the problem of the study alone.

Through this theoretical approach, the dissertation is able to challenge the paradigm that Global Health applies to women's health by asserting why it is necessary to look beyond lack of access and adequate quality care, to the broader constraints of power and resources on reproductive freedom. Furthermore, this allows for an examination of the assumptions that underpin the normalization of everyday acts of violence. It also begins to enable an articulation of the complexity, and intersection of dominant forces, and forms of violence that function to reinforce, in this case risks to health and reproduction, including death. Taking such a contextual view of health systems is supported by development scholars' critiques of the human rights approach to reproductive health, which argues that the issue is not simply a rights issue, but is connected to women's social and economic contexts (Qadeer 1998, 2005; Rao 2004; Silliman *et al* (2016).

Paul Farmer's 2004 theorization of structural violence has particularly influenced my methodological approach. Farmer argues that in order for research to examine the structural forms of violence, a historical analysis must be applied. This is evidenced in the next chapter which analyses the historical roots of the structural violence inculcated in South Africa's health services. Furthermore, considering historical experience of conquest and colonialism is essential to comprehend contemporary patterns

of violence (Scheper-Hughes 2004: 5; Anderson 2015: 6). Anderson adds applying a historical analysis is key to the fullest understanding because "it avoids the totalising fiction of permanent relations of domination and subordination" (2015: 6). Structural violence, its outcomes: who is suffering premature death and constrained capacity, as well as its causes: gendered relations change over time. By examining the social and structural determinants of health through a historically situated analysis this dissertation adds to the feminist analysis filling this gap in the literature of medical sociology (Williams 2003: 131 cited in Anderson 2015: 6; for southern Africa see also Abrahams 1997; Levine 2013; Anderson 2015).

3 The Foundation of Obstetric Violence in South Africa

"Feminists have argued that violence is one of the constitutive elements of South African society" Pumla Dineo Gqola (2015: 176).

I take the position that obstetric violence is a particular type of violence against women. I advance this thesis based on four factors: 1) it endangers a pregnant woman as well as her foetus or new-born, 2) it has a direct impact on her kin, 3) when certain forms are applied systemically it can impact the reproductive health of entire groups, and 4) because it is carried out by health systems, and/or policy. Taking seriously the premise from South African feminist scholarship (Abrahams 2000; Gqola 2010; 2015; Baderoon 2014) that violence, and especially during the period of slavery is a constitutive element of South African society, especially contemporary violence against women I take an historical perspective in establishing the roots of this violence, and the elements causing its persistence in South Africa. The focus of this chapter is to interrogate notions and provisions of healthcare in the context of the social and political processes of colonialism, and of apartheid. To consider the rela-

tionship between these structures, I analyse the consequences the historic construction and ordering of race, gender, and class has had for sexuality, fertility and reproduction. How, and why were health services enabled to be tools of conquest, and how was reproductive healthcare particularly influenced by these characteristics of colonial and apartheid governance? I demonstrate how, and why, early notions and provisions of healthcare enabled obstetric violence to thrive within health services, targeting entire social groups, who are thus recursively impacted by obstetric violence.

By mapping the establishment of race and racism, and gendered sexual violence especially through the long period of slavery which constituted an exploited class within South African society, this Chapter demonstrates how the structural drivers of violence against Black women in the past, are linked with those sustaining obstetric violence in the present. I apply the formulation of the "modern/colonial gender system," and racial and gendered structural violence, that were analysed in the previous Chapter, to explain how these subjugating orders of power interact (Lugones 2008). These notions are applied to explain how healthcare was used during the colonial and apartheid periods as a tool of management and control.

This Chapter is comprised of three sections. "Cape Colony: The Dehumanisation and Appropriation of Black Women" examines the early colonial period of the Cape Colony, an area which encompassed more than half of the geographical territory of the country (Digby 2006: 14,

25), and which includes Cape Town, the metro area where my field study took place. The Cape is the location of the first European settlement, of formal medical institutions, and the establishment of the professionalization of medical and nursing practitioners. I look at the social, economic, and political structures of colonial society: slavery, racialisation, and the rise of racist speculative science in conjunction with the advancement of what is often referred to as 'Western' medicine. This focus on colonial conditioning allows for the examination of the discursive as well as structural ways in which violence against Black women was made permissible, 'rational' and therefore, obscured. These discursive narratives are revisited in Chapter 5 to establish which, if any, factors originating historically persist to rationalise and obscure obstetric violence today. While the Chapter and the dissertation discusses general developments in all parts of South Africa this section focuses on the Cape Colony, an area which encompassed more than half of the geographical territory of the country (Digby 2006: 14, 25), and which includes Cape Town, the metro area where my field study took place. The Cape is the focus of this section as it is the location of the site of the first European settlement, formal medical institutions, and the establishment of the professionalisation of medical and nursing practitioners.

The next section, "Healthcare as a Form of Colonial Governance," analyses how health policy and services were used to implement racial and gendered structural violence, leading to prolonged illness, subjugation, and injury. This section describes how blackness came to be associated with disease, and how racial and gendered structural violence was

expanded through the growth of colonial medicine, missionary medicine, and the professions of nursing and doctoring. This history links to Chapters 4 and 5, which explain how the legacy of racial exclusion in the medical profession causes strains on the field of obstetrics today.

The final section "Apartheid Health and Control Over Reproduction" explicates the ways in which racial and gendered structural violence shaped the origins and practice of women's healthcare. It shows how the association made between Blackness and disease, which was used to rationalise segregation, also connects to later coercive contraceptive programs, including one aimed at arresting the Black population's control over their fertility.

3.1. Cape Colony: The Dehumanisation & Appropriation of Black Women

The history of the wars, enslavements, and settlement by the Dutch (and later the British), at the Cape is well known. I contend that the origins of colonial settlement, slavocracy, and subsequent conquest, are relevant to an investigation of the persistence of adverse healthcare in South Africa. Unlike many colonial territories in Africa and Asia, modern medicine did not arrive abruptly in South Africa through the 19th century 'civilising' missions (Arnold 1993: 290). Rather, as a result of the imperial armed conflict, medicine was an early part of conquest in South Africa, similar to the experiences of Canada, New Zealand and Australia, its set-

tler counterparts (Deacon *et al* 2004: 22). Indeed, medicine was implicated in the initial motivation for settlement at the Cape. The initial motivation of the Dutch East India Company (VOC)–a Dutch company established to challenge and compete with existing European trade and merchant monopolies–was to provide for the welfare and health of its generals, soldiers, and civil servants, who the company required to maintain conquest elsewhere (van Rensburg *et al* 1992: 37). Company medical officers as well as professionals exercised profound influence on the way in which imperial powers managed their expanding control over colonial territory. At times, they embodied the seat of power, and were often entrusted with administrative duties and responsibilities (Arnold 1993: 291; Lund 2003). In fact, Jan van Riebeeck, the founding Commander of the Cape Colony, was a former Assistant Surgeon for the VOC. For these, and other reasons, I propose that part of what shapes present-day South African healthcare, is that notions and provisions of health, were deployed as tools of the colonising process, which ultimately managed and controlled South African society for three hundred and forty-two years.

3.1.1 Racial, Gendered and Sexual Violence During Slavery

As Gabeba Baderoon has argued, while South Africa's slave history is often forgotten (Wicomb 1998), and its meaning has been diminished in some academic literature (Keegan 1996). The institution of slavery that operated for one-hundred and seventy-six years in the Cape Colony is significant (Ross 1983: 16-17), especially to understand the present per-

vasiveness of violence against women (Baderoon 2014). Chattel slavery was the founding social, economic, and political structure in the Cape Colony. Pumla Dineo Gqola's definition of "enslavement" is useful here: "To be a slave is to be reduced to the status of object, dehumanised and denied will and self-ownership. It is to be layered with dishonour. Under these conditions, bodily autonomy is an impossibility, inducing further shame" (2015: 40). For enslaved women, an added burden was that they could neither protect their children, nor guarantee their safety (Abrahams 2000: 30). Anne Stoler's seminal work on colonial societies found that race determined who benefitted from colonial rule, and who was explicitly subject to it (2002: 98). This included those who were considered legitimate progeny, meaning those who could "become citizens rather than subjects" (Stoler 1991: 53). This was also true in South Africa. Racialised slavery entrenched the commodification, and devaluation of Asians and Africans, who would soon become constructed as "black" in the Cape Colony. During slavery, under both Dutch, and English authorities, the entire Cape economy was dependant on slaves. Slavocratic society was extremely violent towards women. The level of brutality enacted upon the enslaved, and arguably the continued extreme burden of work after emancipation, is evidenced by cases of infanticide during both periods (Scully 1996: 89). For example, enslaved women were routinely raped as a means to multiply their masters' workforce (Gqola 2015: 43). Recalling Stoler's argument, in the Cape, as in other slavocratic systems, enslavement followed the maternal line. Rape "was a part of the business of slavery," as utilising enslaved women's fertility was a key to the future property of the VOC–their children–who, following their maternal line

would become subjects, and be racialised as black (*Ibid*). However, although slaves were valuable commodities, colonists in the Cape unlike their counterparts in the United States, took few measures to ensure the "slave labour force was able to reproduce itself" (Ross 1983: 1-3).[17] Historian Robert Ross found it was more common for slaves to be worked to death (*Ibid*).

In 1699, in fulfilment of VOC instructions, the second formal military hospital "the Cape hospital" was built (van Rensburg *et al* 1992: 38, 45). Colonial healthcare was no different than other sectors, and female slaves were forced to perform the function of nursing aides, caring for VOC soldiers and sailors, beginning in this hospital and throughout the period of slavery (*Ibid*). The relationship between these "nurse aides," and patients, illustrates the tragic irony of their positions. Enslaved women were forced to care for, to help sustain the lives of the very soldiers and sailors who were in turn, facilitating the death and dehumanisation of enslaved peoples. To better understand the meaning of this medical institutional juxtaposition Anthony Bogues' notion of "living corpses" is helpful. "Living corpses," are those individuals who, because of historic social conditions, "were never seen as alive" (2012: 34). Bogues is pointing to "erased bodies" who faced "regularized performances of violence as power…enacted" (*Ibid*). The practice of enslaved

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[17] See Elphick and Giliomee (1979: 88) for a table comparing birth and death statistics of Company slaves. For an exhaustive understanding of how slaves were forced to reproduce themselves in the United States see Dorothy E. Roberts work, especially Chapter two in Killing the Black Body: Race, Reproduction, and the Meaning of Liberty (1999).

women whose bodies and subject positions have been denied, nursing their captor's bodies to health, pronounces the very subjugation, and erasure of their own bodies, their own health. The divergent healthcare relationship between the enslaved female black nursing aide/living corpse and her patient/captor highlights the supposed 'natural' dehumanisation designated to non-Europeans, which had become the normative motivation for enacting violence on subjects in the Colony.

As Stoler has argued, "the colonial politics of exclusion was contingent on constructing categories" (1991: 53). The disparate geographical, linguistic and cultural origins of the peoples brought to the Cape as slaves by the VOC, and later by the English, separated them (Ross 1983: 5). It was the processes of slavery, emancipation, imposed government ascriptions, and lived experience, that eventually circumscribed those enslaved within the broad racial taxonomy of "free blacks," and later, as "coloureds." This taxon "free black/coloured," included enslaved people, as well as indigenous Khoekhoe peoples. The latter grouping, when captured by settler commandos or the VOC, were categorized as indentured servants. However their actual experience was also one of enslavement (Scully 1995: 339-340).[18] The Khoekhoe faced wars with col-

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[18] Recently scholars have argued the experience of the Khoekhoe differed little to the lived experience of slavery at the time. See for example Gqola (2010: 15); Adhikari (2014: 47). The taxonomy of terms of this time also suggests this both colloquially, and in government ascription. The colonial terms 'Hottentot' which referred to the Khoi, and 'Bushmen' which referred to the San were abandoned in order to include the Khoi and San into the category 'free blacks' which referred to those formerly enslaved (Scully 1995: 339-340).

onists beginning in the 16th century, escalating to their almost complete decimation during the colonial settlement in the 17th century. This genocide of the Khoekhoe people, included kidnapping for the purpose of enslavement, and extensive scientific denigration into the 19th century.[19] The colonist's reduction of the Khoekhoe's humanity by categorising them as animals or "creatures" rationalised the intention of genocide (Adhikari 2014: 47-49).

The system of slavery normalised the appropriation of enslaved girls' and women's labour, and denied self-ownership of their sexuality. This is well evidenced by the VOC's operation of the Slave Lodge as a brothel where thousands of the Company's enslaved population were housed, and the female slaves provided obligatory sexual labour (Ross 1983: 24; Gqola 2015: 43). According to Gqola, in order to justify the institutionalisation of the rape of slaves, "slavocratic society created the stereotype of African hyper-sexuality. The stereotypes held that slave women could not be raped, since like all Africans they were excessively sexual and impossible to satiate" (2015: 43). Enslaved women were not only objects of ownership and legally incapable of being raped, their construction as hyper-sexual, signified they "would not be rapable even when free. This meant even freed slaves could not be raped" (*Ibid*). Throughout the nearly two centuries of enslavement in the Cape Colony, "not a single man, slave or free, was convicted for raping a slave woman" (Ross: 1993: 114).

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19 For an extensive review of the argument of genocide see: Adhikari, M. 2010. The Anatomy of a South African Genocide: The Extermination of the Cape San Peoples. Athens: Ohio University Press.

The social and political subordination, and collusion of white women with the colonial project, created another path for the expansion of racial gendered structural violence enabling sexual violence. The construction of Black people as plagued by "primitive sexual urges," coupled with the construction of white women as pious, and helpless resulted in the notion that white women needed "protection" from the supposedly "insatiable sexuality" of Black men (Stoler 2002: 58-59). While this construction "had virtually no correlation with actual incidences of rape," it became a common scapegoat for the expansion of violence against Black women, and other forms of colonial controls over Black subjects, and their resources (*Ibid*). As will be shown in Chapter 5, the idea of insatiable concupiscence, framed as reckless behaviour, is routinely applied as a justification for obstetric violence toward Black women and girls. Therefore, the crystallisation of social norms which reduced Black people to animals or creatures, and established the notion of their hyper-sexuality, along with the converse construction of white women's piety, obscured occasions of sexual violence against Black women, and simultaneously provided justification for this brutality.

In the post-emancipation era, these quotidian practices continued to influence societal mores. The racially structured and classed society, coupled with the institutionalisation of discriminatory social norms attendant to sexuality and gender, meant that "the law could be mediated by race and… over-determined by the intersection of femaleness and blackness" (Scully 1995: 342) Whether an instance of rape was reported, how it was evaluated, and the degree of punishment dealt to the rapist, were all con-

tingent on these intersections, and the meanings ascribed to them. White men, for example, were simply never brought to trial. In cases where Black men had been convicted of raping, and at times, of murdering, Black women, white settlers petitioned the governor and judiciary to either commute the sentences, or drop the charges entirely.[20] The outcomes of legal proceedings, affirmed the permissibility of appropriating Black women's subjectivity and sexuality, enacting a form of "colonial body politics,"[21] reinforcing the notion that Black women were "safe to rape" – "unrapable" (Gqola 2015: 4, 43). My shift in focus to speculative science, and the role of colonial body politics within this paradigm, examines how the complicated order of *de facto* and *de jure* white dominance was expanded by science and medicine.

3.1.2 Scientific Racism: A Rationalisation for Violence

Enlightenment scientists of the 18th and 19th centuries advanced the notion of Khoekhoe as "creatures," to argue for the notion of human evolution. This established a "superstructure of scientific racism" that

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20 Scully describes these petitions in detail in her 1995 article. In one case seventy-four settlers from George petitioned the Governor to commute the death sentence of Kobus Goliath for raping and killing a free black female labourer on 28 February 1852. The petition can be found at, CA, CO 615, Memorial of Undersigned Inhabitants at George, undated; and CA, CO 615, secretary to government to Governor Smith enclosing Report of Proceedings in Case of Kobus Goliath for Rape with Intent, to Commit Murder, February 28, 1852.

21 "Colonial body politics" refers to the racist idea that achieved stability as a social norm through colonial governance that white people exclusively held the right to control Black people, and specifically their bodies (Marks 1994; Scheper-Hughes 2004: 264-265).

lasted "one and a half centuries" and rationalised the objectification of Khoekhoe peoples as "pornographic" "objects of study" (Abrahams 1997: 34-45). Initially Khoekhoe men, and later women's physiology was figuratively, and literally collected and dissected. Colonial travel writers such as Le Valliant, wrote in pornographic fascination with the physiology of Khoekhoe people, providing illustrations in diaries that were published and translated into six European languages.22 I argue that this widespread propagation of Western ideas about black people, contributed to the denial of Khoekhoe, and black subjectivity. Together with the legally sanctioned violation of Black women, this denial of subjectivity subsidised the trade and collection of black bodies by European museums, and their counterparts in southern Africa. This facilitated the desecration of graves, and at times the hunting and killing of Khoekhoe people (Legassick, Rassool and South African Museum 2015). The most prominent case of this objectification is that of Sarah Bartmann, an object of voyeurism and ridicule "for entertainment" on stages in Europe. When she died from these traumas in 1815 her body was promptly "dismembered, isolated, decontextualized," and put on public display in Paris at the Musee del' Homme (Museum of Man) until 1974 (Abrahams 1997: 44-45). The extent of the forces of ontological denigration propagated by the widespread practices of scientific racism, evince another facet of the normalisation of violence in South Africa.

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22 His works, which span three volumes on southern Africa were published in French, English, German, Dutch, Danish and Russian. Three of his publications include the especially pornographic illustrations of Khoekhoe women's genitals.

I have argued the systems of slavery and scientific racism enabled by colonial conquest of the Cape and colonial body politics established race, gender, and class as referents for the colonial axis of power. Building especially from the work of South Africa feminists Yvette Abrahams 1997, 2000, Gabeba Baderoon 2014 and Pumla Dineo Gqola 2015 this section has suggested the political, economic and social foundations of colonial society established a racial and gendered structural violence that continues to influence violence against women today.

3.2.   Healthcare as a Form of Colonial Governance

This section builds on the previous findings, by analysing how structures of colonial and apartheid governance enabled the inculcation of racial and gendered structural violence in notions and provisions of health. The relationship of public health policy to notions of racially differentiated disease, and segregation, extends this examination of expanding provision of health through colonial conquest. Finally, apartheid health is analysed with attention to how this form of authoritarian governance, entrenched separatist policy, and how this impacted the medical professions.

3.2.1. Degradation, Disease and Public Health

Jean Comaroff has argued that a medicalised discourse about Africa as the "afflicted continent" was present since the founding of the Cape Colony (1993). During the colonial period the discourse surrounding "the black body… became ever more specifically associated with degradation, disease, and contagion" (1993: 306). A factor in the early implication of medicine into colonial conditioning at the Cape, was that the Company's medical officers and professionals, frequently held key civil appointments of authority within the administration. This included the Founding Commander, but also a Colonial Secretary, and Prime Minister (Lund 2003: 91). These, of course were white male doctors, as licensing regulations generally excluded women, workers, and Black people from the profession (Lund 2003: 91).

The collusion of public health policy-making, and colonial leadership is highlighted in Maynard Swanson's description of late 1800s "sanitation syndrome" (1977: 390). Swanson demonstrates that medical officials saw "infection and epidemic disease" through a "colour difference" (1977: 387). Historian Anne Digby observes that "sanitation" and "civilisation," became associated with "racial hierarchy" (Digby 2006: 169). The medical fraternity's claim that health problems relating to overcrowding, poverty, sanitation were "biological in nature," resulting from the poor hygiene of Black people, allowed the government to obscure that these were part of the social crises caused by colonial conquest and governance, and to successfully avoid any "responsibility" (Lund 2003: 95). In this context, Abrahams notes Black women's constant cleaning became an act of resistance, as well as survival (2000: 30). The notion of racially

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differentiated disease remained entrenched in medical thinking until the advancement centuries later, of technological cures for certain disease, provided undeniable evidence to disprove these racist notions (Jochelson 2001 cited in Digby 2006: 176).

The association made between Black people and disease gave way to an "enclave" policy, to afford the Company to cater for their exclusive concern for the health of "European soldiers, civil servants, and settlers." (Lund 2003: 92). This, I aver offered another layer to the construction of racially disparate modes of life. David Arnold posits the use of public health to control the Black population, marked a shift toward an "interventionist" use of healthcare (1988: 2-3, 13-14). Racially uneven mortality and morbidity evidences the depth and normalisation of the lack of regard for Black people's health (Arnold 1993: 202). The validity given to the association of Black people with disease is shown in the Company's response to epidemics as early as the mid-1800s, by segregating quarantine measures (van Rensburg 1992: 39, 48). These racist notions of disease and contagion continued to inform the public health system, and were used to justify the expansion of the colony. For example, in the 1900s, (after the end of slavery) the colonial government invoked special powers codified through a provision of public health, to strip Black people of "equal protection under the law" to "remove them [to] peripheral locations" using the excuse of an outbreak of bubonic plague (Lund 2003: 93). The societal metaphor of sanitation and infection, links the colonial period to urban apartheid, by the assertion that a central justification for the creation of apartheid, was in fact, the association of

Black people with the spread of disease (Swanson 1977: 387). Public health policy continued as an interventionist tool until enclavism became "impracticable" for the Colony's "economic interests or capacity to govern," at which point, health was used to directly target the Black population (Lund 2003: 92). This latter strategy, the reasoning underlying it, and how it was shaped by gender, will be discussed in the next section.

3.2.2. Healthcare Expansion: A Cause for Racial and Gendered Exclusion

From the early 19th century the government began to build General Hospitals. Keeping with the association between Black people and disease these hospitals were exclusively for the use of white citizens (van Rensburg *et al* 1992: 47; Digby 2006: 168). On a rare occasion the government opened what were designated, Native Hospitals for the use of Black people. Not out of character, the stated purpose of this services was a "civilisation conquest" (van Rensburg *et al* 1992: 47). Also at this time, missionaries became well-established with over twenty active denominations. While the aims of both the medical missionary and colonial healthcare initiatives were compatible, the missionaries were instrumental in the colonial project by facilitating trust between Black people and government doctors. By the late 19th century, hospital care targeting the Black population, especially in mining towns developed specifically to address some issues arising from mining work (*Ibid*). The constraint of the growth of hospital services by race and gender, illuminates the gov-

ernment's interest in the provision of welfare for the Black population centred on preserving the availability of a workforce (Ross 2008: 165-166) which did not include Black women. Thus, the health services that were accessible to the Black population, which was increasingly subjected to disease through the advancement of mining, were fragmented at best. The aim of medical missions was to try and fill these gaps (Digby 2006: 139, 136).

Medical missionary initiatives, like the government's approach, were interventionist and directed through the notion of colonial body politics. Both institutions' approaches were fuelled by the powerful conception that the curative efficacy of medicine demonstrated convincingly, would affirm the advancement of "Western civilisation," and ultimately inculcate in Black people, the sense that they themselves were "backward" and "diseased" (Digby 2006: 30-31). Historian Shula Marks deepens this analysis by recognising medical practice as concerned with the "*social construction* of disease" and used as a subjugating "*cultural* force" (Marks 1997: 209-210 my emphasis). Mission healthcare continued autonomously from this period until 1973 when the apartheid state increased its control over healthcare (van Rensburg *et al* 1992: 68). In the early 1900s two maternity hospitals in Cape Town were accessible to black women, which later afforded access to all Black people. Accessing both the obstetrician-led, government hospital, and midwife-led missionary hospital,

required passing through whites-only areas.23 Accessing services often entailed an arduous journey: traveling on the train for over forty minutes, going through the pass checkpoint to verify legal residence in Cape Town, and if going to St. Monica's (the mission hospital), walking up a steep hill for twenty minutes, all during the late stages of pregnancy.24 Although many stayed only 26 km from town, it could easily take one an additional hour and a half to reach the hospital. (Digby 2006: 239).25 Several nurses in my study had experience training, working, or being born in these hospitals. What I have learned from them, in addition to the ways in which colonial and later apartheid governance shaped the services, is that these first institutions, in light of their surrounding context of deprivation, including that of employment and gendered exclusion, instilled a sense of pride and dignity in having been part of providing a critical service, that connected Black women and their communities.

Doctoring as a Form of Colonial Conditioning

The practice of medicine preserved a racial gendered exclusion, and was almost exclusively practiced by white men (Marks 1994). This remained consistent largely because overseas European training was required, and later, because local training was racially exclusive. As the col-

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23 Personal Interview, Operations Manager, Sister Dineo Ngoqo.
24 Personal Interview, Midwife, Sophia Moses, who worked at St. Monica's in the later years, 10 December 2013.
25 Personal Interview Kabelo Mshumpela, 4 December 2015, who is from Nyanga Township and was born at St. Monica's along with his siblings in the 1940s.

ony expanded, and unified over the centuries, the "flexible and economical" appointments of District Surgeons who were officials, deployed throughout the colonial territory, responsible for caring for government employees, prisoners' healthcare, and including surveillance of the Black population under the guise of public health (Digby 2006: 148, 159; Gready 2007). These positions continued to expand through apartheid, as did the expectation of district surgeons transgress medical ethics when instructed to by the government (TRC 1998; Gready 2007).

By choosing to exclusively focus on males, the practice of medicine had by the early twentieth century, already been established as inherently sexist. Factors leading to the systematic neglect of women's health in the Colony resulted from the government's narrow concern with the health of men. As evidenced above, this attention was particularly concerned with colonial officers, and later this interest expanded to include Black miners (van Rensburg *et al* 1992). Michel Foucault, with his proposal of the "clinical gaze" advanced the understanding that the gaze in the context of medicine is not an intellectual view, but rather a penetrating vast deciphering (1976: 72-73). Therefore, the absence of recognising the health needs of women by the male dominated profession of medicine, was evidence of the arrogance and the power of the biomedical model, to erase women from a valorised view. That is, to erase women's bodily problems from being valued as medical. When the bodily health of women was eventually considered, it was white women's health that was exclusively considered.

Interestingly, the early professionalisation of midwifery in South Africa, which initially included both white and black women, can be understood as male doctors applying a form of gendered conditioning (van Rensburg *et al* 1992: 46). This "new status as semi-professionals, now subordinate[d] medical women to doctors" (Deacon 1998: 274-275). Therefore by "claiming the expertise to train midwives", colonial doctors were able to "assert" they had "superior knowledge of birthing processes" and ensure "referrals at 'difficult' stages, all without damaging their professional standing" (*Ibid*). Therefore, the inclusion of both black and white women in the medical profession of midwifery, was used as a tool to make them ineligible as producers of knowledge and leadership, and reduce their earning capacity. In other words, it was used as a tool of the coloniality of power (Lugones 2008: 3-4). Similar to the "social control" carried out by District Surgeons mentioned above, part of midwives' duties were to report to the VOC. This disqualified Black women as they were seen as savage, objects of social control, or the enslaved who, birthed alone (Kolbe in Deacon 1998: 276, my emphasis). Over time the formalisation, along with discriminatory tropes that Black women were dirty and immoral, undermined the practice of lay midwifery, and set the standard for a low remuneration (Deacon 1998: 280). The development of midwifery shows that there was indeed a preoccupation with women's health. However, the concern was about women's potential economic and political control over the profession, and not their well-being, thus excluding them from power over healthcare.

3.3 Apartheid Health and Control Over Reproduction

The well-known period of apartheid rule in South Africa, lasting almost fifty years, similar to the prior colonial governments, expanded racist governance through the provision of healthcare. "Apartheid health" as it was often referred, established a deeper racial and gendered structural violence by expanding segregation, splitting infrastructure among fourteen health authorities, assigned to various racially exclusive residential areas (Hassim *et al* 2007: 12, Coovadia *et al* 2009: 828). This further entrenched the notion of racially differentiated disease, systematically deprived the Black population of adequate medical leadership and care, and stratified the health workforce even further, by race and gender (WHO 1983). Building on its military foundations, apartheid health also deepened the authoritarian hierarchy of governance, ensuring that power was fragmented by race on the one hand, and concentrated at the top of a racial hierarchy, on the other (Marks 1994: 14; Froestad 2005). In keeping with previous colonial practice, resources made available to the excluded, were often in the form of dehumanising services and maltreatment (de Beer 1984; Scheper-Hughes 2004; Posel 2011: 322). Nancy Scheper-Hughes remarks that "the history of apartheid…[is] etched on [people's] bodies, on their social skin." Drawing on her research experience in Cape Town, she noted that among the "etched" marks from "stab wounds" …were, "scars from untreated infections and botched, discriminatory medical care" (2004: 33). Indeed, my time in the Western

Cape has revealed the same visibility of medical, and non-medical scaring.

Nursing and Doctoring

To maintain control, apartheid health applied different strategies for the differently gendered and powered professions of nursing and doctoring. Each has had specific outcomes for the contemporary healthcare system. Racist ideology largely maintained the exclusion of Black men from doctoring. This is important to note, as it caused a deprivation in doctors that remains today (Coovadia et al 2009: 829; Chopra et al 2009: 1027), an analysis of the persistence and outcomes of this problem in obstetrics is found in Chapters 4 and 5. However, Black women, already subordinated by gender, and therefore interpreted as less of a *threat* to exclusive white male control, were by the 1950s, widely included in the professional class of nursing (Marks 1994). This inclusion marked a victory for Black women, and especially those who worked as nursing aides who had been banned from institutional posts for thirty years (Foster 2003: 30). This inclusion meant more than secure employment and training. In the words of Doreen Foster, a nurse who wrote about the time, it proved, "inferiority was a concept invented in Europe" (2003: 2) However, a racial social order was codified to mandate different training programs, and registers upon this inclusion (Horwitz 2009: 3). Inferior education provided to Black students facilitated the medical malpractice the Black population received, further associating Black professionals with

inferiority. While the inclusion of Black women in nursing was resisted, justifications were made based on the longstanding debate and desire for white nurses to be relieved from the duty of handling Black (especially male) patients (Marks 1994). Such practice was seen as impure and dangerous for single white women (and the state) (*Ibid*).

Further rationalisation for this gender-based exception, arose from interpreting and treating Black nurses as objects that could be, and were "groomed", as tools for "moral[ising] and sav[ing] the sick" (Coovadia *et al* 2009: 829). While it is known that Biblical ethics was a strong influence on early nurse training, rewarding submissiveness and humility and encouraging the same from patients, it is also known that Black nurses were legally, and institutionally discriminated against and subordinated in their professional lives. This included disciplining through acts of humiliation, including physical abuse, strict rules of obedience, victimisation for expressing opinion, discriminatory pay (until the late 1980s) and segregation, to name but a few factors (Foster 2003).[26] They were also at the bottom rung of the medical hierarchy, and with the exception of Heads of Nursing, the majority remain today amongst the bottom rungs, with subordinated power. Scholars have suggested this colonial conditioning, has led to Black nurses in South Africa developing a reputation for "rudeness, arbitrary acts of unkindness, physical assault and neglect," which have been "widely reported" in the treatment of female patients "particularly in sexual and reproductive health services" (*Ibid*). However,

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26 Personal Interview, Operational Manager, Cecilia Ahrends, 2 June 2013.

there is little literature examining such an aspect of nurse training, and I found an elder nurse's accounts to largely contradict this assessment (although most did not recount these histories to me with vivid detail). An ethnographic study on the experiences and history of Black nurses conducted by Foster, herself a black nurse, offers some insight in relation to reproductive health. This study documents accounts of nurses (both Black and white) being trained to normalise, and practice obstetric violence on Black women. For example, accounts show that episiotomies were performed routinely on Black women in the 1930s, and in the 1990s (Foster 2003: 28-29). Additionally, the author argues that the gross abuse of power by white Matrons who "practised… naked racism …nepotism, [and were] inaccessible, unapproachable, and unfriendly," is to blame for what she calls, "black-on-black oppression" in the late 20th century (Foster 2003: 190). The argument that subordination and exploitation by "superior" authorities, especially doctors, described as "master a servant relationship," is also at fault here (Foster 2003: 30, 193).

3.3.1. Reproductive Capacity: A Tool for Social Control

A relevant area of maternal health, often overlooked in the literature on obstetric violence is also one that was central to women's politics globally during the time of apartheid, namely, women's ability to control their reproductive options. The following section examines this context in relation to how the advance of birth control technologies were implicated in colonial, and especially apartheid governance. It does so firstly,

to situate the central connection between obstetric violence and the resources structuring women's reproductive options, and secondly, to analyse how birth control has been used as a form of obstetric violence during apartheid.

In the 1930s, poverty had increased within the rural white population, causing families to move into to urban areas. As a result, elite white women became concerned for a perceived threat *to* "white prestige" (Stoler 2002: 36). These conditions, along with ideas that visible poverty among white people would destabilise colonial control, coupled with advances in contraceptive technologies, and a genuine motivation to promote birth control technologies and methods (such as "spacing") as a way out of poverty for white families, led to the provision of contraception (Kaufman 1996: 30). Eugenicist advocacy to use birth control to prevent the fertility of poor women was not isolated to South Africa. Rather, it echoed sentiments that were circulating among elite groups elsewhere in the world (Knudsen 2006). The motivation for the first promotion of access to birth control, was thus based on maintaining stratified racial and classed boundaries through the protection of the association of whiteness with upper-class prestige. Despite settlers' longstanding fear of "swamping" by the majority Black population, this group was able to secure government subsidies paid in an indirect manner to avoid public debate (*Ibid*). It is important to note that the promotion of access to contraception was rationalised on the basis of preventing poverty among the white population. No attention was given to the extreme poverty enforced on the Black population (Klausen 2004: 57).

Susan Klausen's research demonstrates that while women of high social status did establish the availability of contraception in some coercive ways. This early distribution was not a form of "social control" (Klausen 2004: 155), but rather, it "was accomplished jointly by advocates of birth control and users" (*Ibid*).

3.3.2. Population Control

After expanding nationally, the provision of birth control continued to be maintained and funded clandestinely by the government into the apartheid period (Kaufman 1996). However, the focus shifted from curbing poor white family's fertility toward the obvious intention: limiting the growth of the Black population. Several factors contributed to this shift. Firstly, global attention was moving from the eugenicist attention on local poor and vulnerable groups, toward those abroad. Debates focussed on about how to contain population growth resulting from improved medicine and access to vaccines in the Global South (Connelly 2008). Secondly, the initial approach to curb fertility through economic deprivation, as posited by "the Malthusian approach," which contradicted demographic theory, was not working (Moultrie 2005). Evidence of this was that influx of Black population to urban areas was increasing as were birth rates in these areas (Ross 2008: 159). This context ignited the age-old narrative associating Black people with disease and contagion, and a fear of "racial swamping" (a surplus unemployed population), heightened pressures by elites (Kaufman 1996: 13-14).

By the 1960s, when more sophisticated contraceptive technologies had become available, the shift had certainly taken place, and a strategy that had been used by governments to limit the fertility of unwanted social groups (Knudsen 2006) in this case, using hormonal contraceptives in the predominate form of a Long Acting Contraceptive (LARC) namely, Depo Provera injections, and the pill were made freely available to the Black population (Baldwin-Ragaven, Gruchy and London *et al* 1999). Black social movements had already been public about their suspicions of a sterilising extermination campaign (Kaufman: 1996). At the time, "overpopulation [globally] had been blamed for everything from increased poverty, high unemployment rates, and overtaxed social services to degradation of the environment, famine and genocide" (Knudsen 2006 3-6). The other mechanism conveniently available to the government to avoid the "obvious political nightmare" from a population control policy, was its pre-existing "front" (Kaufman 1996: 26). Its *indirect* subsidy to the non-governmental Family Planning Association [FPA], the "predominantly English-speaking white liberal organization" established in the 1930s was an obvious tool to be expanded (Kaufman 1996: 26). In the 1960s, the government increased funding for "FPA clinics and…local authorities and provincial administrations, and funds explicitly supported services for Africans" (Kaufman 1996: 33). The higher-level subsidies and expansion to broader support for governmental authorities seemed to be a precursor to the "nationalisation of family planning services" (*Ibid*). By the late 1960s, the government began preparations to launch a national program and "slowly appropriated" FPAs' "family

planning clinics throughout the country to render its own services"
(Kaufman 1996: 30). In 1974, at the opening of the parliamentary ses-
sion, the Prime Minister announced the commencement of South Afri-
ca's state-run "Family Planning Program" [FPP], legitimating this by in-
voking "international population agenda" (Kaufman 1996: 36). The
"budget allocation for family planning services" was "substantial" con-
sidering inflation until 1990, and "continuously increased" until 1991
(*Ibid*). Unlike any other health program of the time, the national birth
control program's budget–which largely aimed to limit the Black popula-
tion–was "increased thirteen times" in its first decade (Brown 1987: 264).
The Health Minister promised Parliament the "only hindrance to the
programme's success would be the 'popular' prejudice of the 'heteroge-
neous population'" (HAD cited in Brown 1987: 264). The state's fervent
investment in birth control created a situation where "family planning
service points" outnumbered reproductive health services by more than
50% (Brown 1987: 265-266). Unlike healthcare, the birth control pro-
gram had no staff shortages, and included over 1,000 educators to con-
vince women of the benefits of family planning (*Ibid*).

3.3.3. Depo-Provera, the 'Fourth Stage of Labour'

At the time that the program originated, Depo-Provera was offered
free of cost especially to Black women, though the risks associated with
the LARC were raising controversy. For example, the U.S. Federal Drug
Administration had banned the contraceptive as a result of its risk fac-

tors (Goodman 1985). The women's movement in India successfully prevented its government from including the drug in its contraceptive program. This was in part due to an epidemiologists' work, who later conducted an in-depth analysis of the potential risks associated, to find that Depo-Provera could contribute to infertility, and create conditions for mortality in breastfeeding infants and malnourished women, among other adverse effects (Sathyamala 2000). Despite these warnings, its use in South Africa went forward, has been sustained, and is the main contraceptive method used in poor Black communities today (Towriss 2016). The reasons for this decision, are the drug's efficacy, and ease of use; only one injection is required, every three months.

Analysis of the program has found that not only was the method-choice limited, it was also, commonly coercive. Data reveals varied accounts of coercion from different parts of the country. Brown (1987) as well as Baldwin-Ragaven, Gruchy and London (1999), found that "voluntary" injections had become a requirement for factory employment for Black women. In the context of wide-spread social exclusion and economic deprivation, the authors found women conformed to the requirement, in order to stay employed.

The coercive design of the program is evidenced by this employer behaviour, and more importantly from the results of the program's targets. Several scholars have found that the practice of midwives dispensing Depo-Provera immediately following childbirth without acknowledge-

ment, has been, and remains widespread (Kaufman, 1996; Baldwin-Ragaven, Gruchy and London 1999; Towriss 2016). This practice, what I maintain to be a routine form of "obstetric violence," became so common that it was referred to as "the fourth stage of labour" (Kaufman 1996). Indeed, I found that more than twenty years after the dismantling of apartheid-health's family planning program, this continued to be a routine practice, week in and week out, in more than one of the primary care hospitals participating in my study. Still, it is important to note that recent research into HIV+ women's contraceptive method choices has found that when women do request a certain method, often they are administered another, and this isn't necessarily a more long-acting or invasive method (Towriss 2016).

Further evidence that the apartheid government was willing, and in fact interested in deploying methods of population control, are found in Truth and Reconciliation Commission testimony, and subsequent research. Two scientists working on the Apartheid state's Chemical and Biological Warfare research project (CWB), testified that "fertility and fertility control studies comprised 18 per cent of all projects" (Schalk van Rensburg TRC transcript cited in Gould and Folb 2000: 18). These testimonies confirmed that the purpose of the fertility project, in the view of the military, was to prepare a contraceptive for women that could be administered "selectively" and clandestinely, so that she would not become aware of it (Gould and Folb 2000: 18; for details of the project see also Purkitt and Burgess 2002; Purkitt and Burgess 2005).

3.4 Conclusion

By linking the dehumanisation of the system of slavery, and the objectification, (especially of Khoekhoe women) through racist speculative science during the earliest phase of colonial conquest in South Africa, I have traced those structures that entrenched racial and gendered structural violence, and that facilitated the 'colonial/modern gender system' in South Africa (Lugones 2008). In addition, I have argued the wilful manipulation and denial of quality health services to Black people, were forms of social control and malpractice for instance, as justification for forced removals, and the surveillance of pregnant women, requiring them to pass through checks point, in order to access health services. Additionally, health services, when made available to Black people, were shown to often be coercive and disciplining. This chapter has also demonstrated that the co-option of midwifery, reproductive health and family planning services by the apartheid regime, ensured that medicine fulfilled the government's racist agenda. In doing so, I have identified several important factors that inform my understanding of the persistence of obstetric violence, and South Africa's epidemic of gender-based violence, more broadly.

The first of these is the discourse surrounding the hyper-sexualisation of Black South Africans, especially Black women, which have been consistently deployed to rationalise sexual violence, to the point where this became accepted practice during and after slavery, and continues to be a

narrative used to obscure obstetric violence in the democratic era. Secondly, I posit that the association between Black people and disease, has facilitated the use of public health policy as a justification for questioning, and denying the humanity of Black people. (The connection between these ingrained associations and contemporary practices of violence during childbirth are analysed in detail in Chapter 5). I draw out how from the commencement of the profession of midwifery, it has been subordinated within the field of medical practice by male doctors, in order to secure their control over women's knowledge, health, bodies and finally, over midwives' earnings. Therefore, I argue the institution and profession of midwifery has originated in South Africa on the basis of controlling reproduction, and the destruction and devaluation especially, of Black women's knowledge and practice. I have argued that by midwifery having a subordinated position within the medical hierarchy, limiting the power of its practitioners both epistemologically and as a profession caused vulnerability to its health services being used as "moralising tools," and the facilitators of coercive population control. (I will argue in Chapter 6, that the limited power of midwife clinical managers to control health services, contributes to present vacuums of accountability).

Finally, I have demonstrated that social norms attendant to race, gender, class and sexuality, have been continually repeated since the colonial period in South Africa. This has carried generational impact for society, and for notions and provisions of healthcare, from the era of racist science, to the introduction, and mass distribution of contraception. Collec-

tive violence that attacks the womb, the central location of the reproduction of the body, is a violence not easily repaired, or recovered from. This chapter has shown that the impact is lasting because institutionalised deprivation, and intentional biomedical malpractice are difficult to uproot. In conclusion, the social, economic and political foundations of the "modern/colonial gender system" in South Africa has been exposed as a constitutive part of public health services over centuries, which in turn, has led health services to contribute to the dehumanisation, dispossession and control of Black women. I have argued that discursive "colonial body politics," and character myths of hyper-sexualized, dirty, diseased people, subordinated professional positions, and social controls in the form of dangerous medical technologies, have contributed to ingrained racial, and gendered structural violence. The legacies of this colonial era, as I will elucidate in the subsequent empirical chapters, are extended through the Obstetric Structural Violence that characterises democratic era maternal health.

4 The Political Economy of Reproductive Health

4.1 Introduction

The circumstances in which people are born, grow up, live, work and age, and the systems in place to address illness are widely accepted as the 'social determinants of health' (WHO 2016: 30). While, the extant literature has shown obstetric violence can be found across social markers and quality of development, it has also shown that those socially excluded, poor, subordinated and discriminated against are the most likely to be subjected to this violence (WHO 2015: 1). The previous chapter demonstrated how health services, professions, health policies and practices were inscribed with colonial and apartheid historic orders attendant to race and gender which shaped and were shaped by notions of sexuality and the exploitation of Black people's labour. This evidence established the scope, forms and normalisation of violence against Black women, and the Black population more generally during the colonial and apartheid periods.

Building on these ideas, the suggestion of scholarship on obstetric violence (CRR, FIKA 2007; Bowser and Hill 2010; Sanchez 2014: 50; Freedman *et al* 2014; Freedman and Kruk 2014; Dixon 2015; Honikman *et al* 2015; Sandler *et al* 2016: 51), and especially the well-established feminist argument that reproductive freedom and 'socio-economic conditions' are interdependent (Davis 1983; Roberts 1997; Qadeer 1998, 2005; Silliman and Bhattacharjee 2002; Rao 2004; Silliman, Fried, Ross and Guiterrez 2016; and Ross and Solinger 2017), this chapter interrogates the relationship between obstetric violence and the political economy of the social determinants of health. Additionally, I take this focus to situate the broad current crisis in the public health system in relation to the continued inequitable distribution of health resources, and to explore what is driving the persistence of social exclusion, racial discrimination, and gender subordination that I argue contribute to the structural and obstetric violence in the public health system.

This chapter has two parts. The first situates the current crisis in the public health system in relation to the continued inequitable distribution of health resources, and explore what is driving the persistence of social exclusion. Through this analysis I posit the maintenance of dispossession and racial capitalism resulting from the transitional compromise, are they key factors that maintain the racial bifurcation of contemporary society. To situate these broad factors' impact on the bifurcation of society I turn to examining social determinants of health. Specifically, the "quadruple burden of disease", and risk of morbidity, are examined. During the initial period of political transition the South African government deployed

a social protection system, the relationship between resource constraint and social determinants of health. Social assistance through a cash grants program, as well as remedial efforts to redistribute health resources and increase access are considered along with measures of poverty. Examining the amelioration of health resource disparity, demonstrates how current policy exacerbates inequality by placing extreme burdens on the public health system. By interrogating the political economy of the social determinants of health, this chapter shows how some arrangements that fuel structural violence can be analysed. It also shows how such violence operates on a continuum of political, economic and social arrangements and norms to maintain a stability to its efficacy.

The second section examines the locations in which public primary maternal health services are rendered–where the majority of facility-based observation for this study occurred–and the majority of the health systems' patients and staff reside. Building on the analysis of unequal spending between the public and private health systems discussed in the first section, this section examines the funds lost to corruption. I draw on empirical and secondary data to situate the influence of persisting structural violence on patients' access, and the functioning of the public health system. General safety, food insecurities, and mobility are examined. This evidence demonstrates how the structurally violent conditions resulting from the persistence of social exclusion and racial and gender discrimination impact staff and patients. I propose that over the last twenty years, while progress has been made toward challenging the transitional constraints, the structures and outcomes of social exclusion that

together sustain the racial bifurcation of society, have not been significantly upset. This argument is supported by ethnographic data concerning the lived experience of material deprivation and spatial exclusion, which I show, routinely determines the access, and quality of public healthcare for Black women, as well as the majority of the Black population. This interrogation and instantiation of economic and political context leads to Chapter 5 which analyses the forms and operations of structural and obstetric violence found in the public health system.

4.1.1 Persistent Poor Social Determinants of Health

The distribution of resources to healthcare and the social determinants of health are analysed here to examine the sustained social bifurcation maintained by the political arrangement of the transition discussed above. Specifically, the "quadruple burden of disease", and risks of morbidity are raised to interrogate the role race has in persisting a bifurcation in life chances, and if race remains a defining marker of South Africa's structurally violent context. To understand the role the government has in relation to its mandate to transform the inherited context of structural violence a key remedial effort, namely the social protection system aimed to challenge inequity of social determinants of health is investigated. Attention to social assistance through a cash grants program, as well as efforts to increase access to health services are examined.

Since the democratically elected African National Congress took power in 1994 through a negotiated settlement (Neocosmos 2011: 368) poverty and inequality have been recognised as the country's key challenges (National Planning Commission 2011), research confirms the persisting depth of inequities (See Terreblance 2002; Nattrass and Seekings 2005 for detailed overviews).[27] Constituting and constitutive of this challenge is the "unusual" "quadruple burden of disease" South Africa began to suffer during the period of transition (Bradshaw *et al* 2003). This burden is derived from poverty and under-development related conditions resulting from colonialism and apartheid including: 1) an epidemic of tuberculosis TB, 2) high maternal and child mortality, injury (accidental and non-accidental), 3) non-communicable diseases, and post-transition, these three were joined by 4) an epidemic of HIV/AIDS (Bradshaw *et al* 2003; Weimann *et al* 2016). A rarely mentioned challenge is that South Africa has the highest incidence of Foetal Alcohol Syndrome in the world (Levine 2015 January). Especially notable for this study is that the majority of cases are found amongst communities of farmworkers in the Western Cape province (*Ibid*).

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[27] The transition from apartheid to democratic governance was settled through a negotiation (Bond 2000; Marais 2001; Welsh 2009; Neocosmos 2011). The political and economic arrangements of this transition continue to be contested today (See Welsh 2009: 526; Saul and Bond 2014), as well as the causes of the high-levels of sustained social exclusion (see Pityana 2015: 162-163; Hall 2004: 6; Aliber 2015: 160; Ntsebeza 2007: 126; Du Toit and Neves 2014: 839; Ramose 2007: 319; Ramose 2003: 551; Madlingozi 2017). While beyond the scope of the study to engage in this debate it is important to note that the majority continue to be dispossessed from land (Sibanda 2011: 142; Hall 2015: 140-141), and arguably excluded from control of the economy (Welsh 2009: 526).

The unequal distribution of this heavy burden of disease is another indicator of sustained social exclusion, and the extreme vulnerability challenging especially poor Black women and their families. A study of trends in mortality from 2000-2012 found this quadruple burden remains disproportionate by race. For instance, the Black African majority has continued to have the greatest risk of HIV/AIDS and diarrhoeal disease in the top ten causes of death, while these risks don't feature for Indian and White groups where rather renal disease is one of the trop ten causes of death (Pillay van Wyke *et al* 206: e649-e650). Another stratified difference is that TB and interpersonal violence are not features of mortality for the White population (*Ibid*). According to the National Planning Commission, there has been a "dramatic increase in AIDS-related deaths among young adults", and since 2007 young women have been more likely to die than young men (NPC 2011: 20). Public maternal health services have begun to play a more significant role in AIDS preventions, as it is often the first place for HIV, hypertension and other diagnostic testing for women (Cooper, August 2017). It is the women that disproportionately faces the quadruple burden of disease, who rely on public health services who are according to the WHO 2015 statement are the most vulnerable to harm during maternity and childbirth. It is accepted that health suffers when the circumstances in which people are born, grow up, live, work and age are characterised by economic poverty, and when the health system is of a low quality or not accessible. The consistent differential in causes of morbidity thus further confirms the sedimentation of disparity relating to the intersectionality of gender, race and class which has persisted since the political transition. In this way Black

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women continue to disproportionately face poor social determinants of health.

Scholarship continues to contest what the political and economic arrangements are that encourage the persistence of extreme social exclusion into the democratic era, some posit democratic era macro-economic policies focused on economic growth rather than on closing wealth inequality (Coovadia *et al* 2009 817-34; Mayosi *et al* 2012), while others argue foreground a continuation of control over the economy by the private sector is to blame (Welsh 2009: 526). My interest here is not to enter this debate but rather to analyse the constrained context and what affect it has on public maternal health services, and those who depend upon on, and work within the system.

A key aspect shaping this context is the system of social protections the Government has increasingly used to respond to the challenge of the unusually extreme, and unequally distributed burdens of disease. The objective of this system has been to address inequality by distributing resources to especially address the poor social determinants of health, and the resultant high rates of morbidity and mortality experienced by the majority. In the first five years of the transition the government passed a set of legislations aimed at dismantling the legal, institutional, and infrastructural factors enabling the health service's contribution to structural violence (see Gilson and McIntyre 2007: 675 for an overview of legislated reforms relating to healthcare). In addition, it created a so-

cial protection system. To date this includes: free basic public education, free primary public healthcare, with advanced service costs based on income, along with a range of 'means tested' social grants.[28] Important to this study is the key policy that rendered public health services to be no cost for pregnant, and breastfeeding women and for children under the age of six (Mkhwanazi 2014: 330). For a comprehensive overview of policy changes to reproductive health over the past twenty years see (Cooper *et al* 2004: 72; Cooper *et al* 2016).

The creation of a unified public health system increased utilisation of services. For instance, according to the General Household Survey released in 2016 70,5% of households expressed they would attend public clinics or hospitals upon the onset of seeking care (Statistics South Africa, SSA 2015: 21). Reporting the same year, other sources account for at least 80% of the population relying on the public health system (USAID 2016: 2; Minister of Health 2016). Sources confirm 27,7% of households consult a private doctor, a private clinic or hospital; it is useful to also note these percentages have remained relatively consistent since 2004 when the state first began to collect this data (Statistics South Africa 2015: 21; Minister of Health 2016). Traditional healers were reported to be the first healthcare provider to be consulted by only 0,5% of respondents (Statistics South Africa 2015: 21). Therefore the public health

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28 A key challenge to these protections is that the quality of basic public education and healthcare has become increasingly poor. In South Africa social welfare claimants are 'means tested' to determine eligibility. If one is able to prove with documentary evidence that they are beneath a certain poverty level they qualify.

system is by far the main provider of healthcare. Furthermore, Dr. Mkhize, Chair, ANC Health and Education Committee importantly noted another factor increasing the reliance on the public system is that many of those on medical aid (private insurance schemes) exhaust their annual allocations by mid-year, which causes a significant number of patients to return to seeking care from the public system, as the private hospital fees are unaffordable (2009 June), this was also reported to me by patient participants.[29]

The creation of a unified and more accessible public health system has had a significant impact on the utilization of maternal health services. For instance, approximately 92% of South African women receive antenatal care, and 89% give birth in a health care facility with skilled attendants (South African Demographic and Health Survey 2003, 2007). Due to the high utilization of services there has been great strain of the public health system resources. While this high adherence to the medicalization of maternity and birth are positive developments, the poor quality of the service has been noted by studies of patient experiences and numerous news articles (Kruger and Schoombee 2010; Human Rights Watch 2011; Chadwick *et al* 2014; Honikman 2015; Chadwick 2016). My findings relating to quality of care connected to obstetric violence observed within the public system, and learned through its management and governance processes will be discussed in the following chapter.

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29 Personal Interview, Patient Nadine Ismail, 15 November 2013.

As mentioned above the social protection system includes social assistance grants to date monthly cash grants of South African Rands, 380 ZAR ($28) are provided to: children through their primary caregivers by the Child Support Grant, CSG from a child's birth until the age of eighteen,[30] a Foster Support Grant to support guardians who have taken responsibility for orphaned children until the age of twenty-one, an Old Age Grant (pension), a War Veterans Grant and a Disability Grant (National Planning Commission, NPC 2010: 28; Davis *et al* 2016: 325). It is important to note that while the social assistance program provides support for poor children it does not provide support for their caregivers, not even the 5 millions of whom are 'lone mothers' (Wright *et al* 2014: 222).[31] One constraining material implication this creates is caregivers being put in the position to choose between supporting their own basic needs or their child's (see Wright *et al* 2014 for this impact on women's dignity). Some lone mothers gaining support from the CSG for their children reported the small size of the grant to signify that the government has little consideration for their dignity, in terms of their worthiness for support (Wright *et al* 2014: 224). This is an all to familiar out-

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30 The Child Support Grant, CSG has been increased consistently in order to have an impact on inequality and poverty reduction as evidence has continued to show the amount of investment to be insufficient. The CSG was first dispensed in 1998 providing R100 per month for primary caregivers until the age of seven. As social grants showed a positive impact on absolute poverty both the age and amount of coverage was consecutively increased between 2003-2014 (Davis *et al* 2016: 311). The scheme promotes developmental conditions through a school attendance requirement (Davis *et al* 2016).

31 Lone mothers are defined here as, women caring for children (biologically related or not) in their home without a caregiving partner in the household.

come of the impact gendered structural violence has on caregiving and caregivers, it degrades their self-worth, Chapter 5 picks up on this by showing how these notions are coupled with moral arguments to punish and control women for their sexuality.

Furthermore, the government's lack of provision for caregivers substantiates Anderson's assertion that where structural violence permeates societal structures, its being "obscured from view" shapes policy response (2015: 7). In other words the policy response itself perpetuates inequality. Adding confirmation to this analysis of the way structural violence operates is that a grant assisting single mothers had been in place at the point of transition and in 2001 the government dissolved it (Lund 2008). The reason given for eliminating this assistance was that the granting system had been established in the 1930s during the colonial and apartheid eras as an 'affirmative action'-like policy originally exclusively for White mothers and, despite eligibility being made progressively available to poor families of all racial groups in the 1990s it, like other state services required an administrative process of deracialisation which in the late 1990s was deemed too costly to carry out (*Ibid*).[32]

Despite these interventions being made early on in the transition, in the first decade of democracy, unemployment rose, thereby reducing income, worsening poverty, and increasing inequality (Samson *et al* 2002). As of 2010, the government was spending 3.5% of GDP on social grants

32 For a detailed explanation of this decision also see Kabeer (2008).

(NPC 2010: 28). Currently nearly 17 million people receive social grants the vast majority of grants are received by female-headed households as compared to male counterparts (47% vs 17%) respectively (Reinhard *et al* 2015 cited in Cooper *et al* 2016: 80). The government's aim now is to incorporate beneficiaries by decreasing the social exclusion of deprivation, and to offer recognition and dignity to those historically denied it through social protections (Wright *et al* 2014: 227). Notably, the Child Support Grant has the largest number of recipients, over nine and a half million (*Ibid*). The provision of social securities to the whole population along with the cash transfer program *has* had a direct impact on reducing absolute poverty (NPC 2011: 9), particularly the Child Support Grant (Neves *et al.* 2009; Patel *et al.* 2012 and 2013; Martin 2014; Wright *et al* 2014*;* Davi*s et al* 2016). The issue is that the improvement of quality of life has been nominal especially in relation to the disparity. The reduction was demonstrated by a rise in per capita income and a corresponding decrease in the percentage of people living beneath specific poverty lines. While South Africa does not have a single official poverty line, $2 a day (or 524 ZAR a month per person), provides a rough guide.[33] For example, using this baseline the National Planning Commission compared the proportion of people living below the poverty line in 1995, estimated at 53 per cent, with those in 2008 estimated at 48 per cent (2011: 9). This is a very high level of poverty for a middle-income economy.[34] Moreover,

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[33] The most recent data correlates to 2010 prices.

[34] Adding to this context is the high rate of unemployment. Paul Hendler finds that only 15 percent of South African households have a monthly income exceeding R15,000 ($1,100) enabling purchase into established primary and secondary housing markets (2015: 93). Conservative official unemployment estimates (defined by those

the most recent General Household Survey found 22.3 per cent of households have an inadequate or severely inadequate access to food. Notably this only decreased 1.6 per cent in the last six years (Statistics SA May 2016). Despite the government's protective efforts the distributive outcomes remain nominal aside from their ability to soften the most severe, and absolute poverty.

That distribution of per capita income has remained deeply unequal consistently, aggravating the circumstance of poverty (Marais 2001; NPC 2011). Though a segment of the Black population, has gained economic mobility, current figures corroborate a consistent inequity in income distribution. For instance, the most recent National Planning Commission found "the share of the poorest 40 per cent of the population in national income has remained largely stable at about 6 or 7 per cent" and "the poorest 20 per cent of the population earns about 2.3 per cent of national income, while the richest 20 per cent earns about 70 per cent of the income" (2011: 8). Here the 'poorest 40 per cent' refers to those surviving on $2 per day, while the 'poorest 20 per cent' refers to an income poverty line measured as those surviving on less than ZAR149.08 ($11) per person, per month (National Planning Commission 2010: 26). Thus, over half of the population lives on an income of $11- 60 per month. The structural violence determined by race is aggravated by gendered

seeking work) find 27.7 percent, applying the expanded definition–those unemployed and not working informally– this rises to 36.4 percent (Stats SA 2017: 10-11). The vast majority of working age people not enrolled in education and unemployed are Black (Stats SA 2017: 81). Also in 2013, fifty percent of those formally employed earned less than $225 per month (Stats SA 2013).

structural violence, which heightens the challenges of poverty for women and women-headed households. Not surprisingly, rates of unemployment are higher for women, since they bear the brunt of domestic labour and child rearing which causes poverty to be disproportionate across gender lines (Stats SA 2017: 81). The result of women earning less than men is that women-headed households have higher poverty rates than the average (NPC 2011: 9). This unremarkable context of gender inequality "where such extreme suffering is not only tolerated but also taken as normal" is a clear indication of structural violence (Gupta 2012: 21).

A key example to understand how political and economic arrangements fuel structural violence, is that of state expenditure to health services. Funding for the public health system is 3.5 per cent of Gross Domestic Product (GDP), while funding for the private health system is 5 per cent of GDP an enormous amount considering how few have access to its service (NPC 2011:21). It is important to recall here that 70-80% of the population relies on the public health system. Furthering this bifurcation in resources is that eighty per cent of health specialists are employed in the more well-funded private system, leaving 20 per cent of specialists to face the "long queues" of the majority suffering the greatest burden of diseases waiting for care (Health Minister Motsoaledi, June 2016). Therefore, absence of human resources in the public sector is an issue of both historical and contemporary structural violence. On the one hand the denial of opportunity to the majority to gain specialist training, and on the other the skewed disparity of public funding away from the majority. Making this inequity worse is that the state funds over 40 ZAR billion of

private health system expenditure. Health Minister Motsoaledi, explains these subsidies result from, "20 billion ZAR in tax credits" resulting from "all who have joined medical schemes", and "26.7 ZAR billion" is contributed through the government's medical aid subsidies to state employees for their own contributions and contributions on behalf of their dependents to medical schemes (Presence, May 2017). In this way the distribution of state resources to health services remains unequal and in favour of the wealthiest segment of the population that bears the least patient burden, who also have a lower burdens of disease. As Bourgois and Scheper-Hughes have noted, violence is supported by the social acceptability of a moral economy (2004: 5). The Minister of Health has attacked the social acceptability of the economic and political norms allowing the government to perpetuate such structural violence by using such examples as, government policy subsidising "life saving health services" for the few "elite" while effectively "ignor[ing] the poor…as if they have no right to exist" (Motsoaledi 10 May 2016). Most recently, the Minister has revived efforts to end this convention through a revised proposal for a National Health Insurance, NHI program (NHI White Paper 2017). It is too early to tell if this proposed unification of the private and public health systems will gain the funding to be realised.

The sustained inequity in health service resourcing and social determinants of health evidences the failure of the political and economic arrangements in the democratic era to strengthen the position of, especially Black women. This review of the social determinants found that low-

income Black women face the highest rates of unemployment, risks of disease, disability and morbidity. Additionally, my examination of the social assistance through cash grants program aimed at addressing inequality has shown while the program has helped to reduce absolute poverty, its low monthly payments have not been significant. And in some cases mothers receiving the low remuneration of support for their children have found the small contribution to raise the degrading social and economic context they face. The evidence presented here substantiates how poor social determinants of health in South Africa pose particular challenges to Black women and their children, and that the current social protection system while an important intervention is failing to provide "social security".

Additionally, access to quality health services was shown to remain inaccessible to the majority. A major contributor sustaining this was shown to be the disparate government funding to private and public health systems. This provides further evidence that when structural violence is embedded in societal structures it becomes embedded in policy responses, where in this case government policy remains a barrier to challenging the bifurcation of health resources. These dynamics of the current political and economic arrangements shaping especially, low-income Black women and their families as well as the maternal health services they rely on are argued to contribute constraints which coupled with discriminatory social norms form a continuum of violence shaping maternal health services and consequently shaped by for example the fiscal policies causing disparate health resources. Where the consistency

of social exclusion in turn sustains structural violence of racism, which is exacerbated by gender structural violence leading to discrimination and subordination that contributes to structural, routine and egregious forms of obstetric violence.

4.2. 'Apartheid Health' Service to Public Health System

This second section of the chapter engages empirical data on the remedial interventions aimed to address what the Truth and Reconciliation Commission's Institutional Hearing on Health found was "probably the greatest problem in the health sector," namely "the maldistribution of resources" (TRC 4: 5 ¶31). The systematic denial of high quality health services damaged dignity along with physical wellbeing. Building on the previous analysis of unequal healthcare spending, this section examines the funds lost to corruption. This data is used to examine the infrastructural change from 1996 to the present of the inherited deprivation, remedial interventions and current unequal distribution of healthcare resources on the maternal healthcare system in the Western Cape metro. In this way it begins my analyses of how the lived experience of material deprivation and violence impacts the health system, staff, and patients in the democratic period.

By using the social determinants of health as a framework the remainder of the chapter's focus is on the locations in which public primary healthcare is rendered, which is also where the majority of the system's patients and staff reside. By examining what is often referred to as

the 'peri-urban' areas surrounding urban metros I am able to situate the lived circumstances in which many South African's are born, grow up, live, work and age, and in particular the locational circumstance in which primary care maternal health services provide care. Particularly I draw on empirical and secondary data to examine general safety, food insecurities, and mobility. I posit these social determinants provide evidence for how the continuum of violence operates through the persistence of social exclusion, racial and gender discrimination, and how these structurally violent conditions impact staff and patients. This section contributes to exposing the relationship between obstetric violence and poor social determinants of health in South Africa.

Broad redistributive and unifying interventions have been a necessity to desegregate the colonial and apartheid health services and enable the provision of healthcare services to the whole population. The aim of government was to unify the fragmented system it inherited and base a new unified system on a foundational Primary Health Care System. To expand access nationally, 1,345 primary care clinics frequently offering maternal health services were constructed (many of which were in townships that were previously excluded from healthcare) and 263 facilities were upgraded (Coovadia *et al* 2009: 828).[35] In terms of infrastructure this

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35 There have been distinctions made historically by the state, as well as changes in use by anti-apartheid movements between the terms 'township' and 'location.' The state distinguished between these terms to differentiate between the areas where they removed differently othered Black people. Social movements at times referred to these areas using an inclusive term to build political unity. Today colloquially these terms are used to designate several additional meanings. I use these terms

context meant that at the time of transition public maternal health services available to the Black population in the Cape Town metro were not adequate for the population's needs. Figure 2 (below) approximates these facilities and their segregated designated locations.

Figure 2. Cape Town Public Maternal Health Infrastructure 1996

Cape Town Public Maternal Health Infrastructure 1996

KEY
○ White area
● So-called 'coloured' township
● Black township
◐ Cape Malay area within a 'white' area

TERTIARY HOSPITALS
Groote Schuur — Tygerburg

SECONDARY HOSPITALS
Mowbray Maternity — Somerset Maternity (Shipley) — Helderberg

DISTRICT HOSPITALS
Karl Bremer — GF Jooste

PRIMARY COMMUNITY HEALTH CENTRES
Hanover Park — Heideveld — Retreat — Mitchells Plain
St. Monica's Home — Site C — Gugulethu

[1]This assessment is based partially on Van Coeverden de Groot, Davey, Howland (1982), Rip, Keen, Woods, Van Coeverden de Groot (1988), Rip, Hunter (1990), G. P. Cook (1992), as well as several personal interviews conducted for this study, especially Virginia Cloete, Women's Health Division, Department of Health 17, 23 May 2013; 23 November 2016. Diagram, author's own.

(Authors Own).

interchangeably to refer to the general areas where primary care health services are rendered, and to refer to the specific areas the four Community Health Centres in this study are located, this use additionally helps with anonymization.

The tertiary facilities at the top of the pyramid provide the most sophisticated health services that are carried out by specialists and advanced technology. The level of service is less specialized at the base of the pyramid, where clinics in the form of Maternity Obstetric Units offer primary care services. Patients could walk in to most primary care while access to a more sophisticated service requires a referral (and still does currently). Although it existed prior to this period, it is important to also mention Peninsula Maternity Hospital. Historically, Peninsula is important as doctors oversaw clinical management, and the hospital offered services to most races. It was located just outside the city center (which was a white area then) in District 6, which up until late apartheid was able to maintain a multi-racial residential population. St. Monica's Home was similarly located in proximity to town in the Bo Kaap, a Cape Malay neighbourhood. St. Monica's however, like the Midwife Obstetric Unit's (MOUs) commencing much later in the 1980s was operated by midwives. It was a maternity hospital rather than a clinic, founded in 1917 by missionaries with partial subsidy from the state. Peninsula and St. Monica's locations being in proximity to white areas is important as this meant prior to MOUs commencement, Black women had to be given permission to travel long distances through white areas to access maternal health care. Figure 3 illustrates the maternal health facility infrastructure in 2017 after the redistributive measures mentioned above had taken place.

Figure 3. Cape Town Public Maternal Health Infrastructure 2017

Cape Town Public Maternal Health Infrastructure 2017

KEY
- ○ Former white area
- ● So-called 'coloured' township
- ● Black township

TERTIARY HOSPITALS
- Groote Schuur
- Tygerburg

SECONDARY HOSPITALS
- Mowbray Maternity
- New Sommerset
- Helderberg

DISTRICT HOSPITALS
- Khaylietsha
- Karl Bremer
- Mitchells Plain

PRIMARY COMMUNITY HEALTH CENTRES
- Hanover Park
- Heideveld
- Retreat
- Mitchells Plain
- Macassar
- Vanguard
- Bishop Lavis
- Delft
- Gugulethu
- Kraaifontein
- Elsies River
- Site C
- Michael Mapongwana

(Authors Own).

By comparing Figure 2 with Figure 3 it is clear that since 1996 primary maternal healthcare infrastructure increased significantly in availability and proximity to those who were formerly excluded. This is important, as access to quality maternal health services is critical to preventing disease, as well as maternal and neonatal mortality (Chopra *et al* 2009). Early

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assessments during pregnancy improve maternal and child health outcomes, for instance by identifying complications, such as hypertension, and HIV. Additionally, testing for HIV during pregnancy allows for prevention of mother to child transmission, Prevention of Mother to Child Transmission (PMTCT) treatment to be accessed. Since 2002, PMTCT has been an essential and largely successful part of public maternal health services (Sherman *et al* 2004: 292). Availability especially proximate to where the majority reside allows for early assessment of the appropriate level of care. Correspondingly to expanding the system there has been an increase in the number of patients accessing public health services.

Expenditure however was not increased accordingly resulting in a decrease in per capita public health care expenditure from 1997-2003 (Cooper *et al* 2004: 73). Compounding the lack of allocated expenditure, and the unequal distribution of government resources between the private and public health systems is the significant portions of Department of Health budgets being lost to corruption. For instance, irregular expenditure according to the Western Cape Department of Health's annual reports totalled 119,200,000 ZAR in 2011/10 (DoH Annual Report 2011: 269), 168, 991,000 ZAR in 2013/12, (DoH Annual Report 2013: 444) and seven million eight hundred ninety-six thousand in 2016/15 (DoH Annual Report 2016: 165). Irregular expenditure is defined as spending that has occurred with discord to regulation. This spending is tracked, becomes flagged for investigation and if not pardoned by the relevant authority the Department attempts to recover it, or writes it off as irrecoverable (DoH Annual Report 2011: 301). Significant provincial

spending is associated with the actions associated with irregular expenditure, alleged and confirmed corruption, human resource irregularities, irregularity and/or non-compliance, theft, financial irregularities and nepotism (DoH Annual Report 2016: 223).

Notably, this sampling of budgetary findings demonstrates the province improved significantly between 2013 and 2016 in limiting irregular spending. Moreover, this evidence shows the deprivation of public health system resources arises from several interconnected factors. Firstly, limited resources at government disposal resulting from the negotiated compromise which maintained inequality in market holdings, secondly greater funding of the private health sector through national subsidies (both contribute to limited budgeting resources nationally), thirdly, provincial mismanagement of spending, and finally the human resources crisis (which as shown in chapter 3 arises from apartheid unequal development policies), is related to the remunerative and hiring constraints in the public system[36]. The remaining part of the chapter will analyse how this constraint of resources to public healthcare compromises services, staff and patients.

Figure 3 also illustrates the expansion in access included District Level services, this occurred when two district hospitals opened in 2012 and 2013. However, all other specialised services remain at a costly distance

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36 According to the annual reports cited here 2010-2016 poor remuneration was the reason given for at least 300 staff resignations consistently per annum.

from where the majority of the Cape Town metro population lives. Notably, Figure 3 illustrates the decommissioning of the first District Hospital, GF Jooste located in a black township. The next part of the chapter analyses this development.

Maternal Healthcare

To situate the meanings, impact and outcomes that are attributed to obstetric violence, it is necessary to understand the risks of maternity, and the services health systems provide to manage them. Understanding what maternal health care comprises is especially important as the care women require during their time of maternity relates to the level of risk they and their pregnancy may have. For instance, in South Africa if a woman is HIV+, but is relatively health she may receive care without requiring a doctor's examination. In this example though the woman has a serious chronic illness the health system affords her a maternity experience with the care of senior midwives. What access to health professionals different groups of women have is relevant for the analysis of obstetric violence as disparities in power between patients and health professionals, and amongst health professionals in the clinical environment will be different depending on the form of care a woman needs.

I raise this as I am contending the form of obstetric violence experienced by a pregnant women often relates to the level of care the she receives. For example, a woman could only be subjected to a hysterectomy, or an induced labour at tertiary level, but could be neglected during birth

or denied pain medication at any level of care. On the other hand, the risk of a newborn dying as a result of the neglect of a woman during labour at the primary level may be less than a newborn that is known to require a specialist doctor's attention. Thus, the impact and outcomes of forms of obstetric violence often not only depend on the vulnerability of the woman, but also the level of medical risk the mother and fetus experience during maternity. I provide a brief overview of what maternal healthcare entails to give the reader an understanding of what factors relate to the different requirements of care during maternity. This enables a deeper understanding of the types of medical risks and vulnerabilities different patients, and importantly, staff populations are facing. This is supplemented by Annex 2, which maps the types of medical service provided at each level of care in detail.

The details of the structure, resources and patient volume of care also offers insight to the value of the service, pervasiveness of structural violence, and the risks of obstetric violence. For example, the primary care services which have been expanded, as mentioned earlier are staffed by nurses and midwives. They are managed by an advanced senior midwife, while specialist doctors attend once a week or several times a month to screen high-risk ante-natal and post-natal patients who have been flagged for consideration of referrals for specialized services at a higher level of care. In this clinical setting it is rare to encounter health professionals who are male, or white. This demographic character is relevant as it changes the potential of power disparity. In relation to structural violence of deprivation the service and volume of work is relevant. MOUs,

similar to the more sophisticated levels of care offer antenatal and postnatal outpatient clinics, as well as 24-hour in-patient labour and postnatal wards. However, most MOUs have three beds for their antenatal outpatient clinics where specialized units typically have more, these clinics operate five days a week from 7:00AM – 4:00PM (officially). However, in practice most clinics regardless of level of care assess their last patients before 2:30PM. This will be analysed in Chapter 5. In MOUs usually three midwives, one professional nurse, and one nursing assistant staff these clinics which serve 230-280 outpatients per day, five days a week.[37]

At hospital levels specialist doctors oversee these clinics which are often staffed by medical students and doctors who are training for specialization. The professionalization and authority of the medical professional also has an impact on disparities in power. At the primary level, the daily numbers above include at least thirty 'new bookings;' women seeking service for the first time during a pregnancy. Their initial assessment and diagnosis determine their likely delivery date and what level of service and facility they are referred to for their delivery. Patients booked to deliver at a primary level labour ward are those who have minimal complications, and are presumed to be able to labour naturally without a need for medical intervention. Everyday between four and eight women or

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37 As of 2011 clinics servicing these large patient loads, which are the largest in the province are allocated four midwives, three nursing assistants and one professional nurse posts. CHC Memo, Sub-structure Director, Dr. Jeffery Vlok, 1 July 2011. However, staff shortages remain common, for instance one of the MOUs in the study has had 2 midwives staffing the clinic for twelve months, Personal communication, Midwife, Sofia Moses, 20 November 2016.

girls deliver in a primary care MOU. In other words, the creation of new life for six–eight families per day depends on these units' care. With up to 1,400 outpatients relying on five nurses per week it is clear that while the expansion of primary care has improved access, the incredible pressure and responsibility placed on nurses which compromises the possibility of quality care directly relates to constrained and unequal expenditure, and the lack of human resources ensured by historical social exclusion. I argue these three factors contribute to the structural violence of deprivation in the health system. This argument is expanded on in Chapter 5.

4.2.1 G.F. Jooste: The Birth and Death of a Hope for Services

The case of one mid-level care facility is illustrative of the continued struggle of the Black population to access health services. G.F. Jooste, the first District Hospital located on the Cape Flats opened in 1996. This is evidenced by a comparison of Figure 2 and Figure 3 above. However Figure 3 shows it was decommissioned.[38] I provide an analysis of this "disposal" to show the complex challenges to healthcare access (WC Annual Report 2014/15: 156). this case adds to growing evidence that quality of care has deteriorated and initiatives to expand services "have been largely uncoordinated and poorly monitored" (Moleko, Msibi, Mar-

38 The Cape Flats refers to the flatland area where the majority of Black people in Cape Town were forced to live during colonialism and apartheid and where the majority live to date.

shall 2015: 26). Specifically, it demonstrates that poor planning and likely corruption are compounding the economic constraints discussed previously. This case also demonstrates the social exclusion faced by Black communities, including leaders of civic organizations mandated to participate in oversight and management of health resources. This example also shows how resources continue to be removed and excluded from Black communities, which reflects a continuity in the structural violence of deprivation, and racial discrimination.

In 1996 under African National Congress, ANC rule (of both the province and the city), G.F. Jooste Hospital opened in Manenberg.[39] In its short tenure Jooste would come to offer an advanced level of service for the first time on the Flats. The increasing sophistication of the hospital was due to the clinical and administrative staff's motivation and dedication to finding the means to provide a service that adequately met the uniquely quadruple burden of disease rooted in the patient population it served. The majority of Cape Town's population lives on the Cape Flats, and G.F. Jooste grew to serve "approximately 60% of the population" (Sattar, Mail & Guardian 14 July 2014). Due to the dedication of staff, location, level and volume of service it also became a teaching hospital (Western Cape Government, 9 September 2012). One former doctor called it a "centre of un-official academic excellence" (Sattar, Mail &

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39 The African National Congress ruled both the city and the province until 2006. In that year the Democratic Alliance, DA led the coalition running the city, and in 2009 took over provincial rule. The DA continues to rule both the city and province to date.

Guardian 14 July 2014). As a result many international clinical studies concerning TB and HIV operated through G.F. Jooste hospital (Bicanic *et al* 2009; Meintjes *et al* 2010). The hospital designated a district or level one hospital initially developed itself to offer a regional or secondary level of service, which made its official designation contested at times (Kevany *et al* 2009; WC Annual Report 2014/15: 240; National Department of Health nd: 6).

Until Khayelitsha District Hospital (KDH) opened in 2012 G.F. Jooste was the only advanced hospital in Cape Town located in the area suffering from South Africa's quadruple burden of disease. The perseverance it took to establish a hospital offering specialized services built a culture of camaraderie amongst its staff.[40] To have become a centre for international medical research offered within, and for the context of the excluded flats was a further source of pride for the staff (Sattar, Mail & Guardian 14 July 2014). To date Jooste remains the only 'secondary' hospital to have existed on the Flats in Cape Town. Throughout my research many health professionals held Jooste out as a unique for its culture where health professionals offered one another and their patients mutual respect. Some claimed this was a result of the hands-on work that was required for it to advance the hospital.

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40 Personal Interview, Emergency Medicine Specialist, Ziyanda Mlangeni, former medical student G.F. Jooste 5, July 2013.

In June of 2012 the Western Cape Provincial Department of Health informed the clinical Heads of Department at G.F. Jooste that it had decided to close the hospital in September of that year.[41] According to a former medical intern at the hospital who spoke with the Head of the Emergency Department at that time they asked, "'What am I going to do with my drive-by shootings? *trauma can't wait*'" (*Ibid*). Officials at the Department of Health responded by suggesting, "trauma services could be provided from a 'container' with two or three beds which can accommodate oxygen, 'if you are desperate to continue your department'" (*Ibid*).[42] By suggesting such a poor quality alternative to the Head of a Department the government administrator revealed there is little consideration for the reputation of public care services providing for the Black population.

Manenberg community organizations were also informed of the Departments' plans to close Jooste in 2012 through a presentation about upgrading it to a new regional hospital.[43] A former executive member of the Manenberg Health Committee I spoke with said, "Jooste was close by and accessible, with the struggle of unemployment we could make use of Jooste. When they told us the closure was in order to upgrade and

41 Personal Interview, Emergency Medicine Specialist, Ziyanda Mlangeni, former medical student G.F. Jooste 5, July 2013.

42 The container referred to here, is a modified shipping container. These provide basic infrastructure and are often used in the flats by individual entrepreneurs, and non-governmental organizations to operate small businesses.

43 Personal Interview, former executive member of the Manenberg Health Committee, Nadine Abrahamse, 6 July 2017; Personal Interview, Chair of a Manenberg development board, Mathew Jalil, 6 July 2017.

build a facility with more beds of course we welcomed this, but we didn't trust that they would, we have seen them put cream in our mouths and take away our services before".[44] A coalition of health professional bodies, Jooste staff and local and metro-wide community organizations was formed to oppose the planned closure (Bateman 2012: 823-824). The Chairman of the South African Medical Association SAMA (a member of the coalition) remarked that consultation with communities and medical staff had been, "appalling. …doctors and nurses are about to embark on a process of being re-assigned, or retrenched. Retrenching them is absurd" (Mtyala, Times Live, 11 September 2012).[45] One former medical student said, "What saddens me is that, while there is a lot of improvements, services are getting taken away and are getting worse. I don't see the Department closing hospitals in Claremont and Table View [both historically white-only areas], …not taking consultants away in these areas. The same inequality is being perpetuated but in a different way. They say they are making services better but they are removing care at the most needed level".[46] That the decision was made to dispose of the hospital without transparency and consultation demonstrates the lack of respect and commitment to those racially discriminated against and socially excluded. Furthermore, the ease with which the government deprives the Black population with the resources necessary to improve their life

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44 Personal Interview, former executive member of the Manenberg Health Committee, Nadine Abrahamse, 6 July 2017
45 SAMA is the professional association for South African doctors.
46 Personal Interview, Emergency Medicine Consultant, Ziyanda Mlangeni, former student G.F. Jooste 5, July 2013.

chances that by law they are entitled to, demonstrates a continuity of structural violence that enables extreme deprivation.

The medical fraternity and community managed to prevent the hospital's closure for an additional year and seven months. G.F. Jooste was officially "dispos[ed]" of in July 2014 (WC Annual Report 2014/15: 156), some equipment was donated to the closest Community Health Centre (WC Annual Report 2012/2013: 468), and the "vacated" building was "handed over to Property Management" (WC Annual Report 2014/15: 18). In 2012 when the planned closure was announced the reason given was that a 'new' regional hospital was to be rebuilt on the same site by 2016. At the time of the WC Department of Health annual report for 2012/13 printing Jooste was reported to be built by 2018 (p. 267). Civic organizations requests to rent the building for their services was denied, and the hospital stood vacant without any demolition or construction.[47] In July 2015 the Member of (provincial) Executive Council, MEC of Health, Nomafrench Mbombo, responding to press inquiries about the Department's security company colluding with thieves to loot the hospital, explained the delay of progress with Jooste was due to a "business case" needing to be priced to decide on re-allocating the hospital (Abbas, IOL News 23 July 2015).

At the same press conference the city disclosed the site would now be used by the South African Police Department, SAPS for a new training

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47 Personal Interview, former executive member of the Manenberg Health Committee, Nadine Abrahamse, 6 July 2017.

college (*Ibid*). A spokesperson for the Provincial Premier responding to inquiries about how the city gained a lease for a training college said, "The Land is not being leased to the City, it is being **sold** to the City at R100 [$7]".[48] Community leaders responded to this theft and misuse of their health resources with protest and outrage, one leader stated, "We reluctantly accepted the hospital closure, we know a bigger hospital is needed for dignified treatment where we can feel human, but what they are doing is underhanded, we can't get hold of title for our own homes yet the province can sell Jooste and its' land title for 1!" ZAR.[49] The province's scheme to repurpose the building and land without consultation, by basically giving it away highlights the entitlement the state posses to exclude and manipulate those vulnerable due to exclusion and poverty.

The province has backed out of its' plan to sell the land for a police academy and is considering sourcing other land for a new regional hospital which is being called, "Klipfontein Regional Hospital" the land proposed to house the new hospital is currently occupied by an operational high school in Manenberg, estimated construction will begin in 2020 (Mayors Urban Regeneration Program, 28 June 2017). As of July 2017 G.F. Jooste only consisted of one 200 meter brick wall on a completely emptied grounds. According to the chair of a Manenberg development

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48 Emphasis retained, Personal communication, Spokesperson for Premier Helen Zille, Mathew Majavu, 12 August 2015.
49 Personal Interview, former executive member of the Manenberg Health Committee, Nadine Abrahamse, 6 July 2017.

board who upon noticing the theft of the hospital structures had confronted the security, "the government knew very well that without adequate protection the hospital would be stripped and seized by the poor, that happens across the country. It took months, and the government did nothing but let it go on till nothing was left".[50]

At the time of Jooste's closing it was servicing over one million, six hundred thousand patients annually. These patients, many of whom were managing chronic illnesses now had to find means to access services costing between R56 - R150 ($4-11) twenty minutes to an hour away (WC Annual Report 2012/2013: 468).[51] Meanwhile, in October 2012 the WC Department of Health had opened a level one district hospital in Khayelitsha, KDH, the largest township on the flats. This hospital was a flagship project, a large and impressive facility but only caring for the same number of inpatients as Jooste had (WC Annual Report 2014/15). In November 2013 another District Hospital was opened on the Flats, in Mitchells Plain MPDH, (WC Annual Report 2014/15). Both Khayelitsha and Mitchells Plain District Hospital's had significant problems when they opened and both only became fully operational after a few years.[52]

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50 Personal Interview, Chair of a Manenberg development board, Mathew Jalil, 6 July 2017.

51 The range in cost and time to destination expressed here varies depending on the time of day one would have to travel (private taxis are now charging R150 to transport patients for delivery and other emergencies in the evening) from Menenberg and which facility they could go to. Personal Interview, former executive member of the Manenberg Health Committee, Nadine Abrahamse, 6 July 2017.

52 For Mitchells Plain, these problems included the architectural design of the Emergency Trauma Unit. According to a specialist doctor who was consulting on the opening of the facility the unit was separated by an elevator from the only theatres to provide surgery, this distance took five minutes, which he explained can easily result in death or paralysis in the context of the traumas the unit will respond to. Per-

That for the second wealthiest metropolitan area in South Africa to require over fifteen years to open a stable advanced level one District hospital in an area that has been excluded from higher level health services begs the question are such developmental allocations merely palliative.

The analysis of the Cape Town metro health resources infrastructure illustrated that primary healthcare has expanded accessibility to the Black population. This case has shown despite that this, access continues to be constrained especially, for patients who require more sophisticated diagnostic and in-patient services. The decommissioning of G.F. Jooste hospital illustrates some of the ways in which access to advanced health resources have been undermined by the Provincial, Government and Department of Health's lack of transparency, consultation and seeming manipulation of health resources. I have argued these conditions not only sustain social exclusion, but also contribute to poor of quality care in the public health system generally including maternal health services. The next section evidences how the lack of accessibility can result in adverse maternal and especially neo-natal outcomes.

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sonal Interview, Gerret Cloete, Senior Specialist, Tertiary Hospital, Consulted on Emergency Unit at MPDH, 20 November 2013. Another problem was that telecommunications was not accessible within the hospital. According to a senior specialist working at the hospital on opening day in order for health professionals and administrative staff to communicate via cell phone they had to leave the building. Personal Interview, Senior Specialist, Zanele Madlingozi opening day, 12 November 2013.

4.2.2 Insecurity and Mobility

This section foregrounds the general local context in which the public health system operates. As previously highlighted, situating public health services, as well as the population it serves is necessary to understand the contextual influences on the quality of care. This is especially necessary in South Africa where public hospitals are responsible for responding to trauma cases resulting from an epidemic of violence which results in a death rate from injury that is "nearly twice the global average" (NPC 2011: 20). The Western Cape health system has good clinical outcomes when compared to other provinces (Department of Health 2011: 2). This is especially impressive when understood in the context of the prevalent violence this particular system is responding to. For instance, the South African Police Service's crime statistics which found Cape Town to have 52 homicides occur per 100,000 people; the highest rate of homicide in the country (Lancaster, Africa Check, 7 October 2015). As with other potentials "the risk of murder, and crime in general depends significantly" on one's positionality especially, race, gender, age, economic status and where one resides (*Ibid*). For instance, the crime statistics show the townships and neighbourhoods of Nyanga, Harare, Mitchells Plain, Gugulethu, Khayelitsha and Delft had the highest murder rates, not the mainly white, affluent areas of Cape Town (*Ibid*). It is in these over-crowded underdeveloped locations on the Cape Flats that Trauma Units respond to this scourge of violence, and Midwife Obstetric Units are lo-

cated. Importantly, these Trauma Units are where patients turn when they are denied access to MOUs. Several cases of such incidents will be discussed in Chapter 5. Therefore to analyse the violence occurring within the public health system it is first necessary to further place the insecure and violent locations that inform the service environment, staff, as well as patients. Through first hand accounts of the context of normalized insecurity the direct violences impacting the health system and endangering both staff and patients are examined. Doing so the chapter is able to identify how the continuum of violence operates multidirectionally. As a result of this non-linear pattern it is argued that structural violence is expressed through different forms.

The colonial and apartheid spatial design of locations maintains strict accessibility, where there are few entrances and exits, making townships easy to control. When first entering a location in the Cape Flats to visit one of the primary care hospitals observed in this study it was common to be met with sprawling shacks – small one-room dwellings constructed out of found wood, corrugated metal and stones – to fulfil people's desperate need for shelter. These neighbourhoods zigzag across a dirt landscape separated by foot-paths, occasionally wide enough for a vehicle. It is here in what is called, 'informal settlements' as well as in backyard dwellings (usually shacks), council owned houses and in private properties, that the hundreds of thousands of landless people in Cape Town live (Abbas, Cape Argus, 20 April 2016).

Sanitation for most informal settlements in the Cape Town metro remains as it was under colonialism and apartheid in the form of a 'bucket system' (Social Justice Coalition 2014). According to the City of Cape Town's 2013 Water Services Development Plan, "77,783 households" in informal settlements are not serviced or underserviced with sanitation (Brodie, Africa Check, 7 June 2013). When functioning, which is not always the case, buckets are collected for emptying and empty buckets are provided. These and other sanitation issues are exacerbated by additional conditions specific to the Western Cape. For instance, municipalities failure to provide adequate waste disposal services to poor communities where rodents are prevalent, along with the widespread use of "aldicarb" in the nearby wine production sector drives a "booming illegal trade" in this chemical (Levine 2016). These "acutely toxic pesticides are illegally decanted and sold" at "train stations, informal markets and taxi ranks" (Rother 2012: 486). The chemical is colloquially known as 'two steps' in reference to how many steps rats and mice take before it kills them (*Ibid*). Township residents use this chemical to control "poverty-related pests" applying it to garbage dumps in order to especially keep rodent infestations at a minimum (*Ibid*). These granules have been found to cause poisoning in children (*Ibid*).

The context described here in which the extremely poor in South Africa are forced to live demonstrates the *normalization* of structural violence. These poor conditions are part of what increases the morbidity described in the first section for the socially excluded. Staff regularly remarked on insecurity, especially relating to patients economic positions,

about travelling to and from work, concerns for their own safety in relation to allowing 'companions', (a mothers' chosen person to support their process of childbirth), specifically fathers and men into the Unit, and for me as a foreigner regularly accessing the insecure environments of the locations. It is not uncommon for robberies, and shootings in and around Community Health Centres to affect the daily routines of service delivery. During the seven months of the majority of my facility-based observation I found such everyday violence to cause absenteeism, and services to be redirected to other facilities on a few occasions. The reflections of a Managerial Consultant who was involved in a three-year behaviour change intervention to improve the quality of service in the Metro District Health System best captures this atmosphere and level of precarity.

When I got to the hospital I was minding my own business, just oblivious to the danger around me. I was escorted by …three very big men with bullet proof vests on. I was so oblivious of the risks. I even joked that I must be a very important person to have such an escort. They quickly let me know this was their reality, and this wasn't about me. It was quite something. So you imagine working there, and this is what you have to come to everyday. And also for their family to do deal with, because going in there is high risk everyday. In fact the facility manager was nearly shot a week before. I was sitting in her office, which was pre-fab and she showed me where the [stray] bullets came in, and what happened. There I am coming in with my key message and this is their reali-

ty. So you see, it becomes a bit difficult, how do you then sell this idea? …when they are just really trying to survive, quite literally.[53]

This reflection gives insight to the level of security some hospitals require in order to create a buffer to the everyday violences of assault, homicide etc. they are situated in. I have shown the continuum of violence is not uni-directional but multi-directional.

Access and Mobility

Another deterministic factor within this context of poor social determinants of health is mobility and transportation. As seen in the previous example mobility is key to determining access to health systems, for both patients and staff. A common example of how the continuum of violence is expressed through mobility is when a high-risk woman in maternity, (meaning her childbirth requires a District one or higher level of care) living in a socially excluded area requires accesses to her hospital. The high frequency of attacks on ambulances and paramedics has caused the WC Provincial Department of Health to require "police escorts" before dispatching EMS services to specific locations (Tswanya IOL News, 5 September 2016). At a community march demanding assaults on health workers to cease, the Western Cape Provincial EMS Manager, Phumzile Papu described the situation thus: "We are being attacked in areas where

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53 Personal Interview, Managerial Consultant, Janet Cloete 17, November 2014.

we are needed the most…these are not bread and butter problems: we are dealing with life and death" (Ntongana, Ground Up, 14 September 2016).

Here the excluded health professional is raising the fact that the problem preventing the service to solve mobility for patients is not government spending but rather the insecure locations where patients live. In other words, it is the violence people themselves are creating. This simplistic analysis ignores the complex ways structural violence operates. In my analysis, the violence that prevents Emergency Services from accessing a patient is connected to the continuum of violence which creates the conditions for Black on Black violence. Persistent social exclusion for instance through land dispossession and exclusion from the economy in addition to policy and corruption leads to a reinforcement of unequal spending on health care services. It is this context of inequity that repeatedly determines women in maternity labouring through childbirth on their own. It is my view that this is part of the continuum operating through maternal health services, which creates such "life and death" issues in the words of the Emergency Services worker (Ntongana, Ground Up, 14 September 2016).

This section demonstrated how the political economy of health has constrained both the remedial efforts to redistribute health resources in the democratic era, and contributed to poor quality of public healthcare services. Through a series of examples of the social determinants of

health including health system infrastructure, and high levels of violence and insecurity this context was shown to negatively impact access as a result of mobility for both patients and health professionals.

4.3. Conclusion

This chapter examined the political economy of the social determinants of health. The sustained inequity in health service resourcing and social determinants of health evidences the failure of the political and economic arrangements in the democratic era to strengthen the position of, especially Black women. This review of the social determinants found that low-income Black women face the highest rates of unemployment, risks of disease, disability and morbidity. Additionally, my examination of the social assistance through cash grants program aimed at addressing inequality has shown while the program has helped to reduce absolute poverty, its low monthly payments have not been significant. And in some cases mothers receiving the low remuneration of support for their children have found the small contribution to raise the degrading social and economic context they face. The evidence presented here substantiates how poor social determinants of health in South Africa pose particular challenges to Black women and their children, and that the current social protection system while an important intervention is failing to provide "social security".

Additionally, access to quality health services was shown to remain inaccessible to the majority. A major contributor sustaining this was shown to be the disparate government funding to private and public health systems. This provides further evidence that when structural violence is embedded in societal structures it becomes embedded in policy responses, where in this case government policy remains a barrier to challenging the bifurcation of health resources. These dynamics of the current political and economic arrangements shaping the capacity of especially, low-income Black women and their families as well as the maternal health services they rely on. My thesis is that these constraints coupled with discriminatory social norms form a continuum of violence shaping maternal health services and consequently shaped by for example the fiscal policies causing disparate health resources. This line of analysis argues that a continuum of violence controlling resources, brings about different qualities of life, and further contributes to structural, routine and egregious forms of obstetric violence, all of which is explored in the following chapter.

5   Structural and Obstetric Violence

5.0 Introduction

The previous two chapters have focused on how structural violence based on race, class, and gender are constitutive of South Africa's social and political contexts. I have argued the political failure to achieve historical justice and transform the distribution of material resources provides the foundation for these structural social forces to persist by shaping a continuum of violence. As health systems are products of their political contexts, and reproductive freedom is shaped by the sociopolitical context in which reproduction occurs both are thus subject to this continuum of violence. In this way I have begun to map the multiple and overlapping levels of violence shaping this continuum.

Chapter 3 established how societal structures of racial exclusion and dehumanisation converged with subordination and exploitation based on gender and sexuality. Particularly relevant for my analysis hereafter are the discourses attendant to race and sexuality that obscured and justified

violence against black women during colonialism. To examine the way in which the current health system functions, the previous chapter situated the system and the social determinants of health within the political economy of the democratic era. My attention to the political economy's relationship to sustained obstetric violence derives from the understanding that reproductive freedom is constrained by social discrimination, political, and economic conditions (Davis 1983; Qadeer 1998; Roberts 1999; Rao 2004; Harcourt 2009). Specifically, I argued the lack of historical justice and the embrace of neoliberalism has caused persistent deprivations in mobility and security fuelling a continuum of violence that effects health system functioning, as well as the lived experiences of the majority who are reliant on the public system. I also argue the general poor quality of infrastructure and deprivations of resources in the public health system has persisted due to the slow intervention to address the legacy of racialised infrastructural deprivation. Additionally, the public healthcare system's current lack of resources is exacerbated by the democratic government's provision of increased subsidies to the private healthcare system. This chapter particularly connects to existing theorisations about the production and reproductions of violence, and how local social contexts contribute to continuums of violence (Kleinmann 2000; Schepher-Hughes and Bourgios 2004), for as Schepher-Hughes and Bourgios remind us, violence is "nonlinear, productive, destructive *and* reproductive; … [v]iolence gives birth to itself" (2004: 1, retained emphasis).

This chapter expands on the foundations of the previous arguments by examining how the public maternal health service reproduces violence. Firstly, since my concern is how obstetric violence is generated and propagated, it is necessary to examine patients and health professionals' routine experiences of this system. In other words, how does the maternal health system contribute to violence? What are the forms, and scope of violent practice and behaviour found in maternal healthcare services? This chapter examines how resource constraints, and poor managerial systems and practices impact patients and staff. Secondly, I analyse the different forms obstetric violence often takes and how this relates to constraints in resources, power and discrimination.

The first section argues that the institutional regulation of access to care disciplines patients. I show that from a patients' perspective, access to care is associated with disorganisation, uncertainty, loss of dignity and subordination. Taken together, I argue, these experiences cause economically poor Black women to be subordinate, and accepting of low-quality care. Moreover, my analysis of the experience of nurses finds that resource disparities are compounded by a hierarchy of administrative and managerial power. This reveals how nurses' relation to the health system often reflects loss of dignity, and confidence in the system. My focus on power here foregrounds Chapter 6, which examines how power and accountability are managed and experienced in the health system, including the results of utilisation of legal means (litigation and arbitration). Furthermore, this chapter establishes how poor financial management, and (mis)allocation of funds leading to deprivations in resources, exacerbate

the continuum of violence by leaving both patients, and nurses to 'hustle for healthcare'. By hustle, I mean challenge, mediate and adapt, often by utilising non-formal resources and bending regulations.

The second section analyses a wide range of data on obstetric violence in the public health system in South Africa. By doing so I define the forms and scope of this particular violence against women. I focus the examination on how these relate to gendered and racial structural violence, and the subordinations and material deprivations that patients and nurses must negotiate. Furthermore, through an analysis of the psychological violence enacted on pregnant women by health professionals I demonstrate a connection between the routine tropes used to demean and scold black pregnant women today and those employed to rationalise and obscure sexual violence against black women during colonialism (Abrahams 2000; Baderoon 2014; and Gqola 2015). I argue, the temporal continuity shown in this discursive connection demonstrates the continuum attendant to gender, race, and sexuality, thus sustaining obstetric violence. Lastly, I discuss how patients and nurses challenge, mediate and adapt with this continuum to meet their respective needs, and responsibilities by regularly bending formal regulations. However, often their subordination renders these actions incomplete and at times coopted.

Theoretically the main contribution of this chapter is a critique and further development of the notion of obstetric violence, and an expan-

sion of the idea of structural violence. I argue that obstetric violence is enacted against women in at least four ways: (1) it endangers individual pregnant women *as well as* their foetuses or new-borns; (2) it often has a direct impact on her extended family; (3) it can be applied in a structural form impacting whole groups; and (4) it is carried out by health institutions, and or policy.

5.1. Resources and Quality Care

A critical ethnographic history of the struggle for inclusion of black nurses states: "Quality care is not possible without resources" (Foster 2003: 195). This statement encapsulates the general sentiment expressed by health professionals that I interviewed in seven public hospitals, as well as those von Holdt and Murphy interviewed in eight other public hospitals (2007: 312). The following is a survey of statements provided by midwives involved in my study: "How can we work without such basics like toilet paper?"[54] "The suction equipment is not working. A baby can have breathing problems. It will be your fault as a midwife. Patients know their rights these days, they will demand to know who was on duty, even if they get their lawyers, a registered nurse and not the facility will get the blame".[55] These reflections are concerned with how limited resources contribute to shaping the health system's working environ-

54 Personal interview, Midwife, Buhle Deyi, 21 September 2013.
55 Personal interview, Midwife, Mthwakazi Qumza, 22 August 2013.

ment, and nurse's anxieties. The lack of basic supplies reflected upon here as well as the lack of linen, and linen savers discussed in the previous chapter was so common in some hospitals it was as if the deprivation was a regulation. Nurses in these hospitals carried their own toilet paper. Along with the extreme delays in equipment procurement analysed hereafter, these inconsiderable indignities amount to what Fox Piven and Cloward (1971) refer to as "ritual degradation of a pariah class" (cited in Auyero 2011: 12). The midwives' reflections also express how lack of necessary resources constrains their ability to provide lifesaving quality care, and contributes to their stress.

Applying Bourdieu's theory of the manipulability of temporality and its relation to power (Bourdieu 2000), I argue the disparity in health resources and resultant extreme waiting, influences experiences of structural and obstetric violence. I am concerned with how distributions of health resources enforce a particular relationship between the operations of power and the experiences of time. Bourdieu argues, "making people wait… delaying without destroying hope… adjourning without totally disappointing" are integral parts of the workings of domination (2000: 228). The experience of people in need who are expected to wait patiently and compliantly for attention, for healthcare, even when they are in desperate need, illustrates their vulnerability in relation to power. This position can also be explained as a social exclusion from power. What I am proposing here is that the vast majority of people in South Africa can be characterized as a "waiting populace" (Comfort 2008: 45). In addition to restricted access to care, the vast majority relies on a health system

lacking adequate infrastructure, with poor clinician-patient ratios, and administrative management causing deprivations and extreme waiting. The state forces the socially excluded majority to wait not only for healthcare but in many ancillary arenas as well (housing relocation, and land distribution, for example). The concept that South Africa's socially excluded constitutes a "waiting populace" builds on the application of this theorisation in Latin America where the act of waiting "characterises the life of entire communities" (Auyero and Swistun 2009). By applying sociological theorisations of waiting to the ubiquitous problem of obstetric violence, I posit that where extreme waiting is characteristic of maternal health services similarly to South Africa, this form of subordination arguably contributes to causes of obstetric violence.

I engage with two key regulations determining the allocation of health resources in South Africa. The first follows longstanding rules of access based on geographical demarcations, while the second relates to the embrace of neoliberalism and its forms of management. The former regulation is summarized by a medical consultant: "Where you get to stay determines the service you get."[56] The aim of this regulation is to balance workload distribution by requiring patients to access primary health services prior to any higher level of care at the facility designated to them based on their home (or sometimes work) addresses.

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56 Personal Interview, Emergency Medicine Consultant, Ziyanda Mlangeni, 5 July 2013.

The analysis of the case of G.F. Jooste Hospital in the previous chapter, exemplifies the tensions in the medical fraternity and health system challenges arising from restricting immediate access. Some in the medical fraternity are of the opinion that distribution of services should reflect the locality of burdens of disease and patient volumes.[57] They argue that access to advanced facilities based on residency, in a society where domicile largely remains racially segregated, contributes to poor quality care (*Ibid*). This chapter expands our knowledge of these dilemmas by providing information and analysis of the impact on patients and health professionals. The latter method of regulation, fiscal constraint, was introduced in 2012 after a marked decline in revenue per capita and rising costs caused by the 2008 recession (Blecher *et al* 2017: 25-29). Assurances were made that certain areas of healthcare expenditure would be safeguarded; clinical staffing is one area noted to be set aside from the ensuing hiring moratorium (DENOSA 2017).

5.1.1. Issues of Access

My analysis concentrates on the outcome of the regulation of patient access to care based on residence. Attention is placed on two key outcomes challenging patients, and health system functioning: (1) how extended patient volumes cause congestions; and (2) the expense involved in accessing specialised outpatient care located at a distance.

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57 Senior Program Administrator, Dr. Tendayi Marufu, Sept 11 2017; Manenberg Health Committee, Nadine Abrahamse, 6 July 2017; Personal Interview Head of Department, Dr. Mohammed Zaini 25 August 2017; Ziyanda Mlangeni, 5 July 2013.

Access based on Residency

Patients "waiting" is widely experienced and recognized as characteristic of many public services across developmental contexts (Lipsky 2010). In South Africa according to a Senior Policy Director from the Western Cape Department of Health: "Waiting times are a consistent problem. The two top complaints are waiting times and staff treatment".[58] Too often an exhaustive wait is necessary to gain access to health services. In the well managed (relative to other provinces) Cape Town Metro District system exhaustive waiting translates to patients waiting to be seen by a physician for more than clinical staff's 12 hour shift, and even more than 24 hours.[59] The alternative is a patient having to return day in and day out before being attended to (*Ibid*). According to a national government commissioned intervention into South Africa's main developmental inequalities, significant waiting times commonly result in patients' health complications becoming critical, often to the point of death (Operation Phakisa 2014: 14).[60]

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58 Personal Interview, Sabashni Nair, Senior Policy Director, Western Cape Department of Health, 3, September 2013.
59 Personal Interview, Emergency Medicine Consultant, Ziyanda Mlangeni, 5 July 2013; Observation Delft 10 June 2013, Personal Interview Head of Department, Dr. Mohammed Zaini 25 August 2017.
60 Patients dying while waiting was raised by several participants in my study. Senior Program Administrator, Dr. Tendayi Marufu, Sept 11 2017; Manenberg Health Committee, Nadine Abrahamse, 6 July 2017; Personal Interview Head of Department, Dr. Mohammed Zaini 25 August 2017.

"Waiting" in part results from "patients overwhelm[ing] specific clinic[s] (thereby) creating imbalance[s] of demand", which was shown in chapter 4 (Operation Phakisa 2014: 10). Contributing to this problem is the distribution of health resources starting with the residency requirement, and the continued embrace of the legacy of a primary healthcare approach that contains specialised care within hospitals (Venter 2014: 40). While debates over models of primary healthcare are beyond the scope of this study it is important to note South Africa's challenge connects to its legacy of health system design.

I will now put forward a summary of the narrative of "Nadine," whose experiences of accessing high-risk ante-natal care for the first time illustrates that the number one complaint of waiting times, is compounded by the nurses' brusque interactions with patients:

I was referred to a [tertiary] hospital to the 2nd floor clinic, [from the primary care service] they said they made an appointment for me, and …it is so funny, there is no such thing as an appointment in public hospitals. So when I got to [the hospital] at 7:00AM for my 'appointment time' …it's …full of women -no air coming in– everybody is on top of one another, you're pregnant sitting on these hard chairs, I don't know, [what to do]. A woman told me I have …to get a folder. …So I have to go …sit in another long line to open my folder. So once the folder is open with all of my details I went back to …get told I don't have a urine test. They say, 'Go to the bathroom and find a sample cup'. And then a

Sister comes in and starts shouting, 'you are disgusting, you guys are disgusting, can't you read?' Then in Afrikaans, 'we have written up everything in all three languages and you guys still can't yet read. You are morsel!' Which means you are disgusting–messy. Eventually I could throw in my hospital card and… be in line. And I waited… I think till 12 or 1:00. I was frustrated…because these visits take all day, I am losing pay at work because all of this is before …my official maternity leave.[61]

This account of a first visit to a tertiary facility reveals how the routine practices of the public health system reinforce a social system that disciplines and demeans through waiting. By referring patients to a clinic and omitting or misrepresenting crucial information, keeping them waiting for extremely long periods of time, the health system is asserting that patients' own time, and therefore their social worth, is not valuable (Shwartz 1975 cited in Auyero 2011: 7).[62] In this way the non-negotiable wait becomes the disciplining agent of a racialised structural violence especially impacting those who are economically-poor. Waiting patients are quiet and mostly unaccompanied. Across my observations when patients interacted with health professionals, they were usually talked *to*, not *with*.

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61 Personal Interview, Patient, Nadine Ismail, Nov 15, 2013. In a focus group, a Community Health Committee, Chair, Betty Jaftha similarly reported "Staff don't explain appointment changes and referral process to patients which causes confusion and frustration to patients." 25 October 2013. A patient waiting to be transferred to a secondary facility for over 8 hours was not informed of any progress and why she was still waiting. Observation notes, 21 September 2013.

62 Poor administration of referrals, and managing such related documents have been found to be chronic problems that increase waiting times (Operation Phakisa 2014).

It is important to note, though this does not feature in Nadine's narrative, that patients, including pregnant and post-partum women begin to queue outside hospital security gates from as early as 4:00 am (Furlong 2015). One study of a clinic in the Western Cape found that 80% of patients arrived prior to the hospital opening (Operation Phakisa 2014: 15). The Chief Director of the Western Cape Department of Health echoed the analysis found in the literature on waiting when he remarked, "there is no dignity in so many pregnant women lining up and travelling at 6 am".[63] The "conditions" of waiting that women (including those in their final stages of risky labour, postnatal women and their new-borns) endure while queuing outside, "signal the official disregard for the waiting populace" (Comfort 2008: 45). Nadine's further experience of her last visit to the ante-natal high risk clinic is representative of my observations and many of my brief patient interviews:

My last [ante-natal visit] …I got there at 7:00am …and I wasn't through until 4 pm… I got to the 2nd floor at 10:00 and then only at 2:00 my name gets called… Even if you are in the hallway and you just don't know where to go. The staff say, 'What are you doing here? Why are you standing here? Just put your folder down, and take a seat man! Clear this hallway!'.… I mean these are grown women, we are not children, and even if we were it is not respectful. When I got called, I go an lay on the bed; there are two people there (never the same person). No one intro-

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duced themselves, …nothing, no, 'hello, I am an intern'. They are prick-
ing and prodding me. The intern says to the other one, 'I don't know
how to use the machine, do I press this button, that one?' I am laying
there I already have a difficult pregnancy–it is emotionally taxing. Physi-
cally I am not in the mood, I have been sitting in this freaking hospital
for how many hours? on a hard ass bench, and they don't know how to
use the machine, are you kidding me! So that alone even took longer
than it normally does because the doctors are trying to figure out what to
do. And I wouldn't have even made a problem but they didn't even in-
troduce themselves to me! Then after that, Oh! They make me wait in
the hallway for another hour!

Nadine's account of accessing specialised clinics connects with the
notion of a ritual of degradation where waiting for services does not
simply devalue and exhaust the patient's time, but also degrades their
dignity and person. This account illustrates one way the public health
system *expects* patients to obediently accept the service they receive. That
pregnant women must spend up to nine hours waiting to access two di-
agnostic high-care clinics also corroborates the government's finding that
patients spend most of their time waiting (Operation Phakisa 2014: 2).
Nadine's remarks about her own expression of need illustrate another
part of this multi-directional cycle of dehumanization. By saying that ex-
pressing her needs to her doctor would be "making a problem," Nadine
has internalized the routine belittling mores black women are subjected

to in accessing maternal health services, and more generally.[64] The use of the trope, "a problem" signifies the patient's own contribution to the multi-directional continuum of violence by recycling the idea that her own person, and needs are not-valuable, but rather a nuisance to the system. The internists ignoring the patient's subjectivity, and nurses insisting that women sit obediently, clearing the hall of disorder, reflect routine behaviours that obscure and disregard poor black women. Such practices have developed as an "inertia in the system," as one doctor put it,[65] where an overwhelming patient volume constructs patients as nuisances. This inertia will be analysed in relation to accountability in Chapter 6.

Despite patient's internalisation and recycling of devaluing mores contributing to the continuum of violence, I argue the consistent actions to access necessary services taken by patients for their health, and the health of their families (especially considering the arduous, demeaning, costly and risky barriers described above) demonstrate resistance to racial and gendered structural violence. Women who are in advanced stages of maternity are known to travel far distances to access facilities with resources and adequately trained staff.[66] For instance, every week patients take buses from the Eastern Cape province, where an on-going crisis in

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64 Personal Interview, Patient, Nadine Ismail, 15 November 2013.
65 Personal Interview, Family Physician, Thomas Gordon, Family Physician, 10 August 2013.
66 Observation notes MOU 1, 4 September 2013: patient had travelled from the Eastern Cape to find better quality care in Cape Town; the mother delivered a stillborn, nurses suggested the delay in care may have been the cause of death.

public healthcare has yet to be addressed (Allan *et al* 2004) to Cape Town, using the addresses of local family members and others to seek more adequate care.[67] This final excerpt from Nadine's experience illustrates the intra-personal challenges and vulnerabilities that often limit the actions pregnant women relying on the public service, are willing to take.

So I'm waiting, it's 3:00 and I finally build up the courage to knock, [on the intern's door] and they say, 'No, no, no, we handed your folder over to the genetic counsellor' –and in my head I am thinking when were you going to inform me, and genetic counsellor! Oh my word!, What is wrong?, what is going on? There is no communication– That was when they told me about a possible problem with the cerebellum that these two interns had found.

So …I had to go back up …and at this point I started to cry… I was tired, and this was too much for me. Then I get there and the sister is like, 'And why are you back here?!!' I am like, 'um I was told'. Then she is calling down the hallway in Afrikaans, saying, 'Why is she here, why is this *one* back here?' –As if I am not standing there.– I start to say again, Because I was told to come back Sister. 'But we are closed already, it is after 1:00, you come here now?' I was like, 'Ma'am I was on the second floor I waited forever, and here is my folder'. And it was almost like when they …saw that I was with the geneticist and saw what he said,

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67 Buses on average from the Eastern Cape take up to eighteen hours to reach Cape Town.

they became a bit softer. Then they called a doctor out of a meeting, and then two doctors come and both are busy talking to me and then I had to lay on the bed again and more measurements. <u>I was so hot and tired I left crying at 4:00</u>.[68]

This demonstrates the expectation placed on the patient to obey the routines of the system even if this translates to exponential waiting. Again it shows the normalised response to a patient's presence is to insist that they are a problem. While patients internalise the demeaning assertions in their environments, they also reject these assertions in multiple ways. In the conclusion to this narrative for example, the patient rejects her invisibility (as a result of over-appearing, in patient numbers, so as not to appear at all) with the statement: "As if I am not standing here".[69]

In most of my observations of patient clinician consultations patients were silent, to the point of even being stoic. If doctors or nurses wanted a patient's acknowledgement of comprehension, they would have to solicit it. Often even in private consultations the response given was an unconvincing nod or short answers often in muted tones. These are signs of the outcome of the steep power differential between patients and clinicians; patients are not taking full responsibility of their care needs. In the conditions of the South African public health system where extreme waiting renders patients not having control over their time, thus

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68 Personal Interview, Patient, Nadine Ismail, 15 November 2013.
69 Personal Interview, Patient, Nadine Ismail, 15 November 2013.

not being fully in control of themselves, such limitations to patient participation is another effect of the routine devaluing mores that render poor black women powerless and invisible.

Increased Patient Cost

In many cases the residency access requirement determines the cost a patient will pay in transportation. In some cases this requirement can translate to life or death. For example, technologically advanced district, regional and tertiary hospitals operated by specialist doctors in well-resourced formerly white-only areas, act as primary care facilities for those that reside in the surrounding municipalities. As many of the residents of these areas have access to medical aide they do not rely on the public service, which makes the waiting time at these facilities more manageable. This is where life or death can come in. Transport costs are arguably less for high-risk patients who gain access to these facilities; in cases where patients require a higher level of outpatient care they can access it in the same facility. However, for those whose residential address restricts them to primary care facilities at a costly distance from specialised services, if they require higher level outpatient care they must pay what is often a burdensome cost to obtain these services.

This can lead to undiagnosed complications and accessing inappropriate care during maternity.[70] Exacerbating this situation is that black women in maternity are often particularly ridiculed and penalized for being financially insecure. Such familiar tropes established during the colonial

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70 Observation notes, MOU Support Executive Meeting MOUSE, 13 August 2013. This was discussed as a chronic problem by Senior Obstetricians and Clinic Nurse Managers during the meeting, and was noted this can contribute to neonatal and maternal death.

and apartheid periods to dehumanise and justify violence against black women (discussed in Chapter 3) become mobilised in relation to economic suffering, as well as decisions to procreate.

The authority and prevalence of this practice was exemplified at a MOU Support Executive Meeting (MOUSE) that I observed. The purpose of these meetings is to engage the range of managers responsible for the clinical oversight of public maternal health services, in a learning exercise, so as to better understand "current trends in mortality."[71] Often this represents the clinical leadership of about fourteen hospitals, which includes: Obstetric Medical Officers, (who facilitate the meeting), all Nursing Managers responsible for maternal health clinics, as well as Senior Clinical Obstetric Managers overseeing a particular geographic range of hospitals.

When a recent case of neonatal death was being analysed, the mother's inability to pay for transport, both ante-natally and during childbirth emerged from the Senior Obstetrician's discussion as a likely contributor to the neonatal death.[72] After the doctors briefly discussed the structural transport constraints within the health system, including one doctor's comments that using ambulances in these cases is prohibited by protocol and therefore not a solution, the most Senior Obstetrician participating in the analysis of the case offered the following remark: "If they haven't

71 Personal Interview, Obstetrician, Dr. Michael Price 31 July 2013.
72 Observation notes, M.O.U.S.E. Meeting 13 August 2013.

got any money they shouldn't be pregnant" (*Ibid*). This notion promotes a justification for subordinating poor women's control over their reproduction and sexuality (Sanchez 2014: 21-22). Moreover, this very position prominently drove population control, and eugenic policies globally from the 1940s – 1990s (Connelly 2008; Haartman 2000; Rao 1997; Harcourt 2000). In South Africa to promote this point of view amounts to taking the position that, not only should the majority of black women not become pregnant, but also that the majority of black people should not reproduce. As correspondingly, entrenched poverty persists at disproportionately affecting the Black population (Marias 2011: 309). The majority (20) of the managers present at the meeting were black Senior Midwives in their late forties and older, whose work was to ensure the healthy reproduction of this very indigent population. None said a word. No one else at the meeting responded or even reacted to this remark either. Two conclusions could be drawn from this experience: (1) the position that poor people should not be enabled to reproduce continues to be an accepted position amongst many senior obstetricians within South Africa's medical fraternity; and (2) the power invested in white male doctors continues to silence dissenting views amongst health professions, even when that view promotes racial and structural violence. This experience calls attention to the ways structural violence remains embedded within ranks of power in the provincial health system, that are also shaped by hierarchy and inequalities of power amongst health professionals and managers.

5.1.2. Clinical Managers and Staff

I will now explore the experiences of nurse managers and staff when they are faced with consistent lack of essential equipment and supplies. To show differences in the impact of these challenges in relation to different levels of administrative and clinical power I will discuss my findings at the primary, and tertiary level of management. By doing so I will expand on the multiple and overlapping ways the continuum of violence is inculcated in the health system. Specifically, I will show how constraining the capacity of managers to negotiate everyday challenges relating to material resources, often results in loss of dignity and declining confidence in the health system. I also establish how this leads managers at all levels of clinical care to "hustle" for supplies and equipment.

Human Resources and Clinical Appointments

A critical resource contributing to waiting times as well as demoralisation of staff and managers is the lack of adequately trained clinical staff. When discussing her rotation in the labour ward, one maternal healthcare manager noted: "I always try to take care, but can't make sure it's not short. We are neglected and cry".[73] Here she is referring to the staff roster: even with the number of full-time midwives on staff, the requirement of two midwives in the labour ward at all times, cannot be

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73Personal interview, MOU Manager, Sister Dineo Ngoqo, 5 September 2013.

met. I argue these examples of extreme burden shouldered by a shortage of health professionals, causes a loss of self-dignity among midwives, leading to obstetric violence in the form of a potential neglect of patients.

On another occasion, the same manager reflected on her lack of confidence in the health system: "Overtime from March and April are still not paid. The staff are tired, frustrated, hungry. I can't find staff to cover shifts, patients think we don't care".[74] Problems with overtime not being paid have been chronic, and affect staffing shift parity. Absenteeism is also a chronic issue. In another facility the assistant manager reported, "Staff have been waiting for overtime for January to July. When we raised it with… [the CEO of the hospital] at the Heads of Department meeting today she said, this is still a work in progress."[75] Uncertain as to when they will receive their salaries, nurses also become part of the "waiting populace."

Most health professionals refused to speak about obstetric violence or similar types of "poor quality care," and often were aghast at such inquiries, even though my access to them was under the umbrella of a provincial health department initiative to curb obstetric violence. Most would not admit perpetrating such behaviour, or that it even occurred in their current units. Doctors, who were more secure in their positions than

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74Personal interview, MOU Manager, Sister Dineo Ngoqo, 12 September 2013.
75Personal interview, MOU Assistant Manager, Fatima Peterson, 15 July 2013.

nurses, shared the most about their personal experiences and insights. The result of fiscal cuts, lack of remuneration and hiring freezes begets "skeleton staffing," which in turn compounds waiting times, causing heavier stress loads on clinical staff, and as one specialist doctor admitted: "It changes the way you treat people." He continued: "My heart got stern. I didn't become a doctor to be horrible. I needed… time away to remember how to react to patients on the same level again".[76] Speaking with another doctor about the extreme disparity in patient to doctor ratios he remarked: "Abuse happens because people are stretched and stressed, and they are feeling challenged at a human level – their humanity is being challenged and stretched – and therefore it becomes harder to treat *other people* as humans. …Especially when they haven't been treated as humans themselves".[77]

Throughout my fieldwork the staff shortage, and further lack of appropriately trained staff, was repeatedly asserted as a key grievance. Nurses often cited inadequate staffing as a reason for changing facilities, anxiety and resentment about absenteeism, carrying unbearable workloads, and for fear of punishment for the inability to care for all admitted patients, among other issues. Adding to these problems at the nursing level is that health system functioning is reliant on few general medical doctors and especially senior specialists. This dependence frequently causes breakdown in the functioning of provincial health services, for

76 Personal Interview, Emergency Medicine Consultant, Ziyanda Mlangeni, 5 July 2013.
77 Personal Interview, Family Physician, Thomas Gordon, Family Physician, 10 August 2013.

example in 2017 in KwaZulu Natal, and in 2015-2016 in the Free State where significant portions of services were not functional due to lack of appropriately trained staff (News FS; KZN; PMG Committee). Chapter 3 examined how few black men and women were able to access training or employment as doctors until the 1980s, and even then it was rare (Marks 1994). This legacy of exclusion is relevant as it takes eleven years to qualify as a specialist in most fields of medicine (seven years to qualify as a medical doctor, and an additional four years of training to specialise). This means only two cohorts of general practice doctors who began training in 1990 would have qualified by 2017. Despite the medical schools being designed to produce 1,300 general doctors annually their remains less than one doctor per 1,000 people (World Bank 2015).[78] In this way the structural violence of colonialism/apartheid is implicated in a continuum of violence of inadequate number, and insufficiently trained medical professionals.

The rote behaviour resulting from the extreme imbalance in clinical staffing is exemplified in this specialist doctor's reflections of working at the bottleneck at the primary level. "We work like a military. One-hundred patients want to be seen at the same time. …Part of the problem is that the doctors responsible for triaging patients are not experienced enough. They don't know how to handle complicated cases. They are fresh out of interning, either 6 months or a year and are learning on

78 See Bateman 2013 for a detailed debate about the impacts and gaps resulting from the governments' efforts to address this key challenge.

people in townships".[79] 'Townships' refers to the areas where the majority of the population was removed to during colonialism and apartheid and still resides. A recent review of all-provincial spending since the implementation of the 2012 fiscal constraints demonstrates there has been a sharp decline in increased clinical posts (Blecher *et al* 2017: 30). From the viewpoint of an executive member of DENOSA this austerity has meant staffing considerations are now approached from a "business model" perspective of "the less we spend the more we make".[80] This shift in the approach taken was also shared by an Assistant Manager of a Maternity Obstetric Unit who had been practicing in the system for over thirty-five years. Her sentiment reflected the common feminist argument that health systems cannot be seen as a "product" they have to be seen as "core social institutions at the interface between individuals and the structures that shape their broader society" (Harcourt 2009: 48).

The union representative contended that the economic constraint placed on the service by severe cost-saving measures over the last five years has resulted in hospitals operating with "the bare minimum staffing," despite the "acuity of the patients" a unit is responsible for.[81] My findings confirm DENOSA's account that in practice, cost saving measures have been applied to staffing not only by limiting job creation but also through hiring freezes (DENOSA 2017). For example, despite

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79 Personal Interview, Emergency Medicine Consultant, Ziyanda Mlangeni, 5 July 2013.
80 Sister Sue Davey, Executive Member, DENOSA, 7 September 2017.
81 Sister Sue Davey, Executive Member, DENOSA, 7 September 2017.

both primary and reproductive and maternal healthcare being included in the "non-negotiable" areas, these services are operating with a bare minimum of staff. Of the three, primary care units I had substantial access to, often when a nursing staff member retired, quit, or went on long-term leave, they were not replaced with a new full-time staff member, but rather the post was left vacant for three to six months. In these cases, nurse managers would "motivate" to Heads of Nursing (aka Matrons) and hospital CEOs for coverage from "agency nurses," who are hired either on a per shift basis (in the case of sick leave etc.) or on a short-term contract. In my analysis, this is a form of "hustling," a task that maternity ward managers must often take on weekly.

While I observed these temporary replacements for permanent staff posts to be a common practice at the primary level, participants noted that this practice occurred at higher levels of care as well. For instance, for one specialised unit at a tertiary hospital, this has meant that more than a quarter of the staff positions are filled by agency nurses (often without the commensurate special qualifications) on short-term contracts.[82] For maternal healthcare, securing an agency nurse replacement is difficult as there is a general shortage of midwives. The reliance on such temporary agency staff causes several problems. Firstly, the agency staff may not have adequate training and experience requiring permanent staff to shoulder more of the workload. Secondly, agency staff on a fixed contract, while there long-term do not have investment in the unit or hospi-

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82 Focus Group, Emergency Medicine Nurse, Sandy February 7 September 2017.

tal, and the possibility of meaningful engagement with management is weakened. Thirdly, as agency staff are not employed by the Department of Health the permanent staff are held responsible for any adverse outcomes that occur when they are working. All these factors contribute to violent practices and behaviour within the units.

Equipment and Supplies and Infractions on Dignity

Lack of health equipment and supplies have been widely argued to contribute significantly to the poor work environment of health systems and contribute to obstetric violence (Bohren 2015: 13). Included in the list of "non-negotiable" budget cut areas are: "Infection Control and Cleaning, Medical Supplies,… Food Services,… Essential Equipment and Maintenance of Equipment, Infrastructure Maintenance, …Children's Health Services (including Neonatal and Perinatal Care), and Maternal and Reproductive Health Services" (Blecher *et al* 2017: 26). As noted above, despite primary care generally, and maternal and reproductive health services especially, being prioritised as core areas to safeguard primary care, the units' ability to provide hygienic safe environments were constantly undermined by the long-term deprivation of the 'non-negotiable' basic resources in three of the four units observed in the study.

All four units had difficulty replacing labour ward mattresses and beds,[83] and replacing broken beds continued to be a chronic problem for four years in at least one of the units.[84] When the beds were ultimately replaced, often they were of such a low quality they would break in a month or two, which would start the struggle for replacements all over.[85] This chronic lack of hygienic supplies has become a cycle of increased risk and cost. Without no linen savers or plastic covers, mattresses deteriorate, and without replacements, the dignity of health professionals wears. What I observed in my fieldwork, is that nurses try to avoid exposing patients to the risks they know are present.

In one maternity unit, the CEO's lack of action with regard to the non-negotiable cost-saving area of essential equipment and infrastructure maintenance, led to all of the sinks in the labour and post-natal wards

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83 These chronically included: aprons, toilet paper, hand towels, linen, linen savers (used to absorb and capture the blood and liquids released during, and after childbirth), and at times sterile gloves, and soap were often absent. Observation notes 10, 16, 27 July; 1, 6-8, 10, 15 August; 21, 30 September; 6 October 2013. Additionally, washable hygienic plastic mattress covers, and the replacement of labour ward mattresses that had absorbed too much bodily fluids. When labour ward beds were waiting replacements, antenatal beds were used. Observation notes 15 August; 20 September 2013; Personal Interview, Megan Carstens, Julie Willemse, Substructure Managers, 10 September 2013; Personal Interview, MOU Unit Manager, Midwife, Crystal Abrahams, 10 October 2016.
84 Personal interview, MOU Unit Manager, Midwife, Crystal Abrahams, 10 October 2016; Personal interview, MOU Unit Manager, Midwife, Asanda Mlandu, 26 October 2016.
85 Personal Interview, Midwife, Buhle Deyi, 21 September 2013; Personal Interview, Midwife, Dorianne January 20 September 2013; Observation notes 15 August 2013; Personal interview, MOU Unit Manager, Midwife, Crystal Abrahams, 10 October 2016.

leaking for over three months.[86] As a result nurses, and sometimes mid-wives had to carry 20 litre buckets of water out of the wards to the nearest washroom to empty them several times per shift (*Ibid*). After observing several Head of Department, and other unnecessarily time consuming (all-day) managerial meetings at this particular hospital, I began to understand the CEO's extremely poor managerial style which orbited around his phrase, "that's a work in progress" and "mark that work in progress".[87] Incidents at two other hospitals demonstrate that neglect of infrastructural maintenance of maternal health care services is a common problem. In one case in an antenatal clinic the ceiling caved in injuring a nurse. In a separate case the ceiling caved in on a labour ward (Cronje 2017). In my analysis it is such on-going, flagrant disregard for midwives, nurses and the critical life-bringing work they provide, that causes staff to conclude that the health system's interventions are: "useless," that "[they] are undermined as people, as nurses".[88]

Adding to these problems, vital equipment either was regularly absent, or never upgraded (e.g. emergency trollies, and foetal heart monitors).[89] One Manager reluctantly confessed that the unit hadn't had for-

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86 Sinks remained broken from April – 14 July 2013. Observation notes 3, 16 July 2013; Personal Interview Nurse, Babalwa Mfiki 12 July 2013; Personal Interview, Mr. Lwandle Nozulu, Facility Manager, Community Health Center, 10 July 2013.
87 Observation notes 29 July; 5, 22 August 2013.
88 Focus Group, Assistant Nurse, Megan Webster, 28 November 2013.
89 At several Unit's this regularly included: new-born oxygen monitors, fetal stethoscopes, accurately sized intravenous lines IVs (an IV is necessary when a woman required transferring to a higher-level hospital), dextrostix readers, which is used to read the blood sugar for mothers and newborns in both ante-natal and post-natal

ceps for "three years" after those existing had "broken".[90] When asked how such essential equipment could be chronically out of stock, the manager said: "The only explanation is that the health system, along with senior management is neglecting us" (*Ibid*). She explained that her initial relentless "requests" to her "stock line managers" and her Facility Manager were met with endless "stories that they were on order" so she "went begging to other facilities for the delivery instruments" (*Ibid*). Managers and health professionals at all levels of the system, including tertiary described this common hustle what they term "borrowing" (which is inaccurate, as the items are not returned) from other hospitals, units and warehouses to secure vital equipment and supplies (*Ibid*). Another recent study confirms this is a widespread practice, and that often managers look to their informal networks before approaching the formal supply chain (Chambers 2017).

In the case of the broken birthing equipment "after months" of begging the Unit Manager explained she "gave up" and took up "collections among the nurses in the unit to purchase the instruments herself".[91] The

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care, and suction equipment used for new-borns and litmus paper. Observation notes 10 July 5 August 2013; Personal interview, MOU Unit Manager, Midwife, Dineo Ngoqo 5 September 2013; Personal interview, Fatima Peterson 10 July 2013; Personal interview, Family Physician, Facility Clinical Manager, Dr. Lerato Ndlovu 18 September 2013; Personal Interview Unit Manager, Crystal Abrahams 10 October 2016 confirmed the IV is still a chronic issue.

90 Personal Interview, MOU Unit Manager, Senior Midwife, Dineo Ngoqo, 3 July 2013.

91 Personal Interview, MOU Unit Manager, Midwife, Dineo Ngoqo, 5 September 2013.

manager was visibly embarrassed and ashamed to be a professional and a manager, and yet to be so powerless. She said this cycle only ended, when in late 2013 she made contact with a "Senior Procurement Manager" who finally began "replacing them" (*Ibid*). The same manager explained that when she was transferred to the newly built primary care unit in 2000 it lacked vital basic equipment and supplies which the staff purchased for several months before procurement chains distributed to the unit (*Ibid*).[92] I noticed a pattern of newly commissioned facilities lacking necessary infrastructure and equipment when services commenced, indicating poor planning and management.[93] Clinical managers, nurses, and doctors were continuously found to use their own resources through collegial networks to develop plans to address gaps in quality care out of their own motivation and responsibility to maintain a functioning unit, and or hospital. Clinical managers often expressed feeling cornered by a lack of options to maintain their and their patients dignity, where they resort to informal practices of hustling, as formal procedures required adherence to complicated bureaucracy, and poor functioning. A Trauma Emergency Unit consultant's remark: "I have to decide who gets the ventilator" encapsulates the difficult situations that often motivate health professionals to push back on the resource limits they are faced with.[94]

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92 Specifically, the unit lacked birth registers, fetal stethoscopes, and dextrostix machines.

93 Personal Interview, Emergency Medicine Consultant, Ziyanda Mlangeni, 5, July 2013; Personal Interview, Senior Program Administrator, Dr. Tendayi Marufu, Sept 11 2017

94 Personal Interview, Emergency Medicine Consultant, Ziyanda Mlangeni, 5, July 2013.

In order for the units to be able to provide adequate services to the communities they serve, staff and managers at all levels of the health system *often resort to hustling for healthcare.* In addition to the managers who use staff collections to buy vital equipment, collections are also taken up to provide basic needs for patients, for example toilet paper, pads, diapers, new-born clothes etc. On the other hand I have found that while doctors managing higher levels of care for patients with more complicated needs can face similar challenges, the authority, respect and comparatively better resourced units they manage often result in different experiences. For instance, even when clinical managers are met with procurement breakdowns causing them to hustle for resources within their higher levels of social professional networks, the positioning of their units, and importantly their more skilful and supported management find quicker solutions. Thus, this environment leads to frustrations, but not powerlessness and loss of dignity. Access to such power and confidence both personal and in the system I argue, mitigates and adapts to this continuum of violence.

5.3. Obstetric Violence

5.3.0 Introduction

The previous section has argued health system functioning–through concentrations of power and regulatory impediments to resources–

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contribute to the continuum of violence sustaining obstetric violence in several ways. Firstly, by subordinating, demeaning and disciplining patients in such ways that their compliance with poor quality care is expected and normalised. Secondly, by depriving basic medical resources to primary maternal healthcare services to the point of losses in dignity to nurses and patients is normalised. Thirdly, by limiting the power of nurse managers and nurses to effect resource challenges to the point of subordination. I argue that the ways in which access to services, resources and power are regulated in the health system lead to patients and managers, including doctors, to challenge, mediate and adapt to this continuum of violence. In practice these actions take the form of hustling for healthcare. Often, managers' subordination by the health system renders their informal hustles to find incomplete solutions. At times their hustles can be co-opted by the continuum of violence they aim to mitigate. This section elaborates on this continuum of violence by exposing and analysing the forms obstetric violence often takes. I foreground my data on obstetric violence which has been organised into the categories of "egregious," and "routine" forms. My analysis of this data centres on the relationship between obstetric violence and constraints in resources, power and discrimination which previous literature has noted as key contributory factors. Finally, I draw on the discourses attendant to race, gender, and sexuality during the colonial and apartheid periods analysed in Chapter 3 to examine the common verbal assaults on Black women's' sexuality recorded routinely in my accounts of contemporary obstetric violence in South Africa.

5.3.1 Labelling and Defining Obstetric Violence

As discussed in Chapters 1 and 2 the mistreatment of pregnant women and girls during childbirth has a long history (See Goer 2010). However, violence against women and girls during childbirth by maternal healthcare systems has only gained recognition as a widespread social problem since the 2000s (D'Oliveira, Diniz and Schraiber 2002), and recognized as a problem of global significance recently (WHO 2015). Since its recent attention especially by Latin American and Spanish researchers, legal scholars, feminists and in public health, this global pattern has been argued to take multiple forms and has been described by a myriad of terms. While I have chosen to apply the term 'obstetric violence', others refer to this widespread problem through other descriptors, for instance, 'disrespect and abuse', 'mistreatment', 'disrespectful care', 'childbirth abuse', 'traumatic birth' and 'birth rape'. Here I build on the argument I introduce in Chapter 2 for why 'obstetric violence is a more appropriate theoretically useful term.

The term 'obstetric' denotes why this is a distinguishable type of violence against women as it refers to childbirth, which relates to women's context at that stage of maternity being of: "not one but two" (Pickles 2014). While human reproduction is a social process, maternity, and childbirth are carried out by women. Thus discourses on, and analysis of reproduction often narrate this process as solely concerning women, or women and their foetuses, or new-borns. This perception, while maintaining an essential focus on women's roles–and accordingly, rights to

control their bodies and capacity to reproduce it–neglects a key aspect of this process, namely, that human reproduction is a social process. In other words, this approach removes women and reproduction from their inherently social and kin contexts, and furthermore it erases the social meaning of reproduction. I argue such narrow thinking has had consequences for the theorisation of, and meanings attributed to forms of violence that affect women in maternity (and their foetuses or new-borns). "Obstetric" acknowledges that violence against women in the context of maternity–*childbirth*–which effects more than just a woman, but the social process of human reproduction, her family, and kin. Moreover, the consistent and extreme disparity of risk of maternal and neo-natal mortality and morbidity resulting from the natural human process of maternity is an outcome of obstetric structural violence (see Trends in maternal mortality 1990-2013, WHO 2014). Further, when this type of violence is applied systematically –for instance through coercive or un-consented population control methods as carried out on mass-scale in Puerto Rico and India– obstetric structural violence whether directed at women and/or men is taking place.[95] The term "violence" places attention on these patterns' impact on mortality and morbidity, which I argue is a necessary attention. Firstly, because a woman dying as a result of childbirth is a violation of human rights, and it is "preventable," therefore when it occurs so disparately it is a clear sign that violence is present

95 The term structural obstetric violence is appropriate to refer to acts of violence constraining men's reproductive freedom (for example through forced and unconsented to vasectomies) as obstetric refers to childbirth, which such men would then not be able to contribute to.

(Human Rights Council 2016). Additionally, as the following data and argumentation shows this pattern of behaviour by health systems denotes physical and/or psychological harm has taken place usually within this range of forms:

humiliation,

unnecessary and/or un-consented medical procedures (including administration of contraception, including those that are permanent),

medical neglect causing unnecessary pain,

avoidable life-threatening complications,

and including behaviour attendant to sexuality.

In addition to these forms, the widespread practice of detaining women (and at times their new-borns) in health facilities due to an inability to pay for services is also recognised as a form of obstetric violence. On this basis, I argue that *obstetric violence* and *obstetric structural violence* are the most appropriate and analytically useful terms to apply to this global social problem.

5.3.2 Forms of Obstetric Violence found in South Africa

My primary data draws on months of observation in labour, antenatal and postnatal wards I conducted and the relevant managerial, clinical over-site meetings and provincial policy intervention meetings I participated in, as well as interviews and focus group discussions with mid-

wives, nurses, doctors clinical students, and clinical and administrative managers. I also draw on short-form bedside interviews with patients, several out of facility interviews with patients, and informal discussions with black women who have received public maternal health services. My secondary data draws primarily from a professor's archive of personal correspondence relating to accountability for obstetric violence with heads of departments, sub-districts, and directors within the provincial department of health. This is additionally bolstered on two archives of case law concerning obstetric malpractices (most litigation in this area is settled out of court, thus some documentation of legal actions were obtained outside of public court records through law firms and lawyers), and also internal reports from the provincial department of health, and presentations by independent ombudsman offices.

The findings from this selection of data on maternal health service delivery in the public health system show that both physical and psychological forms of obstetric violence are prevalent in South Africa. These findings are listed in these two categories though as violence is not easily categorised the lists do overlap. These findings pertain to all levels of care primary, district, secondary and tertiary care.

Physical forms of obstetric violence found include:[96]

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96 I have chosen not to include this in the category of physical obstetric violence, however I find it important to note. All childbirth deliveries observed in this study were in the supine position, (lying on the back during childbirth). However, in some cas-

lateral episiotomies (noted by clinicians in these instances to be un-necessary and non-evidence based administrations);

episiotomies done without adequate suturing supplies (causing infection);

un-consenting sterilisation of HIV+ women;

denial of pain medication throughout active labour;

slapping (in the face, & legs), pinching, pulling and dragging by the ear;

using elbows to apply pressure to the fundus (which is against evidence-based practice);

neglect of patients during early and active labour;

denial of access to care; and

lack of contraceptive method choices and administration of un-consented contraceptive methods.

Psychological forms of obstetric violence include:

patients requested to clean themselves, their beds and the floor after childbirth;

a patient left for an unnecessarily long time dirty from childbirth;

delivering on the floor with midwife support;[97]

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es women were regularly allowed to adopt a position of choice prior to active labour. Advocates of natural childbirth argue insisting on the supine position is a form of obstetric violence (Mirsky and van der Gaag 2001: 32).

97 Patients in early stages of labour do get up move around, go to the bathroom in the labour ward, which can lead to delivery in unintended locations. This incident was not observed directly though it was reported as an un-necessary measure.

lack of linen, linen savers and sterile gloves;

scolding (antenatal and labour visits): humiliating insults relating to sexuality, behaviour during labour and previously, insulting performance during labour and intelligence.

I have further organised these findings into two categories: those identified as egregious forms, and those occurring routinely. Here "routinely" refers to occurring weekly consistently month to month, year to year in at least two health facilities participating in this study. By foregrounding my findings in these ways I find they best convey my analysis of how patterns of obstetric violence link to the disciplining and subordination of patients and health professionals and the continuum of violence analysed above.

Routine Acts of Obstetric Violence

Two forms of obstetric violence were routinely observed throughout the facility-based field work in primary care hospitals. The first is a physical violence enacted through the ubiquitous practice of a denial of services. A professor describes the routine imposition of pain on low-risk women in active labour at primary care facilities to a Sub-district Director thus: "analgesia [pain medication] is routinely denied to patients."[98] A

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98 Academic Head of Department, documented in a personal communication with Director, Sub district, Dr. Jeffery Volk 24 June 2011. Acknowledged on observation notes 10 September; 2, 3 October; 15 November; 10, 13-16 December 2013.

manager elaborated on the reasoning for this denial of service in an interview: "When a patient in labour is given pain management medication the nurse must check the foetal heart every 30 minutes because it can interact with the pregnancy. Nurses don't want this *extra work*. Our stock is full, it isn't that the pain meds aren't here, they don't give them."[99] It is clear from my evidence which derives from several maternity obstetric units that managers, including the highest mid-level managers are aware of this problem, however it continues to be routine. The few discussions I was able to have with midwives about this were brushed off with excuses of stock-outs, patients not requesting pain medication, and pain medication not being necessary.

The other form of observable routine obstetric violence that I found has to do with reproductive health, is contraception. Contraception is not usually raised in recent literature, and I find this to be an oversight, requiring correction. I argue that issues relating to contraception can be a form of physical obstetric violence. I found that women are routinely administered the contraceptive depot medroxyprogesterone acetate (DMPA), immediately following childbirth in maternity wards without any communication, whether they have previously identified this to be their method of choice, or not. Often, as one manager put it, "nurses make choices for them. They give them progestogen" (*Ibid*). Progestogen is another term used for DMPA or Depo. A recent quantitative and

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99 Personal interview, MOU Unit Manager, Midwife, Asanda Mlandu, 26 October 2016.

qualitative multi-year study of HIV+ women's experiences of reproductive choices in Cape Town confirms my findings.[100]

DMPA has been the most commonly used and administered contraceptive in South Africa for generations (Cooper *et al* 2004: 74). One aspect of this form of obstetric violence in South Africa that lends the coercive administration of DMPA to be theorised as a form of structural obstetric violence, is that while six forms of birth control are meant to be discussed with patients (including sterilisation during their first ante-natal visit), several of these methods are often not available, even if there had been a consultative discussion between a nurse and patient around them. In the words of a manager: "We have not had 'the pill' in stock for many, many years. And yes, we are supposed to give that as an option when they book" [referring to a woman's first visit].[101]

Two excerpts from the study's observation notes elucidates how often this happens without the patient's informed consent. For example, a woman was about to deliver: "Meanwhile the students are busy sorting out the delivery instruments putting them on a trolley. The midwife checking over them asks, 'What's this?' in a very harsh way. The student says, 'It's the injection'. The midwife says, 'You can't start with this! Where did you learn this?' Student Nurse softly replies, 'We were told to

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100 Presentation C. Towriss 15 April 2016, University of Cape Town.
101 Personal interview, MOU Unit Manager, Midwife, Asanda Mlandu, 26 October 2016.

prepare everything and put it on the trolley. This is how the other Sister showed us".[102] The other example is explained by both the patient and a midwife after the patient's delivery. "The patient says, 'One nurse here never asked me whether I used the injection or not. She just injected me, and I had told her before that I use pills, the injection has me bleed a lot, and also I become thin. She refused to listen to me. She said, No I'm gonna give you 3 months injection. I'm worried because I'm gonna bleed for 3 months and I'm gonna lose weight. Mmh I don't like this at all.' 'They think it's a joke and I'd be sick I won't be having much energy to look after my baby. I told this nurse not to inject me but she never listened to me and I was afraid of her,' Then she shakes her head and keeps quiet. The observer asked the midwife about why she had given the patient the injection she said, "The patients always tell us lies. We don't listen to them anymore. What we care is for her not to have another baby because after giving birth a woman can get pregnant immediately because the womb is open. If we can listen to their lies we wouldn't know what to"".[103]

Additional evidence that coercive contraception is a problem in South Africa come from the findings that HIV+ women have been sterilised "without their informed consent" in two provinces (Strode, Mthembu, Essack 2012: 61). These findings also raise concern about recent authority midwives working throughout the public system in Cape Town are

102 Observation notes, MOU, 13 August 2013.
103 Observation notes, MOU, 10 August 2013.

now receiving to insert LARCs –active for 10 years– directly following childbirth.[104] Given this evidence of contraceptive coercion in labour wards, this initiative may deliver the opposite of reproductive choice. Exacerbating this concern of women's reproductive freedom is that Depo-Provera has been found to be linked to increasing one's risk of contracting HIV (Sathyamala 2001; Mbali, Mthembu 2012: 5; Morison *et al* 2012: 498). The commencement in 2015 of an open label multi-year randomized control trial called the 'ECHO study,' validates this connection.[105] The focus of the study is to bring a conclusion to the scientific debate over the link between DMPA use and increased risk of acquisition of HIV, and is led by primary investigators in the United States, Kenya and South Africa as well as the WHO. The trial is being conducted in primarily in South Africa, with additional sites in Kenya, Swaziland and Zambia. It is aimed to release its findings in 2019 (*Ibid*).

Another pattern that I have included as a form of psychological obstetric violence, and that was found to occur routinely at the primary care level, has to do with deprivation of supplies. Here I refer to the routine absence of linen, sterilised gloves, and what are called 'linen savers', which are meant to absorb the liquids and blood during childbirth. While at first this seems to be an issue that would cause a minor indignity to a woman in a labour ward, a deeper investigation of the challenges such

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104 Personal interview, MOU Unit Manager, Midwife, Asanda Mlandu, 26 October 2016; Personal Interview, provincial head of a relevant programs, Dr. John Dyani, 5 September 2017.
105 For further details see http://echo-consortium.com

poses for the nursing staff as well as the patient delivering without these basic hygienic items calls for this inclusion. Firstly, on several occasions managers and midwives signalled this to be a significant stress and problem. Staff discussed not only the *extra work* this caused for nurses, cleaners and at times midwives themselves, but also how the cumulative effect on the bedding equipment makes mattresses unhygienic. That these are routine challenges managers and patients must face as a result of the absence of basic stock, makes it clear that such deprivations can be understood as part of the "ritual degradations" both patients and obstetric nurses face (Pivan and Cloward 1971 cited in Auyero 2011: 12).

The last form of routine obstetric violence is psychological, and was reported mainly through secondary data and interviews, but was not observable during field visits. This is scolding. Accounts during active labour range from midwives and doctors saying, 'If you do not push I will walk away!', 'Your baby is going to die from labour! You are killing the baby', 'You opened up to get this baby didn't you? It was so easy for you then! You better open up now!', and 'Push! Why did I even tell you to push. You are too stupid to push.'

This last remark was made to a woman during her active labour by an obstetric registrar in their final year of training at a tertiary hospital. The observer, a less senior doctor who at the time was attending to a woman in active labour next door conveyed the incident to me. From their analysis the registrar was "clearly very stressed" assisting a difficult "vacuum

extraction" birth whose patient "was freaked out".[106] The registrar "wasn't able to get through to her, the patient was in shock and beyond what I thought I would ever have to experience in my life- he is shouting at her – Push!..." (*Ibid*). The doctor conveying this story explained this behaviour which he reported he has witnessed many times as a result of the registrar "feeling vulnerable" about his level of competence. He was thinking about his pressures and immense responsibilities. "I have to do a Caesar tomorrow, I have to present all these patients on the senior ward round and still look like I know what I was doing" (*Ibid*). In this estimation the doctor was buckling under pressure and let it out on the most vulnerable person to him, the only person he could blame, his patient. The practice of clinical professionals scolding women and girls when they are seeking antenatal care, and require assistance during labour is widely noted globally (Bowser and Hill 2010; WHO 2014; Bohren 2014). At the end of this section I analyse the connections between the demeaning tropes attendant to race, gender and sexuality established during colonialism and this routine form of obstetric violence.

Episodic Acts of Obstetric Violence

Violence toward patients, and toward women (and their foetuses) in their most vulnerable time of bringing life to the world is egregious in

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106 Personal Interview, Family Physician, Thomas Gordon, Family Physician, 10 August 2013.

any form. Here I emphasize a few particularly physically violent and dangerous practices, to demonstrate the level of dehumanisation that forms of obstetric violence can take. A medical student who spent eight weeks in training in two of the facilities observed in the study, reported several incidents of obstetric violence during childbirth at a secondary hospital. This direct violence ranged from slapping, and various forms of dehumanizing and discriminatory psychological abuse, to what one could term sexual assault. Two particularly egregious practices were described as: "When a woman was entering the second phase of labour (when the head is starting to come out), there was one particular midwife who would put her gloved fingers in the vagina almost like assaulting the patient. She would say she was dilating the cervix further but I mean the woman was already fully dilated. She would constantly put her hand in the cervix".[107] He went on to describe the patients' reaction to these assaults, "the patients were already in excruciating pain, and …the stress of the scenario caused the women to tense up and close their legs which makes it much worse" (*Ibid*). The second example of egregious violence, was midwives putting pressure on the fundus of the uterus with an "elbow" during slow childbirth (*Ibid*). These practices cause additional pain, restrict the power of women during childbirth, and may contribute to risks of maternal and neonatal health.

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107 Personal interview, medical student, secondary hospital internship, Thomas Russell, 30 November 2013.

In this particular hospital a doctor reported: "It seems that the further marginalized the patient, the more they would get abused." He particularly mentioned, "younger women, teenagers" and those "who seemed mentally impaired" (*Ibid*). Additionally, those who did not communicate in any of the languages spoken also reportedly faced greater instances of abuse.[108] In this hospital which received many non-South African patients (i.e. from the continent), "speaking the language" seemed to more relevant than being a foreigner. In another tertiary hospital one Zulu patient reported being "instructed to speak Zulu" to prove she wasn't foreign, because the nurse "did not recognize" her and her "English seemed too good".[109]

Findings relating to episiotomy practices were also significantly violent in both primary and secondary hospitals. An episiotomy is a surgical cut of the vaginal muscle between the anus and vagina used on a discretionary basis if the vaginal opening necessitates enlarging during childbirth. Two managers reported that up until a few years ago at least one senior midwife in their facility would carry out "bi-lateral episiotomies on her patients".[110] The manager further remarked, "In my opinion this is torture" (*Ibid*). In a secondary hospital "three incidents" of "episiotomies cut without local antiseptic first" were reported to the Deputy Manager

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108 Personal communication, Professor Eleanor Grant and Dr. Jeffery Vlok, Director, Sub district 24 June 2011.
109 Personal interview, patient, Lindahokle Xaba, 23 April 2015.
110 Personal interview, MOU Unit Manager, Midwife, Asanda Mlandu, 26 October 2016, interview conducted with the participation of the Operations Manager.

of Nursing.[111] Additionally, on multiple occasions of observation at one primary care unit I was told by the post-natal clinic nurse that mothers were coming in with infected episiotomies because the clinic did not use sterile surgical sutures.[112] It was presumed, because they were out of stock.

5.3.3 Long lasting Narratives Attendant to Racialised Sexuality

Scolding and humiliating discourses used by health professionals have been found to fall into a few types of psychological violence. They are often associated with harsh or rude language, judgemental or accusatory comments, blame for poor birth outcomes, threats of poor birth outcomes, and withholding support (Bohren *et al* 2014: 32). Such practices are often noted to be related to a function of moralising victimisation of pregnant girls, teenagers and young women's exercising of their sexuality. Others find these are commonly applied narratives used to control labour, rather than a more supportive guiding approach.[113]

The former types: judgmental or accusatory comments, and blaming for poor birth outcomes are often discriminatory and attendant to race and sexuality. Given the complex history of racial and gendered structural violence in South Africa attendant to Black people and their sexuali-

111 Personal communication, Professor Eleanor Grant 5 November 2010.
112 Observation notes, MOU, 30 September, 7, 14 October 2013.
113 Personal Interview, Professor Eleanor Grant, 3 May 2017.

ties, these recycled tropes carry specific legitimising and obscuring histories. For example, discourses of hyper-sexualisation of black South Africans, and especially black women enabled their rape and scientific objectification to become normalised and accepted practice during AND AFTER? slavery (Abrahams 2000; Baderoon 2014; Gqola 2015). Furthermore, sexual assault and rape have been found to be especially common in contemporary South Africa, where patriarchal sexist enunciations, blame women, and women's sexualities for the violence they are subjected to. By selecting a few of the common judgemental and blaming tropes inculcated in labour ward and antenatal settings I trace the continuities and differences between these narratives found to justify violence against black women over time.

5.3.4 Constraints in Resources, Power and Discrimination

This chapter has expanded on the theorisation that a continuum of violence exists within the health system. It has argued that both patients, and health professionals are disciplined through "acts of waiting" in the health system, causing subordination and loss of dignity, contributing to a continuum of violence that includes obstetric violence. For patients, the routine indignities of extended waiting for services, results in fear of further disciplining acts, constraining assertiveness, and participation in care. While for health professionals, extended waiting for equipment, supplies and human and other supportive resources, contributes to low morale, perceptions of neglect, abandonment, and lack of confidence in

the health system. Here I analyse how the forms of obstetric violence examined above relate to the challenges that patients and health professionals are mitigating and adapting to.

5.4. Conclusion

This Chapter has expanded my theorisation of the broad social continuum of violence inculcated within the health system, and particularly analysed how it circulates within maternal health. Through an examination of what I argue are key factors enabling this overlapping, multi-layered continuum within the health system (specifically regulations on access to care, the distribution and regulation of resources, and power), I have found these functions of the health system persuade patients, clinical managers, and nurses as well as health professionals more broadly, to "hustle for healthcare." In these cases, hustling takes the form of mitigation and adapting for access to care, access to more quality care, and the ability to provide services.

Through a review and analysis of my findings of patient experiences of extreme waiting, I demonstrate how this continuum of violence normalises poor Black women to be patient, and subordinate. I argue that this disciplining ritual teaches patients to fear asking, and demanding what they need. I argue this inculcation of compliance to poor quality care, contributes to the maintenance of obstetric violence. Furthermore,

I find the normalization of an obedient, quiet, sitting, patient woman in need of maternity care contributes to nurses further disciplining pregnant women who do not comply with this standard.

Similarly, I argue the ritual indignities that low-level managers, midwives and nurses are subjected to through the continuum of violence that operates through deprivations in resources, subordinate, demean, and cause losses of dignity for these health professionals. I have argued especially for clinical nurse managers their lack of power to negotiate these challenges acts as a subordinating disciplining agent. This institutional system and environment that health professionals are beholden to, and dependent on, I argue often leaves them with no good choices but to hustle, and provide services through informal means. Chapter 6 expands on this analyses by detailing the supportive operations of the continuum of violence through poor managerial and accountability systems and practices.

Building on the argumentation in the previous chapters that established the persisting contexts of racial and gendered structural violence and normalized insecurity, I argue that taken together, these factors support a continuum of violence that includes various forms of physical and psychological obstetric violence. Furthermore, I establish continuities between the enunciations originating in the colonial period attendant to black people and sexualities and the routine verbal judgments, and assignments of fault attendant to maternity patients' sexuality.

This chapter establishes my main theoretical contribution to the conception of obstetric violence and expands on the theory of structural violence. By applying the point of departure, that human reproduction is a social process, with its main biological activities carried out by women I improve upon existing conceptualisations of obstetric violence in four ways. Firstly, I have posited obstetric violence is a particular type of violence against women for four reasons: 1) violence against women in maternity effects the woman and her foetus or new-born, 2) it affects her family and kin, 3) It is perpetrated by a health system, and 4) it has the potential to be applied structurally where whole groups are affected. This theorisation enables the distinction between obstetric structural violence and obstetric violence. I do so as a result of several factors. Firstly, the consistency and pervasiveness with which maternal and neonatal mortality and the risk of morbidity is found, and the extensiveness of disparity in this morbidity and mortality globally indicates a structural type of violence. Secondly, to determine what type of obstetric violence I make a distinction resulting from outcomes based on the scale of a community, group or population affected by the form of obstetric violence. For example, the coercive sterilisation of a group on a population scale indicates a structural type of violence.

Accountability & The Relationship between Obstetric Malpractice and Obstetric Violence

6.1 Introduction

In the broad debates on how to improve service delivery, practices of accountability have been a central theme since the 2004 World Development Report (World Bank 2003; Joshi 2010: 4). In previous chapters I have made the case that a distinguishing aspect of this particular violence against women, is that it is implicated within health systems. I have also argued that direct forms of obstetric violence are constituted by their structural form, obstetric structural violence. Against this background and argument this chapter analyses how the functioning of accountability influences the continuum of violence through its third key factor: health systems and their policies. In this way, I explore the relationship between obstetric violence, and obstetric malpractice. I do so firstly by reviewing the positions of the literature on the relationship between obstetric violence and accountability. I then present my findings on the structure and functioning of the policies guiding accountability within South Africa's

maternal health services. Through an examination of a local policy initiative, the functioning of internal disciplinary mechanisms, and the extent and context of legal redress, I explicate the current relationship between obstetric violence and obstetric malpractice in South Africa.

Governance structures concerned with ensuring service delivery, respond to citizen needs through: legislative frameworks; policies and guidelines establishing procedures, including those that set out standards of service; policies relating to citizen oversight; and non-binding and binding disciplinary and punitive mechanisms. Scholarship on health system governance predominantly focuses on macro-level (national and global health) policy and structures (Ruger 2007; Kaplan *et al* 2013), which set out the duties and responsibilities of states in this area of service delivery. Broad scholarship on disrespect and abuse of women during facility-based childbirth supports the general position about the relationship between accountability and service delivery (Goetz and Gaventa 2001), namely that "[n]ational laws and policies and their enforcement are a critical component of strategies for improving …birth care and for governments to hold citizens accountable to such care" (Bowser and Hill 2010: 10). Sanchez' assessment of the women's movements for "humanized birth" in Latin America – as mentioned earlier, these movements coined the term "obstetric violence" – has found this activism considers the increasing scope for legal accountability, a key tool in curbing obstetric violence (Sanchez 2015: 39-62). This literature has shown, that legislative scope has been successfully increased in the last ten years in Vene-

zuela, Mexico, and Argentina, as a result of advocacy drawing on macro-level policy (Sanchez 2014: 4, 50-58). The result has been the development of a unique legislative purview that especially criminalizes three key aspects of obstetric violence: 1) pathologisation of women's reproductive processes, 2) un-necessary medical interventions, and 3) dehumanizing treatment of women during maternity and childbirth (Sanchez 2015: 39-62; see also D'Gregorio 2010; and Pickles 2014). Pickles writing in 2015 found that implementation of obstetric violence legislation in at least one of the countries has not yet occurred (Pickles 2015: 8). Chadwick suggests that perpetrators of acts of obstetric violence "are subject to criminal liability in these countries, which usually amounts to a fine and a signed acknowledgement of wrongdoing on the part of the practitioner and/or the institution" (2016: 423). Though it seems these statutory provisions may be lacking enforcement mechanisms, the establishment of obstetric violence as a legal concept connects these acts to obstetric malpractice litigation, giving reason to explore the relationship.

In-depth research into the operational level of health system governance and policy in low and middle-income countries is an expanding body of work (Gilson and Raphaely 2008). Of the scholarship on the South African case, concentration has often been on issues of leadership. Issues relating to trust (Gilson 2003), for example; the fragmentation of clinical and administrative organisational structures (Froestad 2005); that of nurse operational managers (Jewkes *et al* 1998); human resource department leadership and capacity (von Holdt and Maserumule 2005: 15); frontline staff and mid-level primary healthcare managers (Gilson *et al*

2014); and organisational conflicts due to poor communication and comprehension of overlapping governance structures (Scott *et al* 2014), have largely been the foci of academic engagement.

In South Africa, while legislation (especially The National Health Act 61 of 2003), has mandated the implementation of a social-accountability approach, these measures have generally not been implemented. Where these guidelines have been introduced, their implementation has been weak (Boulle *et al* 2008; Padarath and Friedman 2008; Haricharan 2011; Naledi *et al* 2011: 20). Despite this, I discuss certain empirical findings relating to community oversight below. My evidence shows that internal DoH rules and procedures, and conventional legal medical malpractice mechanisms, are more widely applied in relation to obstetric violence provincially and nationally. This dissertation contributes to gaps in knowledge about the operational level of health system governance in middle income countries, particularly relating to obstetric violence and obstetric malpractice, with regarding the connection between internal health system disciplinary structures, and external legal mechanisms. This chapter addresses the question: *What is the relationship between obstetric violence and internal health system and external legal accountability mechanisms?* Here I contribute an evidence-base on specific behavioural incentives and dis-incentives arising from health system policy, rules and procedures, and legal accountability mechanisms on obstetric violence.

6.2 Approaches to Accountability

In order to examine the relationship between accountability mechanisms and obstetric violence, it is necessary first to clarify the conceptual and practical components underpinning the notion and practice of accountability. Scholarship has established that accountability refers to "holding… individuals, agencies and organisations (public, private and civil society)… responsible for executing their powers according to a certain standard (whether set mutually or not)" (Tisné 2010: 2 cited in McGee and Gaventa: 2011: 11). Getting duty-bearers to take responsibility for their actions at any level of oversight is not an event, but rather, a process. Ideally processes of accountability will involve both *answerability* and *enforceability*. Answerability refers to "the responsibility of duty-bearers to provide information and justification about their actions – and enforceability – the possibility of penalties or consequences for failing to answer accountability claims" (Goetz and Jenkins 2005 cited in McGee and Gaventa 2011: 11). Enforceability, put more precisely, is the set of responsive actions taken by those with legitimate authority, resulting in consequences for transgressions. For example, the fines relating to judicial findings of acts of obstetric violence noted in Chadwick (2016), or suspension from work without pay, is a consequence applied through internal disciplinary hearings found through my research, and discussed in the subsequent section. In the case of a maternal death that occurred at one of the primary healthcare Maternity Obstetric Units during my fieldwork in 2013, the Facility Manager, as well as the Clinical Director of the overseeing Secondary Hospital, had meetings with the mother's

family relaying information about their investigation and the conducting of an autopsy. All maternal deaths occurring in facilities in South Africa, are investigated as per the procedure of the National Confidential Enquiry into Maternal Deaths. The autopsy in this case seemed to relate to the question of negligence, as the mother was low-risk and healthy until the late stage of childbirth. As with several other cases of alleged negligence (discussed in the later section), I was unable to gain confirmation of the outcome of this complaint and investigation, other than the autopsy result still not having been reported to the family, two months after the death.

Answerability requires institutions to make the procedures involved in accountability processes transparent to both their staff, and the public they serve. This includes communicating how grievances can be pursued, how investigations and decisions are come to, who and what enforces them, and may ultimately also entail communicating determinations to the parties involved. Examples of enforceable actions that have been reported to me as consequences of disciplinary hearings resulting from acts of obstetric violence include: staff dismissal, loss of pay, required training, and financial compensation.[114] Internal DoH policy, guidelines and procedures which govern internal disciplinary hearings for example, are key mechanisms in providing checks and balances, through public ombudsman, legal claims, codes of conduct, and hierarchical reporting

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114 Personal Interview, MOU Unit Manager, Midwife, Asanda Mlandu 26 October 2016.

(Malena *et al* 2004: 4). In this case, internal mechanisms aim to regulate and govern the behaviour and practices of public servants; the nurses, midwives, doctors, and managers. My argument is that the examination of accountability mechanisms in practice, is essential to understanding how health systems and their policies have become implicated in obstetric structural violence, as binding consequences can be applied as a deterrent. Moreover, my findings support others that have demonstrated that even when policy and formal grievance systems are in place, they are often not implemented (HRW 2011), nor do they result in answerability and enforceability.

It is also important to draw attention to the conceptualisation of theorists of structural violence in relation to my question about the capacity for mechanisms of accountability to exacerbate, and mitigate obstetric violence. Gilligan, elaborating on Galtung's position, that it is impossible to identify a single actor who commits the violence as it is impersonal, and built into the structure of power (1969 170-171), reasons that perpetrators of structural violence become unnoticeable, because structural causes are continually masked by the assignment of blame to "other natural or [everyday] violence" (2000: 192). Gupta adds that the apparent invisibility of perpetrators also occurs, because the shift of blame may have become a part of the structure of power (2012: 20). Fox, writing from the point of view of accountability in relation to development argues similarly, that adverse practices are indeed obfuscated, however, it is the repeated patterns of behaviour by those in positions of authority which participate in this masking, that are the root cause of the obfuscation of culpability (2007). That transgressions are frequently blamed on

abusive individuals, removes everyday practices from their political sphere, and places them in the sphere of individual answerability (Fox 2007: 666). My study found evidence of patterns of obfuscation to be common at the direct service delivery level, as well as at the level of authority and oversight. In particular, my data on the practice of enforcing accountability for a spectrum of violences experienced by both health professionals with constrained institutional power, and economically poor patients, demonstrates how governance practices of obfuscation contributes to the persistence of obstetric violence.

Speaking about the normalisation of forms of direct violence, Bourgois and Scheper-Hughes (2004: 5) importantly add, that moral economies uphold these patterns through their social acceptability:

"[O]ften the most violent acts consist of conduct that is socially permitted, encouraged or enjoined as a moral right or duty. Most violence is not deviant behaviour, not disapproved of, but on the contrary is defined as virtuous action in the service of generally applauded conventional social, economic and political norms."

As I have argued in previous chapters, this social acceptability of discrimination and abuse in certain cases is key to understanding the persistence of obstetric violence. In the public sphere inequalities in power and security are reproduced through the normalization and social acceptance of state's neglect of the poor (formal and informal). This blatant discrim-

ination is condoned by judgments of moral worth and invidious discourses, for example, poor communities being blamed for their deplorable situations, as a consequence of their own moral or civic deficiency (Gupta 2012: 18). A common example of this in reproductive health, is the invidious discourse used to maintain selective anti-natalism/population control (coercive and forced prevention of pregnancy), which guided global health policy on women's health for five decades (see Hartmann 1995; Briggs 2002; Connelly 2008 for the exhaustive history of this global policy apparatus). A growing number of scholars contend this practice has not changed (Smith *et al* 2013; Towriss 2016). By identifying the moral judgments that underpin everyday violences, I contend that one gains insight not only into the gendered and racist structures of violence, but also the factors that contribute to everyday and symbolic violence sustaining this particular injury against women and families.

6. 3 Health System Governance and Accountability

Since the promulgation of the National Health Act 61 of 2003, authority over the health system has been decentralised, and citizen oversight mechanisms have also been declared (2004). The mandate of decentralisation can be understood as a legislative attempt to overcome the previous policy of "separate development." The Act requires the three spheres of government to co-operate in governing and establishing an approach to primary healthcare, and empowers communities with mandated oversight (Scott *et al* 2014: ii60). Despite the government's inten-

tion to distribute and delineate health service delivery between local and provincial governments, the apartheid legacy of dual and overarching responsibility for primary healthcare has continued within metro areas (Elloker *et al* 2013: 164). This has also meant that provincial structures are not entirely identical, but similar. My mapping of these structures, offers insight into evolving structures of governance and power.

Figure 4 (below) provides a look at the general flow and distribution of national and provincial powers through their governance structures. I describe these elements as five layers of power: National Authority, Provincial Authority, Top, Middle and Lower levels. I have not included the local government in this scheme, as the overall lines of answerability are the same, and overlapping (for detail on these replicated structures in Cape Town and how they connect see Gilson *et al* 2014: 6).

Figure 4. South Africa's Health Governance Structure

Health System Governance
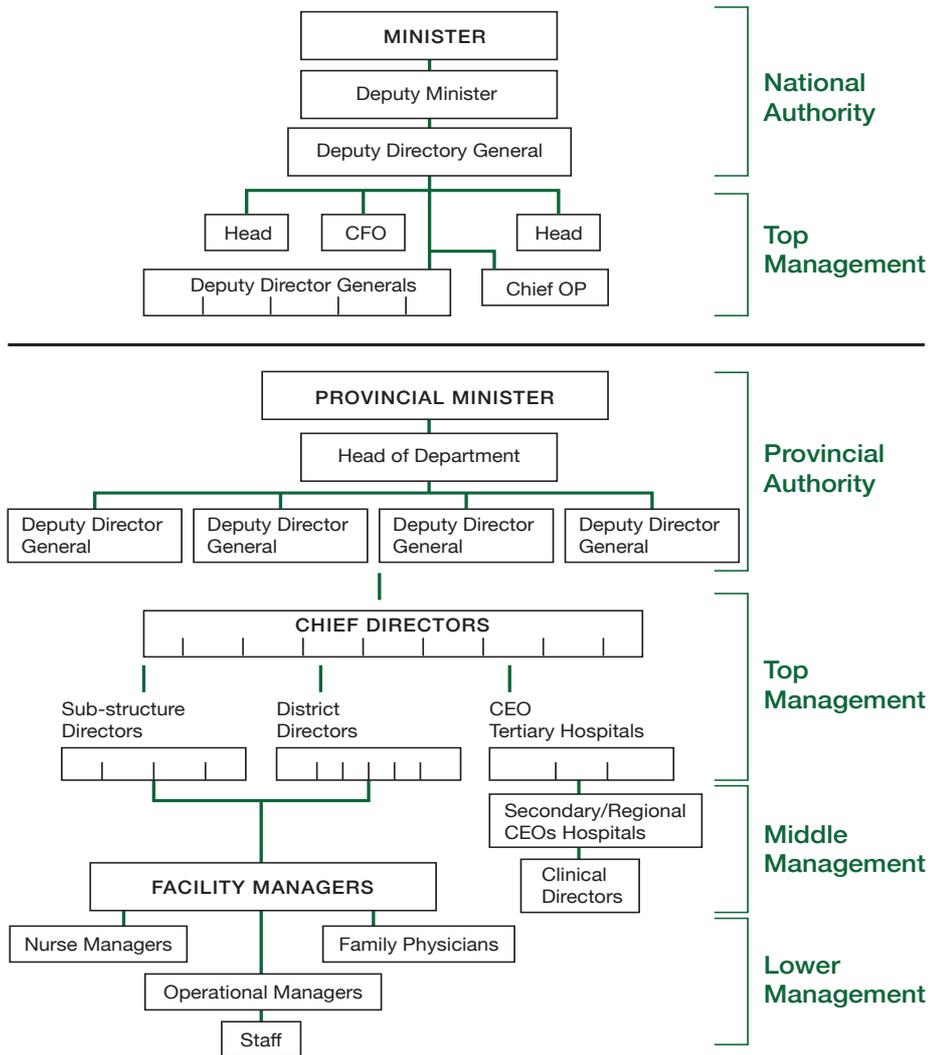
(Authors own), drawing from WC DoH Organograms (2010; 2013); Gilson *et al* (2014).

Adherence to the National Health Act is evidenced by rapid decentralisation at some levels. However, the diagram shows administrative and political powers continue to be concentrated and hierarchically distributed from top to bottom within the Departments of Health. The highest level of power sits with *national authority* and is controlled by the Minister of Health, Deputy Minister, and their Director General. Top management includes two Heads of the Department, a Chief Financial Officer and five Deputy Director Generals. The decentralisation of power over the system has led to the national government being responsible for developing broad health policy and legislation, providing support for specific prevention and disease control (Gilson *et al* 2014: 3-4), and national financing. Ministers of Health are held legally responsible for cases of malpractice throughout the public health system; private insurance companies provide coverage at increasingly unaffordable rates for health professionals practicing in the private sector. This will be discussed in more detail in the section analysing extant case law, below.

The highest level of *provincial authority* rests with the Provincial Minister of Health (MEC), followed by the Head of the Provincial Department of Health, and their Deputy Director General: Chief of Opera-

tions. The MEC is responsible for directing the management of the department and facilitating political and community support for these directives, including ensuring functioning of social-accountability through the appointing of Hospital Boards. In 2013, the MEC of the Western Cape began fielding complaints directly by opening a hotline dispatched through its office. The Head of Health is fiscally responsible for the department, and in partnership with their Deputy, direct the department's strategic approach, and coordinate its clinical and administrative functions. In 2015, the Western Cape MEC and Head of Health appointed an Independent Health Complaints Committee to make recommendations to them on unresolved disputes, which they refer to the board. Effectively, MECs are political appointments, while the Head of Health is perceived to be in charge and to direct the department, and make decisions.[115] The 2009 the *Top* level of management was expanded upon. This was subsequently made transparent through the publication of the provincial department's organogram shows that management authority and operations have also been distributed and delegated to a significantly expanded structure (WC Department of Health 2010). The 2015 creation of a new Deputy position could be interpreted as a further centralisation of power. However, three years later, the new organogram remains unpublished, leaving uncertainty as to the redistribution of authority at the highest levels. McGee and Gaventa acknowledge that such an absence of transparency creates hurdles for answerability and enforceability (2011). Several staff members, managers, and patients reported their confusion

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115 Personal Interview Head of Department, Dr. Mohammed Zaini 25 August 2017.

regarding lines of authority, and how to comply with standards guiding accountability relevant to them.[116] Such confusions are compounded by the seemingly unending series of structural reforms initiated since democracy.

This compounding is evidenced by other research in the MDHS (Scott *et al* 2011:141; Daire and Gilson 2014: ii91). For instance, my findings corroborate that of Scott and her colleagues who have noted the continuous changes over the last twenty years within district health services, are reflected on by MDHS managers and staff as "change fatigue" (2011: 141). However, my evidence also shows primary maternal health services continue to require significant adjustments to align and orient this level of care with their clinical and other governing authorities. I argue this persists due to the context of the entrenched exclusion of these primary care units. Such efforts to locate them within the authority result from at times Departmental efforts to 'relocate them', and at times the Department succumbing to Black communities' on-going demands for health care services.

While all three of the primary care units participating in the study originate through distinct histories that place them in the expansion of services, community oversight of different kinds played a significant role in aligning the units within the oversight and support of the existing lower, middle and top management structures. For example, two of the

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116 Personal Interview, Sister Mthwakazi Qumza, 22 August 2013; 23 August 2013.

MOUs were significantly isolated from all levels of management and oversight prior to the Patient Centred Maternity Care policy interventions (which came about as a result of community and medical student reporting on different forms of obstetric violence). The reflections from an interview transcript with Family Physician Naledi, illustrates the level of isolation one MOU faced for over two years from the Facility Manager of the hospital it was housed in:

Dr. "Engagement with MOU started with this patient cantered health care meeting".

JR "You mean with the facility manager?"

Dr. "Yes, that meeting you attended? That was the first meeting that Mr. Mosima ever had about MOU things".

JR "Do you mean the meeting that we had with the task team?"

Dr. "Yes, in his office. That was the first ever about MOU related things."[117]

What became clear from multiple interviews and observing this MOU as well as a second one, is that in their new settings, these units continued to separate and isolate themselves, maintaining separate management, and separate systems. The units at the point of the PCMC intervention were not integrated with the hospitals housing them. Correspondingly, the Operational Managers didn't communicate with

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117 Personal Interview, Family Physician, Dr. Naledi, 23 September 2013.

other managers, including their respective Facility Managers. During my study, I observed one instance where those appointed as Managers prior to the commencement of administrative change, maintained the same positions thereafter. It was clear that in these "new positions," they avoided one another due to historical precedent. This separation had several consequences operationally, in terms of oversight, accountability, and arguably for obstetric violence. All of the MOUs in the study had documented histories of obstetric violence. It is important to note, that the isolation and separation I found within maternal health primary care units, did not seem to relate directly to the structural violence of racial exclusion. I draw this conclusion from the fact that the hospitals, units, and facility management, represented the demographic breadth of their respective Black communities. This is the case for all three units, even though they are located in distinct Black communities, serving majority disparate Black populations.

Figure 5 below provides my analysis of internal accountability mechanisms, their accessibility to the public, as well as the distribution of power and oversight. The left side maps the guidelines and functioning of the Department's internal complaints procedures, as well as the often parallel Disciplinary Hearings carried out under the internal office of labour relations.

Figure 5. Internal and External Accountability Mechanisms for Healthcare Grievances
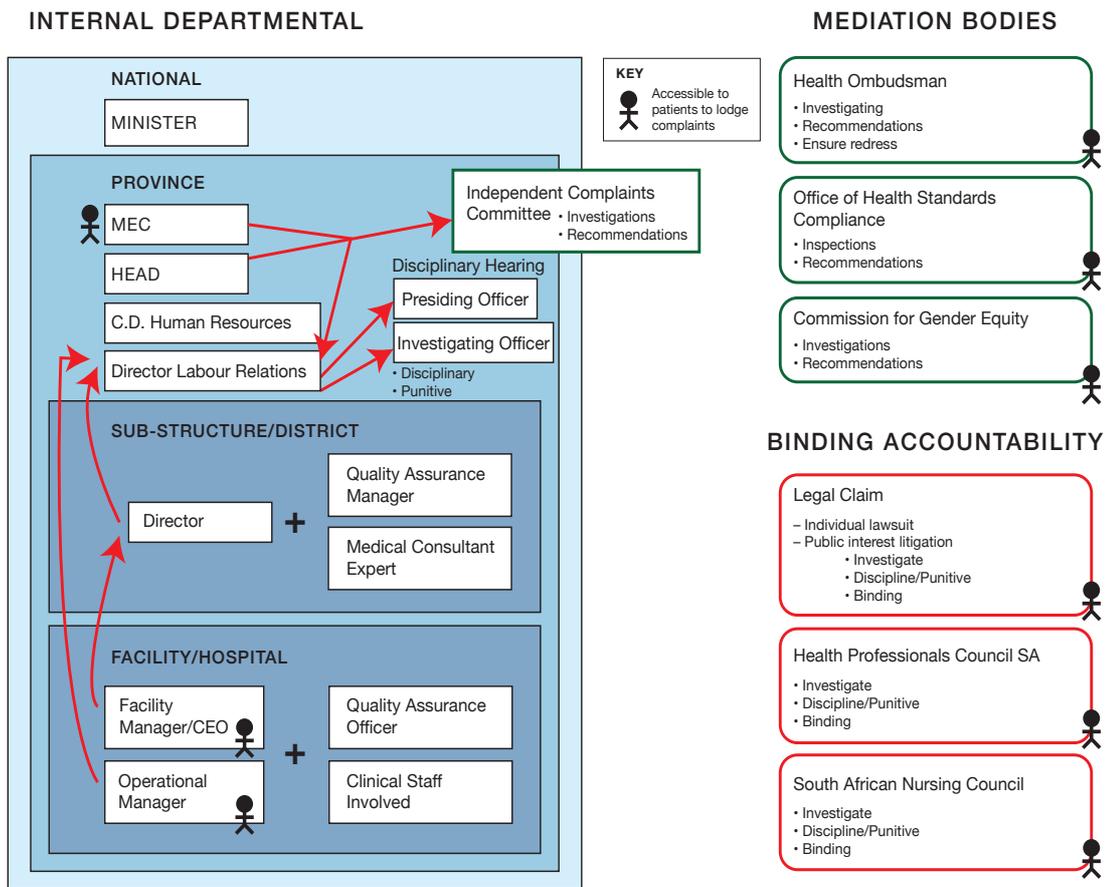
(Authors own)[118]

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[118] Building on Western Cape Circular H111 (2013); Amendment to Circular H111 (2015).

The last published organogram (2013) shows top level management comprised of Chief Directors (currently eight in total), the Directors of Districts and Sub-districts (numbering ten), and finally the CEOs of the three tertiary hospitals. The Chief Directors (CDs) are responsible for human resources; medico-legal issues; design and implementation of health programs; emergency services; infrastructure and maintenance; strategy and coordination; supportive services, including services for professional staff, and financial management. Importantly, the Director of Labour Relations (who is below the CD of Human Resources) oversees Complaint Management relating to the internal investigation of staff transgressions. The primary role of Directors of Districts and Sub-Districts (sub-structures), is to translate strategic policy decisions into long, short, and mid-term operational service delivery. Their main responsibility is to manage district health services through district hospitals and clinic facilities (Elloker *et al* 2013: 164; Scott *et al* 2014: ii61). These authorities are meant to oversee all complaints reported to the MEC, Minister, and institutions (labelled Mediating Bodies in the diagram). Additionally, if a complaint is escalated through the Labour Relations office by facilities below the District Directors, these Mediating Bodies should be informed. I was only able to engage with one of the four sub-structure Directors, and one Chief Director of the metro district during the course of my research. After more than five appointments were made and rescheduled, it appeared clear that these particular authorities wanted little to do with the study. I therefore have limited direct infor-

mation from this level of authority regarding the oversight of accountability.

Middle Management includes the CEOs of secondary or regional hospitals, Facility Managers, Heads of Nursing, and Clinical Managers, at primary, district, and regional hospitals. These managers play important roles in horizontal accountability as their work at the direct line of service includes: reviewing complaints and compliments surveys and reports; participating and sometimes leading internal investigations; and also receiving complaining patients and staff directly. Additionally, Facility Managers preside over meetings between operational managers, staff, and patients, aimed at mediating and resolving complaints at the facility level *in lieu* of broader investigations. Lower Management includes Operational Managers overseeing clinics and wards. These managers are responsible for overseeing their services, including staff. They review complaints and compliments surveys and reports, and also receive complaining patients and staff directly. Operational Managers document and report on incidents, and convene mediation meetings between their Facility Managers, staff, and patients, aimed at mediating and resolving complaints at the facility level.

Gilson and her colleagues argue that the health system is both complex, and adaptive (2017). The governance structure examined above confirms the complexity of the administrative and political power of the health system. A key part to what creates confusion amongst staff about

the structure of governance, and thus how to engage with accountability mechanisms, is that for the last twenty years the structures of government overseeing health have been, and are experiencing "constant health system change" (Gilson *et al* 2014: 7). Constant change has meant that key grievances, even those reported, have been lost, or simply garnered no follow-up. For example, in one of the participating sites, a detailed letter outlining grievances about their Facility Manager management was collectively written and signed by staff representing almost all clinics, and submitted to the sub-district director. A doctor overseeing services in this facility remarked on how impressive the collective effort of staff had been, and that it was demoralising that there had been no response, formal or otherwise. Constant managerial, infrastructural transition, and clinical initiatives have been found to lead to "change fatigue" in the health system (Gilson *et al* 2014: 10). One long-term participatory research team argues that this leads to middle level managers developing "collective mind-sets of passivity and risk avoidance" (*Ibid*). I argue, that this is also true for Operational Managers and primary care clinical staff who are hustling to deliver care. Furthermore, this example shows that such passivity creates barriers to accountability. At the point when I began my fieldwork, two years had passed since the staff's collective submission, and management's silence. I learned that few of their complaints had changed over the intervening years.[119]

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119 Personal Interview, Family Physician, Dr. Naledi, 23 September 2013; Personal Interview, Operations Manager, Sister Dineo Ngoqo, 5 September 2013; Personal Interview, Sister Babalwa Mfiki, 29 October 2013.

On the one hand, this constant change is due to South Africa's transitional aim to transform the "highly centralised and bureaucratic administration" (Ntsaluba and Pillay 1998: 34). However, this is not the only explanation. Non-compliance with the Act in other arenas highlights internal and external contestations of power. Lack of transparency is manifested in confusion amongst Operational Managers, and also clinical staff. The latter group has the least power within the system about how to lodge grievances, how to follow-up on them, and knowledge about who beyond their direct line managers, has organisational authority over the services they are responsible for delivering. It also shows a lack of interest in ensuring answerability and enforceability for the protection and empowerment of staff, and quality of care.

Non-compliance with the Act in other arenas highlights internal and external contestations of power, for example: the often absent and uneven establishment of District Councils and Clinic Committees as stipulated for social-accountability, and the continued historical division of primary health between provincial and local government in metropolitan areas, including in Cape Town (Naladi *et al* 2011: 20). Additionally, "change fatigue" and middle level managers developing "collective mindsets of passivity and risk avoidance," impacts accountability (Gilson *et al* 2014: 7, 10). Importantly, the Director of Labour Relations (who is below the CD of Human Resources) oversees, and appoints the presiding officers who hear and make the final determinations on internal investigations and disciplinary hearings.

My empirical observations and interviews found that the lack of power held outside of the top levels of clinical and administrative management (Figure 4, and Figure 5), challenges the dignity and self-worth of lower level managers and health professionals, i.e. those responsible for direct service delivery. As one Facility Manager asks: "Why won't they [Substructure- and Chief Directors] listen to people who are here?...So it means that even if I am here it has to take someone else to make things happen...I have to say the system has failed me.…Maybe people are not aware that you also have eyes to see, that you [Facility Manager] have mind, I can simply put it like that".[120] This excerpt illustrates the frustration of Senior Managers, when their ability to affect the hospitals they oversee, is hindered by bureaucracy. For example, procurement approvals are not decided upon by their offices, but rather, by the office of the sub-structure above them. Xolie's reflections were not uncommon amongst staff, although she was the only Facility Manager who so candidly expressed dissatisfaction. Xolie's sentiments are reflected in the in-depth research Scott *et al* (2011; 2014) and Gilson *et al* (2014) have conducted with MDHS Facility Managers. I found the undermining of managers and health professionals capacity and authority contribute to what one doctor called "a system inertia" which enforces complacency, and a tolerance of obstetric violence.[121] The opinions expressed by my interlocutors within the health system, support Von Holdt's argument, that such

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120 Personal Interview, Xolie Radebe, Facility Manager, 9 September 2013.
121 Personal Interview, Dr. Thomas Gordon, Family Physician, 10 August 2013.

attitudes lead to environments where staff "turn a blind eye" to cycles of indirect, and direct forms of violence (2010).

Community Oversight

Accountability is challenged by the lack of institutionalised support of community agency, and the tendency for the state to be the only agent with oversight authority. These problems exacerbate, and I aver, are the direct cause, of obstetric violence in the public healthcare system. My evidence reveals that all of the major investments and improvements in relation to contemporary obstetric violence in MDHS community advocacy – from institutional partnerships between students and universities; direct community outcry in the form of protests demanding maternity care services; and citizen reporting to community newspapers – has garnered the most significant attention from the Provincial Government. While national legislation, particularly The National Health Act 61 of 2003, has mandated the implementation of a citizen oversight as mentioned above this implementation has been weak (Boulle *et al* 2008; Padarath and Friedman 2008; Haricharan 2011; Naledi *et al* 2011: 20). Where existing community oversight is organized, it is found to be fragmented at best, unclear of its mandate, and absent at worst (Haricharan 2011: 8). My understanding gained from this research, as well as community meetings, and one-on-one interviews, has shown that the Eastern and Western Cape have a semblance of Health Committees. These Committees are meant to have vested power of oversight concerning

local health system services. In practice though, these Committees have not had the capacity, resources, or empowerment from the system to fulfil this role.

In the Western Cape Metro, where community oversight would be a supportive mechanism to aid the department in achieving the prevention of violence in the health system, this intervention is usually considered a form of political antagonism. This view is part of what has led to the postponement of provincial legislation to guide the work of health committees throughout the country's nine provinces (Haricharan 2011). Additionally, in the Western Cape, the resources supporting the local oversight infrastructure which support these efforts, namely health committees, has recently been defunded (*Ibid*, see Haricharan 2011 for a detailed overview).

6.4 Government Intervention: Patient Centred Maternity Care

This section analyses the functioning of the internally established complaints management protocol, and investigates the development and implementation of the only provincial Code of Practice aimed at curbing obstetric violence, along with the existing case law on obstetric malpractice. I situate these findings within an analysis of the National Department of Health's recent approach to the problems that litigation has presented to the health system.

In the Western Cape, there have been a number of parties aware of, and interested in channelling resources to curb and prevent violence in maternity. These agitators include clinical heads of hospitals, health rights activists, Black communities shut out from access to maternal health services, doulas, and academics. Over time, these actors have put forward different demands and solutions to this problem, and have even implemented oversight, training, and human resource programs in university and health facilities. I argue that the attention garnered from conversations developed through these varied initiatives, is what led the Western Cape Department of Health adopting a policy called "Patient Centred Maternity Care Code of Practice" (PCMC 2013), enforceable at all health facilities in the Western Cape. This policy outlines three fundamental rights of women in maternity, and describes the corresponding duties the state has to enable these rights.

The PCMC policy, and the process that led to its adoption, were demonstrations of the department taking important and consistent steps to raise the profile of obstetric violence throughout the metro-area health system. However, they did not consider, nor develop understanding about the causes of this problem. At present, the PCMC policy "functions" without having addressed this key aspect. The Department's approach can be summarised in the observation of one midwife who said: "they treat it individualistic, but it is the institution problem." This

was a sentiment repeated by nurses, and low-level managers, in addition to the acknowledgement of some "bad apples" being a problem.

While the PCMC intervention successfully identified the main actors affected by violence in maternal health services, I argue that the Western Cape Department of Health did not enable patients or staff, to adequately participate in the development of its implementation. Firstly, patients and their communities were almost entirely absent from this process. Secondly, non-managerial staff was only engaged through surveys, and through low-level meetings. When non-managerial staff was included in higher-level discussions, due to the concentration of power and manner in which the meetings were conducted, their involvement rarely amounted to more than "silent witnessing." Adding to this antagonism, their direct managers often had little influence in discussions either.

Ironically, the focus of PCMC directors and policy implementers, was to place the responsibility of curbing and preventing system-wide violence, on the very staff whose input they ignored. In the following section, I outline the efforts of staff and managers to negotiate the impact of broken systems, lack of resources, and other changes that they were unable to effect, due to Department of Health ambivalence. It became clear to all involved that this was not a tenable solution. I also highlight the reaction of the policy implementers and managers to the results of my study; their failure to adequately implement PCMC policy. I also provide a two-year retrospective of my study, detailing any progress made in

"bucking institutional inertia," and steps taken towards fulfilling the mandate of violence prevention in maternity.

6.5 Obstetric Malpractice: Legal Redress

This section provides my analysis of existing reported case law and settlements on obstetric malpractice in South Africa. Included below is an analysis of twenty-three reported cases.[122] This case law does not give a complete picture of the overall issue of obstetric related medical negligence, given that many matters are settled out of court, or are on-going. Additionally, it can take a long time for these cases to be resolved. For instance, in Khanyi v Premier GP (2011) JDR 0400, cause of action arose in 1999, but findings were only handed down in 2011. Thus, there are likely many cases pending determination, which were not available at the time of the study. In addition to examining extant case law, I analyse an overview of national data on obstetric malpractice, as well as a report of trends in increasing obstetric malpractice in the Western Cape Province. Both specify settlements for indefensible obstetric malpractice.

National Overview of Claims and Settlements

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122 The initial analysis of these cases was provided by a legal theorist through Personal Correspondence: C. Pickles, 2 June 2017. The additional eight were provided through a law firm through Personal Correspondence, 27 June 2017.

Since 2016, the Minister of the National Department of Health has repeatedly noted that malpractice litigation, specifically in the area of obstetric care, has been draining the state budget, causing exorbitant inflation for obstetric insurance coverage, which in turn, has caused several obstetricians to close their private practices. The Minister has warned that without a solution to this problem, the crisis in accessibility of obstetric care will increase. In response to this imminently critical situation, the Minister (Motsoaledi in Presence 2016), the African National Congress (ANC 2017: Para 4.6.6; 5.5.1) as well as the Western Cape Provincial Department of Health (Bass 2015), suggest legislative reform to cap the amount of liability patients could claim for damages incurred within maternity care settings.

According to an overview provided by the National Department of Health's Advocate, Montsho, as of July 2017, the total claims for medical malpractice were 7,889, of which obstetric related cases were 4,063, and the total number of cerebral palsy cases was 3,089. This shows that obstetric-related cases are a high proportion, and are probably the majority of medico-legal claims throughout the country (Montsho, National Department of Health 2017: 31).[123] Not only that, obstetric claims are a

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123 I say probably as the data aggregates payments made to patients and their families for obstetric related cases, and further separates those made specifically for cerebral palsy claims, however in two cases (Limpopo and North West) the number of cases and amounts paid exceed the number of obstetric related claims. These two are therefore outliers, it seemed to me that Cerebral Palsy claims should be a part of Obstetric claims generally, so the numbers should always be smaller, which is the case for the remaining seven Provincial data for 2017. It is likely that there would be

higher proportion of the total amount paid out through settlements for claims. This means that settlements tend to be larger for obstetric related claims than other medical malpractice claims, which makes sense, especially when taking into account reported case law, which shows that the majority of cases concerning claims for disabled children result from indefensible adverse maternal healthcare practices.

Gauteng cites the highest number of cases provincially in all categories, with lowest numbers reported in the Northern Cape. Gauteng Province boasts an advanced legal fraternity: the Department argues that the increasing claims in medical malpractice, correlates to a predatory legal fraternity, rather than the well-documented increasing crisis in public healthcare (Motsoaledi 2016; Motsoaledi 2017). The low proportion in the Northern Cape, is attributable to its small population density. The Western Cape, which remains the province with the best clinical outcomes (Padarath *et al* 2016), seems to be in the middle, close to the average for the nation, (especially after Limpopo, and North West are excluded). While the Western Cape has fewer total cerebral palsy claims than all of South Africa (54.6% vs 72 or 74% including Limpopo and the North West), the province pays out about the same percentage for cerebral palsy claims (about 77.5% of total obstetric claims, which amounts to about 79.8% in South Africa, again minus Limpopo and North West). This means that each individual claim averages a bit more in Western

an error with the numbers reported for these two outlying provinces, which is why I cannot say conclusively obstetric claims everywhere are the highest proportion.

Cape. Total payment to patients nationally for indefensible obstetric claims was ZAR 38,826,100,459 (USD 269,421,760,265).

A preliminary examination of the claims made in the Western Cape shows that on average for the last five years, monies lost to corruption in this province have exceeded those paid out as a result of obstetric malpractice. Nevertheless, the National Ministers of Health, and Justice have convened a working group to draft legislation to limit the amount that patients can claim as restitution for obstetric malpractice.[124] Moreover, the Departments have not proposed any national intervention into corruption, or the crisis in quality care in maternal health.

It is commonly known that obstetric malpractice insurance is a significant cost to medical professionals. This is understandable, due to the high risks associated with pregnancy and maternity. That settlement agreements would be highest for obstetric malpractice would not appear unique to South Africa. It is however beyond the scope of the present study to consider such medico-legal comparisons. Instead, I provide an overview of existing malpractice litigation, to acknowledge the association between poor quality care, and adverse "indefensible" practice. While not all obstetric malpractice results from obstetric violence as defined in this dissertation, I argue that these are correlating factors, where a portion of malpractice cases are likely to come as a result of obstetric malpractice. This is evidenced in the analysis of extant case law below.

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[124] Personal Interview, Lynn McClure, Senior, Medical Malpractice Lawyer, Key Firm Handling Cases and Consulting Gov. 22 May 2017.

Analysis of Reported Case Law

The 23 case law reports demonstrate obstetric malpractice litigation has been occurring in four of the nine provinces in South Africa. Gauteng has the greatest number with 14 cases, of which 4 arise in Pretoria, and 10 in Johannesburg, the Eastern Cape follows with 6 cases, KwaZuluNatal with 3, and 1 for the Western Cape. The national data covering January – July 2017, similarly reflects the greatest number of legal settlements occurred in Gauteng. This case law further demonstrates that the overwhelming majority of cases are settled out of court both in private, and in public healthcare. It was confirmed that the "trend is to settle through a mediator."[125] One strategy used by the Department is to settle clearly indefensible cases that are claiming less than 1 million ZAR without arbitration.[126] All of the reported cases, except one (Sibaya v Life Healthcare Group, Dr. Abdool S. Suilman (2017) JDR 0523), concern litigation against the state. This may mean that the private sector more successfully settles and avoids a pubic scene, or that the cases have not yet been finalised (Chadwick 2016: 424).

Importantly, most of the cases concern claims for harms caused to children during birth or soon after birth, rather than harms caused to

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125 Personal Interview, Lynn McClure, Senior, Medical Malpractice Lawyer, Key Firm Handling Cases and Consulting Gov. 22 May 2017. Personal Interview, Alice Marais, Medico-Legal Department, 6 November 2017.
126 Personal Interview, Alice Marais, Medico-Legal Department, 6 November 2017.

women – even where harm to women is clearly present (Mucavele v MEC GPP (2015) JDR 1942). Hoffmann v MEC EC (2011) JDR 1081 concerns a claim for a woman in relation to her stillbirth. Cerebral palsy features extensively, and is recognised by the courts to be a serious harm.

In some of the case law it states that women claim in their personal and representative capacity – but these claims are not separated and broken down, so it is impossible to determine what is being claimed in relation to the claimant herself, and what is being claimed on behalf of the child. Available case law does not include the amount claimed, because all of the cases (except one – Hoffmann v MEC EC) separated the determination of liability, from the determination of "quantum." Quantum refers to the damages, presented in monetary value, that the court determines the defendant (i.e. state) should pay to the plaintiff. If a woman is successful in proving medical negligence, she can go on to prove the extent of damages at a later date. While the national figures examined above would include litigated cases, I did not find any case law regarding quantum for the cases I considered. Also, most of the judgments are fairly recent, and the portion of the cases concerning quantum, may still be on-going. The state (as the defendant) tends to be liable for the plaintiff's litigation costs where she is successful in establishing negligence. This adds to the state's burden in relation to the overall cost of medical negligence cases.

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. Interestingly, lack of available resources, stillbirth, and adverse treatment in the form of direct violence, does not feature as extensively as I would expect. In the Mucavelev v MEC GPP (2015) case, procedures including sterilisation, were performed on the mother without her informed consent, but these issues were not brought before the court, as her claim centred on harm to the child (Mucavele v MEC GPP 2015 ¶ 7, 51, 65). Madida v MEC KZN (2016) JDR 0477 also exposes harm to the woman, but again the claim is centred exclusively on harm to child (Madida v MEC KZN 2016 para 57-58). In this instance, 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 child developing cerebral palsy (*Ibid*). Both of these cases, though not litigated for these traumas, show egregious forms of obstetric violence, which clearly are linked to adverse medical outcomes, and (in the former case) a permanent limitation to reproductive freedom.

An important affirmation from this case law is that the power of the courts is limited to address obstetric violence, in both its direct and structural types, as judges can only consider the grievances presented to them. For instance, because the mother's involuntary sterilisation was not raised as issue, though recorded in the case, the judge was not em-

powered to deliberate on these arguably related facts. This evidence demonstrates that while the current situation of litigation is causing a level of material compensation for "damages" caused, at present it has little bearing on the health system with regard to the improvement of care. This sentiment is echoed by the judge hearing the case of Madida v MEC KZP when they stated: "As unreasonable as the conduct of the defendant's employees was, any cost order drains the health budget at the expense of health services for all. It does not punish the wrong doers" (Pillay in Madida v MEC KZP 2 ¶ 70-84).

6.6 Conclusion

This chapter examined the functioning of accountability from the three points of view: 1) health system structures and polices, 2) functioning and distribution of oversight and accountability, and 3) existing case law and medical obstetric settlements. This evidence and subsequent analysis allows for several contributions to literature. Firstly, it provides one of the few assessments of accountability mechanisms at the service delivery level, concerning a lower-middle income country. By doing so it provides necessary evidence to consider how accountability is framed at the operational, and administrative levels of health systems. This is important as it allows for consideration about the relationship between governance, internal accountability mechanisms, and health system functioning. Secondly, by demonstrating a clear link between obstetric violence and adverse health outcomes, the chapter contributes a key finding

to literature on obstetric violence, especially by providing evidence to challenge the public health literature on obstetric violence, which often has reported there to be an inconclusive relationship between these two phenomena (WHO 2015).

In general, I found that systems of accountability are fragmented and complex with separate chains leading to the same authorities. From the point of view of the delivery level, these authorities often fail to carry out their mandates. The chapter provides evidence to show that disparate institutions and mechanisms of accountability exist, that when consolidated, could be engaged in enforcement efforts. Critical to this situation, is the lack of power to enforce change and accountability below the Sub-district/Sub-structure Director.

To date however, enforcement is mostly illegible. Where there is evidence, it shows minor enforceability for punishment that may deter routine adverse behaviours. The review of recorded case law showed that courts are not empowered to make judgements proscribing remedial action on the part of hospitals, or the Departments. This shows that litigation, though binding, may not be the strongest avenue for enforcement. An assessment of the PCMC intervention, found this policy insufficiently robust to have a long-standing positive impact on services. In fact, the lack of investment made to support its implementation within the service, had negative outcomes. In particular, these manifested as a loss of trust between nurses and the Department of Health. Furthermore, the

significant amount of time taken from healthcare professionals to participate in the policy implementation process, albeit with constrained voice and influence, further deterred staff from future participation. After investing thirteen months to its deploy, staff saw little, if any, of the support promised to address their grievances. Finally, this assessment also showed that routine practices of obstetric violence would continue, without the intention and ability to follow-up on such cases, by those in positions of significant authority.

In short, the system needs to be overhauled, and strengthened. However, the problem is more intrinsic, than simply trying to bolster a weakened system. I found that the manner and systems facilitating the delivery of health services, often undermines the human dignity of both the patient, and the health provider. This widespread practice forces public servants who want to approach patients and their work with compassion and understanding, to "buck the inertia of the system," as one senior doctor put it. The approach often taken by the Department of Health to achieve accountability, is an authoritarian one: blaming and scolding staff, threatening them, saying: "We have zero tolerance for abuse." This is meant to pressure managers and staff to work more, and work better. Instead however, it creates a fear among staff, and in fact constrains their ability to work at all. For senior staff more accustomed to dealing with such unfounded threats, their response to junior staff members is often frustration, or incredulity. Thus, I conclude that the profound lack of accountability at all levels of hospital governance has resulted in obstetric

violence becoming institutionalised, and pervasively structural in many of its forms.

With regard to extant case law on obstetric malpractice, my review evidenced a national pattern of adverse neonatal outcomes, most commonly brain damage resulting in a form of cerebral palsy. Where obstetric violence in the form of restrictions of autonomy, failure to comply with informed consent procedures, and neglect related to women in maternity courts were constrained to consider these aspects leading to damage to neonates. This led to obstetric violence being accepted as "facts" to the case, and often did not result in opine or feature in judgments.[127] Interestingly, the court in one case did acknowledge the structural aspect of the growing case load relating to public health system negligence, in that they opined that the pattern of obstetric malpractice cases before the courts could not institute necessary recourse as the problem is structural relating to the health system challenges (Madida v MEC KZP 2016 ¶ 70-76).

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[127] Personal Communications, Camilla Pickles, 1 October 2017.

7   Conclusion

7.0 Introduction

In this dissertation I set out to explore the puzzle of the generation and continuation of obstetric violence in South Africa. I used the framework of structural violence, which directs attention to how structures of power shape inequality resulting in increasing disability, mortality and the everyday violence of constraint and humiliation (Scheper-Hughes and Bourgois 2004: 1-2). I applied this framework to analyse the socio-political environments shaping maternal health system functioning and the delivery of services to explain the prevalence of obstetric violence in South Africa. It is my contention that the violation of girls and women in maternity and during childbirth has become built into the practices of public maternal health services in South Africa as a result of the cumulative enforcement of racial and gender discriminatory political-economic arrangements and social norms overtime.

This study reveals that current literature on this subject is inadequate. As such, this dissertation is a response to the need to: determine if the existing characterisation of harm to girls and women in maternity and especially during childbirth by maternal health services as violence holds to extant conceptualisations of types and forms of violence; distinguish and define the multiple forms this practices take; conceptualise what causes and spreads obstetric violence; and explore the relationship between internal health system and external legal mechanisms of accountability and obstetric violence.

This Chapter has three parts. The first part foregrounds my core contribution to knowledge; the novelty and contribution of my methodological design; second highlights my key findings, and their implications, and generalisability and limitations of my research, and; the third part details recommendations for policy and further research.

7.1. Contributions to Knowledge

Core Contribution

The core contribution of this study is the advancement of current conceptualisations of obstetric violence. Specifically, the determination that the violation of girls and women in maternity and especially during childbirth by maternal health services is a particular type of violence

against women. In addition to this my core contribution includes distinguishing, and defining this particular violence's direct, and structural forms. Finally, the conceptualisation of the continuum of violence which propagates and sustains this pattern of violence against women and girls in maternity. This study has resulted in several additional contributions to knowledge. This section addresses each of the research questions to summarise and combine the main research findings. Following this, the contributions to knowledge relevant for theory, methodology and practice are foregrounded.

My main contribution to literature is my advancement of current conceptualisations of obstetric violence. My approach entails building on four key analytical lenses, which I apply and bring together. The four lenses drawn upon are structural, everyday and obstetric violence, and literature theorising constraints to reproductive freedom.

My approach draws on the conceptualisations of "structural violence" (Farmer 2004; Gupta 2012; Anderson 2015), and "everyday violence" (Kleinman 2000; Scheper-Hughes and Bourgois 2004). Everyday violence is used to explain direct, visible and often physical violence, and structural violence assists to explain settings where economic, political and legal structures cause extreme inequality resulting in indirect violence that constrains individuals and whole groups capacities where they become unable to reach their potential, including life expectancy (Galtung 1969: 168-169; Gilligan 1997; Farmer 2004: 305; Gupta 2012: 20; Ander-

son 2015: 3). Scholars have shown structural violence– forces that shape inequality and are built into structures of power– are constitutive of direct and episodic violence (Scheper-Hughes and Bourgois 2004: 1-2). Scholars have applied the theory to explain the ways social discriminations engender unequal power. For example Anderson has used "gender as structural violence" to referred to women's disproportionate risk to HIV (2015: 8).

Reproductive rights movements and scholarship from Latin America and Spain have increasingly described the pathologisation of women in maternity, routine unnecessary and coercive medical interventions, and dehumanising treatment in maternal health services as "obstetric violence" this includes several countries establishing obstetric violence as a legal concept punishable by law (Sanchez 2014: 50-59). More broadly, literature analysing this global social problem has identified this problem to operate at different levels, especially the individual relational level of care (d'Oliveira *et al* 2002; Kruger and Schoombee 2010; Chadwick *et al* 2014; de Silva *et al* 2014; Smith-Oka 2015; Okafor *et al* 2015), and also the service delivery level relating to diagnosis and medical interventions (Farrell and Pattinson 2004; Sanchez 2014), and increasingly at the structural level of health systems and the professions of medicine (CRR, FIKA 2007; Freedman *et al* 2014; Freedman and Kruk 2014; Dixon 2015; Sandler *et al* 2016), including in ways that effect health professionals (Honikman *et al* 2015).

Lastly, my analytical approach draws on the lens established by the scholarship overlapping violence and reproductive health. This scholarship has been concerned with the roots of injustice with regards to reproductive health and has been carried out, not exclusively but principally by women of colour feminists see especially Davis 1983; Roberts 1997; Qadeer 1998, 2005; Silliman and Bhattacharjee 2002; Rao 2004; Silliman, Fried, Ross and Guiterrez 2016; and Ross and Solinger 2017. This literature has successfully theorised how structures of power curtail reproductive freedom, and emphasise the constraint of women's capability to have children safely and with dignity (Ross and Solinger 2017: 55-56). This analytical lens is complementary to that on structural violence as it underscores the economic resources individuals and whole groups possess structure's their reproductive options, indeed the reproductive rights available to girls and women. This view often takes an "intersectional" approach drawing on Kimberle´ Crenshaw's theorisation to explain how gender is structured through race and class to show how people are oppressed through multiple social markers simultaneously (1993). Scholars do so to foreground that the socio-economic and political context individuals, and whole groups live in is central to one's capability to have control over their body, sexuality, and to exercise reproductive liberty.

Building on the findings from this research and these four analytical lenses has led me to advance existing analysis of the distinct direct, and structural ways obstetric violence constrains women and girls reproductive autonomy. Firstly, I define obstetric violence as: physical, psychological violence and/or unnecessary or coerced medical interventions car-

ried out within health systems. This approach draws on prior scholarship (d'Oliviera *et al* 2002; Jewkes and Penn-Kekana 2015) which has framed obstetric violence as a form of gender-based violence. However I argue it is of a particular type of violence against women based on four factors: (1) it endangers a pregnant woman *as well as* her foetus or new-born; (2) it has a direct impact on her kin; (3) when certain forms are applied systemically it can impact the reproductive health of entire groups; (4) and lastly because it is carried out by health systems and/or policy.

Secondly, I advance the thesis that this global phenomena occurring across race, class and cultural differences is *obstetric structural violence.* By which I mean the socio-political causes of the systematic violation of sexual and reproductive health rights carried out by health systems, and/or policy resulting in the constraint of individuals capability to have children safely and with dignity, and preventable maternal and neonatal disability, morbidity and mortality. I argue obstetric structural violence is the cause of direct obstetric violence.

Thirdly, I posit obstetric structural violence is propagated through a continuum of violence. Building on the work of Cockburn (2004), Scheper-Hughes and Bourgois (2004) I use the notion of a "continuum of violence" to emphasise that obstetric structural violence operates and interacts along a continuum drawing continuity with other forms of violence against women. Acknowledging this continuum places emphasis on how both direct and structural forces constrain safety and dignity at the

time of maternity and are shaped by the intersecting social markers which distribute power unequally (Crenshaw 1993). Finally, applying the conceptualisation of a continuum of violence also aims to draw attention to the nuanced ways nurses and low-level managers can simultaneously be targets of, and perpetrators of violence within health systems.

This situated approach takes seriously that health systems do not exist in vacuums, and rather are products of their socio-political environments reflecting and reinforcing their society's dominant social processes (van der Geest and Finkler 2004: 1996). My argument is that, taken together, social norms, political-economic arrangements, and health systems and their policies, drive multiple and overlapping practices and behaviours that generate and sustain a continuum of violence within maternal health services. I advance this thesis on the basis of the evidence from the case study of South Africa. It is shown that racial gendered structural violence established within the colonial health services, and the medical professions coupled with social norms objectifying, exploiting, and inaccurately portraying Black women's sexuality which grew moral judgements and values about pregnancy and childbearing. This in turn drives patterns of obstetric violence. The persistent constraint of resources, including power shaping patients, health professionals and managers social relations adds to these foundations in the contemporary period which is demonstrated to spread violence within maternity care services leaving patients, health professionals and managers to challenge, mediate and adapt to this continuum. Consequently, the limited space afforded to health professionals, and clinic and facility managers often results in their actions

co-optation by the continuum of violence they ostensibly aim to mitigate.

7.2 Novelty and Core Contributions of Methodological Design

My study is also novel as a result of its methodological design. Firstly, while research has posited that historic orders built on social norms that devalue women contribute to the generation of obstetric violence (Dixon 2015; Jewkes and Penn-Kekana 2015; Bowser and Hill 2010), there had not been research into the historical connections between such violence against women and obstetric violence. My approach to examine the origins of this particular type of violence against women in South Africa thus contributes to the body of literature that has taken a historical approach to establishing links between harms normalised through colonial conditioning in the past and violence against women in the democratic period (for instance Gqola 2010; 2015).

Secondly, my approach is novel in the South African case because of my concentration on the internal governance and management of the maternal health services, including a policy intervention and internal and external accountability procedures. Extent scholarship on obstetric violence has importantly focused on the locations of service delivery (Jewkes *et al* 1998; Kruger and Schoombee 2010), but have not devoted in-depth study of the ways in which the health system management and governance influence this environment.

Thirdly, novelty comes from my exploration of the relationship between obstetric malpractice and obstetric violence conceptually, as well as a review of existing South African case law concerning neonatal damages connected to obstetric violence. This approach creates a different type of data than what has been produced and drawn on more often: the narratives of health professionals and women. Consideration of the potential connections and disconnections between obstetric malpractice and obstetric violence opens up potential to conceptualise this violence against women by applying the strengths of interdisciplinary approaches. The movements in Latin America have established that there is a gap in law that poses challenges to remedies for obstetric violence (D'Gregorio 2010). My approach builds on this step forward, along with Pickles (2015) analysis of gaps in South African law and the acknowledgement in literature that accountability is key to preventing obstetric violence (Browser and Hill 2010; Honikman *et al* 2015; Chadwick 2016). I have done so by examining existing case law, which has not been done in the South African case, and I am only aware has been considered in the United States context (Diaz-Tello 2016).

7.2.1 Limitations

The findings of the study are limited by several factors. Firstly, by the study's insubstantial engagement with patients and their families – one of the main intra-relational groups relevant to understanding obstetric vio-

lence. This lack of engagement makes the study less comprehensive of the experience and perception of all groups relating to the research problem. Though despite this the study was still able to offer one of the few in-depth analysis of staff and management perceptions and health system functioning with regard to obstetric violence. Secondly, the ways in which the selection of hospital sites was determined as well as the granting, *and* unevenness of access to hospital locations is also arguably a limitation of the study. This arose from the general requirement of researchers to gain approval by a local Department of Health for access to the health system, a widespread requirement for health science research. As a result of these regulations, and the application of an adapted Participatory Action Research approach the hospital site selection was conducted in consultation with the Department of Health. This poses a certain limitation, as the sites of empirical investigation were not independently selected. Furthermore, after gaining the letters of approval from the Provincial Department of Health CEOs, heads of departments, and clinic managers further determined an unevenness of access to field sites. While, this study has been ambitious and accessed several levels of the health system these caused limitations for the study's depth. Thirdly, the study was granted limited access to middle level management, which asserts a high level of authority with regards to reported patient grievances. This resulted in a limitation, as many of the internally reported cases of obstetric violence were not fully traceable as a result, which constrained my ability to analyse the functioning of internal health system accountability mechanisms. Finally, limitations with regard to the actionable utility or powers of my empirical dataset arose from the routine imposition by

ethics committees requiring researchers 'complicity' in employing a methodological strategy of anonymisation in research involving people. In the case of my ethical approval's this included anonymising the research locations and ensuring confidentiality of all informants. For my study, this requirement has resulted in the limitation of using the research to report to relevant governing authorities on the hospitals, and professionals engaged in both routine and episodic obstetric violence which allows for evasions of accountability, that arguably contribute to the perpetuation of obstetric violence.

7.2. Summary of Salient Findings

With regard to my primary research question: *How and why is obstetric violence generated and propagated in South Africa's public maternal health services?* my study has revealed the combination of 1) social norms attendant to discriminatory discourses on race, sexuality and moral worth coupled with 2) political-economic arrangements encouraging social exclusion and inequality in resource distribution resulting in deprivations and poor social determinants of health, and 3) health system practices and policies drive multiple and overlapping practices and behaviours that overtime have been embedded in the system generating and spreading a continuum of direct and indirect violence within maternal health services.

This thesis is advanced on the basis of the following findings, which arise from research into the following secondary questions.

Discriminatory Social Norms

1. How and why were health services enabled to be tools of conquest and how was maternal health particularly influenced by these characteristics of colonial and apartheid ideology and governance?

Dehumanisation and objectification of Black women physically and ontologically became prevalent, and was made to be normal through the socio-political policies and systems put in place by colonial governments during the periods of conquest, enslavement, and post-emancipation in the Cape Colony. These systems established a historic order of persons that, while contested and resisted were legally entrenched and socially accepted by colonial society. These governance structures fuelled ideologies that characterised Black people as hyper-sexualised and insatiable. With regard to Black women these mythologies rendered them to be incapable of possessing moral value. Consequently, this rationalised and ostensibly made violence enacted upon Black women permissible, including sexual violence in the post-emancipation period. During the time of slavery ideas that Black women birthed differently, insofar as not requiring assistance or mediation of the physical pain caused by labour crystalized and was used to further rationalise their dehumanisation.

Colonial and Apartheid Conditioning of Reproductive Health

Within the context of colonial and apartheid governance historic orders attendant to race and gender were entrenched. The formal practice of midwifery and obstetrics emerged through the normalisation of degrading notions of sexuality, and embodied exploitation. The early founding and establishment of a medical hierarchy within provisions for maternity and childbirth overtime appropriated Black women's knowledge, income and position as lay midwives. This history reveals a key origin of the trajectory of epistemological and practical gendered hierarchy within maternal health. The establishment of colonial health services more broadly was implicated in colonial expansion, entrenching discriminatory racial, gendered ideologies in treatment and provision care, which also reinforced class-based orders. During the apartheid era the inculcation of these ideologies within health services expanded, especially through the inclusion of training (albeit intentionally at a below-average standard) and employing Black women in the profession of nursing.

Resulting from the use of reproductive health and specifically maternal health services as a tool for colonial and authoritarian management and control certain forms of obstetric violence became sanctioned aspects of the provision of reproductive healthcare for Black women. In other words these forms of obstetric violence became built into the provision of 'care'. Findings include: 1) The systematic denial of access to quality care, and at times exclusion; 2) Routine imposition of episiotomy,

and use of post-partum Black women as objects for interns to train in suturing (found in some services); 3) Verbal and psychological assaults concerning sexuality and moral worth; 4) Systemic coercive distribution and administration of LARCS, including sterilisation, and as a requirement of employment.

The Political Economy of Reproductive Health

2. How do the social determinants of health and the political and economic arrangements of the democratic period relate to obstetric violence?

Health Resource Disparity

The creation of a more accessible public health system has had a significant impact on the utilisation of maternal health services. Approximately 92% of South African women receive antenatal care, and 89% give birth in a health care facility with skilled attendants.

However, the quality of care women are able to access relates to the political and economic arrangement continuing to disparately resource health services. Funding for the public health system has been 3.5 percent of GDP, while the private system is supported with 5 percent of GDP. Considering 70-80% of the population relies on the public service,

which only employs 20% of specialised medical professionals working in the country, and further though national guidelines have put an embargo on cutting costs on medical professionals working in maternal healthcare services, in the last five years hiring freezes amongst midwives have become common place. This shows fiscal health policy remains a barrier to alleviating the human and material resource constraints. These constraints contribute to obstetric structural violence, as health professionals are unable to mediate these deprivations without neglecting women seeking care, especially during labour.

In the Western Cape access to primary care level maternal health services was the first to be significantly extended to the Black population during late apartheid and expanded into democracy. Originally, this expansion related to the wide-scale distribution of long acting contraceptives. This has resulted in a demonstrated pattern of coercive and or unconsenting delivery of contraceptives immediately following childbirth. The maternal health service, as well as the system generally has remained a centralised hospital driven service. Tension amongst some members of the medical fraternity and the Provincial Directors of Health are evidenced by the strengthening of the first District Level hospital established in a socially excluded Black township (1996) to a Secondary Level of care, only for it to be disbanded, and then unsecured and looted to the protest of clinical heads of department and patients (2014). The tension surrounds differing ideas about the approach of the distribution of specialised services to care for those most impacted by the quadruple burden of disease.

Poor Social Determinants of Health

Low-income Black women face the highest rates of unemployment, risks of disease, disability and morbidity. The government's social assistance through cash grants program aimed at addressing inequality is utilised predominantly by women-headed households (47% vs 17%) respectively. While the program offering nominal monthly assistance has been shown to reduce absolute poverty, its low monthly payments have not been significant in strengthening women's position. For instance, mothers don't receive support for themselves as carers but rather social assistance is aimed to directly support their children, this is true also for South Africa's 5 million single mothers. The low-remuneration only for their children has also been found to raise the degrading social and economic context low-income women face by perceptions of signifying that the government has little consideration for their dignity, in terms of their worthiness for support. The high levels of homicide, especially found in the townships where primary maternal health services are rendered and where patients and often nurses working in the system reside, compound these challenges. Everyday violence surrounding the hospital service causes anxieties for both staff and patients. From 2012-2013 midwives had their transport subsidy cut by the provincial department as a result of their cost saving efforts. The removal of transport from especially midwives working 24 hour shifts caused increases in stress, which resulted in absenteeism, and resigning from key clinic placements. Other issues around mobility especially contributing to the denial of care, neglect

and abandonment include ambulatory services at times inability to transport patients in labour as a result of volatile crime areas.

Obstetric Structural and Direct Violence

3. What are the forms and scope of obstetric violence in contemporary South Africa, and how do they inform what we know about this type of violence?

Direct forms of obstetric violence are often hidden from view as the health professionals caring for women are often aware of the parameters of evidence-based practice with which they should abide. Thus while both physical and psychological forms of direct obstetric violence were observable in the maternal health services, I became aware of these acts often as a result of them being reported to me, rather than through my direct observation.

Physical forms included:

- episiotomies (which are meant to be carried out rarely) administered without adequate suturing supplies (causing infection);
- lateral episiotomies (noted by clinicians in these instances to be un-necessary additionally are not evidence-based medical practice);
- *denial of pain medication throughout active labour;
- *lack of contraceptive method choices and administration of un-consented contraceptive methods.
- un-consenting sterilisation of HIV+ women;
- slapping (in the face, & legs), pinching and dragging by the ear;

- using elbows and hands to apply pressure to the fundus (which is against evidence-based practice);
- neglect of patients during early and active labour;
- denial of access to care.

Psychological forms included:

- patients requested to clean themselves, their beds and the floor after childbirth;
- a patient left for an unnecessarily long time dirty from childbirth;
- delivering on the floor with midwife support;
- lack of linen, linen savers and sterile gloves;
- *verbal assault (antenatal and labour visits): judging women's birth and fertility choices, accusing women of having little sexual morals, and blaming women for poor birth outcomes.

Those with asterisks above reflect practices found to be routine (defined as: those occurring weekly consistently month to month, year to year in at least two health facilities participating in this study). Importantly, links between acts which restricted women's reproductive autonomy in the past and those occurring in the present can be made. Firstly, the routine administration of long-acting injectable contraception especially found in primary maternal health services is a protocol that was established during apartheid that remains routine today. Similarly, the most commonly reported form of obstetric violence: verbal assaults when seeking services, and during childbirth, can also be linked to narratives used to justify the exclusion of, and violence against Black women during the colonial and apartheid periods.

These forms of obstetric violence reveal acts occur at several levels of maternity healthcare service. For instance the *interpersonal* exchanges between staff and patients in the form of common degrading and humiliating verbal assaults. As well as *diagnostically* as evidenced by the findings of coerced sterilisation; and at the *operational and structural* levels as evidenced by the lack of human resources resulting in denial and neglect.

Accountability: Obstetric Violence and Obstetric Malpractice

4. What is the relationship between obstetric violence and internal health system and external legal accountability mechanisms?

Transgressions within the health system in South Africa are governed through formal guidelines and procedures. Patients are able to report grievances to managers, staff and directly to Ministers whose offices have established protocols to expedite and field problems. In the Western Cape these mechanisms include authorities with binding, punitive powers as well as bodies that are more investigative aimed toward mediation and acknowledgement.

The aim of the Provincial Department of Health most often, with regards to grievances by patients and their families of alleged obstetric violence is to steer these clients away from malpractice litigation as an option for redress. Rather the goal of the internal grievance mechanisms and protocols is to provide a sounding board and offer the opportunity

for mediation with the accused staff member(s), and their managers. Often the reported cases I was aware of did not result in disciplinary action, or in-depth departmental investigations, or litigation proceedings. It seemed there was a lack of transparency and redress within the functioning of these procedures. As a result moving a case forward required concerted dedication on behalf of patience and their families.

Extant case law on obstetric malpractice showed a widespread pattern of adverse neonatal outcomes, most commonly brain damage resulting in a form of cerebral palsy. Where obstetric violence (for instance, in the form of restrictions of autonomy, failure to comply with informed consent procedures, and neglect related to childbirth) did feature, courts were constrained to consider these aspects leading to the damage of neonates, which were the grievances being litigated. This led to obstetric violence being accepted as "facts" to the case, and often did not result in opine or feature in judgments. Interestingly, the court, in one case did acknowledge the structural aspect of the growing case load relating to public health system negligence. The judgement opined that individual cases and settlements were detracting state financing public services that benefit all. This opine is particularly interesting as the court acknowledged a pattern of poor quality care occurring in public maternal health services and the weakness of obstetric malpractice litigation to address the structural drivers of the, often permanent damage to newborns.

7.3 Theoretical Implications and Generalisability

The implications of this dissertation's findings are threefold. Firstly, "Obstetric" refers to childbirth, which relates to women's context at the late stage of maternity and childbirth being of: "not-one-but-not-two" (Pickles 2014: 21-22).[128] Secondly, "Obstetric" denotes that violence against women in the context of maternity and especially childbirth effects a woman, and her foetus; her social context, her family, and kin. Obstetric therefore exposes the social meanings of this type of violence against women. Thirdly, I argue it is important to harness the term "violence" as it accurately describes the forms this harm takes, and keeps attention on its impact on disability, mortality and morbidity. Fourthly, I argue the attention on violence is necessary for one, because millions of women die annually as a result of "preventable," risks of maternity which are uncontested "violations of human rights" (Human Rights Council 2016 ¶1). Moreover, the consistent extreme un-equal distribution of this mortality (WHO 2014) exemplifies a structural form of violence.

My analysis and conceptualisation of how obstetric violence is a particular form of violence against women, which building on existing arguments (Jewkes and Penn-Kekana 2015), advances this understanding and my conceptualisation implies obstetric violence needs to be framed

128 The concept "not-one/not-two" is applied originally, as well as in this dissertation to recognise the intertwined relationship that exists between pregnant women and foetuses during pregnancy, and only in so far as this recognition advances women's rights (Pickles 2014: 21-22).

and considered in relationship to the scholarship and advocacy relating to reproductive rights, justice and freedom broadly. This is key as although forced and coercive contraception has already been included in conceptualisations of obstetric violence (WHO 2015) research and scholarship will be strengthened by connecting with this larger body of scholarship and advocacy. A particularly useful strength of this body of work is its theorisation of the relationship between reproductive rights and socio-economic context in which women live and families grow.

Secondly, my exploration of the connections and distinctions between obstetric violence and obstetric malpractice has broad implications for research, and practice. Especially, that it informs the utility of interdisciplinary scholarship to inform legislation, policy and what data is necessary to argue for the uniqueness of obstetric violence as a particular form of violence against women. Furthermore, this has implications for the types of recommendations associated with initiatives to prevent and encourage redress for this direct, and structural violence.

Thirdly, an implication from my approach to examining the generation of obstetric violence from the formation and stabilisation of historic gender and racial orders shaping power suggests that more historical work is necessary to find the key points at which health systems have become party to shaping and becoming inculcated in patterns of obstetric violence.

Finally, while this work is primarily based on an in-depth qualitative study of maternal health services in seven hospitals in one metro-district health system in South Africa the findings and conclusions are derived from data collected from archival and contemporary secondary data as well, vary in genralisability and must be considered in their context. Firstly, the conclusion that accumulation of racial and gendered discriminatory social, political and economic policies and practices are key structural drivers that embedded and reinforced patterns of obstetric violence in complex ways was found to be reasonably significant in the case of the Cape Colony up until the late 20th century. Given that we know the legal and political structures governing South Africa during colonialism and apartheid were meticulously entrenched in their regimen of enforcement and control, it is reasonable to argue that this conclusion is generalisable to South Africa. The study's empirical interrogation of contemporary maternal health care services used the case of the Cape Town Metro District, which examined service delivery at all three levels of care. Examination of the data found that there are various forms of physical and psychological obstetric violence practiced at the *interpersonal, diagnostic, operational and structural levels* of maternal health services (some routine, and others episodic); invidious discourses honed during colonialism and apartheid about Black girls and women's relating to pregnancy continue to fuel obstetric violence; and finally that disparate distribution of national funding of the public health system and the lack of transportation and security at the primary care level constrains health professionals from providing adequate care to pregnant women, especially with regard to attending to all women presenting in active-labour. These conclusions

were found to be reasonably significant for the case study, thus not generalisable causal findings. That said, these conclusions must be considered in their context, given that the Western Cape Province is wealthy and historically the clinically highest performing health system in South Africa (and perhaps all of Africa), then it is reasonable to assume that the problems occurring in this case setting are also occurring in the other eight South African provinces or in relative and lower performing contexts in Africa. Finally, the study examined health system structures and polices, the functioning and distribution of oversight and accountability, and existing national case law and medical obstetric settlements. This interrogation resulted in several findings and conclusions. Found to be reasonably generalisable at the provincial level but would require comparative study to claim national significance are: the constant change the health system has undergone for decades, which arguably has weakened transparency and accountability mechanisms. This was also found to feed concentrations of power at the top of the health system, and undermine low-level managers authority, resulting in demoralisation. The national data examined importantly found that most metro-district governance is often in contradistinction to national law, and though law mandates community governance and oversight of health services, most often these structures are weak or non-existent. The review of extant national case law on obstetric malpractice confirmed unsurprisingly that this is a national problem resulting in punitive financial compensation. Importantly, the analysis of the monies mandated to be paid to litigants by the state in the Western Cape cases (the province with the second highest number of cases) as compared to the province's monies lost to

corruption found that the latter exceeds the former. As the Western Cape province has been noted in auditor general reports to have relatively good performance in relation to corruption it is reasonable to argue the trend of more money being lost to corruption annually compared to indefensible obstetric malpractice litigation is a generalisable trend nationally. Finally, though the courts have often accepted evidence of practices of obstetric violence in cases trying the state for neonatal damages, courts power was found to be limited to prescribing remedies that would affect health system governance. Rather cases before the court restrict them to ruling on individual redress. While it is presumptive to say limitations of courts legal authority is widely generalizable, there is a growing body of evidence spanning Latin America, Spain and the United States demonstrating these limitations of courts to rule with regard to this aspect of women's reproductive rights are prevalent in several jurisdictions.

7.4 Policy Recommendations

Policy and programmatic interventions must approach the problem of obstetric violence by:

Firstly, acknowledging obstetric violence is a particular form of violence against women that:

- endangers a pregnant woman *as well as* her foetus or new born;
- has a direct impact on her kin;

- when certain forms are applied systemically it can impact the reproductive health of entire communities; and

- is carried out by health systems and/or policy.

As such, this analysis should be used to guide and sensitise all interventions.

Secondly, recognising women's health, and sexual reproductive rights, and health are dependent on individual women, and whole group's access and control of economic, social and political resources. As such commit to intervening in women and marginalised group's resource constraints with the aim to:

- increase the capability to choose to have children (or not) safely and with dignity.

- significantly decrease preventable maternal and neonatal disability, morbidity and mortality.

- increase popular and institutional knowledge of sexual and reproductive justice and rights.

Thirdly, committing to collaboratively work with health professional associations, health system administrators, departments of justice, and importantly, those marginalised in civil society to:

- identify the root causes of obstetric structural violence locally

- strengthen health system, independent institutional, and legal accountability practices to apply binding punitive measures on those governing and leading health systems with regard to trans-

gressions of routine and direct obstetric violence.

It is my conclusion that such actions, taken genuinely, and with material investment will enable health systems the chance to reverse the inhumane problem of obstetric violence. Breaking down the entrenchment of this particular form of global violence against women requires, and deserves this robust effort.

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Appendices

Appendix A

STAFF Participant Information Sheet (1 of 2)

Name of Project: **Everyday Transformation: Institutional Reform within Maternal Healthcare in South Africa** **Lead researcher**: Jessica Rucell, University of Leeds, United Kingdom Phone: 084 814 7381 **/** E-mail: ptjr@leeds.ac.uk **Local Supervisor:** Professor S. Fawcus, University of Cape Town Phone 072 335 4823 / Email: SFawcus@westerncape.gov.za

You or your organisation is being invited to take part in a research project. As you consider taking part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of this research? This is a doctoral academic research project, supported by the University of Leeds and the University of York in the United Kingdom. It studies the daily environment of public maternal healthcare services in the Western Cape. It also examines a government policy intervention called, "Code of Practice for Patient-centred Maternity Care" trying to change patterns of harm in health services. The research expects to finish by October 2014, but early conclusions will be made available to participants, community members and health services before this. Information about staff persons' experiences of health services will be collected from April-December. 2013.

Why is this research needed? The research will provide much needed understanding about the causes of harm in maternal health services, and how best such patterns can be changed. It will also provide staff and patients an opportunity to reflect on the health service and give feedback about the use of current actions to change services. These understandings are key to creating ways to support health workers and patients.

Who will be involved in the research and where will the research take place?
The research will take place in the Western Cape at Department of Health offices, and Health Clinics at times some interviews may be conducted at patient's homes or at UCT. It will engage public servants involved in implementing the Code of Practice at 4 Maternity Obstetric Units (MOUs) and the working environment and social dynamics at 2 of those MOUs. Participants in the research will include pregnant women, and young adults receiving services; their companions, community stakeholders; District, Unit, Facility and Operational Managers; Department of Health Officials, Midwives, Doctors, Nurses, Medical Students; Clerks, Security Guards, other key informants.

How will the research be carried out? To gain information the lead researcher will observe two MOU health facilities and the policy implementation process, she will also analyze documents, interview some participants, read reflective diaries some participants write, and will discuss the research with some participants in groups.

How much time will be taken by participating? At most participants will be asked to spend 3 hours engaged in interviews or discussions with the researcher over two visits. Some participants will have shorter interviews up to 30 mins. Additionally, some health workers may like to take a diary (provided by the researcher) to fill out personal reflections over the course of 2 working weeks.

What topics will the researcher want to discuss? The research's goal is to better understand the social and institutional pressures in the service delivery environment that can lead to harm of staff and patients, and the methods that can prevent harm. Topics to be discussed are: cooperation, decision-making, and communication between co-workers, patients and managers; experiences of health service; workplace and social stressors; the institutional structure of the MOU and health services; and implementation and feasibility of the Code of Practice.

Will participation in the research be confidential? Who will know? The researcher realizes the sensitive nature of the research and that confidentiality and anonymity is especially important as it involves workplace dynamics among public servants.

The following methods have been chosen to create confidential and anonymous participation. Participants will be recruited by in person introductions at staff meetings and in the facility. Interested persons will then be able to contact the researcher by personal telephone and email to organize participation.

While most participation will be on an individual basis, group discussions will also be one way participants can take part. As these conversations will involve several people the groups will have to first agree to keep discussions confidential.

The information recorded by the researcher in written and audio formats will be kept confidential and anonymous. For instance the consent forms only require a first name. Further, this will be done by the researcher using false initials, and titles for instance, "patient" or "nurse" to describe a participant in written works.

All identifying characteristics of the two case study MOUs will be excluded from descriptions of the research, for instance by writing "MOU 1 in the Metro District of the Western Cape".

Will participation be compensated? In order not to bias participation in the research no financial or gifts will be given in exchange for participant's time. However, transportation costs and at times of more than 2hrs of participation snacks will be covered. No participant will take on a financial burden through participation.

Can a participant stop taking part, or withdraw the info they shared? Participants wanting to withdraw from the study can do so by simply telling the researcher. If a participant additionally no longer wants the information they already shared to be used, they can tell the researcher during the period of June – November 2013.

How will participants be informed of the outcomes? Workshops can be conducted for healthcare facilities and their communities where the initial research conclusions could be presented and discussed with interested participants. Briefing reports and other research papers will also be produced to spread the research findings to the Department of Health and participant groups.

If you have any questions or concerns regarding your rights as a research participant please contact: the Chairperson of the **Human Research Ethics Committee, Faculty of Health Sciences, UCT Prof. Marc Blockman. Phone:** 021 406 6626 **Email:** shuretta.thomas@uct.ac.za

Consent form

Participant Consent Form

Name of research project: Everyday Transformation: Institutional Reform within Maternal Healthcare in South Africa
Lead researcher: Jessica Rucell, University of Leeds, United Kingdom

Initial the box if you agree with the statement to the left

1. I confirm that I have read and understood the research project information sheet, dated March 2013 and attached here. I have had the opportunity to ask questions about the project and that I have received contact information for the project.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. Should I not wish to answer any particular question or questions, I am free to decline.

3. I understand that my responses will be kept confidential. I give permission for members of the research team to have access to my anonymized responses, and to directly quote me. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.

I agree for the data collected from me to be used in future research.

4. I agree to take part in the above research project.

_____   _____   _____
Name of participant   *Date*   *Signature*

_____   _____   _____
Name of person taking consent *Date*   *Signature*

_____   _____   _____
Lead researcher   *Date*   *Signature*
To be signed and dated in presence of the participant

Observation check list

<u>Observation Overview</u>

Observations are: Descriptions of activities, behaviors, actions, conversations, interpersonal interactions, organizational processes, and the context and environment in which these take place.

<u>Observation is to be used to understand:</u>
- pressures experienced by midwives & clinical staff servicing labouring women
- pressures experienced by the women in labour
- how staff and patients navigate these pressures
- how staff view, and thus value patients
- how staff view, and thus value themselves and colleagues
- how staff view the health service, management, nursing

<u>General Characteristics of the Facility Experience to Observe and Document:</u>

Space: the physical place or places.
- Environmental atmosphere: intimidating, culturally homogenous/diverse, multi-lingual, friendly, relaxed, strict, scheduled, busy.

- Routines? Do clinical staff do their work in any pattern? E.g. this may express who directs activity and may be able/empowered to exercise power in this way; it may demonstrate how routine decisions are made and if certain people are favoured.

Actor: the people involved
- Look for physical indicators of support -or- the lack of support: number staff including support, cleaners, assistant nurses, sr. medical staff clinics, medical students, presence of security, equipment availability. This may indicate levels of institutional support and how they are mobilised, or may indicate observable absences.

Communication & Manner of Interaction: Verbal, Physical (body language), Silences
- How does communication happen? Is it initiated by patients? By staff? By which staff?
- What is the manner of communication: Is it judgemental? Caring? Aggressive? Friendly? Concerned? Out of need/necessity? Careless? Disparate? Abrupt?
- Are their patterns of communication? If so, between who and how? Who is talking? Who stays silent?

Additional Activities to Reflection on:
Act: single actions that people do.
Event: a set of related activities that people carry out.
Time: the sequencing that takes place over time.
Goal: the things people are trying to accomplish.
Feelings: the emotions felt and expressed.
Reflection: observer's personal response to any of the above.

bing the Space:

y   Intimidating   Multi-lingual   Strict   Fully Stocked

Relaxed   Caring   Lacks Equipment   Private

oes the space change overtime?   What influences such changes?

e is	Describe:				

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The people involved:

Midwives   # Clinical students   # Managers   # Calls to doctors   # Patients

Security   Companions   Cleaners

Describe what the staff are doing and when. (e.g. running from bed to bed – not enough hands; absent, quickly attending to needs)

Describe how staff feel, how patients seem to feel. (e.g. frustrated, calm, asking for help, needs are met)

People	Descriptions:

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Communication: Who initiates communication:

Patients   midwives   cleaners

    Companion   manager

People:	Yes	No	Describe:
Does the clinical staff introduce themselves?			
Does the clinical staff inform themselves of the patient history? (looking at record?, asking history?)			
Does the patient assert their needs?			
Does the patient stay quiet and wait to be attended to?			

Manner of Communication:

Judgemental   Caring   Aggressive   Friendly   Disparate   Absent

    Concerned   Out of need/necessity   Careless   Abrupt

Describe: Verbal, Physical (body language), Silences   (between staff, between patients and staff)
Are their patterns of communication? If so, between who and how? Who is talking? Who stays silent? Is there a rapport?

Sample interview questions

<u>Template of Guide to Semi-Structured Interview Questions</u>

Identify social and institutional factors that enable/block patterns of abuse.

Theme: Health system work experience

1. When did you start working for the service?
   - What was it like to train at that time?
   - What key experiences have shaped your time in the health service?
   - How would you describe the service then as compared to now?, or this clinic as compared to others you have worked in?

Theme: Challenges

2. What challenges come to mind when you think about work?
   - Have these changed over time?
   - What are the 3 most consistent challenges to managing/working in this unit?
   - How do you manage these difficulties?
   - Do you have support? By whom?

Theme: Social/Workplace stress

3. Describe your relationship with your colleagues?
   - Are colleagues a source of support, or tension?, How so?
   - What allows you to support your colleagues?
   - How do you contribute to the environment you have described?
   - What are the best words to describe your working relationships?

   - Is their favoritism among colleagues or managers?
   - What is this based on?
   - Does favoritism show up with the performance reward system?

   - Are their problems of absenteeism?
   - How has affirmative action effected staff/ management relations?

Theme: Abuse

4. Describe when you first witnessed/heard about abuse in maternity?
   - What types of abuse have you witnessed?
   - What was your reaction?
   - How did others react?
   - Have you ever abused a patient?

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- Why do you think abuse happens in this unit/hospital?
- Are their particular people who are vulnerable to abuse here?
- Have you noticed a pattern with what you have described?
- What if any steps have you taken to address this problem?

Theme: Complaints/ Accountability

5. How are issues of abuse dealt with in the unit/hospital/department?
- What has happened after an incident has been reported?
- Have you been involved in investigating an issue of abuse?
- How could this be improved?

- How do staff report problems if they have them?
- Explain the outcomes of some of the cases you have described?
- discrimination, lack of access to services, neglect, physical or verbal abuse, lack of support from health.
-
- Are you familiar with the code of patient centred maternity care?
- What is your opinion of this initiative?
-

- What makes these patterns continue?
- Who has the most power to change abuse?
- How would you try to change these abuses?
- What needs to change to prevent such abuses?

Theme: patients
6. Describe the patients that come here?
- What kind of relationship do you have with them?
- Are their particular types of patients that are harder to work with?
- How can these challenges be improved?   (What can patients/staff/health do?)

MANAGER
7. Describe the type of abuses you manage in the obstetric department?
- How do you address these abuses?
- When did this first come to your attention and what have you done to address it?
- What support do you receive to prevent and address these challenges?

Appendix B

Maternity Health Services Explained

To situate the meaning of obstetric violence, it is necessary to provide an overview of the services health systems provide for maternity care. The care women require during their time of maternity relates to the level of risk they and their pregnancy has. Thus, the impact and outcomes of forms of obstetric violence often not only depend on the form of violence but also the level of medical risk the mother and fetus is in. This annex provides a detailed mapping of the maternal health system, with a lens to providing insight to the meaning, outcome and impact of different forms of obstetric violence may have at the different levels of service.

Primary

Pregnant women's first point of entry to the health system, like most people in South Africa is usually at the primary care level. For pregnant women in the Cape Town Metro this happens at a midwife-led community-based obstetrics unit. These are referred to as Midwife Obstetric Units, MOU. MOUs are clinics located in a Community Health Centre CHC, also referred to as Day Hospitals. Since the late 1980s these centers have been based in townships where the majority of the Black population continues to live. Community Health Centers provide basic services such as, emergency, HIV treatment and counselling, adolescent and

child health, dentistry and eye care amongst others. It is also important to mention that the extraordinarily high 'quadruple burden of disease' that the Black population is exposed to requires these centres to care for large patient groups with poverty-related illnesses, such as chronic infectious disease (Coovadia *et al* 2009: 817). These hospitals remain under-resourced, for instance in staffing, and basic equipment (Cooper *et al* 2004: 77).

Similarly, the MOUs offer basic obstetric services. The majority of pregnant women seek care in public maternal health services. The primary care units MOUs are staffed by nurses and midwives and managed by an advanced senior midwife (specialist doctors attend once a week or several times a month to screen high-risk ante-natal and post-natal patients for instance, with ultra sounds). Most MOUs offer three beds for their ante-natal outpatient clinics, which operate five days a week from 7:00AM – 4:00PM (officially). However, in practice most clinics assess their last patients before 2:30PM. Usually three midwives, one professional nurse, and one nursing assistant staff these clinics which serve 230-280 out-patients per day, five days a week.[129] These daily numbers include at least thirty 'new bookings,' which are women coming in for their first time assessment, which will determine their likely delivery date and location. Ante-natal clinic's main services range from sexual, repro-

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129 As of 2011 clinic's servicing these large patient loads, which are the largest in the province are allocated four midwives, three nursing assistants and one professional nurse posts. CHC Memo, Sub-structure Director, Dr. Jeffery Vlok, 1 July 2011. However, staff shortages remain common, for instance one of the MOUs in the study has had 2 midwives staffing the clinic for twelve months, Personal communication, Midwife, Sofia Moses, 20 November 2016.

ductive health assessment and counselling (including on contraception methods), HIV testing and counselling (at some clinic's they also offer integrated services, which includes treatment), booking for intended childbirth, and referrals for further diagnosis if any complications are identified. That said, it is important to note that ante-natal services are not comprehensive and are neglected in South Africa. As a result patients often "begin labour with very little support and information. This in turn leads to women being afraid, out of control often all of which increases the stress of the labour ward and pressure on staff."[130]

Primary care units also provide childbirth and basic contraceptive services through their labour wards. For the last fifteen years Community Health Centres have provided sterilisation services as part of their reproductive health clinics in their minor surgeries, and the insertion of long-acting reversible contraception (LARC) directly after childbirth.[131] These labour wards support women who have no complications, are healthy and thus are able to have natural births with little to no medical intervention. Labour wards are most often staffed by two midwives and one professional nurse and busiest units additionally staff two nursing assistants (though one nursing assistant on night duty) per shift. These wards are open seven days a week, 24 hours a day. Deliveries are between 135 to 265 newborns per month, which is 1,620 to 3,180 per year. The teams work in 12-hour shifts and provide 24-hour service. The only other 24

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130 Personal communication, Academic Head of Department, Professor Eleanor Grant to Chief Director, WC Provincial Department of Health, David Claassen 23 November 2010.
131 Personal Interview, MOU Operations Manager, Midwife, Fatima Peterson, 20 November 2016.

hour service available in the majority of townships are from small Emergency Trauma Units within the Community Health Centres. MOU labour wards often have five beds for active labour, where women in early labour either wait on a bench in a hallway, or are given a bed if one is available.

Finally, MOUs offer post-natal care to assess and care for women and newborns immediately and up to five days after childbirth. Post-natal wards often have six to nine beds. The three to five labour ward staff are additionally responsible for post-natal wards as well as clinics during their shifts (some Units' dedicate an antenatal nurse to post-natal clinics during the week). Women and newborns move to the post-natal ward usually for 6 hours of observation directly after childbirth. In cases of certain difficulties they will stay longer. Some difficulties delaying mothers and newborns discharge include, when a new-born is unable to breastfeed, when an un-booked mother tests positive for HIV (they are recommended for in-patient care while waiting for the newborn's HIV test results, and when no-one comes to collect the mother and child. The post-natal ward provides scheduled clinics Monday-Friday 7 am – 4 pm, but usually mothers come until 7pm. These clinics are to follow-up with newborns and mothers for the first five days after childbirth. In addition to general follow-up the ward can admit two newborns at a time to provide in-patient phototherapy for those with jaundice.

This staffing allocation, services rendered, and volume of patients requires three health professionals to at times take responsibility for as many as fourteen or more in-patients (excluding their newborns, and out-patients). While these patients have a low-risk of medical complica-

tions they still require consistent attention, which requires more staff than are allocated. The inadequacy of allocated human resources demonstrates that the obstetric violence of neglect is sustained structurally at the primary care level. The majority of primary care clinics are located approximately 35 km from the next level of medical care, where a pregnant woman or new-born would need to be transferred to, or attend clinics if their complications require more specialized medical care (Van Coeverden de Groot, Davey, Howland 1982: 35). Changes to district level hospital infrastructure in the last four years has diminished the distance to District level facilities which offer a step up in access to expertise and equipment. This is discussed later in the chapter.

District

District level hospitals are general hospitals, which offer similar obstetric services to primary care hospitals. However at these facilities clinical care if overseen by Family Care Physicians and Consultants who are medical doctors in training to become specialists in a particular field, in this case obstetrics. MOUs transfer patients to their closest district hospitals for cases of latent labour, eclampsia (seizures brought on by high blood pressure), fetal distress, women with high body mass indexes BMI, and who have past their delivery dates, over 41 weeks for instance. District hospitals also see patients who have had previous caesarean sections.

Secondary

Secondary level hospital facilities offer the next level of care for women with minor complications either found before or during labour at a primary care unit. They provide these services through a similar clinic and ward structure as the primary level. In addition secondary hospitals have intensive care unit's ICU for newborns for instance, for premature newborns, and offer comprehensive management of women with complications such as, twins, pregnant girls fifteen years old or younger (including counselling support from social workers), high blood pressure, and advanced maternal age. Labour wards often have a staff composite of five midwives and an additional five to ten nurses. At this level more sophisticated diagnostic tools are available for example, ultra-sounds. Senior obstetricians provide clinical oversight to all maternity services and offer specialized ante-natal clinics. Labour wards provide caesarean sections (C-section), inductions for cases of latent labour, as well as contraceptive options such as sterilization, and the insertion of long-acting reversible contraception (LARC) directly after childbirth. For instance, the intrauterine device IUD, which is inserted directly into the uterus and can last from 3-10 years depending on the type of IUD.[132]

Tertiary

Tertiary Hospitals offer the most specialized public services and are attended and managed by specialized doctors, registrars (doctors in their final year of specialized training), and consultants. At the ante-natal level

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132 As of 2016 the Western Cape Department of Health is supporting a broader distribution of long-acting methods by training midwives in primary care clinics (who see the majority of pregnant women) to insert LARCs directly after childbirth.

services to manage complex and uncontrolled conditions are distributed through a series of daily clinics, for instance high blood pressure, diabetic, cardiac, and neonatology clinics. Additionally, they have a Fetal Assessment Centre, Maternal and Neonatal ICUs, and theatres for obstetric and neonatal surgery. Additionally, tertiary facilities support women in pre-term labour, and who require bed rest, they also support diagnosis, and treatments for fetal growth, congenital anomalies and other fetal risks. Women are referred to these ante-natal clinics if they have medical histories relating to the four major clinics, and for instance if they are found to have triplets or more, if they have had any prior organ transplants, and history of congenital abnormalities. Patients are transferred to tertiary hospitals if they require more advanced obstetric surgery, for instance if the uterus has ruptured, organ failure occurs during childbirth, latent labour, eclampsia and for instance if a newborn is severely premature, and fetal distress. Additionally, the same contraceptive options post-childbirth at the secondary level are offered at this level of care.

This brief overview demonstrates the varied sophistication of medicalized maternity health care offered to the public in the Cape Town Metro area. It also illuminates the risks involved in reproduction for mothers, and newborns, as well as their families and communities that the state through health professionals and its' health system manages. Thus it provides insight into the importance of this public service not only for the individuals and their families who rely on it but also to the entire society to have contraceptive options, prevent the spread of HIV, manage other complex diseases, and prevent maternal and neonatal mortality.