State of Maternal Health in South Africa

Findings from Eastern Cape and Gauteng

By Ebenezer Durojaye and Gladys Mirugi-Mukundi

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List of abbreviations

African Charter	African Charter on Human and Peoples' Rights
African Children's Charter	African Charter on the Rights and Welfare of the Child
African Commission	African Commission on Humana and Peoples' Rights
African Women's Protocol	Protocol to the African Charter on the Rights of Women
AU	African Union
CARMMA	Campaign on Accelerated Reduction of Maternal and Child Mortality
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CERPD	Convention on the Rights of Persons with Disabilities
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child
C-Section	Caesarean Section
CSOs	Civil Society Organisations
CTOP	Choice on Termination of Pregnancy
EC	Eastern Cape
ECNGOC	Eastern Cape Non-Governmental Coalition
GDP	Gross Domestic Product
HDACC	Health Data Advisory Coordination Committee
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICU	Intensive Care Unit
IMR	Infant Mortality Ratio
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNCWH	Maternal, Newborn, Child and Women's Health
NGOs	Non-Governmental Organisations
NMR	Neonatal mortality rate
RDP	Reconstruction and Development Programme
UDHR	Universal Declaration on Human Rights
WHO	World Health Organisation

EXECUTIVE SUMMARY

South Africa has one of the most buoyant economies in Africa, with better infrastructure than many other African countries. In addition, its per capita spending on health of 645 US dollars is one of the highest among developing countries (compared to Malaysia at 410, China at 322, Egypt at 152, Nigeria at 94 and India at 61). Moreover, in addition to the fact that the right to health is an enforceable right under the 1996 Constitution, South Africa has developed other laws and policies to ensure the realisation of this right. Despite these positive developments, however, it remains one of the countries with unacceptably high maternal mortality ratios, and has made insufficient progress in reducing maternal deaths as envisaged under Goal 5 of the Millennium Development Goals. In 1999 about 800 maternal deaths were recorded in South Africa; by 2012 the figure had jumped to nearly 1500.

One of the greatest challenges in post-apartheid South Africa is the inability of the government to properly realise the socio-economic rights of the people as guaranteed in the Constitution. The challenge is more visible in the area of ensuring access to maternal health care services for all women, particularly those who are vulnerable and disadvantaged. It is also important to note that disparities exist between provinces: rich and poor, urban and rural. According to the Confidential Inquiry Reports, the most populous provinces have the highest number of maternal deaths. Thus, provinces such as Gauteng, KwaZulu-Natal and Eastern Cape continue to record high maternal deaths compared to the other provinces.

The five major causes of maternal mortality in South Africa are:

- non-pregnancy related infections, mainly AIDS (40.5%);
- obstetric haemorrhage (14.1%);
- complications of hypertension (14.0%);
- pregnancy-related sepsis (9.1%);
- medical and surgical disorders (8.8%); and
- complications of pre-existing medical conditions such as cardiac conditions, diabetes, among others (9%).

This research for this report took the form of desktop reviews and focus group discussions and was carried out in Gauteng and the Eastern Cape. The report examines the challenges involved in the realisation of maternal health care services in these two provinces. The purpose of the focus group discussions was to:

- gather information about current South African laws, policies and programmes on maternal mortality and women's reproductive health and rights with particular reference to the Eastern Cape and Gauteng;
- identify the challenges of delivering maternal health care services in these provinces;
- assess the effectiveness of the government's policies and programmes in addressing maternal mortality in the country;
- discuss the role of various stakeholders in improving maternal health care services through campaigns;
- discuss the possibility of establishing a movement that advocates for improved access to maternal health services;
- make recommendations on how to improve maternal health care services in the country.

Our research findings show that the South African government has adopted laws, policies and programmes important in reducing the maternal mortality rate in the country. These include the adoption of a progressive Constitution in 1996; the enactment of the National Health Act of 2003; the Choice on Termination of Pregnancy Act of 1996; the White Paper on the Transformation of the Health Care System; and the Patient Charter of 2000. In addition, the government has established programmes addressing the challenge of access to maternal care. These include the Strategic Plan on Campaign on Accelerated Reduction of Maternal and Child Mortality (CARMMA) and the Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition 2012-2016. Moreover, the government has continued to increase its budgetary allocation to the health sector.

Despite these laws and policies on maternal health and the allocation of resources to the health sector, there remain many challenges that militate against access to maternal health care services. These include lack of political will to properly implement laws, policies and programmes on maternal health, a dearth of health care personnel, a weak health care system, and the negative attitudes of health care providers. The focus group discussions in the Eastern Cape and Gauteng revealed other challenges in the provinces hindering access to maternal health care services. These include unethical practices in the health care system; the negative attitudes of health care providers; stigma and discrimination; stock-outs and shortages of essential medicines; inaccessibility to health care centres; teenage pregnancy; lack of commitment; overcrowding; and late registration for antenatal care.

The report thus makes some important recommendations to tiers of government and civil society groups with a view to improving the situation. These include:

National Department of Health

- There is a need for constant dialogue and engagement with civil society groups and community members in the design and formulation of policies and programmes on maternal health care services in the country.
- More coherence is needed among government departments that have a role to play in addressing maternal health care.
- Allocation to maternal health under the strategic plan programme should be increased and clearly distinguished from that of HIV/AIDS and other line items.
- There is a need for qualified health care providers to be recruited and trained in human rights.
- Accountability mechanisms in the health sector should be strengthened.

Provincial Department Health

- Explore other means of ensuring safe motherhood, such as doula.
- Invest in the training of health care providers in rural areas.
- Embark on massive employment of qualified health care providers to meet the shortages in the health care sector.

Chapter nine institutions

- Be more vigilant in holding the government accountable in realising access to maternal health care services.
- Establish a joint monitoring committee comprising government officials and representatives of Chapter nine institutions.
- Investigate incidences of corruption and mismanagement at national and provincial level and provide appropriate sanctions.

Recommendations to civil society groups

- Continue to monitor steps and measures adopted by the government at all levels towards ensuring access to maternal health care services.
- Continue to empower women in rural areas and informal settlements in order to make them aware of their health rights.
- Form a coalition or movement agitating for better maternal health care services in the country.

CHAPTER 1

INTRODUCTION

1.1 Introduction

Two decades into democracy the South African health system faces various challenges, including inequities in access to health, poor coordination among the spheres of government, dearth of health care personnel and poor implementation of laws and policies. More importantly, when the country joined the league of democratic nations in 1994 it inherited a highly fragmented, dysfunctional and weak health system.[1] The apartheid regime created separate health care systems for blacks and whites. While the former had access to poor and underfunded health care facilities, the latter enjoyed access to a well-funded and quality health care system.[2] These disparities linger more than twenty years since the country attained democracy in 1994. To a large extent access to health care services is still determined by class, race, geographical location and gender.

South Africa has one of the most buoyant economies in Africa, with a better infrastructure than many other African countries. In addition, its per capita spending on health of 645 US Dollars is one of the highest among developing countries (compared to Malaysia at US$410, China at US$322, Egypt at US$152, Nigeria at US$94 and India at US$61).[3] Moreover, in addition to the fact that the right to health is an enforceable right under the 1996 Constitution, the country has developed other laws and policies to ensure the adequate realisation of this right.

Despite these positive developments, however, South Africa remains one of the countries with unacceptably high maternal mortality ratios that has made insufficient progress in reducing maternal deaths as envisaged under Goal 5 of the Millennium Development Goals (MDGs).[4] As at 1999, about 800 maternal deaths were recorded in South Africa; by 2012 the figures had jumped to nearly 1500. Due to inaccurate data, the maternal mortality ratio in South Africa has remained a subject of

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[1] Ngwena, C, Cook R.J. and Durojaye, E. (2013). "Right to Health in Post- Apartheid South Africa" In Zuniga J.M, Marks S and Gostin L. (eds) *Advancing the Human Right* to *Health.* 129.

[2] Ngwena, C, Cook R.J. and Durojaye, E. (2013). "Right to Health in Post- Apartheid South Africa" In Zuniga J.M, Marks S and Gostin L. (eds) *Advancing the Human Right* to *Health.* 129

[3] See World Bank Health Expenditure per capita available at http://data.worldbank.org/indicator/SH.XPD.PCAP (accessed on 12 September 2014).

[4] World Health Organisation et al *Trends in maternal mortality* (2012).

contestation.[5] In its 2013 MDG Report, the government, relying on the Civil Registration and Vital Statistics System, estimated that the maternal mortality ratio was 269 deaths per 100 000 live births.[6] These figures differ from the recent Report on Confidential Enquiry into Maternal Deaths in South Africa, which puts the figures at 159, 146 and 140 deaths per 100 000 live births in 2011, 2012 and 2013, respectively.[7] While this seems to reflect a gradual reduction in maternal deaths, the figures are still far below the percentage envisaged in MDG 5: between 1990 and 2015 to reduce maternal deaths by 75%.

1.2 Maternal health as a worldwide challenge

Maternal health is an important health issue and a fundamental human right. International law contains several legal instruments which call for the protection of women in the motherhood cycle through the prioritisation of the reproductive health and rights of women.[8] Worldwide, maternal mortality remains a major challenge to human development, with an estimated 800 women dying every day due to complications related to pregnancy and childbirth, the majority of them in sub-Saharan Africa. Maternal deaths are clustered around labour, delivery, and the immediate postpartum period, with obstetric hemorrhage being the main medical cause of death.[9] Other related causes of maternal death are unsafe abortions; complications resulting from HIV/AIDS, among others.[10] The saddest aspect of this disturbing state of affairs is that between 40% and 70% of these deaths are preventable through improving access to interventions for preventing or treating

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[5] For a more elaborate discussion of these challenges in the context of South Africa, see generally Bradshaw D (2012) 'Maternal mortality ratio – trends in the vital registration data' *South African Journal of Obstetrics and Gynaecology* 18(2) 38-42.

[6] See South Africa Millennium Development Goals Country Report (2013) 74.

[7] Tenth Interim Report on Confidential Enquiry into Maternal Deaths in South Africa 2011/2012.

[8] Maternal health is closely linked with the right to the highest attainable standard of health that is contained in the International Covenant of Economic, Social and cultural Rights (ICESCR) article 12; the Convention on the Elimination of All Discrimination against Women (CEDAW) article 12; the Convention on the Rights of the Child (CRC) article 24; the Convention on the Rights of Persons with Disability (UNCRPD) article 25; the African Charter on the Human and Peoples' Rights article 16, and its Protocol on the Rights of Women in Africa article 14; as well as the African Charter on the Rights and Welfare of the Child, article 14. Hunt and de Mesquita contend that the right to health is an important tool in the realisation of maternal health as it provides a framework for designing effective policies to reduce maternal mortality as well as avail tools and strategies for advocacy and accountability. See Hunt P & de Mesquita JB (undated) 'Reducing maternal mortality: The contribution of the right to the highest attainable standard of health' 3, available at *http://www.unfpa.org/webdav/site/global/shared/documents/publications/reducing_mm.pdf* (accessed 6 June 2013).

[9] Ronsams C & Graham W (2006) 'Maternal survival 1: Maternal mortality - who, when, where and why' 368 *The Lancet* 1189.

[10] Ronsams C & Graham W (2006) 'Maternal survival 1: Maternal mortality - who, when, where and why' 368 *The Lancet* 1189.

pregnancy and birth complications, in particular emergency obstetric care.[11] The need to respond to this challenge was acknowledged internationally through the incorporation of a goal to reduce maternal mortality as one of the major components of the United Nations Millennium Development Goals (MDGs).[12] At the time of the commencement of the MDGs in 2000, the maternal mortality rate (MMR)[13] for sub-Saharan Africa was estimated at 1000 deaths per 100 000 live births, almost twice the MMR in South Asia, four times that in Latin America and almost 50 times higher than the MMR in industrialised countries.[14] Now, 13 years after the commencement of the MDGs, the figure has improved considerably with sub-Saharan Africa having a MMR of 500 maternal deaths per 100 000 live births, as compared to 220 deaths in Southern Asia, 200 deaths in Oceania, 80 deaths in Latin America and the Caribbean, 78 deaths in North Africa and 71 deaths in Western Asia.[15]

1.3 Provinces with higher prevalence of maternal mortality in South Africa

The Confidential Inquiry Reports states that the most populous provinces have the highest number of maternal deaths.[16] The table below shows the number and percentages of maternal deaths per province, as per the Confidential Inquiry Reports on Maternal Mortality.

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[11] Hunt & de Mesquita (undated) 'Reducing maternal mortality: The contribution of the right to the highest attainable standard of health' 4.

[12] See The United Nations Millennium Declaration A/55/L.2 (2000), available at *http://www.un.org/millennium/declaration/ares552e.htm* (accessed 6 June 2013), which contains in para. 19 the resolve of the international community to reduce maternal mortality by three quarters and to also achieve universal access to reproductive health. See also Ronsams & Graham 1189, who contend that MDG 5 marked the very first time that maternal mortality featured so prominently in the high rank of global pronouncements, providing an appropriate platform to galvanise political will to effectively respond to the challenge.

[13] Maternal mortality rate (MMR) can be defined as 'the annual number of female deaths per 100,000 live births from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes). The MMR includes deaths during pregnancy, childbirth, or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, for a specified year', see Index Mundi 'South African maternal mortality rate' (2013) available at *http://www.indexmundi.com/south_africa/maternal_mortality_rate.html* (accessed 20 May 2013).

[14] Ronsams C & Graham W (2006) 'Maternal survival 1: Maternal mortality - who, when, where and why' 368 *The Lancet* 1190.

[15] Maternal Mortality Estimation Inter-Agency Group (WHO, UNICEF, UNFPA & the World Bank) 'Trends in maternal mortality: 1990 -2010' (2012) 1, available at *http://esaro.unfpa.org/webdav/site/africa/users/africa_admin/public/Trends%20in%20maternal%20mortality%20A4.pdf* (accessed on 6 June 2013).

[16]Department of Health 'Confidential Inquiry on Maternal Deaths, 2002-2004' (2006) 4, available at *http://www.doh.gov.za/docs/reports/2004/savings.pdf* (accessed on 21 May 2013).

Table 1: Maternal deaths reported per province in 1998-2010[17]

1998		1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
EC	56	95	120	103	113	112	145	149	154	160	215	263	232
FS	94	79	96	119	100	171	161	150	170	164	139	171	120
Gau	131	138	171	184	213	205	251	222	257	190	268	319	293
KZN	188	252	238	245	238	275	209	268	354	339	366	378	385
Lim	27	63	88	71	72	108	101	181	199	211	222	196	198
Mpu	66	72	128	97	98	120	75	74	108	87	128	115	150
NW	58	54	115	106	80	135	111	105	100	84	97	161	134
NC	22	18	29	23	38	28	40	53	53	58	59	53	52
WC	34	34	50	42	60	67	80	61	53	73	60	110	82
Total	**676**	**805**	**1035**	**990**	**1012**	**1221**	**1173**	**1263**	**1448**	**1366**	**1554**	**1766**	**1646**

(Key: EC - Eastern Cape; FS - Free State; Gau - Gauteng; KZN - KwaZulu-Natal; Lim - Limpopo; Mpu - Mpumalanga; NW - North West; NC - Northern Cape; WC - Western Cape)

It should be noted that these figures only account for the deaths reported to the National Committee for Confidential Enquiries into Maternal Deaths (NCCEMD) secretariat and entered on the MaMMAS database.[18] There is a general underreporting of maternal mortality deaths, and the quality of information on the cause of death is often inadequate. As such, these numbers must be scaled up by 50% so as to be indicative of the maternal mortality rate in the different provinces in South Africa.[19]

1.4 Causes and risk factors of maternal mortality in South Africa

The five major causes of maternal deaths in South Africa are:[20]

- non-pregnancy-related infections, mainly HIV and AIDS (40.5%)
- obstetric haemorrhage (14.1%)
- complications of hypertension (14.0%)
- pregnancy-related sepsis (9.1%)
- medical and surgical disorders (8.8%)
- complications of pre-existing medical conditions such as cardiac conditions, diabetes among others (9%).

[17] Saving Mothers Report 2008-2010 (note 11 above) 2.

[18] Saving Mothers Report 2008-2010 (note 11 above) 1.

[19] See Bradshaw (n 3 above) 38-9.

[20] CARMMA (note 13 above) 7; *Saving Mothers Report 2008-2010* (note 11 above) xi-xiii.

South Africa has taken steps, including legislative and other measures, to improve maternal health services for women. While these measures have led to a significant reduction in maternal mortality in the country, the rate of this reduction is still far from the annual 5% envisaged in MDG 5.

CHAPTER 2

METHODOLOGY

2.1 Introduction

This research was essentially based on a desktop review of laws, policies and programmes on maternal health in South Africa. In addition, two focus group discussions were conducted in two provinces – the Eastern Cape and Gauteng. Originally, the plan was to conduct the focus group discussions in two of the disadvantaged provinces – Eastern Cape and Limpopo – which also have high maternal mortality rates; however, due to some logistical challenges the focus group discussion scheduled for Limpopo could not take place. The researchers on this project had arranged a focus group discussion with civil society groups in Limpopo, but on the day of the discussion some of the participants were not willing to proceed with it because the Provincial Department of Health had not given approval for the discussion to take place. We informed them that an ethical clearance had been obtained from the University Ethics Committee and that in other provinces such as Eastern Cape we were able to conduct a similar meeting without hitches. Due to the reluctance of the participants to continue with the focus group discussion, the meeting was discontinued. It was clear from this incident that a great number of civil society groups in Limpopo have close links with the Provincial Department of Health and were unwilling to antagonise policies or programmes proposed by the government.

The choice of Eastern Cape and Gauteng is based on the dynamics of these two provinces in terms of equity in access to health care services. The Eastern Cape is mainly rural and poor compared to other provinces. It has one of the highest rates of maternal mortality, and weak infrastructure. Gauteng, on the other hand, is a prosperous province with more of an urban setting. It also has better facilities and infrastructure compared to other provinces. Despite this, however, the maternal mortality rates in Gauteng remain high and disparities exist regarding access to health care services among the districts and municipalities.

2.2 Aim of the focus group discussions

Two focus group discussions in Eastern Cape and Gauteng were organised to gather pertinent information on the situation of maternal mortality in the two provinces. The focus group discussions were conducted with stakeholders, including civil society groups, health care providers, women, and health care managers. About 10 organisations/participants were invited to attend. The purpose of the focus group discussions was to gather information about the current South African laws,

policies and programmes on maternal mortality and women's reproductive health and rights with particular reference to Eastern Cape and Gauteng. More specifically, the discussions aimed to:

- identify the challenges in maternal health care services in each of the provinces;
- assess the effectiveness of the government's policies and programmes towards addressing maternal mortality in the country;
- discuss the role of various stakeholders in improving maternal health care services by spear-heading a campaign on maternal mortality;
- discuss the possibility of establishing a movement advocating for improved access to maternal health services; and
- offer suggestions and recommendations on how to improve maternal health care services in the country.

The aim of the research was to examine the causes of maternal deaths in South Africa and the steps and measures adopted by the government to address them. The information gathered from the focus group discussions is collected in this research report, which will be used as an advocacy tool when engaging with decision-makers, including the national and provincial departments of Health and parliamentary portfolio committees.

The choice of civil society groups for the focus group discussions is informed by the important role they play in facilitating access to health care services, including maternal health care for vulnerable and marginalised groups. Many civil society groups, including community-based organisations, work in rural areas and are able to reach poor women in these areas. More importantly, over the years civil society groups have played an important role in deepening democratic culture and ensuring accountability towards the realisation of the rights guaranteed in the Constitution. They have also mobilised the citizenry to demand justice and ensure an equal society. It is worth remembering that the success of the *Treatment Action Campaign case* was largely due to the ability of civil society groups to mobilise the public to demand for improved and equitable access to health care services for vulnerable and marginalised groups in society.

Aside from acting as a watchdog to the government to ensure accountability, civil society groups also assist the government in realising its constitutional duties by providing important social services to the population, especially vulnerable and marginalised groups. It is hoped that this report will assist in prompting civil society groups to form an alliance advocating for improved access to maternal health care services in South Africa.

CHAPTER 3

MATERNAL HEALTH AS A HUMAN RIGHT

1.5 Introduction

The enjoyment of the right to the highest attainable standard of health would necessarily include access to maternal health care services. The right to health has been recognised in numerous international and regional human rights instruments including the International Covenant on Economic, Social and Cultural Rights (ICESCR),[21] the Convention on Elimination of All Forms of Discrimination against Women (CEDAW),[22] the Convention on the Rights of the Child (CRC),[23] the African Charter on Human and Peoples' Rights (African Charter),[24] the African Charter on the Rights and Welfare of the Child (African Children's Charter)[25] and the Protocol to the African Charter on the Rights of Women (African Women's Protocol).[26] South Africa has ratified all these instruments. Article 12(1) of the ICESCR recognises the right of everyone to the enjoyment of the highest attainable standard of health, whereas article 12(2) recognises the underlying determinants of health, including maternal care. Article 12 of the CEDAW also recognises that all women, on an equal basis with men, should enjoy the right to health. More importantly, article 12(2) of CEDAW enjoins states to realise the right to health care services for all pregnant women. Other UN human rights instruments that have recognised the right to health include article 5 of the Convention on Elimination of Racial Discrimination[27] and the Convention on the Rights of Persons with Disabilities.[28]

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[21] International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966; GA Res 2200 (XXI), UN Doc A/6316 (1966) 993 UNTS 3 (entered into force 3 January 1976).

[22] Convention on the Elimination of All Forms of Discrimination Against Women GA Res 54/180 UN GAOR 34th Session Supp 46 UN Doc A/34/46 1980.

[23] Convention on the Rights of the Child GA Res 25 (XLIV), UN GAOR Supp No 49 UN Doc A/RES/44/25 1989.

[24] African Charter on Human and Peoples' Rights OAU Doc CAB/LEG/67/3/Rev 5, adopted by the Organisation of African Unity, 27 June 1981, entered into force 21 October 1986.

[25] African Charter on the Rights and Welfare of the Child, OAU Doc CAB/LEG/24.0/49 (1990) (entered into force 29 November 1999).

[26] Protocol to the African Charter on the Rights of Women, adopted by the 2nd Ordinary Session of the African Union General Assembly in 2003 in Maputo CAB/LEG/66.6 (2003), entered into force 25 November, 2005.

[27] International Convention on the Elimination of All Forms of Racial Discrimination, G.A. res. 2106 (XX), Annex, 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc.

[28] The Convention on the Rights of Persons with Disabilities adopted on 13 December 2006 during the sixty- first session of the General Assembly by resolution A/RES/61/106

Both the Committee on Economic, Social and Cultural Rights (CESCR) and the CEDAW Committee have issued relevant general comments or recommendations touching on the right to health in general and of women in particular. For instance, in its General Comment 14, the CESCR has noted that states must ensure the availability, accessibility, acceptability and quality of health services, including maternal health care services. Moreover, the Committee has emphasised that states parties must give priority to the right to health of vulnerable groups, including women and children. Also, the CEDAW Committee has noted that states must ensure access to health care services peculiar to women's needs.[29] More importantly, the Committee has noted that states must ensure allocation of adequate resources to facilitate access to health care services needed by women and girls. It further notes that article 12 of the Convention requires governments to respect, protect and fulfil women's right to health.

In 2009, the Human Rights Council (HRC) for the first time adopted a resolution on maternal mortality in which it calls on states to take steps and measures to address maternal mortality across the world.[30] The HRC further noted that maternal mortality constitutes a gross violation of women's fundamental rights, including the rights to life, health, dignity and non-discrimination. The HRC's Technical Guidance on maternal mortality urges states to adopt appropriate laws and policies to ensure safe motherhood and prevent women dying during childbirth and pregnancy.[31]

At the regional level, all three major human rights instruments – the African Charter on Human and Peoples' Rights, the African Charter on the Rights and Welfare of the Child and the Protocol to the African Charter on the Rights of Women – contain provisions on the right to health, including access to maternal health care services. South Africa has ratified these regional instruments. Article 14 of the African Women's Protocol guarantees women's rights to health care, including sexual and reproductive health care. More importantly, article 14(2) enjoins states to:

- provide adequate, affordable and accessible health services, including information, education and communication programmes to women, especially those in rural areas;
- establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding.

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[29] General Recommendation 24 of CEDAW on Women and Health UN GAOR 1999, Doc A/54/38 Rev

[30] Human Rights Council Preventable Maternal Mortality and Morbidity and Human Rights A/HRC/11/L.16/Rev 1, 16 June 2009.

[31] United Nations. Human Rights Council, 18th Session. Practices in adopting a human rights-based approach to eliminate preventable maternal mortality and human rights. A/HRC/18/27; 8 July 2011

The African Commission has adopted a resolution on maternal mortality as a human rights challenge in Africa. According to the Commission, maternal mortality has remained a serious challenge in Africa and should therefore be declared a state of emergency.[32] It further notes that high maternal mortality rates in Africa constitute serious human rights violations which warrant the immediate attention of African governments.

1.6 Realising a rights-based approach to reduce maternal mortality rate

For sustainable development to be achieved, South Africa must reduce the MMR below 228 deaths per 100 000 live births, as per MDG 5. In order for the government to achieve this target, it must adopt a human rights approach in the development and implementation of its intervention strategies as maternal mortality is not only a health but a human rights concern. A human rights approach will need to address the root causes of maternal mortality, including poverty and inequality, which often contribute to high maternal mortality rates in rural and poor urban areas where health services are either inadequate or inaccessible. In this context, the right to equality and non-discrimination[33] as well as the right to health must play a prominent role in the development and implementation of the State's strategy in lowering the MMR so as to enhance the prospects of achieving MDG 5.

In the prevention of maternal deaths, the right to health must be understood broadly as an entitlement to an available, accessible, adequate, effective, well-resourced, culturally acceptable and integrated health system which encompasses health care and the underlying determinants of health and is responsive to national and local priorities.[34] Hunt and de Mesquita elaborate on some of the critical services that must be accessible to women in this integrated health system so as to prevent maternal deaths:[35]

- emergency obstetric care;
- a skilled birth attendant;
- education and information on sexual and reproductive health;
- safe abortion services where not against the law;

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[32] See the African Commission on Human and Peoples' Rights Resolution on Maternal Mortality in Africa Meeting at its 44th ordinary session held in Abuja, Nigeria, 10-24 November 2008, ACHPR/Res 135 XXXXIIII reproduced in E Durojaye & G Mirugi-Mukundi *Compendium of Documents and Cases under the African Human Rights System* (2013).

[33] For a discussion of the importance of gender equality in enhancing maternal health, see Hunt & de Mesquita (note 6 above) 7.

[34] Hunt P & de Mesquita JB (undated) 'Reducing maternal mortality: The contribution of the right to the highest attainable standard of health' 5.

[35] Hunt P & de Mesquita JB (undated) 'Reducing maternal mortality: The contribution of the right to the highest attainable standard of health' 5-6.

- other sexual and reproductive health care services, such as family planning services;
- primary health care services.

The obligations of the State arising from the right to health and its relevance to the prevention and reduction of maternal mortality are summarised in Table 2 below. Efforts of the South African state in reducing maternal mortality must therefore, of necessity, be measured against this right to health obligation.

Table 2: Obligations arising from the right to health in relation to maternal mortality[36]

Criteria of obligation	Right to health requirement	Relevance to maternal mortality
Available	An adequate number of goods, services and facilities necessary for maternal health, as well as sufficient numbers of qualified personnel to staff the services.	Increasing care and improving human resource strategies – including increasing the number and quality of health professionals and improving terms and conditions – will be key for reducing maternal mortality in many countries.
Physically and economically accessible	Maternal health and sexual and reproductive health services which are both physically and financially accessible.	Physical access to, and the cost of, health services often influence whether women are able to seek care.
Accessible on the basis of non-discrimination	Health services must be accessible on the basis of non-discrimination.	Ensuring women's access to maternal health and other sexual and reproductive health services may require addressing discriminatory laws, policies, practices and gender inequalities in health care and in society that prevent women and adolescents from accessing good quality services.
Accessible information	The right to seek, receive and impart information and ideas concerning health issues, including information that can help prevent maternal mortality.	Laws or policies that restrict women's access to information on sexual and reproductive health have a direct impact on maternal mortality.
Acceptable	All health facilities, goods and services must be respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender and life-cycle requirements.	Preventing maternal mortality and enhancing access to maternal and other sexual and reproductive health care is not simply about scaling up technical interventions or making the interventions affordable. Also important are strategies to ensure that the services are sensitive to the rights,

[36] Table accessed from Hunt P & de Mesquita JB (undated) 'Reducing maternal mortality: The contribution of the right to the highest attainable standard of health' 6.

		culture and needs of pregnant women, including those from indigenous and other minority groups.
Good quality	Maternal health care services must be medically appropriate and good quality.	The quality of care often influences the outcome of interventions and it also influences a woman's decision of whether or not to seek care.

Taking into account the above obligations, some of the policies and programmes that must be put in place to enhance maternal health and reduce the MMR in South Africa include:

- Assess, integrate and align all existing maternal health policies and programmes from a human rights perspective.
- Enhance the professionalisation of maternal care in all facets of the motherhood cycle. This cannot be achieved unless there is adequate political will as well as adequate prioritisation of resource allocation to enhance the training, development and retention of skilled health workers as well as the maintenance of focus on the equity of access to facility-based obstetric care.[37]
- Equality and non-discrimination both vertical and horizontal must be enhanced so as to ensure that women belonging to the most vulnerable population groups, such as poor women, have the necessary access to efficient maternal health programmes.
- Improve the reporting of and collection of disaggregated data on maternal mortality so as to enhance an evidence-based assessment of causes of maternal mortality and to adequately target vulnerable populations and provinces.
- Enhance participatory and cooperative practices in the development of maternal health policies and programmes so as to enhance the viability, acceptability and effectiveness of the interventions. These practices should also encompass the monitoring and evaluation of the designed interventions so as to determine their impact in reducing maternal mortality, and where ineffective, to make the necessary adjustments.

Some of the above factors have already been identified and proposed for implementation in the latest Saving Mothers Report 2008-2010. They include, among others, reduction in maternal mortality rates; general improvement in the economy; strengthening of the health system; reduction in fertility rates and increase use of family planning methods; improvement in the education levels

[37] Horton R (2006) 'Healthy motherhood: An urgent call to action' 368 *The Lancet* 1129.

of the population; continuing focus on involving communities in the appropriate use of the health system; empowering women; and accelerating HIV prevention and treatment.[38]

1.7 Other interconnecting rights in relation to maternal health

The right to life

The right to life is guaranteed in many international human rights instruments and national law, including article 6 of the International Covenant on Civil and Political Rights, article 5 of the African Charter and section 11 of the South African Constitution. There is a growing consensus that the violation of the right to health may result in the violation of the right to life.[39] This is because deaths during childbirth and pregnancy can be avoided. Thus, deaths arising from poor or lack of access to maternal health care services will result in the violation of the right to life guaranteed in human rights instruments.

This broad interpretation of the right to life so as to impose positive obligations on states to preserve lives has been the position of some national courts and international tribunals in recent times. For example, the Indian Supreme Court held that failure on the part of a government hospital to provide emergency treatment to a citizen amounted to a violation of the right to life guaranteed under article 21 of the Indian Constitution.[40] The Court explained in that case that the Indian government could not rely on the excuse of a lack of resources to justify its failure to save lives. More recently, an Indian High Court has found that death resulting from lack of access to maternal health care services amounted to a violation of the right to life guaranteed in the Constitution.[41]

The decisions in the above cases cogently emphasise the positive nature of the duty imposed on states to guarantee the right to life, and the indivisibility of the right to health and the right to life. These decisions coincide with the reasoning of some treaty monitoring bodies. For instance, the Human Rights Committee in its General Comment 6 noted that the right to life should be interpreted broadly to include other rights such as to housing, food and health care.[42] The Committee also noted in one of its Concluding Observations that lack of access to reproductive health care services, including services related to contraception for women, is a violation of their

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[38] Saving Mothers Report 2008-2010 (n 11 above) vi.

[39] See, for instance, The Right to the Highest Attainable Standard of Health, UN Committee on Economic, Social and Cultural Rights, General Comment No 14, UN Doc E/C/12/2000/4 para 3; see also Yamin AE (2003) 'Not just a tragedy: Access to medication as a right under international law' 21 *Boston University International Law Journal* 370.

[40] PachimBangaKhetMajoorSamity v State of West Bengal (1996) 4 SCC 37.

[41] *LaxmiMandal v DeenDayalHaringar Hospital*; and *Jaitun v Maternity Home, MCD*, MANU/DE/1268/2010, cases WP(C) 8853/2008 and 10700/2009 (High Court of Delhi) judgment on 04.06.2010.

[42] The Right to Life, UN GAOR Human Rights Committee 37th session Supp. No. 40.

right to life.[43] In particular, the Committee has consistently expressed grave concern over high rates of maternal mortality, framing it as a violation of women's right to life [44]

Right to dignity

The right to dignity is guaranteed in numerous human rights instruments. For instance, the UDHR in its preamble declares that the 'recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world'. It provides further in article 1 that all human beings are born free and equal in dignity. In other human rights instruments, the protection of human dignity is often expressed in provisions relating to the right to be free from inhuman and degrading treatment. For example, article 7 of the ICCPR provides that 'No one shall be subjected to torture or cruel and inhuman or degrading treatment or punishment. In particular no one shall be subjected without his free consent to medical or scientific experimentation'. This provision has often been interpreted to ensure that prisoners are treated humanely. However, it is also important in holding states accountable in fulfilling their obligations to ensure access to sexual and reproductive health services that are respectful of people's rights. Section 10 of the South African Constitution guarantees the right to dignity of everyone. This requires that every human being should be treated with respect and decency.

Failure by states to ensure quality maternal health care services to pregnant women may result in the violation of the right to dignity. Moreover, maltreatment of pregnant women attending antenatal care will amount to the violation of their right to dignity. The word 'dignity' is difficult to define precisely. Nonetheless, the court in the *National Coalition of Lesbians and Gay* case noted that 'it is clear that the constitutional protection of dignity requires us to acknowledge the value and worth of all individuals and members of our society'.[45]

The Human Rights Committee in *KL v Peru*[46] explained that forcing a woman to carry a pregnancy to term against her will constitutes inhuman and degrading treatment under article 7 of the ICCPR. The Committee notes further that this is so when a pregnancy is potentially harmful to the health and life of a woman and the government has failed to guarantee her access to safe abortion services. These interpretations support the argument that the maltreatment of pregnant women attending

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[43] See Human Rights Committee Concluding Observations: Chile 30/3/99 UN Doc CCPR/79/Ad. 104,15.

[44] See, for instance, Human Rights Committee Concluding Observations: Bolivia 01/04/97 UN Doc. CCPR/79/Ad. 74, 22; Concluding Observations: Guatemala 27/08/2001 UN Doc CCPR/CO/72GTM, 19.

[45] National Coalition of Gay and Lesbians v Minister Justice South Africa, CCT 11/98; [1999] (1) SA 6 (CC).

[46] *Karen NoeliaLlantoy v Peru* U.N. Doc. CCPR/C/85/D/1153/2003, 22 November 2005.

antenatal care and accessing poor maternal health care services in most rural areas undermines the right to dignity of women, for which the South African government must be held accountable.

Under the African Charter, article 5 recognises an individual's right to dignity. It provides that '[e]very individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status'. It further prohibits all forms of cruel, inhuman and degrading treatment against any human being. Article 3 of the African Women's Protocol also guarantees women's rights to human dignity. It provides that 'Every woman shall have the right to dignity inherent in a human being and to the recognition and protection of her human and legal rights'. Article 3 further provides that 'Every woman shall have the right to respect as a person and to the free development of her personality'. These provisions can be invoked to demand that pregnant women deserve access to quality maternal health care services that is culturally acceptable and respectful of their fundamental rights.

Right to equality and non-discrimination

High maternal mortality rates may result in violation of the right to equality and non-discrimination against women. These rights are equally threatened by lack of access for poor or disadvantaged women to maternal health services. Article 12 of the CEDAW requires states to ensure access to health care services to women on a non-discriminatory basis. Given that maternal mortality in South Africa is rampant in rural areas compared to urban areas and the fact that black women are the worst affected by maternal mortality, this raises the issue of inequalities and inequities in access to maternal health care services. Thus, the South African government can be held accountable for the violation of the rights to equality and non-discrimination.

The right to equality and non-discrimination are relevant to maternal mortality particularly where poor, disadvantaged and vulnerable women in rural areas are concerned. In *Alyne v Brazil*, the CEDAW Committee for the first time held that a state could be in violation of the right to non-discrimination for failing to prevent the death of a poor indigenous woman living in a rural area who lacked access to reproductive health care services.[47] The Committee made a number of recommendations to the Brazilian government, including that it increases the allocation of resources to the health sector and the training of health care providers.

From the foregoing, it is clear that the South African government is obligated under international and regional human rights law to respect, protect and fulfil women's right to health care services,

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[47] *da Silva Pimentel v Brazil* Committee on the Elimination of Discrimination against Women. Communication No. 17/2008.CEDAW/C/49/D/17/ 2008. Decision of 25 July, 2011.

including maternal health care services. This is particularly so given that South Africa has ratified most human rights instruments, notably the CEDAW, the African Charter, the African Children's Charter and the Protocol to the African Women's Protocol.

CHAPTER 4

LEGAL AND POLICY FRAMEWORK ON MATERNAL HEALTH IN SOUTH AFRICA

4.1 Introduction

Over the years the South African government has shown commitment towards realising the right to health, particularly maternal health. To this end, the country adopted a number of policies and programmes to address the unacceptably high maternal mortality rate in the country. This section of the report considers some of the steps the government has taken to address maternal mortality with a view to ascertaining whether they are consistent with the country's obligations under international law.

4.2 Legislation relevant to maternal health

Constitution

When in 1994 South Africa became a democratic state, it ushered in a new dispensation and shed the cloak of apartheid. More importantly, in 1996 South Africa adopted a new Constitution which has been hailed as one of the most progressive constitutions in the world. Apart from delineating the roles and powers of the different arms of government, the Constitution serves as the supreme law and is central to developing laws and policies relating to health. It provides a transformative agenda to address past inequality in the country. In its preamble the Constitution envisages a society that is built on democratic principles, including respect for the human rights, equality and dignity of all people.

Of particular importance is the equality provision in section 9. This section prohibits discrimination on various grounds, including gender, age, sex, race, pregnancy, sexual orientation and disability. It is clear that section 9 adopts a substantive rather than a formal-equality approach to non-discrimination. It is important in protecting the rights of vulnerable and marginalised groups, including women and children. This approach, as we shall see, is crucial in relation to the sexual and reproductive health needs of women, including maternal mortality.

In addition to guaranteeing civil and political rights, the Constitution explicitly guarantees socioeconomic rights, including the right to health in its Bill of Rights. The right to health under the South African Constitution is broadly captured in three sections, namely:[48]

- Section 27 – right to access to health care services
- Section 28 – right to health of children
- Section 35 – right to health of persons in detention

However, for the purpose of this study, the focus will be on the provision of section 27. Section 27(1) of the Constitution provides for the right to access to health care, including reproductive health. Also, section 27(3) states that 'no one may be refused emergency medical treatment'. Section 27 must be read together with the general obligations of the state in section 7, which enjoins the government to 'respect, protect, promote and fulfil' the rights contained in the Bill of Rights. In essence, this means that in relation to health care services, the government is obligated to refrain from interfering with the enjoyment of the right to health; adopt appropriate measures to ensure that a third party does not interfere with a citizen's right to health; create an enabling legal environment to realise the right to health; and ensure allocation of adequate resources to guarantee the enjoyment of this right.

More specifically, section 27(2) provides that 'The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights'. This provision is aimed at clarifying the nature of the government's obligation in relation to the right to health care services. It does not imply that the government must provide access to health care for all on demand. Rather it means that the government must take all reasonable steps to ensure that the right to health is respected, protected and fulfilled so that people enjoy access to decent health care services, free from discrimination and abuse.

In a number of landmark cases, the Constitutional Court has clarified the significance of this provision. The first case to explain the provision was the *Grootboom* case.[49] This was an eviction case that originated in the Cape Town High Court. In that case Mrs. Grootboom and fellow applicants were facing eviction from their homes, which they illegally occupied, without provision of alternative accommodation. In adopting the reasonableness test to ascertain if the government had fulfilled its obligation under section 26(2), the Constitutional Court held that the government's policies and programmes on housing have been unreasonable in the sense that they have failed to

[48] Constitution of the Republic of South Africa (1996) Act 108.

[49] Government of the Republic of South Africa v Grootboom 2000 3 BCLR 227 (CC).

meet the urgent needs of those desperate for housing. This case established an important precedent that any steps or measures taken by the government towards realising socioeconomic rights must pass the reasonableness test.

In the *Treatment Action Campaign* case,[50] the Constitutional Court was called upon to examine whether the antiretroviral (ARV) therapy programme of the government, which limited access to Nevirapine to 18 pilot sites and research centres, was reasonable. Building on the *Grootboom* case, the Court found that given the threats to lives posed by the HIV epidemic, there was no justification for the government to limit access to ARV to 18 sites as this amounted to a failure to fulfil its obligation under section 27(2) of the Constitution. These cases are relevant in determining the nature of the government's obligation to address maternal mortality. They clearly show that laws, policies and programmes to address maternal mortality must be reasonable in the sense that they must respond to the needs of vulnerable and marginalised women who are susceptible to maternal death.

In addition to section 27 of the Constitution, other rights are directly or indirectly important for the enjoyment of health, including maternal health care services. These include the right to dignity recognised in section 10 of the Constitution and the right to reproductive autonomy in section 12. In the *Makwanyane* case, the Constitutional Court explained the importance and centrality of the right to dignity to the enjoyment of all other rights in the Bill of Rights. According to the court, 'recognising the right to dignity is an acknowledgment of the intrinsic worth of human beings: human beings are entitled to be treated as worthy of respect and concern.'[51] Implicit in this statement is that pregnant women accessing antenatal health care services deserve to be treated with the utmost respect and should not be subjected to abuse (physical or emotional) or inhuman treatment by health care providers. It also implies that vulnerable and disadvantaged pregnant women, particularly those in rural areas or informal settlements and those living with HIV or disabilities, should not suffer discrimination while seeking medical care.

National Health Act of 2003

As part of its obligation to fulfil the right to health, the government has enacted some laws to further strengthen the Constitutional provisions on the right to health. One of the important pieces of legislation in this regard is the National Health Act of 2003. This is a comprehensive set of

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[50] Minister of Health v Treatment Action Campaign and Others 2002 10 BCLR 1033 (CC).

[51] S v Makwayane and Another 1995 (3) SA 391 (CC).

legislation addressing various issues relating to people's health. The Act, which replaced the Health Act of 1977, aims at addressing the inherited inequity and fragmentation of the health care system that characterised the apartheid regime. Its preamble acknowledges past socioeconomic injustices, imbalances and inequities in health care services in South Africa. It therefore sets out to heal the divisions of the past by establishing a society based on democratic values, social justice and respect for fundamental rights. Some of the underlying principles of the Act are:

- to unite the various elements of the health system and actively promote and improve its overall quality;
- to provide for a system of cooperative governance and management of the health care system within national standards, norms and guidelines;
- to provide for a system based on decentralised management, principles of equity, efficiency, sound governance, a spirit of enquiry and advocacy that encourages participation;
- to promote a spirit of cooperation and shared responsibility among private and public health professionals and providers.

The National Health Act explicitly assigns different roles to the three levels of government – national, provincial and district – regarding the provision of health services, including maternal health care. This implies that the provision of access to maternal health care services rests on all three tiers of government. An important provision of the Act is free medical health care services to pregnant women and children under the age of six years. This is codification of a policy introduced by the Mandela government in 1995. Drawing inspiration from the *White Paper for the Transformation of the Health System* (discussed below) and the Patient Charter, the Act recognises the rights of health users, including:

- the right to information about their health, treatment and care and the right to refuse treatment;
- the right to information and informed consent by a health care provider and right to participation in decision-making in this regard;
- the right to be treated with dignity while seeking medical care;
- the right to have their medical records kept confidential and to have their complaints investigated.

These rights are relevant for women and girls seeking maternal health care services. Experience has shown that women accessing antenatal care services are often subjected to various forms of abuse and human rights violations by health care providers.[52]

The Choice on Termination of Pregnancy (CTOP) Act 92 of 1996

This Act guarantees access to safe abortion services to all South Africans. It replaces the Abortion and Sterilisation of Pregnancy Act 2 of 1975, which limited access to comprehensive abortion services. The World Health Organisation has observed that unsafe abortions contribute to about 13% of all maternal deaths in most parts of sub-Saharan Africa.[53] In this regard, the CTOP Act provides for abortion on demand during the first trimester and on the fulfilment of certain conditions during the second and third trimester. More importantly, the Act affirms the right of adolescent girls to consent to abortion services without the need for parental consent. This is consistent with the constitutional provision to realise the right to reproductive autonomy of every individual, particularly women and girls. This aligns with the government's constitutional obligations to ensure access to health care services, including reproductive care for all.

4.3 Policies on health relevant to maternal health

White Paper for the Transformation of the Health System

The *White Paper for the Transformation of the Health System in South Africa* was adopted by the African National Congress-led government in 1997. It remains one of the earliest and most comprehensive policies on health, covering virtually every area of the health sector. The main aim of the White Paper is to improve the health system through achieving new missions, goals and objectives. According to the *White Paper*, all health care sector policies and legislation should be based on a common vision which reflects the principles of the Reconstruction and Development Programme (RDP). It also envisages a health system that would aim to provide 'caring and effective services through a primary health care approach'.

In essence, drawing inspiration from the Alma-Ata Declaration on primary health care, the *White Paper* places great emphasis on realising primary health care services for the people. It aims at ensuring that most people's entry into the health care system is at the primary level, where they are

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[52] Human Rights Watch "*Stop Making Excuses": Accountability for Maternal Health Care in South Africa* (2011) New York: Human Rights Watch.

[53] World Health Organization, United Nations Fund for Population, World Bank. (2014). *Trends in maternal mortality.* Geneva: World Health Organization

provided with basic health care and education, while more complicated services are dealt with by specialist hospitals. It also emphasises the importance of a unified health care system that places a premium on equity. For this to happen, the *White Paper* envisages a health care system in which the three tiers of government, civil society groups and the private sector are united in the promotion of community goals.

With regard to maternal health, the *White Paper* emphasises accessibility of maternal, child and women's health services to women, children and adolescents, especially those in rural areas. It proposes an integrated maternal health care service that is efficient, cost-effective and of good quality. It further recommends the establishment of maternal, child and women's health units at national, provincial and local government levels. More importantly, the *White Paper* proposes an inter-sectoral approach to health services for women and children and the allocation of adequate resources to improve maternal health care services.

Patient Charter 2000

The Patient Charter, adopted in 2000, emphasises the need for participation of patients not only in policy development but also decision-making affecting their health. It provides that patients have the right of access to health services, including emergency treatment irrespective of the patient's ability to pay; provision for special needs, especially for vulnerable groups, including pregnant women, the elderly and people living with HIV; a positive attitude by health care providers that demonstrates courtesy, human dignity, empathy, patience and tolerance; and access to health information, including information about services and how best they can be used, in a language understood by the patient.

The Charter further lays a premium on certain ethical and legal issues in treatment, including respect for privacy and confidentiality; the need for informed consent before treatment; the right to be referred for a second opinion on request to a medical provider of one's choice; the right not to be refused medical attention; and the right not to be abandoned by a medical provider that took responsibility for one's treatment. With regard to accountability in the health care setting, the Charter provides that everyone has the right to complain about health care services and to have such complaints investigated and addressed.

4.4 Programmes on Maternal health

South Africa's Strategic Plan on Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality (CARMMA)

In line with the African Union's directives, the South African government launched its Campaign on the Accelerated Reduction of Maternal, Newborn and Child Mortality (CARMMA) in 2012. The aim of this continental policy is to ensure that no woman should die while giving life. CARMMA was launched by the AU in 2009 to address the high maternal mortality ratios in Africa. During the launch, the AU adopted the slogan 'Africa cares: No woman should die while giving life'. CARMMA builds on other continental commitments on sexual and reproductive health and rights of women including the Maputo Continental Framework on Sexual and Reproductive Health (2006-2010, now extended to 2015),[54] the Abuja Call for Accelerated Actions towards Universal Access to HIV, Tuberculosis and Malaria Services (2006-2010, now extended to 2015)[55] and the African Health Strategy (2007-2015).[56] The main goal of CARMMA in South Africa is to accelerate the reduction of maternal and child mortality and morbidity through accelerated implementation of evidenced-based interventions.[57]

One of the overall objectives of CARMMA is to accelerate the implementation of key strategies to reduce maternal and child mortality through advocacy for quality maternal and child health care services, health care system strengthening, community empowerment and involvement, and effective collaboration with partners and stakeholders. The main targets of CARMMA in South Africa are aligned with target 5A of the Maputo Plan of Action. These include reducing maternal deaths by three quarters between 1990 and 2015. Indicators to measure this include maternal mortality ratio; reduction in the incidence of unsafe abortions; proportion of births attended by skilled personnel; access to quality motherhood services; contraceptive prevalence rate; adolescent births; and antenatal coverage.

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[54] Reprinted in Durojaye E & Mirugi-Mukundi G Compendium of Documents and Cases on the Right to Health under the African Human Rights System (2013) Community Law Centre: Cape Town.

[55] Durojaye E & Mirugi-Mukundi G Compendium of Documents and Cases on the Right to Health under the African Human Rights System (2013) Community Law Centre: Cape Town.

[56] Durojaye E & Mirugi-Mukundi G Compendium of Documents and Cases on the Right to Health under the African Human Rights System (2013) Community Law Centre: Cape Town.

[57] See South Africa's Strategic Plan for CARMMA 2013.

Department of Health Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition 2012-2016

The Strategic Plan for MNCWH and Nutrition in South Africa was launched by the National Department of Health on 4 March 2012. The vision of the Plan is to ensure accessible, caring, quality health and nutrition services for women, mothers, newborns and children. The guiding principles of the MNCWH Strategic Plan include:

- sustained political commitment and supportive leadership
- commitment to realising the human rights of women, mothers, newborns and children
- working with all sectors to improve the lives of women, mothers, newborns and children
- provision of an integrated service using a life-cycle approach
- optimising performance of all concerned with MNCWH care
- effective communication
- empowerment of communities and families, including men;
- protecting and respecting children
- ensuring linkages between community, primary health care and hospital levels of care.

These principles are similar to those of the *White Paper* discussed above. The main goal of the Strategic Plan on MNCWH is to reduce by 10% the maternal mortality rate (MMR); infant mortality rate (IMR); neonatal mortality rate (NMR); and child mortality rate. These targets are represented below in Table 3.

Table 3: Goals of the Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition 2012-2016

Indicator	Baseline 2009 HDACC	Target 2014 HDACC	SP 2016
MMR (per 100 000 live births)	310	270	-
U5MR (per 1000 live births)	56	50	40
IMR (per 1000 live births)	40	36	32
NMR (per 1000 live births)	14	12	11

Sources: Health Data Advisory Coordination Committee Report 2011 and Strategic Plan on MNCWH and Nutrition in South Africa

In order to meet these targets, it is important that every woman, child and newborn receives priority intervention services as part of a comprehensive service package at community, primary health care and hospital level. The Strategic Plan on MNCWH also identifies certain key interventions essential to reduce maternal, newborn, child and infant mortality in the country. Some of the important interventions for maternal health include provision of basic antenatal care services (at least four visits); initiation of HIV testing and access to ARV therapy during pregnancy, as well as other services that prevent mother-to-child transmission of HIV; introduction of dedicated obstetrics ambulances; and establishment of maternal waiting homes and post-natal care within six days.

Also, key interventions for the health of women in general include increased access to contraceptive services, as well as pregnancy confirmation and emergency contraception post-rape care for adults and children; provision of youth-friendly counselling and reproductive care services at health services, including school health services; and improved health coverage of cervical cancer. Some of the key strategies to realise this include:

- addressing inequity and social determinants of health;
- developing a framework for MNCWH and Nutrition services;
- strengthening community-based MNCWH and Nutrition interventions;
- increasing provision of key MNCWH and Nutrition interventions at PHC and district levels;
- increasing provision of key MNCWH and nutrition interventions at district hospital levels;
- strengthening the capacity of the health system to support the provision of MNCWH and Nutrition services;
- strengthening human resource capacity for the delivery of MNCWH and Nutrition services.

4.5 Analysis of national performance

The above discussion has shown that the South African government has taken some steps and measures to advance the health needs of pregnant women. However, whether or not these measures are adequate and have really improved the health conditions of women in the country is another issue entirely. In this section of the report, an attempt is made to analyse the effectiveness of the laws, policies and programmes adopted by the government to advance the health needs of women.

Despite the good intentions of the South African government to improve the health conditions of women and fulfil its obligations under international law, a number of challenges hinder the realisation of women's right to the highest attainable standard of physical and mental health. These include poor implementation or lack of coordination among relevant government departments, lack of skilled health care personnel, unethical attitudes of health care providers, lack of political will on the part of policy makers at national and provincial level, and lack of facilities at primary health care level.

Furthermore, the South African government's policies and programmes to address maternal and child mortality have been in the spotlight recently. For instance, in 2012 the World Health Organisation in its report on the state of maternal mortality across the world noted that South Africa is one of few countries that is not making enough effort to reduce maternal deaths.[58] The report further expressed the fear that if the situation continues, South Africa may not achieve MDG 5, which aims at reducing maternal mortality by 75% by 2015. Reports by some international human rights organisations such as Human Rights Watch have confirmed the fact that the South African government has not shown enough political will to address maternal and infant mortality in the country. In its 2011 report on the state of maternal mortality in South Africa, Human Rights Watch identified systemic challenges – such as the lack of an oversight function in the health care sector, negative attitudes of health care providers, ill-equipped health care centres in rural areas and a dearth of skilled health care personnel – as contributing factors to high maternal and child mortality in the country.[59]

Lack of political will

There seems to be disconnection between laws and policies and actual implementation. While resources have been allocated to the health sector, little result is shown for it, as the country still struggles to meet MDG 5. An example of a case that exemplifies lack of political will by the government to address health challenges facing women and children is *The Minster of Health v Treatment Action Campaign* case.[60] In that case the Treatment Action Campaign instituted a legal challenge against the government's policy to provide Nevirapine in only 18 pilot sites across the country despite the drug's great potential to reduce transmission of HIV from pregnant HIV-positive women to the newborn babies. The government contended that the efficacy of Nevirapine

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[58] World Health Organisation et al. *Trends in Maternal Mortality 1990-2010* (2012) WHO: Geneva.

[59] Human Rights Watch "Stop Making Excuses": Accountability for Maternal Health Care in South Africa (2011) Human Rights Watch: New York.

[60] 2002 10 BCLR 1033 (CC).

had not been ascertained and that rolling out such programme across the country would be too expensive for the government to sustain. The Constitutional Court held that the South African government's policy on this issue was unreasonable and inconsistent with their obligations under section 27 of the Constitution and commitments under international law. The Court then ordered the government to roll out a programme that would facilitate access to ARV therapy for women and children infected or affected by HIV.

The decision clearly shows the ineffectiveness of the approach adopted by the South African government to meet its obligation in relation to the right to health under the Constitution.

Dearth of health care personnel

One of the main challenges militating against access to health care services for South Africans in general and women in particular is the acute shortage of health care providers. While the government has outlined in the Strategic Plan a commitment to address the shortage of health care providers in the country, there is still a huge deficit. Moreover, there is a pronounced imbalance in the distribution of the workforce in the private and public health care sectors. It has been noted that about 70% of all doctors in South Africa work in the private sector. This implies that only about 10 600 doctors provide services for approximately 85% of South Africans, who do not have health insurance.[61]

In essence, this translates to the fact that at least 46% of South Africa's 49 million rural people are served by 12% of doctors and 19% of nurses in the public sector.[62] A 2007 report has shown that there were 7.7% doctors per 10 000 people in South Africa. While the ratio is higher than in most African countries, it is still far from meeting the needs of South Africans. Moreover, great disparity exists among the provinces as relatively wealthier ones such as Western Cape and Gauteng have 14.6% and 12.7% of doctors per 10 000 people, respectively, compared to poorer provinces such as the Eastern Cape and Limpopo that have 2.7% and 1.8% of doctors per 10 000 people, respectively. A more recent report has shown that 56% of doctor posts are vacant (14 351), along with 46% (44 780) of nursing jobs in the country.[63] This situation shows that public health care services are

[61] Health Economics and HIV & AIDS Research Division (HEARD). *Human Resources for Health: A Needs and Gaps Analysis of HRH in South Africa* (2009) Durban: HEARD, University of KwaZulu-Natal.

[62] Hamilton K & Yau J 'The global tug-of-war for health care workers' available at *http://www.hrhresourcecenter.org/node/1264* (accessed 2 September 2014).

[63] Rondanger L 'SA needs 14 351 doctors, 44 780 nurses' available at *http://www.iol.co.za/dailynews/sa-needs-14-351-doctors-44-780-nurses* (accessed 18 September 2014).

grossly insufficient and inequitable; and it is compounded by the fact that South Africa remains one of the largest exporters of health care professionals to developed countries.[64]

While the shortage of health care personnel is a general problem in the country, the situation is worst in the rural areas where health care services are most needed. This has resulted in poor delivery of health care services, particularly with regard to maternal health care. One of the indicators for MDG 5 is the number of pregnancies attended by skilled health care personnel. While South Africa is doing fairly well in this respect, disparities exist among provinces and between urban and rural areas. Experience has shown that the number of pregnant women in the rural areas with access to skilled care personnel is still very low compared to their counterparts in urban areas. One reason for this is the dearth of health care personnel in rural areas. The Committee on ESCR has noted that health care services must be available, accessible, acceptable and of good quality.[65] This requires a state to ensure the training of health care providers in large numbers to meet the needs of the people. Also, the CEDAW Committee in one of its decisions has urged the Brazilian government to allocate adequate resources for the training of health care providers in order to ensure better access to maternal health services in the country.[66]

Weak health care system

Although South Africa spends a substantial amount of money on the health care system, this has not translated into better and more efficient health care system for the people, particularly pregnant women in rural areas. The health care system in the rural areas still lacks adequate human resources and infrastructural facilities. Experience has shown that most health care facilities in the rural areas lack essential amenities such as transportation and medicines to prevent maternal death. Cases were reported where women could not be transported to a more equipped hospital in the city due to the unavailability of ambulances.[67] There have also been reported cases of women unable to get medication to treat minor health conditions.

Due to corruption, mismanagement and the poor allocation of resources to the health sector in some provinces, access to quality health care services has remained a serious challenge. Reports have

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[64] Hagopian A, Thompson MJ & Fordyce M et al. (2004) 'The migration of physicians from sub-Saharan Africa to the United States of America: measures of the African brain drain' 2 *Human Resources for Health* 17 available at http://www.human-resources-health.com/content/2/1/17 (accessed 17 December 2008).

[65] The Right to the Highest Attainable Standard of Health, UN Committee on Economic, Social and Cultural Rights, General Comment No 14, UN Doc E/C/12/2000/4.

[66] Alyne v Brazil.

[67] See, for instance, Section 27 Death and Dying in the Eastern Cape: An Investigation into the Collapse of a Health System (2013).

shown a lack of basic amenities such as constant electricity, water and sanitation in health care facilities in rural areas in provinces such as the Eastern Cape and Limpopo.[68] This creates barriers for pregnant women to enjoy access to quality maternal health care services.

While the National Health Act and the *White Paper on Health* emphasise the need to focus on primary health care services, in reality health care centres in rural areas remain underfunded and understaffed. The Committee on ESCR in its General Comment 14 notes that one of the minimum core contents of the right to health is to ensure access to primary health care services for all.[69] It further notes that states are obligated to ensure that access to primary health care services, including maternal health care, is guaranteed to all, particularly vulnerable and marginalised groups.[70] While reports have shown that allocation to the health sector by the South African government in the past three years has been substantial, this has not in any way led to better services in the public health care system.

Table 4: Budgetary allocation to the health sector and IMMR in South Africa 2011-2013 by the National Department of Health

Year	Budgetary allocation	No. of maternal deaths	IMMR/ 100 000	Percentage of reduction	MDG expected percentage
2011	R112.6 Billion	1560	159	1.4	5
2012	R121.9 Billion	1426	146	3.5	5
2013	R133.6 Billion	1401	140	1.4	5

As shown in the above table, it would seem that the yearly increase in budgetary allocation to the health sector is yielding positive results, given that the number of maternal deaths shows some decrease from 2011 to 2013. On the face of it, the initial conclusion that can be drawn is that the government's huge spending on the health sector is justified. However, a closer look at these figures reveals that despite the huge sum of money allocated to the health sector, the percentage of decrease in maternal deaths is minimal (1.4%). This falls short of the envisaged 5% yearly decrease in

[68] Section 27 Death and Dying in the Eastern Cape: An Investigation into the Collapse of a Health System (2013); see also Human Rights Watch "Stop Making Excuses": Accountability for Maternal Health Care in South Africa (2011) Human Rights Watch: New York.

[69] Committee on Economic, Social and Cultural Rights, General Comment 14, para 47.

[70] Committee on Economic, Social and Cultural Rights, General Comment 14, para 47

maternal deaths to meet the target for MDG 5. This is a clear indication that South Africa is far from achieving MDG 5.

It should also be noted that the government has made a conscious attempt to allocate resources to revamp the health care system in general. To achieve this, the government has created a consolidated grant known as the Health Facility Revitalisation Grant, which includes hospitalisation infrastructure, health infrastructure and nursing colleges and school grants. This consolidation is aimed at achieving flexibility in the movements of funds to improve infrastructure in the health care system. Allocation to improve infrastructure in the health system has increased from R3.5 billion in 2010 to R5.8 billion in 2012.[71] The government is further committed to increasing this amount in the next three years, as shown in Table 5 below.

Table 5: Programme allocations for 2013/14-2015/16

Programmes (R' million)	2012/13	2013/14	2014/15	2015/16
Administration	403	411	425	450
National health insurance, health planning and system enablement	315	492	638	672
HIV/AIDS, TB, maternal and child health	9 265	11 029	12 867	14 546
Primary health care services	126	109	106	111
Hospital, tertiary health services and human resource development	17 351	17 911	19 073	19 903
Health regulation and compliance management	597	754	816	1 002

[71] See Department of Health Presentation to the Parliamentary Select Committee on Social Services, 23 April 2013.

Total budget allocation	**28 057**	**30 706**	**33 925**	**36 684**

As the table shows, allocation to infrastructure and human resource development would seem to carry the highest amount, followed by the allocation to HIV, TB, maternal and child health care. Given that the allocation to HIV and maternal health is lumped together it becomes very difficult to ascertain the percentage of the amount allocated to maternal health alone. It should be noted that South Africa currently provides access to HIV treatment to about two million people, the largest antiretroviral therapy programme in the world. Commentators have often expressed concerns about the huge resources allocated to HIV programmes at the expense of other sexual and reproductive health programmes.[72]

Negative attitudes of health care workers

Another challenge limiting access to maternal health care in South Africa is the negative attitudes of health care providers. Studies have shown that pregnant women accessing antenatal care services are often treated in a humiliating and degrading way by health care providers. Some women have complained of being shouted at and told to stop shouting even when they are in pain. In some cases pregnant women have complained of being neglected or abandoned by health care providers. A report by Human Rights Watch shows that the negative attitudes of health care providers act as barriers to accessing maternal health care services in South Africa.[73]

It is clear from the above that while South Africa has made great strides in realising the right to health through laws, policies and programmes, poor implementation remains a great challenge, and a lot more is required in other aspects. More importantly, there is a need for better coordination of delivery of health care services for women and children between the National and Provincial Departments of Health.

While South Africa is one of the few African countries that spends a considerable amount of its resources on health and has attained universal access to HIV treatment, particularly prevention of mother-to-child transmission, it has yet to fully meet its commitment in the Abuja Declaration to commit 15% of its budgetary allocation to the health sector. Moreover, inequities exist in allocation

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[72] De Lay P et al. (2007) 'Are we spending too much on AIDS?' *British Medical Journal* 334-5; T Fleischer T et al. (2010) 'Will escalating spending on HIV treatment displace funding for treatment of other diseases?' 1 *African Medical Journal* 32-4.

[73] Human Rights Watch "Stop Making Excuses": Accountability for Maternal Health Care in South Africa (2011) Human Rights Watch: New York.

of resources to the health sector in the different provinces. While the more affluent provinces tend to spend more on the health sector and have relatively better health outcomes, poor provinces such as Limpopo and the Eastern Cape tend to experience poor health outcomes.

CHAPTER 5

FINDINGS OF RESEARCH ON MATERNAL MORTALITY IN THE EASTERN CAPE AND GAUTENG

5.1 Introduction

This section presents the findings of the two focus group discussions held in the Eastern Cape and Gauteng. Most of the findings coincide with the challenges hindering access to maternal health care services at the national level.

5.2 Maternal health in the Eastern Cape

The Eastern Cape, with a land mass of 168 966 square kilometres, is the second largest province in South Africa, but one of its poorest. It was formed in 1994 and has a population of about six million people spread across 37 local municipalities.[74] Statistics show that there are high levels of unemployment (54% of the population), low household incomes (under R6 000 per annum for 53.7% of families) and, nationally, the highest percentage of people living in poverty (67.4%).[75] The Provincial Department of Health is much concerned about improving the health of the people. In this regard, the Department's 2009-2014/15 Strategic Plans are aligned to the goals and objectives of the National Department of Health. Thus, the main priorities of the Provincial Department for the next five years include the following:

- implementing the National Health Insurance Plan;
- improving the quality of health care services;
- overhauling the management system;
- improving human resource management;
- revitalising physical infrastructure;
- accelerating the implementation of the HIV and AIDS plan and the reduction of mortality due to tuberculosis;
- improving the population's health;
- social mobilisation for better health;

[74] Statistics South Africa 2012.

[75] Statistics South Africa 2012.

- reviewing drug policy;
- research and development.[76]

From the above it is obvious that the government has not accorded maternal and child health the desired priority when compared with other health challenges. While the Eastern Cape government is concerned about reducing mortality from HIV and tuberculosis, nothing was mentioned about addressing the high rate of maternal mortality in the province. This begs the question of what will be done about the number of maternal deaths the province records yearly.

Over the years the Eastern Cape has been in the spotlight due to its failing infrastructure and poor health care delivery services. It has one of the highest maternal mortality rates in the country. According to the Confidential Enquiry into Maternal Death in South Africa, about 185 maternal deaths per 100 000 live births were recorded in the Eastern Cape in 2012.[77] This figure is higher than the national average of 150 deaths per 100 00 live births. However, it is lower than the 286, 308, and 301 deaths per 100 000 live births recorded in Limpopo, Gauteng and KwaZulu-Natal, respectively.[78] Some of the districts with the worst maternal mortality rates in the Eastern Cape include Buffalo City, OR Tambo, Chris Hani and Alfred Nzo.[79] The Eastern Cape health care system is besieged by a myriad of problems ranging from poor allocation of resources, shortage of qualified health care personnel, corruption and mismanagement, lack of transportation, poor infrastructure, lack of medication and supplies to a moratorium on employment of health care personnel.[80]

Table 6: Budgetary allocation to the health sector by the Eastern Cape Department of Health

Year	Budgetary allocation	No. of maternal deaths	IMMR/ 100 000	Percentage of reduction	MDG expected percentage
2011	R14.2 Billion	210	158.6	1.4	5
2012	R15.1 Billion	183	146.4	3.5	5
2013	R16.2 Billion	173	140	1.4	5

[76] Eastern Cape Provincial Department of Health.

[77] Department of Health (2013) Tenth interim report on Confidential Enquiries into Maternal Deaths in South Africa Department of Health: Pretoria.

[78] Department of Health (2013) Tenth interim report on Confidential Enquiries into Maternal Deaths in South Africa Department of Health: Pretoria.

[79] HSRC District Health Barometer 2013.

[80] See Section 27 Death and Dying in Eastern Cape: An Investigation into the Collapse of a Health System (2013).

In 2011, the Eastern Cape government set aside R96 million for the mother, child and women's health programme, which included the integrated nutrition programme, while in 2012 it allocated R76.2 million to maternal and child services.[81] Despite this, however, the maternal health situation in the province has not improved.

5.3 Eastern Cape Focus Group Discussion, 7 August 2013

The focus group discussion was held in the boardroom of Eastern Cape Non-Governmental Coalition (ECNGOC) based at the Emonti Science & Technology Park, Sunnyridge, East London, in the Eastern Cape. About six different organisations participated in the focus group discussion.

The Eastern Cape Non-Governmental Coalition (ECNGOC) was established in 1995 as an umbrella body of non-governmental, faith- and community-based organisations in the Eastern Cape committed to improving the living conditions of vulnerable and marginalised groups in South Africa.

ECNGOC is the most representative structure of the development sector in the Eastern Cape Province. It regularly hosts dialogues between non-governmental organisations (NGOs) and civil society organisations (CSOs) at the community level around issues affecting the daily lives of the people. As such it plays a significant advocacy role in many consultative stakeholder forums and government-led development structures and processes. ECNGOC has recently (May-July 2013) conducted a study campaign on access to primary health care services for young people. The study focuses on the relevance of access to primary health care as a vehicle for realising equitable and affordable health care services. The core business of the ECNGOC is to create a vibrant civil society. The ECNGOC firmly believes that if there is any

5.4 Findings from the focus group discussion on maternal health services in Eastern Cape

Unethical practices in health care services

One of the participants recounted how he went to the health clinic to seek medical attention for pain in the anal area. At the registration counter at the public health clinic he told the nurse about the nature of the pain in his anal area and was asked how he got it. The patient was embarrassed to

[81] Eastern Cape Department of Health.

express himself since he had had sex with another male. The nurse was heard discussing the matter with a colleague down the corridor in front of other patients waiting in the queue. As such, the patient was not able to express himself fully. He felt that his privacy had been violated as a male sex worker. He indicated that in his line of work he is aware that female, male and transgender sex workers regularly encounter similar challenges in accessing health services. He further explained that due to a fear of stigmatisation and violence, many sex workers shy away from seeking medical attention, including antenatal care. This may compromise the health and wellbeing of sex workers.

Negative attitudes of health care providers

A participant narrated a situation where he took his five-month-pregnant wife to hospital because she was bleeding. He explained that on arriving at the hospital, the nurses, without examining her, concluded that she was in the process of having a miscarriage. They contacted the doctor and booked her for an operation to remove the pregnancy using Dilation and Curettage (D&C), which is a surgical procedure often performed after a miscarriage. The next morning, as the woman was being taken to the theatre, her husband insisted that she should be examined by a doctor. The doctor found that the unborn child was still breathing and that there was no need to remove the pregnancy by D&C. The participant explained that had he not known about his right to an examination by a doctor or that nurses are obliged to make informed decisions, he and his wife would have lost the child due to the nurses' negligence.

According to the participants, nursing is viewed as a career to make money rather than a calling to serve. The participants further expressed the view that generally nurses do not provide compassionate and ethical care to patients. It was noted that sometimes nurses make derogatory comments about patients, such as 'oh, you are lesbian' and 'why didn't you condomise?' Participants believed that these negative attitudes undermine the dignity of patients and may cause some people (especially from the gay and lesbian community) to shun health clinics out of fear of being abused or molested.

This clearly shows the lack of *professionalism on the part of nurses*. Poor attitudes by health workers discourage pregnant women from accessing antenatal and other health care services. The crippling staff shortages and non-payment of salaries is symptomatic of the health crisis in the Eastern Cape.

In the survey that was carried out in the Eastern Cape with a focus on the Chris Hani, OR Tambo and Amatola districts, one of the participants made the following observations about access to health services in the province:

1. One of the critical issues was the geographical spread of the Eastern Cape.

2. Clinic facilities located in specific districts are very far for communities to access. The patients have to walk or take a bus.

3. The facilities are not adequately resourced. The personnel are not adequately trained and are extremely rude and do not adhere to the expectations of the Batho Pele principle.

4. In terms of professionalism, the nurses do not maintain privacy and confidentiality. They do not cater for the essential health needs outlined in the Peoples Charter and Health Charter.

5. Some of the facilities are run-down and there is no maintenance. Patients are therefore referred to the provincial hospital from the district clinics to access essential hospital equipment. The district clinics are limited in terms of services that they can provide.

Stigma and discrimination in health care services

One of the issues that came up during discussion relates to the stigma and discrimination that vulnerable and marginalised groups often encounter in accessing health care services. Generally, sex workers are stigmatised and encounter discrimination in communities on a daily basis. One of the participants shared his experience of this, recounting how when he disclosed his sexual orientation as a gay and sex worker, he was isolated from the community and rejected by his family. He further explained that when he experienced abuse he was unable to seek redress as there was no one to provide assistance. This sometimes causes him to be angry and violent towards those who are hostile to him.[82]

Stock-outs and shortages of essential medicines

Participants lamented the sorry state of infrastructure in most health clinics in the province. According to the participants, most of the clinics are dilapidated and lack space, electricity and essential equipment. This is compounded by the lack of essential medicines in many of the clinics. Moreover, stock outs and shortages of essential medicines and medical supplies are

[82] Sisonke/SWEAT has a support group for its members.

common occurrences due to the chaotic supply chain. Participants summed up that the poor quality of facilities hampers access to quality health care services in the province.

Inaccessibility of health care services

The Eastern Cape is predominantly made up of rural areas, which implies that for people to access district health care clinics they will need to pay for transportation. In most cases, the means of transportation is not regular, and when it is regular, many people, particularly women, are unable to afford the fares. One participant described the situation of an elderly woman who needs to access the district hospital. She would need to leave her home at 4 a.m. to walk to the bus stop, which can take up to two hours. Once on the bus, it could take as long as four to six hours to reach her destination, which is the district health centre, where she would have to join a queue at the hospital. The queue moves slowly and by the end of the day when she has to take the bus back to her rural home it could already be dark or she might even have missed the bus home and be forced to spend the night at the hospital or bus terminal.

In addition, bad road networks make it difficult for ordinary transport services and medical emergency transport services to reach the community. As such, if one requests an ambulance to transport someone to hospital, it takes time to arrive at the community, by which time the patient might have died. The transport and emergency medical services are non-existent in some districts in the Eastern Cape. This could have serious implications for maternal health services as many pregnant women in rural areas are unable to seek antenatal care due to the cost of transport fares or of accessing emergency help when complications arise.

Abuse of patients' rights in the health care setting

The participants indicated that gender abuse and violence is rife in the Eastern Cape. Gender abuse of pregnant women complicates the pregnancy and may result in a still birth. Gender violence is a critical issue, especially where a woman is beaten by a partner that results in the loss of her child. Emergency services in a situation of domestic abuse are difficult to access, especially during pregnancy, because of the distance to the health clinic and unavailability of transportation. Participants expressed concern about the fact that health care providers involved in the violations of patients' rights are not properly held accountable for their misdeeds.

Teenage pregnancy

The issue of teenage pregnancy is regarded as a serious challenge in the Eastern Cape. The survey by ECNGOC found that teenage mothers face challenges in trying to access health services. OR Tambo district had the second highest teenage pregnancy rate in the country (measured by how

many births are to women under 18 years). This statistic confirms studies that show that teenage pregnancy is high in the Eastern Cape.[83] One of the indicators for measuring progress to reduce the maternal mortality rate under MDG 5 is the rate of adolescent births in a country. The higher the rate of adolescent births, the higher the likelihood of maternal deaths.

Lack of political commitment

The participants were aware that the Eastern Cape is currently facing a crisis in its public health care system. The ECNGOC has engaged with the provincial MEC on health on several occasions in an advocacy capacity. Although the health care strategies are laudable on paper, their implementation has been a challenge. The difficulty lies in lack of political will by the provincial health managers to implement the health strategies. ECNGOC acknowledged that sustainable development takes at least 10 years to assess the impact and see results. The lack of political will has contributed to the crumbling health system in the Eastern Cape. One participant cited the experience of Dr Mary Shelela (SabonaSonke Foundation) as an example of lack of political will to support individual initiatives to improve the health system. Despite the inroads made by Dr Shelela with her eye clinic, she has continued to struggle to lobby for access to optical health care for the elderly in the Eastern Cape. One would have expected unreserved support from the provincial government.

5.5 Maternal health in Gauteng

Gauteng is one of the smallest provinces in South Africa, accounting for only 1.5% of the land area.[84] Nonetheless, it is highly urbanised, containing the country's largest city, Johannesburg, its administrative capital, Pretoria, and other large industrial areas such as Midrand and Vanderbijlpark. Indeed, Gauteng is often regarded as the economic hub of the country and contributes greatly to the financial, manufacturing, transport, technology, and telecommunications sectors, among others. It also plays host to a large number of foreign companies requiring a commercial base in and gateway to Africa. For this reason, Gauteng is said to be one of the wealthiest provinces in the country and contributes to a third of South Africa's gross domestic product (GDP).[85] In addition, it generates about 10% of the total GDP of sub-Saharan Africa and

[83] See the HSRC Report on Teenage Pregnancy in South Africa.

[84] Statistics South Africa *State in brief* (2006).

[85] Gauteng Economic Development Agency.

about 7% of total African GDP.[86] As of 2011, it had a population of nearly 12.3 million, making it the most populous province in South Africa.[87]

As in the case of Eastern Cape, the Gauteng Department of Health has aligned its priorities with the National Department of Health's ten-point plan. In addition, one of the strategic objectives of the Gauteng Department of Health is to place emphasis on the health needs of vulnerable and marginalised groups. To this extent, Objective 1 aims at addressing maternal, child and infant mortality. Objective 3 aims at ensuring satisfaction of patients, efficiency in the delivery of primary health care services and efficiency of hospitals.[88]

Table 7: Budgetary allocation and maternal mortality ration in Gauteng 2011-2013

Year	Budgetary allocation	No. of maternal deaths	IMMR/ 100 000	Percentage of reduction	MDG expected percentage
2011	R25.2 Billion	257	122.6	1.4	5
2012	R24.5 Billion	308	142.4	3.8	5
2013	R 28.2 Billion	205	134	1.5	5

5.6 Gauteng Focus Group Discussion, 30 July 2014

The focus group discussion was held at the offices of the Sonke Gender Justice Network in Braamfontain, Johannesburg. The invitation was sent to 60 people from civil society and academic organisations working on issues around women's rights and health rights. At least 15 people confirmed that they would participate, and nine people actually participated in the focus group discussion.

5.7 Findings from focus group discussion on maternal health services in Gauteng

Some of the important outcomes of the focus group discussion in Gauteng include the following:

[86] List of African countries by GDP.

[87] Statistics South Africa *Census* (2012).

[88] See Gauteng Department of Health Strategic Objectives available at *http://www.health.gpg.gov.za/Pages/Strategic-Objectives.aspx* (accessed 30 September 2014).

Negative attitudes of health care providers

The participants began by noting that one of the main challenges for women in accessing health care services in Gauteng is the negative attitude of health care workers. Nurses and doctors lack empathy and compassion to assist women during pregnancy and childbirth. Participants described witnessing pregnant women being ridiculed and turned away by the nurses in the health clinics. The poor attitudes of nurses toward pregnant women often discourage women from seeking medical attention early on in their pregnancy.

Another participant shared her experience of trying to assist an immigrant mother in Pretoria whose baby was born with both male and female reproductive organs. As a result Steve Biko Hospital referred her for blood tests to determine the gender of the baby. Thorough blood tests are urgently required to check the levels of sex hormones in the baby's blood, and chromosome analysis in order to determine sex. Although the mother visited the hospital every two weeks, nine weeks after the birth of the baby, Steve Biko Hospital had failed to diagnose the baby. The unwarranted delay in determining the gender of the child also delays the naming of the baby as well as the possible chance of a medical or surgical intervention. The baby's birth has also not been registered because of the complexity of the issue. The participant indicated that the doctors or nurses attending to the mother were possibly reluctant to attend to her due to prejudice towards her nationality or immigrant status.

Poor quality of health care services

- Health care workers do not communicate to mothers and patients as they ought to. A participant shared her experience of a friend who was expecting twin babies. The mother was ill and heavily medicated when she gave birth at a private hospital in Pretoria. Since the babies were born prematurely, they were kept in the intensive care unit (ICU). The nurse occasionally brought the babies to breastfeed. The woman was discharged from hospital and asked to come back after two weeks to collect her babies. Upon returning to the hospital she was given one baby and when she enquired about the other baby, she was told that the baby had died during birth. The woman was distraught. When she asked if she could view the body of the baby who had died, she was told by the nurse that it had been in the boot of a car and could not be traced. The mother suffered pain and anguish, and is in the process of suing the Department of Health and the hospital for negligence.
- This case illustrates two issues.

i. The lack of communication by the nurse or doctor immediately after the birth that there had been a complication during birth that had resulted in the death of the one twin.
ii. The poor attitude of health care workers or nurses who lack compassion and are mechanical at work, which is contrary to their work ethic.

Unethical practices of health care providers

- The participants said that although mothers are healthy and have good reason to anticipate uncomplicated childbirth, they were often advised to undergo an elective Caesarean section (C-section). The casual attitude of health care professionals towards C-section and epidurals was worrying. One of the participants indicated that perhaps doctors are given incentives to use these drugs by pharmaceutical companies. The presence of representatives of pharmaceutical companies in the hospitals encouraging mothers to use formula milk is a regular occurrence. The participants were concerned that this could be a norm in hospitals and the health care system to encourage formula-feeding instead of breastfeeding.
- One participant noted that mothers who indicated preference for vaginal births as a birth plan are sometimes not handled with professional attention. The average cost of a C-section in a Gauteng hospital is R30 000. The participants recounted their experiences and indicated that they had been pressured from health professional to give birth though a C-section.
- This is perhaps a reflection of the change in medical practice standards that reflects an increasing willingness on the part of medical professionals (doctors) to follow the caesarean path under all conditions (even in low-risk births when it is unnecessary). Gauteng has the highest number of medico-legal cases arising for obstetric and gynaecological reasons. The participants acknowledged that perhaps this was a contributing factor for doctors recommending C-sections.
- In response to the high medico-legal cases that the Gauteng Department of Health has been involved in, the Department has begun reviewing midwifery practice standards to prevent litigation. This, however, has been conducted without consultation with stakeholders such as midwives in the private sector.

Overcrowding at hospitals

Unsatisfactory access to health care is a result of various factors, notably the distance people have to travel and the time they have to spend waiting before they can be attended to, which have a huge

influence on the way people respond to the health care system. One participant shared an experience of a friend who gave birth to a healthy baby with six fingers. The doctors at Charlotte Maxeke Hospital in Johannesburg referred her to Coronation Hospital for minimal medical attention. When she arrived the queues were long and she had to sit and wait for over six hours for the new-born baby to receive attention. This was for a mini-medical procedure that should have been carried out as soon as the baby was born, but it had to be delayed due to long queues at the hospital.

Late registration for antenatal clinics

During the discussion it was revealed that currently Gauteng experiences overall low-level attendance of antenatal classes, with less than 20% of women in Gauteng attending such classes. This is evident especially among women who are poor and live in rural or informal settlements. Attending antenatal care clinics is aimed at reducing the number of mothers and infants dying during pregnancy. Late or incomplete attendance has major health consequences, especially for women infected with HIV who often require several visits during pregnancy to initiate the necessary drugs to secure their health and be put on treatment to eliminate the chances of babies contracting HIV. The participants mentioned that some factors that influence adherence to the antenatal care services include HIV stigma, fear of a positive test result, and concerns over confidentiality and poor treatment by health care providers.

Furthermore, many young women (teenagers) are hesitant to join antenatal classes for fear of being ridiculed by health care workers. At district clinics, the nurses were abusive whenever young pregnant girls asked them for assistance. As a result, teenage girls are easily discouraged from returning to health facilities because of bad health worker-patient relationships. As a consequence the young pregnant girls who do not attend the pre-natal classes may not be aware of the labour and birthing processes. Teenage pregnancy is an ever-increasing dilemma in South Africa. Participants of the focus group discussion were of the view that since teenage pregnancy (which accounts for about 20% of pregnancies in Gauteng) can have a profound impact on a teenager's life, it is recommended that pre-natal classes offered in clinics are tailored to the unique needs of teenage mothers-to-be. Such pre-natal classes should be conducted with compassion by care workers.

One of the participants (mother-to-mother) shared an experience where a pregnant woman attending antenatal care approached her as a ‘mentor mother’ and shared her concern that she had attended the antenatal clinic and told the nurse that she had high blood pressure (BP). The nurse said she had ‘red-carpet’ and sent her home to rest and come back after two weeks. When the mentor mother tried to intervene and bring to the attention of the nurse that the pregnant woman needed extra

attention and should be referred to a hospital because of her high BP, she was turned away. After two weeks the pregnant woman lost her baby and returned to the clinic with the mentor mother. They were attended to by a different nurse and they gave her the background. The nurse conducted a urine test and informed the woman that she had a sexually transmitted infection (STI). The woman who had lost her baby through miscarriage was very disappointed and the mentor mother enquired why the test had not been conducted two weeks previously. The nurse told them, 'I am not here to fix someone else's mistake.'

The nurse had failed to diagnose the pregnant woman and refer to a doctor to manage her condition. If a routine urine test had been conducted the woman would have been put under treatment and perhaps this would have protected her pregnancy. The mother-to-mother participant was of the view that mentor mothers are often stationed at clinics and are willing to assist overwhelmed nurses with minor logistics, including registration of pregnant women and conducting simple tests such as urine tests and blood pressure.

Lack of accountability mechanisms

Most of the participants lamented that a major human rights abuse that women experience in the health care sector is lack of accountability and the mechanisms for redress in the case of human rights violations. It was pointed out that some of the pregnant women who experienced human rights abuses in the health care setting often do not know what to do or to whom to complain. This can be frustrating, to these women as they are forced to suffer in silence.

Participants also pointed out that due to the fear of abuse some women are reluctant to attend antenatal care or seek medical attention when in need. This is a very important issue as the Gauteng government has stepped up a programme to ensure that women make at least four antenatal care visits before delivery. While this programme is laudable, its success depends greatly on how friendly and compassionate the public health care setting is. Many users of public health care still have a negative impression of the system and are not confident that culprits of human rights violations in the health care setting are dealt with accordingly.

Increase practical/field training for medical students and student nurses to increase skills

Medical school and nursing school need to be contextually responsive to challenges facing the South Africa health system, such as understaffing. One of the participants, who has been an assistant lecturer at the University Medical School, indicated that although the academic training was thorough and highly competitive (out of 9 000 applications to medical school only 900 get

placements at public universities), students performed poorly once they were in the work environment.

The heavy workload and long working hours often frustrate most students (medical students and student nurses), as a result of which they prefer to work in the private sector or overseas. This is an indication that medical students and student nurses are not able to respond positively to the practical challenges of being in the field (hospitals and clinics). It was suggested that students need to have more practical time to be able to be responsive to the practical situation of the health system. As a result of several labour union protests in the medical field, the nurses and doctors are now earning better salaries. However, this has not been sufficient incentive for them to venture into the public sector.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

It is clear from this study that while the South African government has adopted legislative and other measures to address high maternal mortality rates in the country, poor implementation of these measures has not led to positive results. The number of women still dying during pregnancy and childbirth is still relatively high and unless drastic actions are taken South Africa is unlikely to achieve MDG 5. Thus, the following recommendations are made to National Department of Health, Provincial Department of Health, civil society groups and chapter 9 institutions and other stakeholders.

6.1 National Department of Health

- There is a need for constant dialogue between government officials and users of public health institutions, especially women, around the development of policies and programmes on health care services for the people. This will ensure that policies and programmes are sensitive to the needs of the people. More importantly, it will enable government officials to identify the major gaps and needs of users of public health services. Moreover, through this dialogue users of public health are able to develop confidence in airing their views and concerns about the challenges they encounter in the health care setting.
- More often than not, the various government departments that have important roles to play in addressing maternal mortality hardly communicate with each other about their respective roles in improving access to maternal health care services in the country. There is a need for constant communication between government departments and institutions with regard to issues affecting maternal mortality. This will ensure coherence in formulation and implementation of policies and programmes on maternal health.
- The National Department of Health should clearly make a distinction as regards the allocation for HIV and maternal health in the annual budgetary allocation. Currently, allocation to maternal health is the lowest of Objective 3 in the Department of Health Strategy programme. On the other hand, allocation to HIV still takes the lion's share at almost three times the allocation to maternal health. Therefore, there is a need to increase the allocation of resources allocated to maternal and newborn health.
- There is a need for regular human rights training for health care providers to address human rights abuses in the health care setting. In this regard, it is necessary for a human

rights module to be incorporated into the curriculum of medical and nursing schools in South Africa.

- Currently, the accountability mechanism to ensure redress for human rights violations experienced by patients is weak and almost non-existent. Therefore, in line with the amendment to the National Health Act, there is a need for the establishment of the office of an ombudsman to examine patients' complaints and provide a remedy where necessary. This will go a long way in minimising human rights violations in the health care setting.

6.2 Recommendations to provincial governments

- Commit more resources to the health sector in general and maternal health in particular.
- Invest more in the training of health care providers to meet the acute shortage of health care personnel in rural areas.
- Embark on continued training of health care providers so that they are more responsive to the needs of the people.
- Consistently work with civil society groups in order to ensure access to maternal health care services in the rural areas.
- Roll out ambulances and other means of transportation in rural areas in order to facilitate access to emergency obstetrics care services**.**

6.3 Implementing alternative support systems, especially for low-risk mothers

Provincial departments should consider implementing alternative means of realising access to maternal care services for women; this would help to alleviate the crowded hospitals. In this regard, one of the participants suggested the doula model, the mentor mother model and the birth homes model as practical examples.

The participant shared her experience of working as a doula. She said that one needs to be trained for two weeks before one embarks on practical training for 12 months before one is certified as a doula practitioner. A doula is a trained person, usually a woman, who has knowledge of the biological processes of labour and childbirth. She provides psychological encouragement and physical assistance. She uses her knowledge to explain to the mother and the partner what is happening around them. She also offers emotional support to both the mother and her partner throughout labour and delivery and, to some extent, afterwards. This technique, also referred to as 'mothering the mother', recognises that women have the power to birth and assists the mother in accessing her own 'Mother Nature'. Currently, the doula will run a pilot project in the new Jabulani

District Hospital in Soweto for low-risk mothers. The facility has active labour wards that are well equipped.

One of the participants who manages a birth house in Pretoria proposed the model as a viable option. A birth house is a small medical midwifery practice which operates an active birthing unit that is established to cater for mothers in a small intimate space that offer comprehensive maternity services, birthing options as well as birth and parenting classes. A birth house is supported by a network of obstetricians and paediatricians who make up the multidisciplinary team. The participant indicated that she was inspired to work in a birth house after being frustrated by the various protocols and limitations placed on the women who gave birth in the hospital environment where a woman's ability to birth naturally was undermined and 'high-tech' birth was unnecessarily administered.

The participant from Mother2Mother described the "Mentor Mothers" model where mothers in the community undergo basic training and are able to work at the antenatal clinics and alongside health delivery teams (doctors and nurses) in a medical facility to serve the needs of HIV-positive pregnant women and new mothers. This would help fill the gaps in critically understaffed public health systems. The main goal of the mentor mothers is to empower and facilitate mothers with HIV to fight stigma in their communities, to live positive and productive lives, and to ensure that their babies are born healthy by preventing babies from contracting HIV through mother-to-child transmission.

6.4 Chapter nine institutions

- Chapter nine institutions such as the South African Human Rights Commission and the Office of the Public Protector can play an important role in holding the government accountable to its obligation to realise maternal health. Therefore, there is a need for these institutions to be more active in ensuring that the government lives up to its obligation regarding maternal health.
- Given the poor implementation of policies and programmes on maternal health, it is recommended that a joint monitoring committee or group, including government departments, civil society groups, women and Chapter nine institutions, be set up to assess the challenges involved in the implementation of policies and programmes on maternal health in the country. This will ensure transparent and effective implementation of these policies and programmes.

- Corruption and mismanagement remain endemic in the health sector at national, provincial and municipal levels. It is therefore important for relevant institutions such as the Office of the Public Protector and Accountant General to be more vigilant in ensuring transparency and accountability in the handling of resources at all levels of government.

6.5 Recommendations to Civil Society Groups

- There is a need for continued monitoring of the government's activities at all levels to ensure that policies and programmes on maternal health are properly implemented.
- Civil society groups, including community-based organisations, should continue to empower women in rural areas and informal settlements through human rights training so that they can make informed choices about their health and rights.
- Civil society groups should mobilise themselves as a coalition with the goal of increasing the accountability of maternal health care services in South Africa.