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No Time for Justice? Obstetric Violence, Damages Claims and Prescription Periods in South African Law

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Abstract

Obstetric violence is currently not acknowledged as a form of gender-based violence in South African law. In this article I deal with the various issues associated with this failure to correctly categorise obstetric violence. One of the issues relates to access to legal recourse for survivors through delictual claims (torts). Delictual claims are wrongful acts or limitations of rights that can lead to legal liability in the form of monetary compensation. The current framing of obstetric violence as medical malpractice limits women's time to launch a case to only three years after the violation. To show how this issue of prescription (a legal principle where an outstanding debt can be extinguished after a prescribed time period) plays out, I focus on the 2020 report by the South African Commission for Gender Equality (CGE) on the forced or coerced sterilisation of women living with HIV at state healthcare facilities. I also examine the current case of the Centre for Applied Legal Studies (CALS), a university-based human rights law clinic, which represents over 40 women who have experienced different forms of obstetric violence at state-run facilities. In both of these examples, I explain how justice through legal recourse is denied to these victims or survivors through the mischaracterisation of obstetric violence as medical malpractice in current South African law. To show that the three-year 'limit' or prescription period to institute a legal claim is unjustifiable, I explore three reasons why women may not choose to or be able to proceed with a legal claim within that time period. The first of these relates to the 'personal' barrier women face around

acknowledging they have experienced obstetric violence and bringing a claim against the state. The second, the 'political' barrier, includes the general and prevalent systemic gender discrimination experienced by women in South Africa and the specific barriers women face around access to dignified treatment in the country's public healthcare system. Finally, an 'economic' barrier is the general inaccessibility of legal representation for economically disadvantaged people in the country. Proceeding from the above, I then argue that by acknowledging obstetric violence as a form of gender-based violence and aligning it with legislation around prescription periods for other forms of gender-based violence (such as sexual offences), the burdens related to access to justice (at least in delict) can be lightened for survivors.

I am terrified to go back to a government facility.

You see, I know this doesn't seem like a scary ordeal. Most horror stories contain abuse, and death. But the way I was dehumanized, and ripped of my basic human rights has dented my soul.

I feel as though a very important time in my life was taken from me, and instead of a beautiful memory of the birth of my child, I now have the trauma of having to protect my daughter from the cold, while we were neglected, without medical care after serious abdominal surgery.

Shana Fife[1]

Chadwick defines obstetric violence as 'violence against women and girls during labour and birth'.[2] She explains how activists worldwide have adopted the term in the struggle to promote 'humanised birth' for women and girls. Obstetric violence includes acts such as neglect; verbal, emotional, physical, and sexual abuse; lack of confidential and consensual care; and inappropriate or non-evidence-based medical interventions (including non-consensual episiotomies and

[1] Fife, S. My Grooteschuur Unhospitable Experience. *Into a Housewife*. https://intoahousewife.wordpress.com/2018/05/15/review-my-grooteschuur-unhospitable-experience/

[2] Chadwick, R. J. (2016). Obstetric violence in South Africa. *SAMJ: South African Medical Journal*, *106*(5), 423-424. At 423

sterilisations).[3] Furthermore, obstetric violence can include the denial of treatment as well as the denial of provision of medication, such as pain killers before, during or after birth. Finally, obstetric violence can also include the forced or coerced provision of contraceptives post-partum, a practice which is increasingly occurring at South African healthcare facilities.[4]

Significantly, obstetric violence falls under the umbrella of gender-based violence, as it is characterised by discrimination and hatred towards women and girls. Chadwick describes obstetric violence as part of the 'societal devaluation of women and girls' and the 'normalisation of violence against them'.[5] Pickles agrees with Chadwick and explains how birthing women are treated in healthcare facilities correlates with the women's socio-economic status and constitutes a form of gender-based violence.[6]

The descriptions of the systemic nature of obstetric violence and its categorisation as a form of gender-based violence more broadly were expressed by the United Nations Special Rapporteur on violence against women, Dubravka Šimonović, in 2019 in her

[3] Ibid. at 423. The period in which obstetric violence can occur is not settled in South African law, however the period of pregnancy, labour and postpartum has been adopted by scholars such as De Waal et al. See van der Waal, R., Mayra, K., Horn, A., & Chadwick, R. (2023). Obstetric violence: An intersectional refraction through abolition feminism. *Feminist Anthropology*, *4*(1), 91-114.

[4] The Centre for Applied Legal Studies (CALS) is a public interest, university law clinic, which focuses on strategic litigation to realise the rights contained in the South African Constitution. CALS represents numerous women and birthing individuals across South Africa who have experienced obstetric violence at public health care facilities, with the aim of proceeding with a case to attain damages for the individuals. Clients completed questionnaires, which in turn formed their legal documents, such as affidavits for the court. Although the individual's full names will be used in court documents, the court may decide to redact their names in due course. I have chosen to use their initials in this article to attempt to protect their identities. MM states that, "For contraceptives we were informed of why they were compulsory, and that no one leaves [the hospital] without it. [The nurses do] not ask for consent. The type of contraceptive was not explained. The side effects are not explained. You must find out yourself. They say definitely injections and not the pill. You can choose between 2 months and 3 months. They had run out of 2 months, so no real choice."

[5] Chadwick, R. J. (2016). Obstetric violence in South Africa. *SAMJ: South African Medical Journal*, *106*(5), 423-424. At 423

[6] Pickles, C. (2015). Eliminating abusive 'care': A criminal law response to obstetric violence in South Africa. *South African Crime Quarterly*, *54*, 5-16. At 7.

report, 'A human rights-based approach to the mistreatment and violence against women in reproductive health services with a focus on child birth and obstetric violence'.[7] Šimonović refers to the Committee on the Elimination of Discrimination Against Women's (CEDAW's), General Recommendation 19, which defines gender-based violence against women as, 'violence which is directed against a woman or that affects women disproportionately'.[8] She goes on to describe how certain forms of obstetric violence, such as forced sterilisations and forced abortions, have been recognised by CEDAW and regional courts as constituting acts of gender-based violence.[9] Furthermore, where these acts result in physical and psychological harm, they may even amount to torture or cruel, inhumane and degrading treatment.[10]

Contrasting to other forms of gender-based violence (such as rape and femicide), obstetric violence is a relatively new term in South African parlance. Unfortunately, unlike other forms of gender-based violence, obstetric violence is not formally acknowledged in South African law.[11] Instead, obstetric violence currently falls under the field of medical malpractice rather than gender-based violence in legislation and common law in the country.

In this article I deal with the problems associated with South African law not recognising obstetric violence as a form of gender-based violence. One of the issues relates to access to legal recourse for survivors through delictual claims (torts – a legal principle where an outstanding debt can be extinguished after a prescribed time

[7] Šimonović, D. (2019). *A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence* (A/74/137) .

[8] Šimonović, D. (2019). 6

[9] Šimonović, D. (2019). 9

[10] Šimonović, D. (2019).9 and Committee on the Elimination of Discrimination against Women. *General recommendation No. 35 on gender-based violence against women, updating general recommendation 19* (CEDAW/C/GC/35, Issue.

[11] South African law acknowledges other forms of gender-based violence such as domestic violence, harassment, rape and femicide. The country will also likely soon have formal hate crimes legislation which acknowledges harm caused by hatred and discrimination based on factors such as gender or gender identity, sex and sexual orientation. See Prevention and Combatting of Hate Crimes and Hate Speech Bill [B9-2018]. https://www.justice.gov.za/legislation/hcbill/B9-2018-HateCrimesBill.pdf.

period). The current framing of obstetric violence as medical malpractice limits women's time to launch a case to only three years.[12]

To show how this problem plays out, I will examine the 2020 report by the South African Commission for Gender Equality (CGE) on the forced or coerced sterilisation of women living with HIV at state healthcare facilities. I will also examine the current case of the Centre for Applied Legal Studies (CALS), which represents over 40 women who have experienced different forms of obstetric violence at state-run facilities. In both these examples, I will explain how justice through legal recourse is denied to these victims or survivors through the mischaracterisation of obstetric violence as medical malpractice in current South African law.

To show that the three-year 'limit' to institute a legal claim is unjustifiable, I will explore three reasons why women may not choose to or be able to proceed with a legal claim. The first will be around the 'personal' barrier women face around acknowledging they have experienced obstetric violence and bringing a claim against the state. The second barrier, the 'political' barrier, includes the general and prevalent systemic gender discrimination experienced by women in South Africa and the specific barriers women face around access to dignified treatment in the country's public healthcare system. Finally, an 'economic' barrier is the general inaccessibility of legal representation for economically disadvantaged people in the country.

Proceeding from the above, I will then argue that by acknowledging obstetric violence as a form of gender-based violence and aligning it with legislation around prescription periods for other forms of gender-based violence (such as sexual offences), the burdens related to access to justice (at least in delict) can be lightened for survivors.

[12] Prescription Act 68 (1969). The Prescription Act is concerned with the extinguishing of a debt due to the passage of time.

1. Prescription, damages and obstetric violence in South Africa

1.1. The Commission for Gender Equality's 2020 report

In 2020, the CGE released its report titled, 'Investigation report on the forced sterilisation of women living with HIV/AIDS in South Africa'.[13] The investigation was centred around the allegation by two complainant entities, Her Rights Initiative and the International Community of Women Living with HIV. The entities acted on behalf of 48 women living with HIV/AIDS. The women claimed that medical health practitioners had forcefully or coercively sterilised them because of their HIV/AIDS status at state medical health establishments in the country.[14]

The CGE, in its report, found that the women did not give informed consent for the sterilisations.[15] Furthermore, it found that many rights in the South African Constitution had been violated through forced or coerced sterilisation. The rights infringed upon included the women's rights to equality and freedom from discrimination, the right to bodily integrity and freedom and security, the right to the highest attainable health standards (including sexual and reproductive health), and the right not to be subjected to cruel, torturous or inhuman and degrading treatment.[16]

The recommendations made by the CGE included various systemic interventions around eradicating forced or coerced sterilisation, such as amendments to legislation around informed consent and compulsory information about the sterilisation procedure that must be communicated to individuals. The CGE also recommended that the National Department of Health (NDOH) revise all consent forms and conform with the sterilisation procedures set out in the International Federation of Gynaecology and Obstetrics guidelines.[17] Finally, concerning personal recourse for

[13] Commission for Gender Equality. (2020). *Investigation report on the forced sterilisation of women living with HIV/AIDS in South Africa*. https://cge.org.za/wp-content/uploads/2021/01/forced-sterilisation-of-women-living-with-hiv-and-aids-in-south-africa.pdf.

[14] Ibid. at 10.

[15] Ibid. at 53.

[16] Ibid. at 53.

[17] Ibid. at 56.

individual women, the CGE recommended that the NDOH facilitate dialogues between their office and the individual survivors to provide them with redress.[18]

The two entities, on behalf of the individual survivors, proceeded with this CGE complaint as the Prescription Act had extinguished the women's claims under delict. Thus, the women could not get monetary compensation through ordinary damages claims against the NDOH.

In its report, the CGE acknowledged this barrier to justice when it stated that 'there was limited opportunity for legal redress and remedy'. A substantial amount of time had lapsed between the time the cases were documented and the complainant's lodging.[19] Fortunately, framing the issue as gender discrimination permitted the CGE to investigate as this falls within the CGE mandate and does not attract prescription. However, the CGE is predominantly a 'toothless' entity, without legal power to enforce its recommendations. Despite its recommendations and recent incidents of further egregious acts of obstetric violence at healthcare establishments in the country, there has been little to no recourse, both systemically and individually, for survivors.[20]

One of the reasons for the NDOH's lack of movement towards providing redress for the survivors is that the recommendations of 'Chapter 9' institutions such as the CGE are not binding.[21] Thus, the NDOH has no legal requirement to assist the individual

[18] Ibid. at 56.

[19] ibid. at 11.

[20] For another example of the systemic nature of obstetric violence in South Africa, see Swemmer, S. (2023a). Pregnant women of Rahima Moosa Hospital join the ranks of victims of pervasive obstetric violence. *Daily Maverick*. https://www.dailymaverick.co.za/opinionista/2023-03-23-obstetric-violence-the-case-of-rahima-moosa-hospital/.

[21] Colloquially, South Africans call the six state institutions which are set up with the aim of strengthening constitutional democracy in South Africa (of which the CGE is one) 'Chapter 9 institutions'. The institutions are established in terms of Chapter 9 of the South African Constitution. Pierre De Vos. (2013). Balancing independence and accountability: The role of Chapter 9 institutions in South Africa's constitutional democracy. In D. C. L. Nijzink (Ed.), *Accountable government in Africa* (pp. 160 - 177).

survivors or begin the process of addressing the systemic issues related to obstetric violence in the country.

At the time of writing, the NDOH has manifestly failed to implement any of the recommendations made by the CGE in its 2020 report. In a letter penned in December 2022 by Her Rights Initiative on behalf of almost 100 women (including many of the original 48 CGE complainants), the women describe the South African government as 'dragging its feet' in providing both systemic and individualised redress for all the women who have come forward alleging that they have experienced forced or coerced sterilisation at public healthcare establishments.[22]

As set out briefly above, no real movement around the CGE case has occurred due, firstly, to the nature of the CGE recommendations not being binding on the NDOH. Secondly, due to prescription, the 48 survivors of forced or coerced sterilisation could not approach a court (with binding power) for compensation as their claims had been extinguished. With the continued applicability of prescription to obstetric violence cases, the survivors will remain 'between a rock and a hard place', having to continue to hope for the good faith of the NDOH to provide recourse in line with its duties under the Constitution.

1.2. The Centre for Applied Legal Studies' clients

In 2020, and around the period of the CGE report launch, CALS was approached by a researcher who had engaged with 20–30 women (predominantly in the Western Cape) who had experienced instances of obstetric violence from public healthcare establishments in South Africa.[23] Within the initial meeting with the researcher, it became apparent that most of the women's potential claims had already prescribed in terms of the Prescription Act.[24]

[22] Mntambo, N. (2022). 85 Forcefully sterilisaed HIV-positive women please for Ramaphosa's intervention. *EWN*. https://ewn.co.za/2022/12/07/85-forcefully-sterilised-hiv-positive-women-plead-for-ramaphosa-s-intervention.

[23] BK. (24 January 2020). *Re: Strategic litigation case - obstetric violence*. (Email thread)

[24] Ibid.

As CALS began engaging with the women, a picture of obstetric violence as another form of systemic gender-based violence emerged. It became evident that women had been suffering from obstetric violence for decades, with a handful of cases going back to the mid-1990s.

Based on the emerging issue of prevalence and the reported decades of violations, CALS decided to begin advocacy work around obstetric violence and provide workshops for women. The workshops centred around advising women on what obstetric violence is and the pathways to recourse that could be explored. CALS's aims in holding the workshops were to begin bringing awareness to the issue, start conversations in communities, and to test the pathways to recourse provided for by the government.[25] Through partnerships with organisations and social movements such as Embrace – the movement for mothers, Treatment Action Campaign (TAC) and Women Affected by Mining United in Action (WAMUA), CALS came to represent over 40 women who had experienced obstetric violence across South Africa.[26] Many of the CALS clients found themselves in a similar position to that of the women of the CGE report in that their claims for compensation had prescribed. The number of women whose cases had prescribed reached almost 69% of those who approached the organisation between 2020 and 2023.

Considering the vast number of women who have come forward with claims having prescribed, this suggests that many survivors will be unlikely to have their cases heard by a court and have a chance at compensation under the current prescription laws adopted in the country. CALS has thus begun research into a litigation strategy to remove the barriers to justice currently imposed by the Prescription Act. Set out below are some of the considerations around the current law and the barriers to proceeding with cases. I will then turn to an analysis of other gender-based violence legislation

[25] A copy of the handbook used by CALS for workshops is available at S Swemmer et al. (2022). *Obstetric Violence Know Your Rights Handbook and Pilot Project*. https://www.researchgate.net/publication/369023783_Obstetric_Violence_Know_Your_Rights_Handbook_and_Pilot_Project.

[26] The different organisations and movements can be found at: Embrace: https://www.embrace.org.za/; Treatment Action Campaign: https://www.tac.org.za/; WAMUA: https://macua.org.za/. At one point in 2022 CALS represented 78 survivors of obstetric violence.

relating to prescription that must be traversed to successfully argue for an amendment in law which acknowledges obstetric violence as a form of gender-based violence and, thus, similarly to other forms of gender-based violence, not subject to prescription periods for compensation.

1.3. Prescription, discrimination and the mischaracterisation of obstetric violence as 'medical malpractice'

Currently, in South Africa, obstetric violence falls squarely under the auspices of medical malpractice law. Van der Heever describes medical malpractice as, 'liability … incurred when patients suffer damages, which may be attributed to substandard care provided by health practitioners or hospital personnel involved in their treatment'.[27] The legal basis for a malpractice claim can be based on a breach in a legal duty (or a 'duty of care'), professional negligence, assault due to lack of informed consent, performing an unnecessary procedure, or breach of a contract.[28]

Obstetric violence can overlap with medical malpractice, for example a forced or coerced sterilisation can be classified as damage suffered due to substandard care and based on a lack of informed consent. However, placing obstetric violence solely in the realm of medical malpractice is problematic as it underplays the egregious and discriminatory nature of the act and erases its basis as a human rights violation first and foremost.

The issue with the framing of obstetric violence as 'malpractice' or a 'mistreatment', as suggested by Chadwick, is that it is too neutral. [29] It thus avoids engaging with and acknowledging the fact that obstetric violence falls within the realm of discrimination against women and often operates in ways that are aggressive, humiliating and disrespectful to women, violating their dignity, undermining their human rights, and limiting their access to reproductive justice.[30]

[27] Patrick van der Heever. (2016). Medical Malpractice: The other side. *De Rebus*, *October*.

[28] Ibid.

[29] Chadwick, R. J. (2016). Obstetric violence in South Africa. *SAMJ: South African Medical Journal*, *106*(5), 423-424.

[30] Ibid.

The neutrality of 'medical malpractice' terminology allows obstetric violence to forgo scrutiny as a structural and systemic human rights violation. Instead, it labels systemic and gendered acts of violence as 'mistakes' or 'negligent acts' by healthcare practitioners. They specifically highlight the necessity to look at the effect on the individual and, very importantly, to recognise that the actions associated with obstetric violence are 'gendered, sexist and systemic'.[31] To categorise obstetric violence as a form of gender-based violence is both legally significant and significant for survivors who can identify the form of violence, name what they have experienced, and communicate this with other women.[32]

Legally and politically, framing systemic violence, especially structural gender-based violence, is essential as it recognises that acts are not isolated acts or individualised actions. Instead, correct framing assists in the acknowledgement that violence is deeply rooted in societal structures, power dynamics, and institutional practices. In this way, the correct framing can encourage locating root causes, seeking accountability, identifying trends, promoting structural change, and empowering survivors.

The consequences of this mischaracterisation in law are that it leads to great injustice, as seen above in the instances of the survivors in the CGE report and many of CALS clients. The injustice is two-fold. First, the mischaracterisation affects the type of recourse one can ask for. Second, the mischaracterisation can limit the time within which individuals can launch a case.

In the instance of the women from the CGE report and many of CALS's clients, obtaining justice through compensation for obstetric violence (currently medical

[31] Lévesque, S., & Ferron-Parayre, A. (2021). To use or not to use the term "obstetric violence": Commentary on the article by Swartz and Lappeman. *Violence against women*, *27*(8), 1009-1018. At 1011.

[32] Ibid.

malpractice) violations are generally limited to three years after the incident occurred. This is set out under section 11 of the Prescription Act.[33]

There are, however, certain factors which can suspend prescription; these include if the individual is a minor child, is 'insane', or is under curatorship, or if the individual is outside of South Africa.[34] Furthermore, section 12 of the Prescription Act sets out under what circumstances prescription is deemed to start running. According to the Act, there are three ways that prescription can be described as starting at some time *after* the actual incident took place. These three ways that prescription is delayed are set out from 12(2)–12(4) of the Act. Although the problems surrounding each section will be discussed below, the overarching problem concerns the Act's rigidity and thus its non-accommodation of factors and contexts which may deviate from universalised notions such as the *reasonable person*. The problems become heightened when considering the personal, political and economic barriers to access which will be examined in the next section.

The first way prescription can be delayed is when the debtor wilfully prevents the person who would claim compensation from knowing that a debt has arisen.[35] An example of delaying of prescription is in the case of *Trollip v. Phatshoane Henney Attorneys* (*Trollip)*.[36] Here, Trollip (the person claiming compensation), attempted to proceed with a claim against her attorneys, Phatshoane Henney Attorneys, based on their alleged negligence in handling her motor vehicle accident claim. The attorneys, in response, claimed that Trollip's claim had prescribed in terms of the Prescription Act and, thus, she could not proceed with a damages claim against them.

The Supreme Court of Appeal heard the appeal of this case, and stated that in terms of section 12(2) of the Prescription Act, Trollip's claim only became due, or time only started running, when the attorneys advised her that they had failed to handle her

[33] Prescription Act 68 (1969).

[34] Ibid. at section 3.

[35] Ibid. at section 2.

[36] Trollip v Phatshoane Henney Attorneys (3683/2018) [2022] ZAFSHC 158. At para 2.

motor vehicle claim in a sufficient manner.[37] The court found that Trollip's claim against the attorneys had not prescribed because the attorneys had wilfully not informed Trollip that they had been negligent in the handling of her motor vehicle accident claim.[38] Furthermore, the court found that Trollip's period to launch the claim against her attorneys only began to run when a new set of attorneys advised her of the possibility of a claim against Phatshoane Henney Attorneys for negligence.[39]

The difficulty of relying on section 12(2) in the instance of obstetric violence claims is that, unlike in the instance of the *Trollip* case above, doctors do not have the same legal duty as attorneys to make their patients aware of their negligence. Furthermore, insurers for healthcare practitioners may also prevent these individuals from disclosing facts related to their negligent acts, which could then nullify the practitioner's claims. Currently, in South African case law, section 12(2) remains underexplored and, at this juncture, does appear to rest on the question of whether a legal duty to disclose negligence exists.[40] Nonetheless, until such time as the question of whether healthcare practitioners have this legal duty to disclose negligence is either decided upon by courts or clarified through legislation, this avenue to delay the starting of prescription remains obscure.

The second mode of delay is where the person claiming compensation does not know the identity of the debtor *and* the facts from which the debt arose. The proviso in this instance is if the person claiming compensation could have come to know these two factors by exercising reasonable care.[41]

The problem with this section of the Act is that it places a burden on the person claiming the compensation to ascertain both the identity of the debtor as well as the

[37] Prescription Act 68 (1969). Para 12.

[38] Trollip v Phatshoane Henney Attorneys (3683/2018) [2022] ZAFSHC 158. At para 22.

[39] Ibid.At 12.

[40] This is also supported by Duvenhage v Eerste Nasionale Bank van SA Bpk [2005] 4 All SA 41 (N). where the court found that a bank manager had a legal duty to act in the best interest of his clients and not to deceive them. Furthermore, the court found that the bank manager had not acted with the care expected of a bank manager'.

[41] Prescription Act 68 (1969), at section 12(3).

facts that give rise to the claim. The standard is not judged on the individual person's ability to deduce or find out these two things but rather on the threshold of the reasonable person.[42]

Case law around what a reasonable person could and could not be expected to know in relation to this section has predominantly been conservative. For example, in *Eskom v. Bojanala Platinum District Municipality,* the high court explained that prescription begins to run when the claimant has come to know the facts from which the claim arose, not certainty around the law or the rights associated with the debt.[43] Therefore, the law does not cater for situations where individuals may not know that they can claim damages for the violation they have endured or where individuals do not have the resources to approach an attorney for assistance making a claim. Currently, in South African law, it is largely deemed that a reasonable person would know that they have a right to claim compensation for the damages they have endured.

The final method of delaying prescription is in the instance of sexual offence violations. Section 12(4) states that prescription will not begin running if the debt is based on:

> the alleged commission of … any sexual offence in terms of common law or a statute … during the time in which the creditor is unable to institute proceedings because of his or her mental or intellectual disability, disorder or incapacity, or because of any other factor that the court deems appropriate.[44]

Currently, prescription related to the right to claim compensation for sexual violations is delayed only in instances relating to mental and psychological factors such as Post Traumatic Stress Disorder or fragmented memory relating to trauma. The Prescription Act does not, however, deal with factors which may prevent individuals from pursuing a claim that rests on social and political factors, which could include individuals feeling shame around the violation, being dissuaded from disclosing violations by family or friends, the culture of silence related to gender-based violence

[42] Drennan Maud & Partners v Pennington Town Board 1998 (3) SA 200 (SCA). 209 F-G

[43] Eskom v Bojanala Platinum District Municipality and Another 2003 JDR 0498 (T).

[44] Prescription Act 68 (1969). At section 12(3).

in South Africa, and lack of resources to proceed with attaining legal assistance in pursuing a claim.[45]

The history of the amendment of the Prescription Act to include the content of section 12(4), has been based on conscientising the courts and legislature around gender-based violence. The emphasis of this conscientising has included showing the courts that survivors of sexual violence can face numerous barriers to disclosing their violation and proceeding to court within the time limits.

The case of *Levenstein v. Late Estate Frankel* (*Levenstein*) preceded the legislative amendment, which resulted in the above content being added to section 12(4) under the Prescription Act in 2020.[46] Although the case dealt with criminal law prescription periods, it facilitated the movement of the legislature to address both civil and criminal law prescription periods around sexual offences.

The case concerned eight individuals who were sexually assaulted (in terms of the pre-2007 law) by well-known and politically connected businessman Sydney Frankel.[47] The eight individuals had been sexually violated between the period of

[45] Notably, however, there is a case before the high court in KwaZulu Natal (a South African province) that is challenging the constitutionality of imposing prescription periods to claims arising from sexual violations altogether. AR v AB, AN & Minister of Justice and Correctional Services (D8482/2020). CALS has been admitted as an *amicus curiae* in the case and will provide the court with expert evidence around social and political reasons why individuals do not proceed with compensation claims related to sexual offences within the 3 year prescription period.

[46] Levenstein and Others v Estate of the Late Sidney Lewis Frankel and Others (CCT170/17) [2018] ZACC 16; 2018 (8) BCLR 921 (CC); 2018 (2) SACR 283 (CC).

[47] South Africa amended the definitions of various sexual offences in 2007 through the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32, (2007). The purpose of the amendment was to align the Act with the Constitution as well as various international conventions to which South Africa was a signatory. Prior to SORMA the definition of rape was narrow and excluded boys and men as well as the anal penetration of girls and women. The old pre-2007 definition of rape was the intentional and unlawful sexual intercourse with a woman without her consent. This is where 'sexual intercourse' was defined as the insertion of a penis into a vagina. Under SORMA the definition of rape is where any person (A) unlawfully and intentionally commits an act of sexual penetration with a complainant (B) without consent. 'Sexual penetration' includes penetration of the

1970–1989 by the businessman and approached the police around 2015 to lay a charge of sexual assault.[48] At the time of laying the charge, South African law had prescription periods of 20 years for all sexual offences other than rape, which did not have a prescription period attached.[49]

The eight individuals challenged the section of the law dealing with prescription periods relating to all sexual offences in criminal law, citing them as being unconstitutional for limiting their various rights under the Constitution.

The Constitutional Court found in favour of the eight individuals and noted that individuals experience various barriers to disclosing sexual violations and thus approaching the police and laying a charge may be justifiably delayed. Notably, on the delays in disclosure the court stated that,

> [o]f pivotal importance to the case before us is this: that the systemic sexual exploitation of women and children depends on secrecy, fear and shame. Too often, survivors are stifled by fear of their abusers and the possible responses from their communities if they disclose that they had been sexually assaulted … These characteristics of sexual violence often make it feel and seem impossible for victims to report what happened to friends and loved ones – let alone state officials. Combined with this is the frequent impact of deeply-located self-blame … disables the victim from appreciating that a crime has been committed against her for which the perpetrator, and not she, is responsible … Even if a survivor is fully aware that she was abused, she naturally weighs up the possibility of reprisals from the perpetrator together with the possible lack of support from the police and statistically small

genitals of one person into or beyond the genital organs, anus, or mouth of another person. Also, sexual penetration includes the penetration of any other body part of one person or an object into or beyond the genital organs or anus of another person. Finally, sexual penetration includes the penetration of the genital organs of an animal into or beyond the mouth of another person.

[48] Levenstein and Others v Estate of the Late Sidney Lewis Frankel and Others (CCT170/17) [2018] ZACC 16; 2018 (8) BCLR 921 (CC); 2018 (2) SACR 283 (CC). at para 8.

[49] Criminal Procedure Act 51 of 1977. At section 18.

> eventuality that reporting will actually, eventually, result in a conviction in a criminal court.[50]

The *Levenstein* case was a landmark decision in South Africa acknowledging the barriers that survivors of gender-based violence in the form of sexual violence face in accessing justice. After the *Levenstein* decision, the legislature sought to amend laws relating to prescription periods for sexual offences in both civil claims and criminal cases; the amendment formed section 12(4) above.

As explained by the United Nations Office of the High Commissioner, 'sexual violence is a form of gender-based violence.' Furthermore, gender-based violence includes a 'harmful act directed against individuals or groups of individuals on the basis of their gender. It may include sexual violence, domestic violence, trafficking, forced/early marriage and harmful traditional practices'.[51]

Not only is obstetric violence also a form of gender-based violence, it also has similar (and some different) manifestations of barriers to disclosing violations and seeking recourse. Some of the similarities will be discussed below and include what I term the personal, political and economic barriers to recourse and justice. I will go on to argue that sexual violence and obstetric violence's shared classification as gender-based violations and overlapping barriers to disclosure and pursuing cases of obstetric violence should thus be included under section 12(4) and benefit from delayed prescription periods.

[50] Levenstein and Others v Estate of the Late Sidney Lewis Frankel and Others (CCT170/17) [2018] ZACC 16; 2018 (8) BCLR 921 (CC); 2018 (2) SACR 283 (CC). at para 56 – 57.

[51] United Nations Office of the High Commissioner. (2014). *Sexual and gender-based violence in the context of transitional justice* https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/OnePagers/Sexual_and_gender-based_violence.pdf

2. The personal, political and economic barriers to justice

2.1. The personal barrier to justice

In a study by Mayra *et al* of women's experiences around obstetric violence in India, it was found that women often find it difficult to narrate what had occurred to them in their birthing experience due to a lack of being accustomed to medical language and terms.[52] Furthermore, the researchers also found that women also may experience shame and stigma associated with discussing one's genitals and the link of sexual intercourse to birth.

Notably, the researchers found that a common descriptor of the birthing experience for the women was the term 'pain' and that, like in other studies, there were similar overlaps between the narratives of rape victims and women who experience obstetric violence.[53] The researchers explain that the discourse around rape and that associated with obstetric violence often has survivors using terms such as 'stripped off', 'tethered', 'forcibly exposed', 'sexual organs put on display' and 'disempowered'.[54]

Morris *et al* go further and suggest that the experience of obstetric violence can cause women to connect the obstetric violation with other gendered violations such as rape.[55] The researchers also find that women can experience similar psychological and emotional responses to sexual violations as they do to obstetric violence. Women who previously experienced sexual violations and then obstetric violence may compare the

[52] Mayra, K., Sandall, J., Matthews, Z., & Padmadas, S. S. (2022). Breaking the silence about obstetric violence: Body mapping women's narratives of respect, disrespect and abuse during childbirth in Bihar, India. *BMC pregnancy and childbirth*, *22*(1), 1-19.

[53] Ibid. Kitzinger, S. (2005). *The politics of birth*. Books for Midwives Press. , Scotland, M. (2020). *Birth Shock: How to Recover from Birth Trauma-why at Least You've Got a Healthy Baby Isn't Enough*. Pinter & Martin.

[54] Mayra, K., Sandall, J., Matthews, Z., & Padmadas, S. S. (2022). Breaking the silence about obstetric violence: Body mapping women's narratives of respect, disrespect and abuse during childbirth in Bihar, India. *BMC pregnancy and childbirth*, *22*(1), 1-19.

[55] Morris, T., Robinson, J. H., Spiller, K., & Gomez, A. (2023). 'Screaming, "No! No!" It was Literally Like Being Raped': Connecting Sexual Assault Trauma and Coerced Obstetric Procedures. *Social Problems*, *70*(1), 55-70.

two, with the traumatic birth prompting memories of the sexual violation.[56] Furthermore, Morris *et al* located other similarities between the two groups of survivors which includes avoiding the hospital, also known as 'traumatophobia'; dissociation; anxiety, depression and PTSD; relationship problems; self-blame and not reporting the violation.[57]

Marton explains that traumatophobia in relation to rape survivors develops as a defensive reaction to the circumstances of the rape; this can include fear of being inside, fear of being outside, fear emerging from being alone, and the fear of someone coming up behind them.[58] Individuals who have been sexually violated may experience anxiety, dissociation, and PTSD. Studies showing the possible emergence of these disorders around sexual offences have historically been well documented.[59]

South Africa has extremely low reporting rates around sexual violence. In a study by the South African Medical Research Council in 2002, it was found that only 1 in 9 women report rape cases to the police; furthermore, in 2011 and in the province of Gauteng, it was found that the number was only 1 in 25 women reporting their violation.[60] Smythe notes that other problems associated with survivors' experiences around the police in South Africa include the police refusing to open cases for sexual violence, police officials not permitting the survivor to report the incident to an official in a private space, police failure to make arrests, and no information being provided to survivors post opening a case.[61]

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[56] Ibid.

[57] Ibid.

[58] Marton, F. K. (1988). Defenses: Invincible and vincible. *Clinical social work journal*, *16*(2), 143-155.

[59] Foa, E. B., & Riggs, D. S. (1994). Posttraumatic stress disorder and rape ; Nöthling, J., Lammers, K., Martin, L., & Seedat, S. (2015). Traumatic dissociation as a predictor of posttraumatic stress disorder in South African female rape survivors. *Medicine*, *94*(16).

[60] Jewkes, R., & Abrahams, N. (2002). The epidemiology of rape and sexual coercion in South Africa: an overview. *Social science & medicine*, *55*(7), 1231-1244 ; Mercilene Machisa *et al.* (2011). *War at Home*. https://www.saferspaces.org.za/uploads/files/GenderLinks-13452_begin_war_at_home.pdf. The Gauteng study was the last study into reporting at the time of writing and thus the new numbers around reporting are not yet ascertainable.

[61] Smythe, D. (2015). *Rape Unresolved: Policing Sexual Offences in South Africa*. http://hdl.handle.net/11427/30657

Women cite reasons for their failure to report sexual violations to the police as including individuals' personal barriers but also views around poor police attitudes, fear of secondary victimisation, and deficient police investigations.[62]

Similarly, around the barriers to reporting obstetric violence, Mayra *et al* note that women may not proceed with reporting obstetric violence as they may assume the violence is normal or they may be afraid of being silenced.[63] This is supported by a study by Perera *et al* in Sri Lanka where they found that women rarely reported obstetric violence incidents to legal or institutional authorities and furthermore did not disclose this within their informal social support networks.[64] Instead, the women approached a different hospital for obstetric care and needs post the violation.[65] The researchers found that women largely remained silent about obstetric violations. Furthermore, the lack of reporting was based on no knowledge of the pathways of reporting and finding assistance; some women chose silence as they thought reporting would result in their babies being harmed.[66]

In consultation with CALS's clients, a theme around reporting was the feeling of not being listened to by hospital administrators and entities with legal obligations to hear complaints.[67] Many individuals also experienced feeling 'tired' of trying to navigate the paths to redress when coupled with no meaningful engagement by the individuals within the overarching accountability mechanisms.[68]

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[62] Swemmer, S. (2023b). S v P – The Abuse of Protection Orders to 'Gag' Victims of Rape. *Potchefstroom Electronic Law Journal - forthcoming*.

[63] Mayra, K., Sandall, J., Matthews, Z., & Padmadas, S. S. (2022). Breaking the silence about obstetric violence: Body mapping women's narratives of respect, disrespect and abuse during childbirth in Bihar, India. *BMC pregnancy and childbirth*, *22*(1), 1-19.

[64] Perera, D., Lund, R., Swahnberg, K., Schei, B., & Infanti, J. J. (2018). 'When helpers hurt': women's and midwives' stories of obstetric violence in state health institutions, Colombo district, Sri Lanka. *BMC pregnancy and childbirth*, *18*(1), 1-12.

[65] Ibid.

[66] Ibid.

[67] References to the experiences of the clients emerged during the process of taking client statements.

[68] Ibid.

2.2. The political barriers to justice

In feminist studies it is well-recognised that the 'personal is political' when it comes to gender-based violence and the experiences of women in society.[69] Hanisch's words are important as they highlight that the personal negative experiences of women are often based on or emanate from the structures of social inequality, rather than being isolated and individual in nature.

Politically speaking, gender discrimination in South Africa is prevalent and relentless. The country has some of the highest gender-based violence rates globally. For example, femicide sees a woman murdered every four hours in the country.[70]

Women, and specifically black women, in the country suffer from the highest rates of unemployment with 40.6% without jobs.[71] Currently in the carework economy women remain the predominant individuals, with carework often being un- or underpaid, undervalued and unaccounted for in the economy.[72] In terms of low-income grants or social assistance, women make up 98% of the caregivers who get grants for child-care assistance, emphasising both the level of economic disadvantage of many women as well as the disproportional obligation of childcare on women.[73]

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[69] Hanisch, C. (1969). The personal is political.

[70] Africa Check. (2017). Femicide in South Africa: 3 numbers about the murdering of women investigated. https://africacheck.org/fact-checks/reports/femicide-south-africa-3-numbers-about-murdering-women-investigated

[71] Mahlakoana, T. (2022). Black women bear the brint of SA's unemployment crisis. *Eyewitness News*. https://ewn.co.za/2022/05/31/black-women-bear-the-brunt-of-sa-s-unemployment-crisis

[72] Wekwete, N. (2017). *The global care economy in the context of the changing world of work*. https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/CSW/61/meetings/Naomi%20Wekwete%20-%20The%20care%20economy%20in%20Southern%20Africa.pdf

[73] Gemma Wright, David Neves, Phakama Ntshongwana, & Michael Noble. (2015). Social assistance and dignity: South African women's expereinces of the child support grant. *Development Southern Africa, 32*(4). https://repository.uwc.ac.za/bitstream/handle/10566/6613/Social%20assistance%20and%20dignity%20South%20African%20women%20s%20experiences%20of%20the%20child%20support%20grant.pdf?sequence=1&isAllowed=y

It is not surprising then that the experiences of women and specifically black women accessing healthcare mirror the discrimination and violence they face in both their private and public existence in the country.

Currently, approximately 17.4% of women can afford medical aid in relation to their healthcare needs.[74] Medical aid allows individuals to attain health care from privately run facilities within the country which are better equipped to offer higher levels of medical care to patients. Most women in the country must then rely on the burdened public health care system for their health needs, especially in relation to obstetric care.

The structural nature of obstetric violence is currently playing out in public health establishments in South Africa, such as in the instance of Rahima Moosa Mother and Child Hospital, in the Gauteng province. Rahima Moosa Mother and Child Hospital delivers the second-highest number of babies in the country and is the only hospital in the country that assists only mothers and children.[75] In 2023 South Africa's Health Ombudsman published a report on the status of care at Rahima Moosa Hospital when video footage surfaced on social media of pregnant women lying on the floor in the hospital.[76] Some of the egregious acts of obstetric violence recorded in the ombudsman's report include pregnant women being forced to sleep on the hospital's floor; receiving medical care while seated on chairs; only being assessed if there was

[74] SA, S. (2022). *The status of women's health in South Africa: evidence from selected indicator*. http://www.statssa.gov.za/publications/03-00-18/03-00-182022.pdf

[75] Laetitia Rispel, & Yosef Veriava. (2023). Rahima Moosa: South Africa's only mother and child hospital is falling apart - a veteran doctor reflects on why. *The Conversation*. https://theconversation.com/rahima-moosa-south-africas-only-mother-and-child-hospital-is-falling-apart-a-veteran-doctor-reflects-on-why-202977

[76] Office of the Health Ombud. (2023). *Investigation report into allegations against Rahima Moosa Mother and Child Hospital (RMMCH)*. https://healthombud.org.za/wp-content/uploads/2023/03/Investigation-Report-into-allegations-against-Rahima-Moosa-Mother-and-Child.pdf.

a complication; and clinical decisions being based solely on what had been entered on their files.[77]

The structural nature of obstetric violence is highlighted in the instance of Rahima Moosa Hospital, as the *status quo* of obstetric violence is maintained throughout the systems within the hospital and beyond into various levels of government. In this instance, the hospital is 80 years old and has not been properly maintained. For example, the ombudsman's report cites that the hospital has a failing sewerage system, leaking pipes and dilapidated buildings.[78] There is a clear lack of proper use of assigned funding and mobilisation of resources at the hospital. The issues around funding permeate the South African healthcare system, which has been made worse by pervasive corruption in the system and notoriously poor leadership.

From August 2018 to June 2022 South Africa held a commission of enquiry into rampant state corruption at numerous state-owned facilities within the country. The Zondo Commission revealed that corruption within the public sector had crippled the country and stripped many state departments of their resources.[79] In recent years it has become apparent that the public health sector has similarly been the victim of wide-spread corruption and maladministration. For example, in 2021 a whistle-blower, Babita Deokaram, a financial officer for the Gauteng Department of Health, was assassinated in her car for her exposure of 227 companies that benefitted from

[77] Swemmer, S. (2023a). Pregnant women of Rahima Moosa Hospital join the ranks of victims of pervasive obstetric violence. *Daily Maverick*. https://www.dailymaverick.co.za/opinionista/2023-03-23-obstetric-violence-the-case-of-rahima-moosa-hospital/

[78] Office of the Health Ombud. (2023). *Investigation report into allegations against Rahima Moosa Mother and Child Hospital (RMMCH)*. https://healthombud.org.za/wp-content/uploads/2023/03/Investigation-Report-into-allegations-against-Rahima-Moosa-Mother-and-Child.pdf.

[79] The Commission is known colloquially in South Africa as the 'State Capture Commission' or the 'Zondo Commission'. For more information see The Judicial Commission of Inquiry into Allegations of State Capture, Corruption and Fraud in the Public Sector, Including Organs of State at https://www.sastatecapture.org.za/.

illegal tenders with a Gauteng hospital.[80] Reports show that over 1 billion rand ($50 686 500.00) was lost in corrupt deals at the hospital in the province since 2021.[81] An example of some of the brazen orders for 'hospital equipment' includes one plastic bucket costing R10 000 ($507.39) and an order for skinny jeans totalling R500 000 ($25394.83).[82] The effect of corruption on women is often overlooked, though research in Latin America has shown that women suffer corruption to a greater extent than men due to the unequal power relations between the two.[83] Corruption can, in turn, exacerbate unequal power relations and thus limit women's access to public resources. The use of 'sextortion' (the misuse of power to obtain benefit or advantage) is one of the forms of exploitation that disproportionately affects women. As Téllez explains, sextortion affects women and girls throughout Latin America and especially in low and middle-income countries as well as remote areas.[84]

Research by Transparency International revealed that the number of women who die during birth increases exponentially in countries with higher instances of bribery.[85] Transparency International explains that when it comes to corruption and public services, the barrier to services is heightened for more economically disadvantaged women; they state that women, 'often have fewer resources to use informal payments

[80] Ndaba, B. (2023). Babita Doekaran killed for exposing R1bn corruption at Tembisa Hospital, says Panyaza Lesufi. https://www.iol.co.za/pretoria-news/news/babita-deokaran-killed-for-exposing-r1bn-corruption-at-tembisa-hospital-says-panyaza-lesufi-fbdb09a1-6e0e-4006-bbb3-a90f17b22279

[81] Ibid.

[82] Citizen Reporter. (2022). *Tembisa Hospital's R500 000 skinny jeans contract one of the deals Babita Deokaran died for* (Citizen, Issue. https://www.citizen.co.za/news/south-africa/controversial-tembisa-hospital-r500-000-skinny-jeans-august-2022/

[83] Angélica Fuentes Téllez. (nd). *The Link Between Corruption and Gender Inequality: A Heavy Burden for Development and Democracy*. https://www.wilsoncenter.org/publication/the-link-between-corruption-and-gender-inequality-heavy-burden-for-development-and

[84] Ibid.

[85] Angélica Fuentes Téllez. (nd). *The Link Between Corruption and Gender Inequality: A Heavy Burden for Development and Democracy*. https://www.wilsoncenter.org/publication/the-link-between-corruption-and-gender-inequality-heavy-burden-for-development-and

to access services or circles of influence and can be more frequently "denied" access to services because of their inability to pay bribes'.[86]

With South Africa's continued battles with extremely high levels of corruption, poor service delivery and the provision of sufficient healthcare will remain a challenge. Considering the feminisation of poverty and the unequal effects of corruption on women in the country, obstetric violence in state healthcare institutions will remain pervasive. Justice for obstetric violence will also remain unattainable so long as women have three years to litigate against the government.

2.3. The economic barriers to justice

The final barrier to recourse within the prescribed period is access to legal assistance. As McQuoid-Mason noted in 2002, urban and rural economically disadvantaged people (predominantly black) comprised 50% of the South African population.[87] The World Bank noted that in 2020, approximately 55.5% (30.3 million people) in South Africa lived in poverty at the national upper poverty line.[88] With the high poverty rates within South Africa, access to paid legal assistance is only available to the wealthy, whereas free legal assistance is severely limited due to resources.

Legal-Aid South Africa is the government service for free legal assistance for those whose needs fall into certain categories of legal interventions. Legal-Aid does not help with all forms of litigation and is instead limited to family matters (divorces, maintenance, domestic violence), evictions, employment issues and issues emanating from contracts.[89] Without the option of using Legal-Aid, women are faced with two other legal options.

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[86] Janna Rheinbay, & Marie Chene. (2016). *Gender and Corruption Topic Guide*. https://knowledgehub.transparency.org/product/topic-guide-on-gender-and-corruption

[87] McQuoid-Mason, D. (2013). Access to justice in South Africa: are there enough lawyers? *Oñati Socio-legal Series, 3*(3).

[88] World Bank Group. (2020). *Poverty and Equity Brief* https://databankfiles.worldbank.org/public/ddpext_download/poverty/33EF03BB-9722-4AE2-ABC7-AA2972D68AFE/Global_POVEQ_ZAF.pdf

[89] Legal-Aid South Africa. (nd). *Get Help*.

The first is approaching a non-profit legal organisation for assistance, such as the Centre for Applied Legal Studies, the Legal Resources Centre, Lawyers for Human Rights and the Women's Legal Centre. Unfortunately, organisations like these are entirely dependent on donor funding and simply cannot assist every individual in a claim for obstetric violence. Partnerships with Legal-Aid, privately funded law firms, and non-profit legal organisations around providing services for women who are victims of obstetric violence may be an avenue to consider in the future.

The final legal option for women is to approach a lawyer who offers to take on legal cases on a contingency basis. These types of contingency agreements mean that women will only have to pay the lawyer if they win. The Contingency Fees Act sets out the parameters of these agreements. A lawyer can claim up to 25% of the woman's total award if it is not 100% more than the lawyer's normal fee.[90] This option can also be problematic. For example, lawyers are not forced to take on every client's case and thus may prioritise 'easy wins' or only cases for large amounts of money. In the instance of obstetric violence, unless the violation is physically incapacitated or physically measurable to a certain extent, the case may be more difficult to be litigated successfully. Violations with emotional and psychological impacts are more difficult to prove and often attain meagre compensation.

Conclusion

The barriers to justice around obstetric violence in South Africa are numerous. However, as I have argued throughout this piece, one way to begin removing the barriers to justice for obstetric violence survivors is by eradicating prescription periods related to the violations. This eradication will give victims time to navigate through the personal, political, and economic burdens relating to obstetric violence and justice through the legal system.

To do away with the 3-year limit for claims, I have argued that South African law must classify obstetric violence correctly as gender-based violence and a human rights violation rather than medical malpractice. With South African law already allowing

[90] Contingency Fees Act 66 of 1997.

for the pausing of prescription in terms of sexual offences, obstetric violence can be reclassified and join sexual offences under the umbrella of gender-based violence in the Prescription Act.

By developing the law with the acknowledgement that obstetric violence shares many of the same issues around why women do not disclose violations, the law will make time for justice for victims of obstetric violence and recognise the nature of the obstetric violence as being equally egregious as sexual violence in the country.

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