

**South African Policy Analysis on Respectful Maternal Care**

by

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## **ABSTRACT**

Every woman has the right to receive respectful maternal care (RMC), which includes high quality of care that is dignified, respectful and free of violence and discrimination.

Addressing disrespectful maternal care requires interventions at multiple levels including policy. The purpose of this study was to determine the extent to which current policy addresses RMC in South Africa, and identify any potential gaps therein. The study was conducted through a desk-based review of policy documents, accessed through internet search engines, academic portals, and requests from governmental and other public healthcare agencies. Each policy document was assessed for relevance to the study and then analysed using a framework of analysis. The key policy documents related to maternal care in South Africa, in varying levels of detail, address the rights related to providing RMC. While there are some gaps in the policy, all rights related to RMC are addressed to some extent across the range of policy documents reviewed. This however has not deterred violation of these rights. This thesis discusses the disparity between what policy says and what appears to be implemented, it highlights some of the potential gaps in South African policy on offering RMC and some of the perceived strengths of South African policy related to RMC.

**DECLARATION**

I declare that this thesis entitled “South African policy analysis on respectful maternal care” is my own work, that has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references



Signed: SP Gormley

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## **ABBREVIATIONS**

CDC	Centre for Disease Control
DMC	Disrespectful Maternal Care
HSSREC	Humanities and Social Science Research Ethics Committee
RMC	Respectful Maternal Care
SA	South Africa
Stats SA	Statistics South Africa
WHO	World Health Organisation

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## CHAPTER 1: A DESCRIPTION OF THIS STUDY

### 1.1 Introduction

A woman should be entitled to the highest standard of healthcare, including care during her pregnancy and birth, which is dignified and respectful. She also has the right to experience care which is free of violence and discrimination (WHO, 2015). The expectations of what quality maternal care is, has expanded from merely receiving a technically competent model of care to a more holistic version of person-centred care that encompasses the concept of respectful maternal care (RMC) (Lambert *et al.*, 2018).

RMC, or at least aspects thereof, appear to have started gaining the attention of the global maternal health community due to activism in South America during the 1990s (Bowser & Hill, 2010). Initially the focus was on the dehumanising treatment of women and the extensive medicalisation of birth. As RMC became more widely explored, the categories of disrespectful care expanded. Disrespectful and abusive care in childbirth can manifest in various forms, including emotional, verbal, physical and sexual abuse, neglect, denying a birth companion, breaching patients' confidentiality, non-consensual care, and the use of inappropriate and unnecessary medical interventions (Chadwick, 2016). While there are "obvious forms" of violence perpetrated by healthcare providers against mothers, there are also structural conditions which provide an environment conducive to and may encourage disrespectful maternal care (DMC) (Chadwick, 2016).

RMC plays a critical role in the health and wellbeing of both mother and child. The impacts of disrespectful maternal may include severe medical complications, mental health challenges and negative impacts on the bonding of mother and child after the birth (Rucell, 2017). The

negative perceptions of care received by pregnant women may prevent them from accessing care, resulting in poor outcomes for both mother and baby (Chadwick, 2016). The provision of RMC is essential in upholding the rights of women and their new-borns, as well as ensuring the provision of technically competent, high quality maternal healthcare services.

In South Africa, abusive treatment during childbirth has only been highlighted as a significant challenge more recently than in other countries (Chadwick, 2016). The normative nature of disrespectful maternal care in South Africa, together with the poor healthcare infrastructure, extensive discrimination and massive inequity in the country, provides conditions in which disrespectful maternal healthcare are pertinent (StatsSA, 2020). This is particularly evident in the public health sector which has significant infrastructure challenges, overburdened staff and serves the most vulnerable and disadvantaged members of the population (Maphumulo & Bhengu, 2019).

Amongst the literature on RMC, there is a large focus on reporting on the incidence of mistreatment amongst women accessing maternal healthcare. In some studies, this is measured through observations of client-provider interactions (Abuya *et al.*, 2018; Maputle, 2018); while other studies gather the information through interviews or questionnaires with women following the birth of their child (Chadwick *et al.*, 2014; Duggan & Adejumo, 2012; Lambert *et al.*, 2018). Other studies pay attention to the perception of midwives in providing maternal healthcare, focusing on the challenges they face in provision of care as well as their poor working environments (Bradley *et al.*, 2016). There are also several organisations or initiatives such as the White Ribbon Alliance, the International Childbirth Initiative and the Maternal Health Task Force that have produced resources on RMC.

The introduction of multi-component RMC policies has been shown to positively impact on the birth experience and experience of mistreatment in four African countries, including South Africa (Downe *et al.*, 2018). Therefore, the implementation of policies addressing RMC at a national level, across the whole health system, may contribute to effectively addressing the challenges related to RMC in the country. Evidence-based policies need to be integrated into national health programmes and services. This may include the development of national policies and guidelines (WHO, 2018).

## **1.2 Problem statement**

In order to address the incidence of DMC in South Africa, it is likely that interventions at all levels of the socio-ecological model (individual, relationship, community, societal) will be required (CDC, 2020). Policy impacts mainly on the societal level of the model. Therefore, introduction of new policy and changes to existing policy can contribute toward a holistic effort to address DMC in South Africa. It was unclear from the literature reviewed for this study, to what extent existing healthcare policies address RMC directly, and how they might influence the South African Health system's potential to offer RMC. A content analysis of existing policy allows for an understanding of how existing policy addresses and provides for RMC and what the potential gaps are. Addressing these gaps may contribute towards providing a policy environment which better enables RMC. This study conducted a content analysis of existing South African policies to determine if and how RMC is addressed. It was conducted through desk-based activities, making use of internet search engines and academic portals for relevant policies to be included in the analysis.

## **1.3 Purpose**

The purpose of the study was to gain an understanding of how respectful maternal care (RMC) is addressed in South Africa and where it might need to be improved. This study can be used by researchers studying the field of RMC, to gain an understanding of how it is currently addressed in policy and how this might influence the current maternal healthcare environment. The report can be used by government officials and policy makers to establish an understanding of RMC, its importance and where policy in South Africa is potentially lacking in terms of providing an environment in which RMC can be provided. Advocates may use this report to support their efforts to advocate for improved RMC in South Africa. It provides a collation of resources which speak to the importance of RMC and its potential to improve maternal and new-born health outcomes in South Africa; and it provides a collation of evidence that disrespectful maternal care (DMC) is a challenge in South Africa. Finally, it provides insight into how RMC is addressed in the country, where the gaps are and how it might be improved. Overall, the report serves as a starting point to improve healthcare policy in South Africa in terms of RMC, through establishing what already exists and where it is potentially lacking.

The following chapter provides a review of the literature surrounding RMC, with a particular focus on South Africa. It also considers the influence of policy on maternal care and situates this thesis within the body of literature which already exists.

## CHAPTER 2: LITERATURE REVIEW

### 2.1 Defining RMC

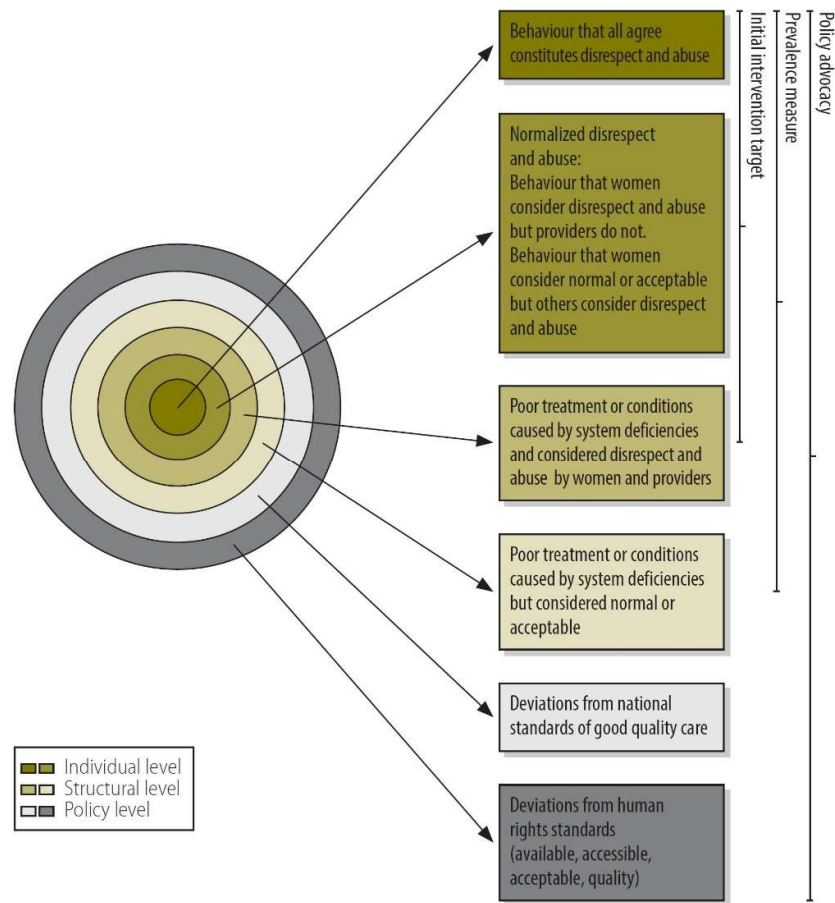
The quality of maternal care is largely hinged on the quality of the clinical care provided by healthcare providers. However, it is argued that without respect and dignity, care cannot be considered good quality (Odallo *et al.*, 2018). Therefore, the provision of RMC extends beyond clinical care. Care must uphold the human rights of both the mother and newborn; including their rights to respect, dignity, confidentiality, information, and informed consent. They should also be provided with the highest attainable standard of health, freedom from discrimination and from any form of ill-treatment (The White Ribbon Alliance for Safe Motherhood, 2011).

The scope of RMC extends beyond labour and childbirth, it should also include the antenatal and postnatal care periods (Sacks & Kinney, 2015). Rucell *et al.* (2019) include inadequate access to abortion, coerced or non-consensual sterilisations and administration of injectable contraceptives as part of the scope of RMC. The lack of availability and access to a range of modern safe contraceptives should be considered denial of care (Rucell *et al.*, 2019).

Defining and measuring RMC is challenging because there are many factors which influence the perceptions of mothers and their expectations of care during labour. Therefore, what some may consider abuse or disrespectful care, others may consider to be normal (Morton & Simkin, 2019). Further to this, the birth outcomes also have an impact on a mother's perception of the care she receives (Oosthuizen *et al.*, 2017).

Freedman *et al.* (2014) developed a detailed definition of disrespect and abuse of women during childbirth, which considered a research, policy, and rights agenda. The definition is built upon consideration of the local consensus on what constitutes disrespect and abuse, the

subjective experience of both the mother and her family, as well as the healthcare service provider; and the intentionality of the behaviour. The diagram below, taken from Freedman and colleagues' paper "Defining disrespect and abuse of women in childbirth: a research, policy and rights agenda" shows the different levels of the definition, providing a framework which ensures that every experience has a place within the definition (Freedman *et al.*, 2014).



**Figure 1: Freedman and colleagues' visual representation of their definition of disrespect and abuse of women in childbirth (Freedman *et al.*, 2014)**

The figure shows 6 layers within the definition of disrespect and abuse of women during childbirth. The key in the figure shows that the two outer layers are at the policy level – this is particularly pertinent for this study, as it looks at how policy addresses RMC. However,

along the right-hand side of the figure, it shows that all six levels of the definition should be used in policy advocacy. Policy provides the context for the structural level and individual level. As a result, policy can influence these levels too (Freedman *et al.*, 2014).

## **2.2 The importance of RMC in improving health outcomes**

The provision of maternal care, which is respectful and maintains the dignity of mothers and ensures that their rights are upheld is not a luxury but a necessity (Morton & Simkin, 2019). There is evidence that women's mistrust of the health system, in particular of maternity care providers, deters them from seeking medical care during pregnancy and labour (Chadwick, 2016; Morton & Simkin, 2019) even in high risk cases (Odallo *et al.*, 2018). As a result, women may also be deterred from accessing antenatal and postnatal care due to their negative perceptions and fear of ill treatment (Chadwick, 2016).

The range of behaviours, acts and unnecessary procedures that amount to disrespectful maternal care can have wide ranging and devastating impacts (Morton & Simkin, 2019).

These impacts may range from medical complications (Rucell *et al.*, 2019) to negative impacts on the bonding of mother and child after the birth (Chadwick *et al.*, 2014).

Neglecting mothers in labour reduces the likelihood of early identification of complications which may have negative impacts on both mother and infant (Rucell *et al.*, 2019). Mothers in labour require a sense of calm and reassurance; the constant fear and solitude that is sometimes experienced by mothers can cause labour to slow (Morton & Simkin, 2019) and introduce the potential for further complications and need for interference in the natural labour and birthing process. Morton and Simkin (2019) highlight that the highly medicalised nature of maternal care, sometimes manifesting through coercion of mothers to agree to

procedures (e.g. caesarean sections) or performing unnecessary and non-consensual procedures (e.g. episiotomies) can be unsafe for mothers and infants and cause unnecessary challenges for the mother later on.

The effects associated with a birthing experience marred by disrespectful care can have long term effects on both mother and child (Chadwick *et al.*, 2014). Separation of mother and child after birth can have negative impacts on bonding, as well as on feeding of the infant (Morton & Simkin, 2019). The World Health Organisation (WHO) (2020) recommends that mothers should initiate breastfeeding within the first hour of the infant's life and maintain exclusive breastfeeding for the first six months to provide their child with the best possible nutrition. Separating an infant from its mother after birth interferes with the implementation of this recommendation. The impact of traumatic birthing experiences has also shown to have significant mental health implications, including negatively impacting on the relationships mothers have with their children and partners (Chadwick *et al.*, 2014). The trauma associated with some births has caused woman to experience post-traumatic stress disorder or depression (Morton & Simkin, 2019), hampering their abilities to care for their infant (Chadwick *et al.*, 2014).

### **2.3 What are the standards required for RMC?**

The provision of respectful maternal care is grounded in the upholding of a mother and her newborn's rights during all stages of maternity care (The White Ribbon Alliance for Safe Motherhood, 2011). The *Respectful Maternity Care Charter: The Universal Rights of Childbearing Women* defines 10 human rights as the universal rights of women and newborns.

**Table 1 Ten Universal Rights of Women and Newborns**

1.	Everyone has the right to freedom from harm and ill-treatment
2.	Everyone has the right to information, informed consent and respect for their choices and preferences, including companion choice during maternity care and refusal of medical procedures
3.	Everyone has the right to privacy and confidentiality
4.	Everyone is their own person from the moment of birth and has the right to be treated with dignity and respect
5.	Everyone has the right to equality, freedom from discrimination and equitable care
6.	Everyone has the right to healthcare and to the highest attainable level of health
7.	Everyone has the right to liberty, autonomy, self-determination, and freedom from arbitrary detention
8.	Every child has the right to be with their parents or guardians
9.	Every child has the right to an identity and nationality from birth
10.	Everyone has the right to adequate nutrition and clean water

(The White Ribbon Alliance, 2011)

Demanding RMC is particularly challenging in an environment where harmful practices, such as neglect and other forms of disrespect, have become normalized, (Chadwick, 2017; Dutton & Knight, 2020). These normalised behaviours effectively amount to human rights violations. The medicalisation of childbirth means that women tend to lack autonomy during the process

of childbirth (Lalonde *et al.*, 2019). The provider holds the power and largely dictates the process (Chadwick, 2017). This means the provider could make decisions based on their own preferences and comfort over the mothers. For example, healthcare workers dictate the birthing position; perform episiotomies or make use of assistive devices, such as forceps or suction, during the birth, regardless of the mother's preferences (Lalonde *et al.*, 2019). Instead, Lalonde *et al.* (2019) describe a preferred process in which a partnership between the mother and her healthcare provider exists. Here, the mother becomes an active participant in the decisions made during her pregnancy and labour; while guided by a skilled professional (Lalonde *et al.*, 2019; Oosthuizen *et al.*, 2017). Maternal healthcare providers should be aware of the rights of the mother, her child, and her family; and cognisant of the significance of the birth to them. This should take into consideration cultural sensitivities and the vulnerabilities of the mother and infant, such as the mothers age, migrant status, or a particular race group (Oosthuizen *et al.*, 2017).

The provision of information to mothers and their partners or families upon request is insufficient in upholding their rights. Information should be proactively provided to the relevant parties ensuring they are adequately informed to make decisions related to themselves and their newborn (Odallo *et al.*, 2018). The provision of RMC does not rely only on the good nature of the providers but also on the environment and infrastructure required (Odallo *et al.*, 2018). Providers themselves are often not treated with respect and dignity. Governance in facilities is weak and results in inefficient systems, overworked staff, and inadequate facilities – therefore challenging the provision of RMC (Oosthuizen *et al.*, 2017). Several factors may contribute to an enabling environment for RMC. Buy-in from leadership at all levels is highlighted as a critical component for RMC (Morton & Simkin, 2019). Odallo *et al.* (2018), add, the need to have an accessible and fair complaint and redress system in

place within facilities. The redress system should be used effectively by those governing the facility to improve the services at the facility (Odallo *et al.*, 2018).

#### **2.4 Nature of the problem in South Africa**

The South African public health system is plagued with numerous challenges, including those related to human resources, physical infrastructure, shortage of resources and poor supply chain management (Maphumulo & Bhengu, 2019). Maternal care, faced with its own complex set of challenges owing to the nature of the care, is provided within this challenging health system. It can be expected, that disrespectful maternal care, evident in some of the world's most well-resourced and effectively governed healthcare systems, would be exacerbated in a healthcare system like that in South Africa.

There have been several studies conducted in South Africa which provide evidence that disrespectful maternal care is a reality in healthcare facilities around the country. Physical violence (Rucell *et al.*, 2019), verbal abuse (Lambert *et al.*, 2018), neglect (Lappeman & Swartz, 2019) disallowing companions during labour (Brown *et al.*, 2007) and unnecessary medical procedures (Lambert *et al.*, 2018) are all evident across healthcare facilities in South Africa. The maternal care experience in South Africa, in particular, in the public sector, deter women from making use of maternal healthcare (Lambert *et al.*, 2018). Brown *et al.* (2007) reported that women would rather give birth at home than go to a healthcare facility.

Various social and structural conditions in the country further exacerbate the challenges associated with disrespectful maternal care. These factors create an environment in which disrespectful maternal care is normative (Chadwick, 2017; Oosthuizen *et al.*, 2017). Socially,

South Africa is marred by high levels of inequality (StatsSA, 2020). Obstetric violence forms as a means of discipline (Chadwick, 2016) which has become normative in relation to factors such as class, gender and race (Chadwick, 2016; Oosthuizen *et al.*, 2018; Rucell *et al.*, 2019). Further to this, disrespectful maternal care, and in turn obstetric violence, is described as gender based-violence (GBV) since it is only women who require maternal care (Chadwick, 2017). Refugees (Rucell *et al.*, 2019), young girls and women with a lower education level (Oosthuizen *et al.*, 2017) are shown to be the most significantly impacted by negative maternal healthcare experiences.

Various structural factors, including political-economic arrangement, health systems and related policy provides for and thus enables violence and its persistence in maternal health (Rucell, 2017). There are several factors, other than a high disease burden, which contribute to the high volumes of patients in healthcare facilities across the country. The rapid urbanisation experienced in South Africa means healthcare facilities in cities are dealing with larger numbers of people than they have the capacity for (Maphumulo and Bhengu, 2019). This places a significant burden on the facility in terms of space, staffing, and resources such as medication. The distribution of healthcare workers in South Africa is also significantly skewed, with most human resources being concentrated in the private sector, which serves a significantly smaller proportion of the population (Maphumulo and Bhengu, 2019).

Physical infrastructure challenges, widespread in South Africa's public healthcare sector, play a significant role in preventing effective change in practices in healthcare (Maphumulo and Bhengu, 2019). For example, limited space and the absence of partitions in labour wards cause severe challenges for healthcare workers to ensure a patients' privacy during

examinations and to allow for birth companions (Chadwick, 2016). Other factors such as shortage of appropriate medications, result in women not having access to appropriate or adequate pain relief options (Lambert *et al.*, 2018).

The general lack of repercussions for providing such inappropriate or inadequate care further contribute toward an environment where disrespectful maternal care becomes pertinent. As discussed above, the normative nature of disrespectful care in South African healthcare facilities means that mothers come to expect such treatment. It fails to prompt any desire to report an incident or complain about the treatment received. This hesitance to report incidents is also related to the power dynamic between a healthcare worker and the mother, who may just be grateful to be receiving skilled clinical care (Chadwick, 2017; Lambert *et al.*, 2018; Rucell *et al.*, 2019). That said, even if a patient did want to lay a complaint, the mechanisms to do so are virtually non-existent and are certainly not made known to the patients (Maphumulo and Bhengu, 2019; Rucell *et al.*, 2019) While the efforts to implement a measure of recourse within healthcare facilities themselves appears to be weak, there has been some attention paid to the abusive practices in maternal health by the legal fraternity (Chadwick, 2016; Pickles, 2015).

While the disrespectful care of a patient by a healthcare provider can never be justified; there are various factors pertaining to healthcare workers and the challenges they face which need to be considered as catalysts of disrespectful maternal health care. Healthcare workers, in particular midwives and nurses, are themselves disrespected by their management, doctors and co-workers (Lambert *et al.*, 2018). There is a general lack of support for healthcare workers, they are overburdened due to staff shortages (Lambert *et al.*, 2018), they experience

trauma (Lappeman and Swartz, 2019) and they are expected to perform optimally under resource constrained conditions.

The normative nature of disrespectful care and the lack of repercussions may also contribute towards some concerning perceptions being shared amongst healthcare providers. Lambert (2018) found that healthcare workers, their managers and policy makers appear to share the view that a woman in labour is unable to make her own choices, making consent unnecessary (Lambert *et al.*, 2018). Further to this, some healthcare staff feel that because of their skills, they are better positioned to make choices on behalf of the mother (Lambert *et al.*, 2018). The value of clinical care is placed well above caring behaviours, particularly in such resourced constrained environments (Lambert *et al.*, 2018).

## **2.5 Policy influence on RMC**

Policies exist at all levels of government and within institutions. The National Health policies of a country contribute towards defining a country's vision and strategies toward ensuring the health of their population. Policies contribute toward defining a common environment in which healthcare is provided, including how care should be delivered and accessed. Effective health policy should balance out the efficient use of limited resources while maintaining high quality care (Nimptsch, 2020). All policies should be evaluated and monitored closely from initiation to ensure that implementation is contributing toward achievement of the policy goal and that any unintended consequences are dealt with immediately (Nimptsch, 2020).

A strong human rights lens can be applied to policy when determining how it might provide for RMC – since the upholding of human rights will provide for the provision of RMC.

Vazquez and Delaplace (2011) explain that human rights focused public policy is characterized by “people’s empowerment” and compliance with International Human Rights Standards. People’s empowerment means that policies view individuals as right-holders rather than recipients of a country’s goodwill. This, however, requires that rights are recognised, means to fulfil these rights are determined, individuals are aware of their rights and there are enforcement mechanisms in place to uphold the rights. Without empowerment, a policy cannot be considered one based on human rights (Vazquez & Delaplace, 2011).

The unintended consequences of health (and other) policy on RMC may not have been considered a factor in policy evaluation due to the normative nature of certain practices but also due to RMC only recently receiving more attention in South Africa (Chadwick, 2016). The outcomes, and potential unintended consequences of policies, influence individuals differently depending on various socio-demographic, economic and environmental factors (Oliver *et al.*, 2019). This is particularly relevant to South African policy which influences a very diverse population. Hence, the potential and extent of unintended consequences are complex. Policy may directly address RMC but it may also indirectly influence it through the provision of guidelines which either enable RMC or perpetuate treatment which is disrespectful.

The provision of RMC is a necessity in South Africa and the right of every woman who accesses maternity care in the country. The provision of high-quality clinical care, respectful treatment and active participation in decision making regarding her maternity care must become the norm in the South African healthcare sector. However, to effectively provide RMC, there needs to be an environment which enables such care. Effective policies could

contribute toward creating an environment in which RMC can be effectively provided. This study will provide insight into how RMC is addressed in South African policy and offer recommendations on how it might be improved.

The literature reviewed for this report provides evidence that disrespectful maternal care is a reality in South Africa. Furthermore, it describes the negative impacts on maternal health and the health of new-borns. There are several existing challenges which create an environment in which disrespectful maternal care becomes the norm. These challenges include healthcare sector infrastructure, cultural norms, human resource challenges and poor working environments for healthcare workers. This study will analyse the policy environment surrounding maternal health and determine what exists within policy that either addresses or impacts on respectful maternal care in the South African healthcare sector. Policy forms the foundation of the environment in which healthcare services are provided. The analysis of the policy environment may reveal areas of the policy which are creating an environment where the practice of respectful maternal care is made challenging. In addition, the analysis may reveal areas of the policy which could be changed to further enable the practice of respectful maternal care. The next chapter describes the approach taken to carry out the policy analysis.

## **CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY**

### **3.1 Aims and Objectives**

#### **3.1.1 Aim**

The aim of this study is to understand how respectful maternal care is addressed in existing policy in South Africa.

#### **3.1.2 Objectives**

The objectives of this study are as follows:

1. Identify current policies in South Africa that are related to issues of respectful maternal care.
2. Provide an overview of the existing policy in South Africa in terms of how it relates to respectful maternal care.
3. Apply the RMC charter of universal rights of women and newborns to analyse existing South African policy in terms of the standards required for respectful maternal care.
4. Identify potential gaps in South African policy in addressing respectful maternal care.

### **3.2 Study Design**

To determine how existing policy in South Africa addresses issues related to RMC, a desk review of South African policy documents was conducted. The approach used to analyse the documents is referred to as the READ approach (Dalglish *et al.*, 2020). Broadly this approach requires the (1) reading of materials to be analysed, (2) extracting data from the materials, (3) analysing the extracted data and (4) distilling the findings (Dalglish *et al.*, 2020).

### **3.3 Study population and sampling process**

The materials were obtained from publicly available sources, scrutinised for their relevance to this policy analysis and those considered relevant will be analysed using a framework of analysis. Broadly the analysis will focus on content, actors, and process (Walt *et al.*, 2008). In addition, the framework provides for specific analysis on how the policy document addresses the rights of mothers and their newborns (The White Ribbon Alliance for Safe Motherhood, 2011).

### **3.4 Data collection**

#### **3.4.1 Parameters of search**

The documents included in the policy analysis were required to fulfil the set criteria. The documents included in the policy analysis either addressed the topic of ‘maternal health in South Africa’ or were expected to address the topic (the absence of which may then have become pertinent to the policy analysis). Policy documents included in this analysis were those which are considered current and active documents.

An online search of PubMed, Google Scholar, and the websites of South African National and Provincial Departments (Health, Social Development, Police, Justice) was conducted for potentially relevant policy documents to be considered for the policy analysis. Boolean phrases used for the online searches included:

'Respectful maternal care' OR 'obstetric violence' OR 'disrespect and abuse during childbirth' AND 'policy' OR 'guideline' OR 'gazette' OR 'action plan' OR 'white paper' OR 'green paper' Or 'report' AND 'South Africa'

The references of selected policy documents were also searched for additional related information.

Documents which fulfilled the inclusion criteria were checked for duplication. Duplicates were removed from the selection. Finally, the titles, abstracts or executive summaries and the full text of each document were screened for relevance to the study. To be included in the study, they needed to be (1) a current policy document, (2) South African and (3) related to maternal care.

### **3.5 Data analysis**

#### **3.5.1 Content analysis**

Each document selected for inclusion was reviewed. Any mention of the following, either explicitly or implied: - respectful maternal care; obstetric violence; maternity care and prevention of disrespectful care and/or abuse was scrutinised to understand the content of the policy. In addition, the documents were also reviewed to understand: who the actors involved in the development and implementation of the policy were, the context in which the policy was developed and is being implemented, and finally what the process was in implementing the implementation of the policy (Walt *et al.*, 2008).

The content of the policy, related to RMC, was documented within the framework of analysis. Policy revisions, amendments or other formal changes to the policy were also reviewed.

### 3.5.2 Framework of analysis

The framework of analysis (see Appendix 1) is divided into two sections – the first section was developed based more generally on principles of analysing health policy (Walt *et al.*, 2008). The second section of the framework has a focus on human rights and provides a framework to analyse policies through a human rights lens.

The first three areas of analysis in the first section of the framework include content (as it relates to RMC); actors; context and process. These three areas are highlighted as important areas of focus for health policy analysis (Walt *et al.*, 2008). The next four areas of analysis were included in the framework because they are important factors to consider when conducting policy evaluations (CDC, 2012). These areas include evidence, comparisons, specificity of the policy and unintended effects of the policy.

The second section of the analysis framework focuses on the human rights applicable to maternal care, as they are outlined in the Universal Rights of Women and Newborns (The White Ribbon Alliance for Safe Motherhood, 2011). Each policy was analysed to determine if and how it addresses the rights of mothers during maternity care. The information collected from each policy was collated into a single spreadsheet within the framework of analysis. This allowed for easy reference across the policies to determine which areas were addressed in which documents and to identify similarities and contradictions.

Following the content analysis, the South African policy reviewed was considered within the context of existing literature, policies, and practices of other countries to determine what recommendations could be offered to improve existing policy, in South Africa, to effectively address RMC.

### 3.6 Ethical considerations

Ethical clearance for this study was provided by the Humanities and Social Science Research Ethics Committee of the University of Western Cape (HSSREC Reference Number: HS21/2/1). The approval period for this study extended from 25 March 2021 to 25 March 2024.

Data collection for this study was entirely desk based. Data was not collected from any individuals. As a result of the desk-based nature of the study, there were little to no ethical considerations for this study. There is no need for informed consent to be obtained, nor confidentiality assured. All data used, was already available in the public domain.

## CHAPTER 4: RESULTS

A total of nineteen policy documents were included in the policy analysis. Sixteen of these documents presented with findings related to respectful maternal care. These documents included four (4) guidelines, four (4) Acts, two (2) policies, three (3) strategy documents, one (1) Bill, one (1) Standards document and the Constitution. The list of policy documents included in this analysis are provided in Table 2.

**Table 2: List of policy documents included in analysis**

1	The Constitution of the Republic of South Africa, 1996
2	Guidelines for Maternity Care in South Africa: A manual for clinics, community health centres and district hospitals. Fourth edition. 2016 National Department of Health
3	Updated guideline: Intrapartum care in South Africa (March 2019)
4	61 of 2003: National Health Act, NDOH, 2004

5	National Core Standards for Health Establishments in South Africa, NDOH, 2011
6	Guidelines for the Prevention of Transmission of Diseases from mother to child, National DOH, 2019
7	Infant and young child feeding policy, 2007
8	National Contraception and Fertility Planning Policy and Service Delivery Guidelines, 2013
9	National Contraception Clinical Guidelines, National DOH, 2019
10	Draft Department of Basic Education (DBE) National policy on the prevention and management of learner pregnancy in schools, 2018
11	National Department of Health (DOH) Strategic Plan 2020/21 – 2024/5
12	Strategic plan for maternal, newborn, child and women's health and nutrition in South Africa. 2012-2016
13	South African citizenship Act, 1995
14	South African Citizenship Amendment Act, 2010
15	The Children's Act 38 of 2005
16	Women Empowerment and Gender Equality Bill

The content of each policy document was analysed in relation to rights related to RMC.

Table 3 shows which of the RMC rights are reflected in each of the policy documents. The

table does not necessarily indicate that the right is reflected extensively or adequately in the document, simply that it is reflected in the document.

**Table 3 RMC related rights reflected in key South African policy documents**

RMC-related rights	Policy Documents															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Everyone has the right to freedom from harm and ill-treatment.	X	X	X		X											
Everyone has the right to information, informed consent and respect for their choices and preferences, including companion of choice during maternity care and refusal of medical procedures.	X	X	X	X	X	X	X	X		X						
Everyone has the right to privacy and confidentiality.	X	X	X	X	X			X							X	
Everyone is their own person from the moment of birth and has the right to be treated with dignity and respect.	X	X	X	X				X		X		X				
Everyone has the right to equality, freedom from discrimination and equitable care.	X		X	X	X	X		X	X	X					X	
Everyone has the right to healthcare and to the highest attainable level of health.	X	X	X	X	X			X		X						X
Everyone has the right to liberty, autonomy, self-determination, and freedom from arbitrary detention.	X	X	X	X	X	X	X	X	X	X					X	
Every child has the right to be with their parents or guardians.	X	X	X		X											

Every child has the right to an identity and nationality from birth.	X	X											X	X		
Everyone has the right to adequate nutrition and clean water.	X	X	X				X				X					

The most pertinent policy documents for maternal care in South Africa are likely to be the *Guidelines for Maternity Care in South Africa: A manual for clinics, community health centres and district hospitals* and the *Updated guideline: Intrapartum care in South Africa (March 2019)*. The latter was developed in response to WHO recommendations to address RMC. One of the two updates in this updated guideline, is specifically related to RMC. In this review it was determined that both documents addressed nine out of the ten RMC rights. More than any of the other documents reviewed, excluding the country's constitution which addresses all ten rights at a general population level, within the Bill of Rights. This results section has been structured by describing how each right is reflected across the policies included in the analysis.

#### **4.1 Everyone has the right to freedom from harm and ill-treatment.**

The South African constitution requires that “everyone has the right to freedom and security of the person.” It specifically includes the right to be free from all forms of violence from either public or private sources, which would include healthcare facilities. This directly addresses the right of woman to freedom from harm and ill-treatment as one of the rights to be fulfilled to provide RMC.

The only two policy documents that refer directly to abuse are the *Updated guideline: Intrapartum care in South Africa* and the *National Core Standards for Health Establishments*. In the former, “no physical abuse” is briefly listed under the need to “Respect Dignity.” The examples provided include being slapped during delivery and aggressive vaginal examinations. The *National Core Standards for Health Establishments* requires that staff should treat patients with courtesy and empathy and that there is zero tolerance for abuse.

The other policies reviewed in this study address the pain management aspect of this right more directly and thoroughly than that of causing physical harm. Providing assistance when experiencing pain and discomfort is addressed in the *Guidelines for maternity care* and the *Updated guideline: Intrapartum care in South Africa*. In the former, the focus is on pharmacological pain relief options. In contrast, the latter mentions breathing techniques, mobilisation, and support from the companion as options for pain relief. Drug-free measures of pain relief are encouraged as a first option.

#### **4.2 Everyone has the right to information, informed consent and respect for their choices and preferences, including companion of choice during maternity care and refusal of medical procedures.**

The right to information and informed consent is addressed in the constitution through the “right of access to any information that is held by another person and that is required for the exercise or protection of any rights.” In the *Department of Health’s strategic plan*, two of the Batho Pele principles and values for healthcare focus on consultation with citizens and provision of full and accurate information. Provision of information based on benefits, risks, complications, and alternatives is encouraged in relation to procedures in healthcare facilities. The provision of information is encouraged, not only for mothers themselves but also in general to the community. This is particularly true for prevalent challenges such as hypertensive disorders during pregnancy. The *National Health Act* requires that all levels of government must disseminate appropriate, adequate, and comprehensive information related to healthcare services, health promotion, disease prevention and should also participate in relevant community health promotion initiatives.

There are isolated areas where the choice or preference of the woman is mentioned in the maternity specific guidelines. This includes very specific instances such as the choice of whether to await spontaneous labour in the case of a miscarriage and reviewing their contraception choices. The National Health Act requires that healthcare practitioners must inform users of their right to refuse and the implications, risks, and obligations thereof. There is no mention of the need to respect the decision of the woman and her family.

Throughout the *guidelines for Maternal Care*, healthcare workers are encouraged to provide information and obtain consent on an ongoing basis. This ranges from gaining consent for routine examinations to major interventions or surgeries. In emergency situations, woman should be provided with required information, and then fully debriefed thereafter. She should receive a full explanation of the emergency management and any potential complications. The *guidelines for the prevention of transmission of communicable disease from mother to child* also has a strong focus on providing information and obtaining informed consent. The pre- and post-counselling that has become inherently associated with HIV testing for example, is a means of sharing information with patients, discussing treatment plans and addressing challenges that patients face. *The guidelines for maternal care in SA* require that information should be provided at least verbally but preferably in written or illustrated form. Further to this, community healthcare workers (CHWs) serve as a vehicle for information as they are required (through the *National Health Act*) to actively communicate with pregnant women regarding their pregnancies, their health, and the health of their children.

The *updated guideline on Intrapartum care* encourages participatory decision making. This is further encouraged in the *National Health Act* where it encourages the participation of even those who do not have the legal capacity to provide informed consent to be consulted on their treatment.

Avoiding coercion is addressed in several policies through the call for clear, accurate and non-biased information to be provided to patients. While coercion can be difficult to identify, it is further discouraged by the policies specifically discouraging procedures such as episiotomies and caesarean sections.

#### **4.3 Everyone has the right to privacy and confidentiality.**

The right to privacy and confidentiality is addressed in the *Constitution, Updated guideline to intrapartum care in SA, the National Health Act, and the National Core Standards for Health Establishments* in some detail. The *updated guideline on intrapartum care* requires that privacy is created and respected for women at all points during labour and deliver. It emphasises its importance particularly during history-taking, examinations, and delivery. The *National Health Act* requires that all information related to a user of the healthcare system to remain confidential. Information about a patient may only be disclosed for a legitimate purpose within the scope of duties and in the interest of the patient. The *National Core Standards* list respect and dignity as a patient right and within that domain, the standard is that ‘staff treat patients with care and respect with consideration for patient privacy and choice.’ In addition, the domain on management of information has standards which ensure the confidential management of personal information. The *contraception policy and service delivery guidelines* require that women should be able to exercise their reproductive choices

in confidentiality and privacy. The *Children's Act* provides for confidentiality for children over the age of 12 years in accessing any form of contraceptive or contraceptive advice.

In the *Guidelines for maternity care in SA*, there is mention of the need for anonymity of patients during perinatal meetings. There is no mention of the need for confidentiality in taking and maintaining patient records. In contrast, the *National Health Act* does indicate that all information related to users of the healthcare system should remain confidential and that access to health records must be limited and only disclosed in the best interests of the patient. The *updated guideline on intrapartum care* lists respecting privacy as part of implementing respectful, supportive, and women-centred care. The *National Core Standards for Health establishments* requires that care provided, maximises patient privacy and that patient records are archived securely and accessed only by authorised personnel. There are no standards that speak to the sharing of verbal information.

*The contraception policy and service delivery guidelines* make special mention of adolescents. While healthcare workers are required to report suspected cases of abuse, the policy does also call for consideration of sexually active youth who may choose not to access reproductive healthcare services due to fear of being reported. This means that the needs for confidentiality of adolescents need to be taken into consideration when they are in their best interests.

There is little mention of privacy for women during labour and childbirth being maintained in the policy documents reviewed for this study. There are however standards in the *National Core Standards for Health Establishments* which require that the layout of the establishment

is planned or adapted to ensure it meets service and patient needs; and that areas are adequately furnished and provide an acceptable environment for patient care.

#### **4.4 Everyone is their own person from the moment of birth and has the right to be treated with dignity and respect.**

The South African constitution is founded on the principle of human dignity, the achievement of equality, and the advancement of human rights and freedoms. The documents reviewed in this study were found to address this right mostly in terms of the provision of complaints and redress procedures. Excepting the two main guidelines on maternal care – *Guidelines for maternal care in SA* and *Intrapartum care in SA (Updated guideline)*. Any reference to complaints and redress were missing from these policies.

The *National Health Act* requires that any person may lay a complaint; that there must be procedures in place for the laying of complaints and that this procedure must be effectively communicated to all users of the healthcare system. The *Nursing Act* provides for inquiries into any complaint, charge, or allegation of unprofessional conduct against a practitioner. The *National Core Standards for Health Establishments* have standards around complaints management: they should be recorded through formal procedures; complaints should be screened to address adverse events; procedures should be in place for receiving and addressing complaints; complaints must be used to improve the service delivery and that they should be addressed within relevant timeframes. One of the Batho Pele Principles in the *DOH Strategic Plan* is “redress.” The principle requires that where the standard of a service is not upheld, the individual or individuals impacted should receive an apology, an explanation, and

a timeous remedy. It further requires that any complaints should be received and responded to with sympathy and positivity.

#### **4.5 Everyone has the right to equality, freedom from discrimination and equitable care.**

The achievement of equality is a founding principle of the South African constitution. It calls for no discrimination on any grounds including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language, and birth. One of the Batho Pele principles in the *DoH Strategic plan* is around equal access to healthcare services to which a person is entitled. The *updated guideline on intrapartum care* indicates under the heading of “respect dignity” that there should be no discrimination based on age, parity, race, or nationality. The *National Health Act* requires that vulnerable groups, such as women, children, older persons, and persons with disabilities be protected, respected and that their rights should be fulfilled. In Chapter 2 of the *National Health Act*; healthcare workers are required to take into consideration things like language and literacy when providing information and obtaining informed consent from patients.

In the *guidelines on prevention of transmission of communicable diseases from mother to child* it specifies that adolescent girls, young women, and sex workers should be offered services and that there should be specific outreach services to these women. In addition, it delves into the psychological stressors and medical risks experienced specifically by adolescent girls. It emphasises the need for non-judgemental, confidential, and quality youth

friendly sexual and reproductive healthcare services that take into consideration the challenges and risks specific to this group of vulnerable women.

The *Contraception policy and service delivery guidelines* highlight in their background that satisfaction with access to contraceptive services is lowest amongst teens, older women, rural women, and women with lower levels of education. In response to this, a chapter has been dedicated to special considerations for certain groups of people with regards to contraceptive services. The *National Contraception Clinical Guidelines* appears to put a strong emphasis on treatment of adolescent girls by specifying them throughout the guidelines. This is supported by the *Children's Act* which allows for children over the age of 12 years to access contraception and contraceptive advice without the consent of a parent.

The contraception guidelines also require that healthcare workers should be accommodating to all persons, remain non-judgemental, provide special consideration where it is required, and ensure that staff is not rude or prejudiced toward any patient. It specifically points out the needs of disabled persons when accessing a service and in particular calls for avoiding the patronisation of disabled persons. It also cautions healthcare workers on making assumptions related to their patients and rather to take the diversity of the population into consideration when treating patients. Examples include assuming that all women are heterosexual. The *National policy on the prevention and management of learner pregnancy in schools* focuses specifically on school-going girls. It calls for comprehensive sexual and reproductive healthcare services including contraceptive technologies for these girls. The focus on discrimination in this policy is within schools against girls that are pregnant.

The Human Resource for Health strategy addresses non-discrimination at the level of training healthcare workers. Goal 3 in the strategy includes producing a competent and caring, multi-disciplinary health workforce through and equity-oriented, socially accountable education and training system.

#### **4.6 Everyone has the right to healthcare and to the highest attainable level of health.**

The *South African constitution* provides for the right to access health care services, including reproductive healthcare. It also requires that no person may be refused emergency care.

Accessibility to healthcare services is highlighted in the *National Health Act*, which requires that all pregnant and lactating women; and children under the age of six years (who are not members of medical aid schemes) should receive free healthcare. The Women Empowerment and Gender Equality Bill requires that access to health and reproductive rights for women through service provision by designated public and private bodies. The *updated guideline on intrapartum care* requires that care should not be withheld from a woman if she shouts for help.

With regards to attaining the highest level of healthcare; various good practices are encouraged in some of the policies; while unnecessary and inappropriate procedures are discouraged. In the Chapter on Normal Labour and Delivery in the Guidelines for Maternity care; procedures such as enema, pubic hair shaving, insertion of a urinary catheter are all discouraged. Procedures such as artificial rupture of membranes, episiotomies and caesarean sections are discouraged without valid indications. The guidelines provide specific conditions under which such procedures should be performed. It indicates, that even in cases of pre-eclampsia and eclampsia, if the cervix is favourable, vaginal delivery is not a

contraindication. The Guidelines for Maternity Care encourages companionship during labour. The updated guideline on intrapartum care encourages that mother and baby should remain skin to skin during the third stage of labour. The frequency with which a woman should be assessed while in labour is documented in the Guidelines for Maternity care chapter on record keeping. The National Healthcare standards include several standards that intend to uphold the quality of services provided in healthcare facilities. These include: patients receive care and treatment that follows nursing protocols, meets basic needs, and contributes to their recovery. Facilities are required to implement strategic priority programmes or health initiatives (including maternal and child health).

To ensure the highest quality of services and that the environment within which services are provided are of the highest standard, the National Health Act requires that facilities need to comply with the quality requirements and standards and that these should be monitored by the Office of Standards Compliance and inspectorate for health establishments. In addition, there are also requirements for the provision, distribution, development, management, and utilisation of Human Resources within the national health system to ensure the persons accessing it can obtain the highest level of care. The National Healthcare Standards measure patient satisfaction with cleanliness and hygiene; linen, food, and accessibility to clean water. The National Core Standards for Health Establishments include standards on hygiene and cleanliness.

Other areas of the reviewed policies addressing quality of care include the contraception policy and service delivery guidelines aiming to provide expanded choice of contraception, a

mix of contraceptives and ensuring adequate supply of contraceptives and fertility counselling.

#### **4.7 Everyone has the right to liberty, autonomy, self-determination, and freedom from arbitrary detention.**

The rights to liberty, autonomy, self-determination, and freedom from arbitrary detention are closely related to the rights to non-discrimination and to that of informed consent. Therefore, the findings related to those will not be repeated here. However, it is worth noting that the policies related directly to maternal care do not provide mention of freedom to arbitrary detention. The constitution does provide for the right to freedom and security of the person which includes not being deprived of freedom arbitrarily or to be detained without trial. The constitution also provides for the right to bodily integrity, including the right to make decisions over reproduction, to security and control over their body and to not be subjected to any medical experiments without their consent.

#### **4.8 Every child has the right to be with their parents or guardians.**

The Constitution states that every child has the right to family or parental care. *The guidelines for maternity care* address the child's right to be with their parents or guardians in Chapter 17 where it indicates that the mother and child should not be separated unless one of them requires special or intensive care. The chapter on HIV in these guidelines, as well as the *updated guidelines on intra-partum care* encourages skin-to-skin contact immediately after birth regardless of HIV status. In addition, the guidelines indicate that a non-viable baby should be allowed to be held by the parents. Avoiding separation of children from their parents is also a standard in the *National Core Standards*.

#### **4.9 Every child has the right to an identity and nationality from birth.**

Section 28 of the South African constitution indicates that all children have the right to a nationality from birth. According to the South African citizenship Act, 1995 and the South African Citizenship Amendment Act, 2010 any child born to at least one South African parent, will automatically be granted South African citizenship. If, however, a child born in South Africa and neither of the parents are South African, then the child can be registered and obtain a birth certificate, but will not be considered South African. That child will take on the nationality of the parent or parents.

#### **4.10 Everyone has the right to adequate nutrition and clean water.**

The South African constitution requires that all persons have access to sufficient food and water. Regarding the nutrition of children, South Africa promotes exclusive breastfeeding across four of the policy documents reviewed in this study: the *Strategic Plan for maternal, newborn, child and women's health and nutrition in South Africa*; the *Infant and Young Child Feeding Policy*; the *guidelines for maternity care* and the *updated guidelines on intrapartum care*. The *policy on infant and young child feeding* recommends exclusive breastfeeding until six months and then continued breastfeeding until two years old and beyond. Healthcare workers are not to recommend formula feeding unless in the instance that a medical condition requires it. The woman's right to adequate nutrition and clean water also encompasses her right to receive information and support on child nutrition and specifically the benefits of breastfeeding. The *policy on infant and young child feeding* calls for counselling and support provided to mothers throughout their pregnancy and in the period thereafter to encourage optimal infant feeding. The *guidelines on maternity care* specifically address breastfeeding

for HIV positive mothers and the post-natal care and support that should be received by mothers.

Regarding the nutrition of mothers during labour, *the guidelines for maternity care* mention nutrition for the mother following an uncomplicated caesarean section. She may receive oral fluids and a light meal if she is hungry. The *updated guideline* allows for the intake of oral fluids during labour and food until the mother reaches the second stage of labour.

## **CHAPTER 5: DISCUSSION**

The extent to which RMC is addressed in South African policy had not been investigated. This study provides a content analysis of existing policy that contributes toward an understanding of how existing policy addresses and provides for RMC, what the potential gaps are and evidence of practices which are in contradiction to policy. Addressing the gaps may contribute towards providing a policy environment which requires and better enables RMC; however, effective implementation of the policy remains necessary to provide RMC.

The key policy documents related to maternal care in South Africa, in varying levels of detail, address the rights related to providing RMC. A conclusion cannot be drawn on whether the policies adequately provide for a policy environment that encourages respectful maternal care, because such requirements have not yet been defined in the literature.

Therefore, this study highlights where rights related to RMC are addressed and makes suggestions regarding where they may not be adequately addressed. While there are some gaps in the policy, all rights related to RMC are addressed to some extent across the range of policy documents reviewed. This however has not deterred violation of these rights. This

discussion therefore, focuses on three main areas; the first is the disparity between what policy says and what appears to be implemented in reality, the second is to highlight some of the potential gaps in South African policy on offering RMC and the third is to highlight some of the perceived strengths of South African policy related to RMC.

### **5.1 The Policy-Implementation Gap**

Healthcare policy is meant to contribute to shaping the context in which healthcare is delivered. South Africa may be considered progressive in its policy making but quality policy making cannot be realised if it is not implemented. While a policy may address all the necessary content, its implementation relies heavily on the adaption of the policy to the context of implementation; including taking into consideration the actors involved in implementing the policy (Davids *et al.*, 2020). Applying a rights-based approach in the development of policy, is encouraged to ensure that rights of patients are upheld. Provision of RMC is centred around the upholding of woman and newborns rights. Hence this policy review placed a specific focus on how maternal and newborn rights are represented in South African policy.

Legislation addressing violence against women (VAW), which is considered extensive in South Africa, on its own is ineffective in dealing with the problem (Mogale *et al.*, 2012). Evident by the persistently high incidence of VAW (Govender, 2023). Mogale *et al.* (2012) attribute this to the lack of consideration within policy and legislation for cultural, social and economic factors in which VAW is entrenched. This is likely to make implementation of the legislation and policy incredibly challenging. This situation appears comparable to that of respectful maternal care. While upholding the rights of women receiving maternal care are addressed across multiple policy documents; their implementation remains poor (Mapumulo

*et al.*, 2021). This is further emphasised by midwives that have expressed that ‘quality of care’ is merely theoretical and not principles that are actively implemented in the facilities (Dutton & Knight, 2020). Our findings provide evidence that the rights related to RMC are addressed in South African policy. However, the literature provides an abundance of evidence that these rights are still being violated regardless.

The right to freedom from harm and ill-treatment requires that women receiving maternity care should not experience any form of physical abuse and that any physical touch should be as gentle, comforting, and reassuring as possible (Windau-Melmer, 2013). This right is addressed in four of the policy documents, including the two key maternal healthcare policies. Despite this, as recently as 2024, 7% of women from rural South Africa reported being physically abused while receiving maternal care at a public health facility (Doherty *et al.*, 2024). Furthermore, women are faced with threats of violence, having their legs forced open during examinations and a hostile and punitive environment is common (Chadwick *et al.*, 2014). In addition to physical abuse faced by women at the hands of healthcare workers, they also face the risk of harm and even death that comes with the shortages of equipment and ambulances in the public sector (Dutton & Knight, 2020). The right to freedom from harm and ill-treatment also requires that woman receive assistance when experiencing pain and discomfort. This aspect of the right is more extensively addressed in the policy documents reviewed than that of physical abuse. However, reports of requests for pain medication being ignored or declined are not uncommon in the literature (Malatji & Madiba, 2020). Pain management is also directly influenced by the poor supply of medication and equipment (Lambert *et al.*, 2018). Women cannot be provided with any form of pain management simply because there is none available.

Women should have the right to information, consent and respect for their choices and preferences. This right is one of the more extensively addressed rights within the policy documents reviewed with nine of the sixteen documents addressing the need for information provision and consent. Communication, however, is highlighted in the literature as an area that needs the most attention (Doherty *et al.*, 2024). Maputle (2018) reports that midwives are ineffective in facilitating participation of mothers in the processes surrounding her maternal care. This leaves the mother disempowered, and with no consideration for her cultural preferences. Both midwives and their senior management have reported that obtaining consent is not necessary because a woman in labour is not able to provide consent (Lambert *et al.*, 2018). This completely negates the woman's right to autonomy and is concerning in light of the strong policy stance on informed consent. Multiple studies reported examinations being conducted without consent (Malatji & Madiba, 2020; Oosthuizen *et al.*, 2017).

Information sharing is also reportedly limited, Maputle (2018) reported very few women accessing birthing classes and that midwives do not provide the opportunity for mothers to ask questions while receiving care; they are repeatedly dismissed and not provided with any information regarding the progress of their labour, leaving them with no sense of autonomy or control over their situation (Chadwick *et al.*, 2014). This leaves the women heavily reliant on the healthcare workers to make decisions on her behalf. The presence of a companion is encouraged by South African policy guidelines, however, very few women are afforded this right (Doherty *et al.*, 2024; Malatji & Madiba, 2020; Mapumulo *et al.*, 2021). A woman with a companion experiences better communication with the staff and the facility in general. She is also less likely to feel neglected and abandoned (Dutton & Knight, 2020).

A woman's right to privacy and confidentiality means that no one is allowed to expose her or her information. Her privacy and confidentiality should be protected during counselling,

physical exams, clinical procedures and in handling her medical records and personal information (Windau-Melmer, 2013). The maintenance of a woman's privacy while receiving maternal care appears to be one of the most poorly managed aspect of providing respectful maternal care despite being included in seven of the sixteen policies reviewed. The very nature of the way public healthcare facilities are structured and arranged makes maintaining privacy a challenge. The small spaces mean that multiple women are labouring or even giving birth in the same room in front of one another (Mapumulo *et al.*, 2021). This makes the allowances for companions even more challenging because a woman's privacy is violated further through being exposed to companions as well as other labouring women. There are however standards in the National Core Standards for Health Establishments which require that the layout of the establishment is planned or adapted to ensure it meets service and patient needs; and that areas are adequately furnished and provide an acceptable environment for patient care. Fulfilling these standards, for example through the provision of dividers between labouring women, would assist in ensuring privacy.

While the structure of the facility may be beyond the control of healthcare workers, they too engage in inappropriate behaviour by speaking to or about patients where others can overhear their conversations (Drigo *et al.*, 2020; Mapumulo *et al.*, 2021). These violations of privacy are not only rights violations but they can also create trauma for those who overhear conversations or witness examinations or births. One woman reported so little privacy in the labour ward that she was in, that she saw the dead bodies of both a mother and her newborn while she was still going through labour herself (Mapumulo *et al.*, 2021).

All women have the right to be treated with dignity and respect. This means that she should not be humiliated or verbally abused, she should be able to express her views freely and she should also be asked for her feedback on the maternity healthcare services she has received (Windau-Melmer, 2013). Despite the constitution of South African being founded on the principle of dignity, evidence of undignified care is rife. Women are shouted at (Malatji & Madiba, 2020; Mapumulo *et al.*, 2021), spoken to in harsh and abusive language (Malatji & Madiba, 2020), met with bad attitudes of healthcare workers (Drigo *et al.*, 2020) and made to withstand petty humiliations (Chadwick *et al.*, 2014). Women report having to clean up soiled linen or to clean the floor after they have bled (Chadwick *et al.*, 2014).

Every woman has the right to equality, freedom from discrimination and equitable care. This means that regardless of a woman's ethnicity, culture, social standing, educational level, economic status, age, language, HIV status, moral behaviours, or sexuality she should receive equal and respectful care (Windau-Melmer, 2013). In contradiction with this requirement, Oosthuizen and colleagues (2017) found that age, language, educational level, and period of residence in the area was significantly linked to midwives' attitudes, communication, and caring behaviour. The mothers interviewed in a study by Malatji and Madiba (2020) reported receiving judgemental comments about their parity and foreign nationals received a poorer quality of care too. These are all examples of how the already disrespectful maternal care provided in the South African public health system is exacerbated by discrimination against certain groups. Marginalised groups have come to expect abuse and disrespect when accessing public healthcare (Oosthuizen *et al.*, 2017).

In addition to being treated with dignity, respect, and a caring nature; woman also have the right to the highest attainable level of healthcare. Woman who are being left unattended for extended periods (Chadwick *et al.*, 2014; Malatji & Madiba, 2020), have no access to beds, being ignored when complaining of pain and being denied painkillers (Malatji & Madiba, 2020) are having this right violated. Healthcare workers are often reported to not take woman seriously, leaving them until the baby's head is crowning already (Chadwick *et al.*, 2014) or dismissing a woman who was in premature labour because it was too early for her to be having the baby (Mapumulo *et al.*, 2021). These practices are placing women in harm's way and influencing levels of maternal and newborn morbidity and mortality.

Policy is just one component of a multi-level system that is providing maternal healthcare services. There are many other factors which, despite the quality of policy, make providing RMC challenging. Despite South Africa's progress in implementing rights for women, there remains a gender imbalance ingrained within our society (Mapumulo *et al.*, 2021). This means that the abuse of women is normalised and therefore overlooked. The value of women and their reproductive labour is neither identified nor acknowledged making the challenges they face in receiving maternal care inconspicuous (Dutton & Knight, 2020). In addition, the public healthcare facilities are still tainted by the South African legacy of inequality (Chadwick, 2016). The structural inadequacies do not provide for the numbers of woman who require care, they do not provide for the need for a companion during labour, and they remain poorly resourced with both equipment and staff (Dutton & Knight, 2020). This type of environment is, at a minimum, unpleasant for women accessing, and downright intolerable for the healthcare workers expected to provide quality services. Healthcare workers are accused of having demeaning attitudes toward women (Mapumulo *et al.*, 2021) and ignoring women in their facilities (Malatji & Madiba, 2020); in the context of high staff shortages,

lack of equipment and devaluing of their own contributions towards maternal care by their superiors (Chadwick *et al.*, 2014; Doherty *et al.*, 2024). While this does not excuse the poor quality of care that is provided, it does offer some explanation. The focus for this study was on the rights of women receiving care, however, it is also valuable to consider the rights of healthcare workers who may be better equipped to provide RMC if their own rights are upheld.

Lambert *et al.* (2018) shows that it is not that healthcare workers do not know how they are supposed to act, their practice is simply dissonant to their knowledge. They also show that a more appropriate attitude and level of care is provided when visible clinical leadership is present and when staff have received training. The training is likely to be necessary due to the insufficiencies in the country's midwifery training related to ethics of care (Chadwick, 2016).

## **5.2 RMC gaps in South African policy**

There are several gaps in the overall South African policy in relation to addressing RMC that this study highlights. These gaps are quite specific but are being considered in the context of what some of the significant challenges are in provision of RMC in South Africa. The gaps highlighted here are largely related to the two main maternal health policies – Guidelines for maternity care in South Africa and Intrapartum care in South Africa. These gaps include:

- Making specific reference to abuse of women receiving maternal care
- Respecting the choices and preferences of women
- The right to confidentiality, related specifically to records
- Complaints and redress procedures in guidelines on maternal care

While abuse of women receiving maternal care is a notable challenge, it is not addressed extensively in the policies reviewed. It may be that policy developers expect that healthcare workers would be going about their duties upholding the requirements of their oath which includes to not do any harm. Instead, it appears that the normative nature of disrespectful care of mothers (Chadwick, 2017; Dutton & Knight, 2020) means that it may be a factor which needs to be addressed more directly in policy. As aggressive behaviours have become the norm, these need to be addressed directly as violations of rights and inappropriate maternal healthcare.

Respect for the choices and preferences of women contribute toward the provision of RMC (Windau-Melmer, 2013). The medicalised perception of child birth needs to change and instead be replaced with an understanding of the sentiment and pivotal value a birth experience is for a woman and her family. Respect for choice and preference is not explicitly addressed across the policies. There are isolated areas where choice or preference of the woman is mentioned in the maternity specific guidelines. These include the choice of whether to await spontaneous labour in the case of a miscarriage and reviewing their contraception choices. These are specific and limited; they do not take into consideration personal and cultural preferences of woman related to labouring and birthing. Of course, allowing a woman the opportunity to provide informed consent, is essentially providing her with a choice. However, dealing with refusal by a woman when requesting consent is not widely addressed in the policies. Only the National Health Act requires that healthcare practitioners must inform users of their right to refuse and the implications, risks, and obligations thereof. It is also not clear in the policies that women are informed of their right to refuse.

The right to privacy and confidentiality may be negatively impacted by the many challenges faced by the South African public healthcare system (Maphumulo & Bhengu, 2019).

Shortages of human resources may result in multiple healthcare workers conducting examinations. The physical infrastructure may result in multiple women labouring and even delivering in the same room without any form of separation between patients. Privacy and confidentiality are addressed in the updated guideline to intrapartum care in SA, the National Health Act, and the National Core Standards for Health Establishments in some detail. It is however, largely missing from the guidelines for maternity care in SA. Other than a brief mention of the need for respect, privacy, and companionship in the chapter on ‘normal labour and delivery’ and that patient names should not be used in perinatal meetings.

Possibly one of the most conspicuous gaps in the South African policy related to RMC is the absence of any mention of confidentiality in the chapter on record keeping in the Guidelines for maternity care in SA. There is an entire chapter dedicated to record keeping but no mention of the need for confidentiality or how to maintain it while taking and maintaining patient records. This contrasts with other documents such as the National Health Act which indicates that all information related to users of the healthcare system should remain confidential and that access to health records must be limited and only disclosed in the best interests of the patient. In addition, the National Core Standards for Health establishments provide for maintaining confidentiality of records through standards which require that care provided, maximises patient privacy and that patient records are archived securely and accessed only by authorised personnel.

Areas of the policies that addressed the right to be treated with dignity and respect, were largely related to the provision of complaints and redress procedures. This, however, was not the case in the two main guidelines on maternal care – Guidelines for maternal care in SA and Intrapartum care in SA (updated guideline). Any reference to complaints and redress were missing from these policies. In contrast, the National Health Act requires that any person may lay a complaint; that there must be procedures in place for the laying of complaints and that this procedure must be effectively communicated to all users of the healthcare system. The Nursing Act provides for inquiries into any complaint, charge, or allegation of unprofessional conduct against a practitioner. The National Core Standards for Health Establishments have standards around complaints management: they should be recorded through formal procedures; complaints should be screened to address adverse events; procedures are in place for receiving and addressing complaints; complaints must be used to improve the service delivery and that they are addressed within relevant timeframes. One of the Batho Pele Principles in the DOH Strategic Plan is “redress.” The principle requires that where the standard of a service is not upheld, the individual or individuals impacted should receive an apology, an explanation and a timely remedy. It further requires that any complaints should be received and responded to with sympathy and positivity. The absence of any reference to the complaints and redress process in the maternity guidelines potentially compounds the perception that women receiving maternal care should not be complaining about the services they receive.

### **5.3 Strengths of South African policy related to RMC**

Throughout the guidelines for maternal care, healthcare workers are encouraged to provide information and obtain consent on an ongoing basis. This ranges from routine examinations to major interventions or surgeries. In emergency situations, woman should be provided with

required information, and then fully debriefed thereafter. She should receive a full explanation of the emergency management and any potential complications. The guidelines for the prevention of transmission of communicable disease from mother to child also has a strong focus on providing information and obtaining informed consent. The pre- and post-counselling that has become inherently associated with HIV testing for example, is a means of sharing information with patients, discussing treatment plans and addressing challenges that patients face.

There is some focus on the way in which information is provided and whether it is being provided in a clear and understandable way which is an important component of this right(Windau-Melmer, 2013). The guidelines for maternal care in SA require that information is provided verbally and written and illustrated information is encouraged. Further to this, community healthcare workers (CHWs) serve as a vehicle for information as they are required (through the National Health Act) to actively communicate with pregnant women regarding their pregnancies, their health, and the health of their children.

The updated guideline on Intrapartum Care in South Africa encourages participatory decision making. This is further encouraged in the National Health Act where it encourages the participation of even those who do not have the legal capacity to provide informed consent to be consulted on their treatment. These practices are aligned with those that encourage a partnership between the mother and her healthcare provider(Lalonde *et al.*, 2019; Oosthuizen *et al.*, 2017)

The element of avoiding coercion is addressed in several policies through the call for clear, accurate and non-biased information to be provided to patients. Coercion of women into consenting to unnecessary procedures presents a danger for both mother and child (Morton & Simkin, 2019). While coercion can be difficult to identify, it is further discouraged by the policies specifically discouraging procedures such as episiotomies and caesarean sections.

Adolescents have a strong focus, particularly in the contraception policy and service delivery guidelines which make special mention of them. Healthcare workers are required to report suspected cases of abuse. Taking into consideration the ages of consent in South Africa, this means that some children who are engaging in consensual sex should be reported as a suspected case of abuse. However, the policy does also call for consideration of sexually active youth who may choose not to access reproductive healthcare services due to fear of being reported. This means that the needs for confidentiality of adolescents need to be taken into consideration when they are in their best interests.

#### **5.4 Limitations**

This policy analysis was based on information obtained entirely from desktop research. Therefore, it has not provided insights into any challenges in implementing policy that have not already been documented and are publicly available. Without knowledge of what constitutes adequate inclusion of RMC in policy, it is challenging to determine whether South African policy is adequately addressing RMC. At the time of submission, the author was aware that there was a pending release of a policy which would have been relevant to this study. Therefore, this study does not include a review of that policy and may alter the findings of this study.

## 5.5 Recommendations

- The findings on the gaps in policy could be used by policy makers to improve future policy to ensure they better address RMC.
- The findings in this study reveal that despite rights related to RMC being addressed throughout South African policy, there is still evidence that they are being violated. This can be used to advocate for other interventions which focus more on improving the implementation of policy rather than on changing it.
- More research could be conducted into what constitutes adequate policy to ensure RMC.

The expectation of quality maternity care has expanded from just technically competent care, to care which takes into consideration the woman's experience of care. The normative nature of abuse, neglect and structural conditions which perpetuate disrespectful maternal care need to be addressed at every level of the socio-ecological model. This study highlights that to some extent, the policy level has taken into consideration respectful maternal care and the rights related thereto. It also highlights though that despite this, there are significant challenges in terms of ensuring that the policy is implemented. This is evident from the body of literature that shows the multiple infringements on the rights of mothers. Respectful maternal care plays a critical role in the health and wellbeing of both mother and child. As South Africa continues to place effort on improving maternal and child health indicators; addressing the challenges related to the provision of respectful maternal care remain paramount.

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## APPENDIX 1

### Framework of Analysis – Part 1

Policy	Content (as it is related to RMC)	Actors	Context	Process	Evidence	Specificity of the policy	Unintended effects of the policy
	Describe the element of the policy that addresses RMC. (Refer to potential elements of RMC)	Who developed or drives this element of the policy? Who implements this element of the policy? Who is impacted by this element of the policy? Who may be resistant/in opposition to this element of the policy? Are there other actors/stakeholders with roles and responsibilities related to this element of the policy?	What was the context in which this element of the policy was developed (what was the reason for it?) How does context influence the implementation of this element of the policy? How do resource availability influence the implementation of this element of the policy?	How is the implementation of the element of the policy monitored? Were there any key changes to this element of the policy in its development?	What evidence supports/opposes this element of this policy?	Is the wording of the policy specific? Is there room for misinterpretation of this element of the policy? Is there anything ambiguous about this element of the policy?	Are there any unintended effects of the policy (either potentially or already experienced)?

Framework of Analysis – Part 2

Policy	Everyone has the right to freedom from harm and ill-treatment	Everyone has the right to information, informed consent and respect for their choices and preferences, including companionship of choice during maternity care and refusal of medical procedures	Everyone has the right to privacy and confidentiality	Everyone is their own person from the moment of birth and has the right to be treated with dignity and respect	Everyone has the right to equality, freedom from discrimination and equitable care	Everyone has the right to healthcare and to the highest attainable level of health	Everyone has the right to liberty, autonomy, self-determination, and freedom from arbitrary detention	Every child has the right to be with their parents or guardians	Every child has the right to an identity and nationality from birth	Everyone has the right to adequate nutrition and clean water.
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Does the policy address: - physical harm to the woman or child - gentle and compassionate care - receiving assistance when experiencing pain or discomfort	Does the policy address: - provision of care without consent (to woman and/or newborn) - provision of information to woman and/or newborn (regarding woman and/or newborn) - refusal of care (for woman and/or newborn) - autonomy of woman	Does the policy address: - the sharing of information about the woman or her child	Does the policy address: - respectful and compassionate care for both woman and newborn - non-humiliating treatment - avoidance of verbal abuse - speaking about a woman or newborn in a manner which is not degrading or disrespectful	Does the policy address: - discrimination - equality	Does the policy address: - denial or withholding of care - provision of high-quality care, including use of current best practices - timely care - cleanliness and safety of environment	Does the policy address: - detention of woman and newborns at healthcare facilities	Does the policy address: - practices which should keep parents/guardians with their newborn at all times - provision of care to premature babies or newborns with medical conditions	Does the policy address: - birth registration (including in the case of death) - legal nationality of newborns	Does the policy address: - Provision of nutrition and water during labour - Provision of adequate nutrition for newborns - Support on child nutrition - Breastfeeding
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