“Violence and its impact on the right to health”

Submission to:

The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Purpose:

To inform the Special Rapporteur’s forthcoming report to the 50th session of the Human Rights Council

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Email: ohchr-srhealth@un.org

"Violence and its impact on the right to health"

Type of Stakeholder (please select one)	**X** Member State ☐ Observer State ☐ Other (please specify)
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Can we attribute responses to this questionnaire to your State publicly*? *On the OHCHR website, under the section of SR health	Yes: **X** No Comments (if any):

"Violence and its impact on the right to health"

I. Introduction to Centre for Applied Legal Studies

The Centre for Applied Legal Studies (CALS) is a civil society organisation founded in 1978 by Professor John Dugard. The organisation was founded during this period to encourage law reform and improve access to justice during apartheid in South Africa.

The organisation is based in the School of Law at the University of the Witwatersrand. CALS is also a law clinic registered with the Legal Practice Council. As such, CALS connects the worlds of academia and social justice and brings together legal theory and practice. CALS operates across a range of programme areas: civil and political justice; business and human rights; environmental justice; land, home and rural democracy; and gender justice.

The Gender Justice programme at CALS focuses on responses to gender-based violence in South Africa. This includes *all* forms of violence (private and public) against individuals related to their sexual orientation and gender identity. Obstetric violence is one of the forms of gender-based violence that the programme focuses on. The programme engages in research, advocacy and community training on obstetric violence. The programme aims to inform victims/survivors of their rights and legal recourse in relation to this form of gender-based violence, to advocate for South Africa's legislative acknowledgement of the prevalence of this form of gender-based violence and respond adequately with laws and policies to prevent the violence and provide adequate recourse for victims/survivors, and to persist in securing recourse for current and historical victims/survivors of this form of egregious violence.

II. Questionnaire

1. **Please describe, share data and information on the characteristics, number of cases, and the profile of victims and perpetrators in your country/ies or region(s) regarding:**

1.1. gender-based violence against women
1.2. gender-based violence and other forms of violence against children:
1.3. gender-based violence against LGBTI or other persons based on real or imputed sexual orientation, sex characteristics, and gender identity:
1.4. violence against persons with disabilities, including GBV.
1.5. gender-based violence against men
1.6. conflict gender-based violence, including sexual violence
1.7. Please share analysis and available evidence on the impact of COVID on the above.

The particular form of gender-based violence against women (and girls) and birthing individuals focused on in this submission is obstetric violence.[1] Obstetric violence is defined as direct physical, psychological violence and/or unnecessary or coerced medical interventions experienced by women, birthing individuals, and pregnant persons and carried out within reproductive healthcare services.

In South Africa, experiences of childbirth are shaped by racial and class inequalities. A growing body of research evidence, developing since 1998, has identified forms of obstetric violence in the public hospital system in rural and urban areas in four of the nine provinces, namely the Eastern and Western Cape's, Gauteng and KwaZulu-Natal. In addition to this, anecdotal information from various sources has identified obstetric violence in most provinces and the private health system. Obstetric violence is most often directly perpetrated by midwives, nurses, and obstetricians.

The private and public healthcare systems remain unequal and divided along racial and class lines. An estimated 83% of the population rely on the public health system, which is free of charge for pregnant women/birthing individuals,

[1] It is important to note that not only 'women' experience obstetric violence. We thus, use the phrase 'birthing people' along with 'women' to describe the victims/survivors of this violence.

and generally offers low-cost services.[2] However, the high cost of the private health system has meant that it continues to be available to the white and black population with wealth, who can afford it. For instance, this division is easily understood by deeply unequal maternal mortality rates (MMR). MMR is estimated to be approximately 40 people per 100,000 live births in the private health system,[3] while recent MMR estimates in the public health system are around 333 deaths per 100,000 live births.[4] This means economically disadvantaged, mainly black people giving birth in the public health system, are more than seven times more likely to be at risk of death during childbirth than the predominantly white individuals giving birth in the private sector. Importantly, when the annual independent inquiry into maternal deaths was able to compare the causal factors between the systems they reported, 'the pattern of disease resulting in maternal deaths is the same'.[5]

The existing evidence demonstrates obstetric violence manifests as psychological violence ranging from neglect to verbal assaults. Neglect occurs, for instance, when those in active labour are turned away from health facilities; told to pay (for a free-of-charge service); told to go to emergency trauma units instead of maternity services; denied care by not being attended to; and left soiled from childbirth. Verbal assaults are based on those that judge individuals' sexuality and fertility choices, their age, economic & disease status, nationality or ethnicity.

Physical forms of obstetric violence include physical assaults and unnecessary and routine medical procedures. Assaults have instances of birthing individuals being slapped in the face and on their legs, dragging them by the ear on the

[2] The Council for Medical Schemes. Annual report 2014/15. Council for Medical Schemes; 2015 Available at: https://www.medicalschemes.com/files/Annual% 20Reports/AR2014_2015.pdf.
[3] C, Bateman, 'Dismal obs/gynae training contributing to maternal deaths – Motsoaledi'. *South African Medical Journal*, 2014, 104 (10), pp. 656-657.
[4] RE, Dorrington *et al*, 'Rapid mortality surveillance report 2012'. Cape Town: South African Medical Research Council. ISBN: 978-1-920618-19-3.
[5] National Department of Health (NDoH), South Africa. 2014. *Saving Mothers 2011 - 2013: Sixth Report of the Confidential Enquiries into Maternal Deaths in South Africa*. Pretoria: NDoH. Pp 44. Available: http://www.kznhealth.gov.za/mcwh/Maternal/Saving-Mothers-2011-2013-short-report.pdf.

ground, applying pressure to the *fundus* (abdomen) during labour, and isolating and abandoning birthing individuals who are in active labour. These individuals have described this as being torture.

Both coercive and forced medical procedures such as c-sections, administration of contraception, and sterilisation, are all considered as types of assault, and have been recorded in the country.[6]

Unnecessary and routine medical procedures are equally instances of physical violence and thus can constitute sexual assault (where informed consent is not obtained). These include routine episiotomies, vaginal exams/cervical checks (the procedures are to be performed once every 2 hours to indicate progression of labour by checking cervix dilation).[7]

The possible impacts of obstetric violence – it is thought that obstetric violence can result in trauma, post-partum depression, and physical damages to women/birthing people, foetus, and newborns, which can result in death and life-long disabilities. An important factor here is that the physical damages result from *preventable and unnecessary acts.*[8]

2. **Please describe whether the legal framework prohibits and sanctions these forms of violence and the definitions and forms of violence included in the legal system. Please explain redress options for survivors of violence (the pathway they go through if they decide to file a complaint), levels of impunity and if access to comprehensive physical and mental care for GBV-survivors is recognized as a form of reparation.**

[6] This is discussed below in the submission.
[7] Guidelines for Maternity Care in South Africa, Department of Health 2015.
[8] National Department of Health (NDoH), South Africa. 2017. *Saving Mothers 2017: Annual Report on Confidential Inquiries into Maternal Death in South Africa*. Pretoria: NDoH. Available at http://www.health.gov.za/index.php/shortcodes/2015-03- 29-10-42-47/2015-04-30-08-18-10/2015-04-30-08-24-27/category/559-saving-mothers?download=3414:2017-saving- mothers-annual-report.

Currently, in the South African legal system, there is a lack of formal recognition of the term 'obstetric violence'. For example, South Africa has legislation that acknowledges other forms of gender-based violence such as domestic violence, harassment, sexual offences, gender-based cybercrimes, yet no explicit legislation has been enacted around obstetric violence.[9]

The legal framework currently applicable to the prohibition of acts of obstetric violence and providing recourse mechanisms around obstetric violence can be found through the general application of laws and policies such as the Constitution, the National Health Act 61 of 2003, Health Professions Act, Nursing Act 33 of 2005, Sterilisation Act 44 of 1998, Choice of Termination of Pregnancy Act of 1996, as well as general principles of delictual and criminal law.

The prohibition of obstetric violence and the criminal justice system – the common law crimes of assault, assault (GBH), and murder can apply to instances of obstetric violence. This is dependant on whether it can be shown that the act by the healthcare practitioner does, in fact meet the requirements of the criminal offence.

The current system of placing obstetric violence under vague statutes and common law crimes is insufficient and had created a dangerous situation where there is impunity around acts of obstetric violence.[10]

Reporting mechanisms resulting in misconduct hearings by professional bodies – the victim/survivor of obstetric violence has the right to report the healthcare practitioner to the relevant practitioner's professional body.[11] In terms of the

[9] Domestic violence – Domestic Violence Act 116 of 1998, Harassment – Protection from Harassment Act 17 of 2011, Sexual Offences – Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007, Cybercrimes – Cybercrimes Act 19 of 2020.

[10] For a further discussion on the development of criminal sanction around obstetric violence see C, Pickles, 'Eliminating Abusive 'Care': A Criminal Law Response to Obstetric Violence in South Africa, *SA Crime Quarterly* 2015, 53, pp. 5 – 16.

[11] In the instance of doctors, this is the Health Professions Council of South Africa (HPCSA), and for nurses, this is the South African Nursing Council (SANC).

councils, the recourse available for the victim/survivor is an investigation into the healthcare practitioner's conduct, and if a finding is made in favour of the victim/survivor then the council can impose various penalties, which may include (for example) suspension or having the individual's name removed from the register of practicing practitioners.[12] An issue with the disciplinary measures taken by the various councils is that without the recognition of obstetric violence as a form of gender-based violence the sanctions accorded to guilty individuals tend to be extremely lenient.[13]

Recourse through the use of delictual action – the final form of recourse available to the victim/survivor of obstetric violence is through a medical negligence claim for damages. The problem with choosing this method of legal recourse is twofold, first many victims often only become aware that they have this avenue of recourse too late and thus prescription prevents their successful claim.[14] The second issue is once again around the lack of recognition of obstetric violence as a form of gender-based violence and thus case law which grants miniscule monetary damages rewards in comparison to the gravity of the harm of the violence.[15]

Although recourse is available through delict, as set out above, the broader issue with this route is that adopting a delictual approach to recourse ultimately *privatises* the response to this form of violence. The obligation to protect birthing people from obstetric violence resides with the state (through both the bill of rights and international law) and thus the response should not be through singular legal cases but rather a public policy and legislative response, with

[12] In terms of the HPCSA the various penalties are set out in section 42(1) of the Health Professions Act 56 of 1974 and sections 48 and 49 of the Nursing Act 33 of 2005.
[13] For example in 2021, Dr N Kipanga was found guilty of having 'performed [an] abdominal hysterectomy without [the patient's] consent' and was given a R10 000 fine.
[14] See the periods of prescription in South African civil cases in the Prescription Act 68 of 1969. An example of this can be seen with reference to the coerced/forced sterilisation case set out in the Commission for Gender Equality
[15] For a brief discussion on the disparity between damages amounts rewarded and the gravity of the limitation of rights of victims of obstetric violence see S, Swemmer, 'Obstetric Violence: A War Waged Against Women that is being Waged in the Shadows', *Daily Maverick*, 28 November 2021. Available at https://www.dailymaverick.co.za/opinionista/2021-11-28-obstetric-violence-a-war-against-women-that-is-being-waged-in-the-shadows/.

adequate health care and psycho-social support services for victims/survivors.[16]

3. **Please share examples of the types of structural and institutional violence with origins within the State, (perpetrated or condoned by the State) or perpetrated by those not representing or affiliated to the state in your country/ies of region, and who is affected. In particular, describe structural/institutional violence in medical settings against women and girls, LGBTI persons and persons with disabilities or any other individuals or groups relevant in your country/ies or regions.**

As mentioned previously, obstetric violence cases in South Africa have been recorded as early as 1998. This was in a study by the Jewkes *et al* who explored the clinical neglect, and verbal and physical abuse of women and birthing people by nurses.[17]

In 2014 Chadwick *et al* once again confirmed the existence and pervasiveness of obstetric violence in South Africa.[18] The study focused on obstetric violence committed in public sector hospitals in the province of Cape Town in South Africa. The findings include that more than half of the participants shared 'narratives of distress; in relation to their birth experiences, including negative interpersonal relationships with caregivers, lack of information, systemic neglect and abandonment, and the absence of a labour companion.

As stated above, the South African Commission for Gender Equality released a report in 2020 on forced sterilisation of 48 women living with HIV that had

[16] Some of the rights in the South African bill of rights which are limited through the commission of obstetric violence includes dignity, equality, reproductive autonomy, safety and security of the individual and the best interest the child. South Africa has a bill of rights which operates with the state having both negative and positive obligations in terms of these rights.
[17] R, Jewkes *et al*, 'Why do nurses abuse patients? Reflections from South African Obstetric Violence Services' *Social Sciences & Medicine*, Vol 47, Issue 11, 1998, pp. 1781 – 1795.
[18] R, Chawick *et al*, 'Narratives of Distress about Birth in South African Public Maternity Settings: A qualitative Study, *Midwifery*, 2014, 30(7), pp. 862 – 868.

undergone force/coerced sterilisation at fifteen public hospitals, located in the provinces of Gauteng and KwaZulu-Natal. The complainants alleged (and this was confirmed by the Commission) that their unlawful sterilisation was based on healthcare practitioners discriminatory attitude and views around HIV positive birthing individuals. An example of this, is where one complainant recalled her encounter-

> 'When I asked the nurse what the forms were for, the nurse responded by saying: "You HIV people don't ask questions when you make babies. Why are you asking questions now, you must be closed up because you HIV people like making babies and it just annoys us. Just sign the forms, so you can go to theatre'.[19]

Some of the findings of the report include that the complainants had not been asked for their consent prior to the sterilisation procedure, and where consent was acquired this did not equate adequately to the notion of 'informed consent'. Thus, the complainant's had their rights to dignity, bodily integrity and freedom and security of their bodies violated.[20]

4. **Please also share information on the impact of criminalization of sex work, same sex relations, transgender persons, abortion, drug abuse, harmful practices in obstetric care, female genital mutilation on the violence experienced by the affected individuals and their enjoyment of the right to health.**

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5. **Please share information on the health and other type of responses provided by the State and/or other actors in your country/ies or regions in focus to survivors of each/some of the aforementioned forms of**

[19] CGE Report at pp. 48.
[20] CGE Report at pp. 48.

violence. Please assess what works well and not so well, and whether COVID-19 impacted the response and how.

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6. **Please specify the budget allocated in your country/ies in focus, to health-related response to survivors of all/some forms of violence mentioned above. Please indicate the percentage of the national budget devoted to this; the percentage of the international aid provided or received for this. Please explain the impact of Covid 19 to the funding of responses to all/some forms of violence in your State/institution.**

The South African government has, publicly declared its 'longstanding commitment' to the fight against gender discrimination including gender-based violence and femicide; however, one can question whether or not this fight is reflected in the national budget.[21] As expressed by Waterhouse, it is challenging to ascertain funding due to lack of information in the Budget Review and Estimates of National Expenditure documents.[22]

Reference to funding around the health responses to obstetric violence similarly remains difficult. And as set out above, until such time as obstetric violence is recognised as a form of gender-based violence, this form of violence will be relegated under generalised categories of harm related to medial malpractice.

In 2020, Minister of Health Dr Zweli Mkhize, tabled an amount of R62,5 billion for the years 2021 and 2022.[23] The allocation of the amount catered to administration, national health insurance, communicable and non-communicable diseases, primary health care as well as hospital systems and

[21] S, Waterhouse, 'A Deafening Silence on Gender-Based Violence and Femicide', *Daily Maverick,* 25 February 2021. Available at https://www.dailymaverick.co.za/article/2021-02-25-a-deafening-silence-on-gender-based-violence-and-femicide/.
[22] Ibid. A problem is that gender-based violence is not delineated in a meaningful way.
[23] Minister Zweli Mkhize: 'Health Dept Budget Vote 2021/22' available at https://www.gov.za/speeches/minister-zweli-mkhize-health-dept-budget-vote-202122-13-may-2021-0000.

health systems and governance.[24] In the speech and report delivered by Dr Zweli Mkhize, it was mentioned that service providers were tasked to analyse the R100 million liability claims on the department of health, of which they were reduced to R32 million.[25]

The government of South Africa has invested a great deal of money in the fight against COVID-19 and its effects on the population.[26] For instance, the introduction of the social distress grant and the investment in vaccine procurement. COVID-19 is said to have also crippled the healthcare system in South Africa.[27] It was expected that the government would make the necessary investments to strengthen the healthcare system and improve the access to and the responsiveness of the healthcare system.[28] However, the budget proposed further cuts to a healthcare system that is already considered 'crippled'.[29]

7. **Please describe the needs of survivors of the abovementioned forms of violence as identified by your State/institution. Please share survivor-self identified needs and those of their families, with a focus on health emergency and long-term needs.**

The most common needs of victims/survivors of obstetric violence is medical and psycho-social support, access to medical records, as well as strengthened pathways to recourse.

Some examples of the needs of victims/survivors post-violence are set out below:

[24] Ibid.
[25] Ibid.
[26] Ibid.
[27] Ibid.
[28] R, Rensburg, 'South Africa's health system is on its knees: the budget offers no relief', *Daily Maverick*, 17 November 2021. Available at https://mg.co.za/opinion/2021-11-17-south-africas-health-system-is-on-its-knees-the-budget-offers-no-relief/.
[29] Ibid.

- Surgeries to alleviate pain, poor vaginal and sex functioning – in the case of one of CALS' questionnaire participants, she expressed that after giving birth she developed a bacterial infection that would not heal, she describes that,

  'I had a tear and infection after giving birth and the tear would not heal. They then recommended surgery to me. I did a first surgery, was unhappy, and had to do another one because the stitch had went off and there was a hole back there and my sexual pleasure was gone. This second surgery also did not work and as a result, I have an opening by my vaginal opening that has not healed'.[30]

  The participant also explains the effects of the ineffectual surgeries on her physically and emotionally, she states that

  > 'Yes. I do not feel enough as a woman. I am so insecure. I am scared that people will know my secret and tell other people. Each time a relationship doesn't work out, I just think of the entire ordeal. I can't even share conversations with other women. My own pleasure is not the same'.[31]

- Counselling to address trauma for both victims/survivors and their families – CALS has seen (through its questionnaires) that psycho-social support for victims/survivors and their families is urgently required. However, at this point in time, there are grossly inadequate responses by the state in this regard. An example of the psychological and emotional devastation of obstetric violence can be seen by the statement of a deceased victim's daughter recorded by CALS,

  > '[My] baby brother… couldn't play with his mother because by the end, even touching her caused her to scream out in pain. There was a family rift with the [my] older brother, and they hadn't spoken in 5 years. He [her brother]

[30] CALS Questionnaire (further information cannot be provided in order to secure the anonymity of the individual.
[31] Ibid.

managed to see her on the day she died. [My] step-dad started drinking and smoking, and has not dealt with it well mentally’.[32]

- Access to medical records – the CGE in their report has noted the difficulty of getting access to one’s own medical records in South Africa. They have indicated that access to the complainants’ medical records (for investigation of the complaint) was challenging due to poor record-keeping at hospitals, Department policy around destroying older files, missing files and in some instances, hostility by hospital reception staff.[33]

- Information about recourse options – there is a lack of knowledge by individuals around what obstetric violence is as well as the existence of the various routes for recourse. In 10 of CALS’ trainings with community members in mining-affected communities in South Africa, CALS found that generally, women and birthing individuals were not aware of the existence of the term ‘obstetric violence’, most of the participants were also similarly unaware of any of the recourse mechanisms currently available to them.

- Legal support – legal support is costly in South Africa, and thus, justice is not accessible to many individuals in the country. One of the few methods of legal support in instances of obstetric violence is through medical malpractice claims. This is available because these certain types of law firms will take on cases on a contingency basis. This is where they will take a percentage of the damages awarded to the victim/survivor. Thus, in essence, the client will not have to pay for legal assistance. This is not a silver bullet and creates the situation where only ‘winnable’ cases or extremely egregious cases of malpractice will be the primary cases taken on. Furthermore, and extremely common in obstetric violence cases, is that if the 3-year prescription period has elapsed, firms will be unwilling to proceed with a damages claim, as the ‘winnability’ of the case decreases significantly.

[32] CALS Questionnaire.
[33] CGE Report pp. 49 – 50.

8. **Please share examples of good practices and examples of comprehensive health responses to survivors of violence and indicate efficient multi-sectoral efforts at the community, national, regional and international levels by State or non-State actors.**

In addition to being a signatory to a number of international commitments, South Africa has various laws and policies that represent good practices focusing on women’s reproductive health and rights. In South Africa, responses to obstetric violence are guided by legislation that governs sexual reproductive health rights South Africa.

The Constitution of the Republic of South Africa 1996, section 27 of the Constitution stipulates the right to health care services (including reproductive rights) and the right to emergency medical treatment.

The Choice of Termination of Pregnancy Act of 1996 (as amended act 38 of 2004). This legislation promotes and protects access to abortions and has specifications around access for later-term abortions in particular.

The Sterilisation Act 44 of 1998. This legislation provides the right to sterilisation and regulates the right, attaching criminal penalty for failure to comply with consent requirements. This right is subject to the individuals being fully informed about the procedure. Furthermore, ensuring that individuals have a safe, effective, affordable and dignified fertility procedures.

The National Health Act 61 of 2003. This legislation mandates the provision of free healthcare services to all pregnant and breastfeeding women, and the Choice of Termination of Pregnancy Act, which legalises abortion services and mandates this service be provided free of charge. These rights are extended to all women and birthing persons, without bias on the basis of legal status in the country.

The National Health Act and The National Patients Rights’ Charter set out the factors that need to be in place in order for a person to decide for themselves what they want in regard to their healthcare and for them to realise that decision otherwise known as ‘informed consent’.

Guidelines for Maternal Care in South Africa (2015). The guidelines provide, among other things, a practical approach for primary healthcare to manage pregnancy, labour and childbirth with the ultimate aim of reducing deaths of mothers. The guidelines are for health professionals providing obstetric, surgical and anaesthetic services for pregnant women. The guidelines are aimed at supporting the localised development of protocols for identifying, diagnosing and managing common and serious pregnancy and delivery problems. The guidelines respond to recommendations by National Committee On Confidential Enquiries Into Maternal Deaths the overall aim is to improve clinical management and referral to reduce pregnancy-related deaths and ill health.

Department of Health Complaints Procedure (2017). The purpose of the procedure is to provide direction to the health sector in managing complaints, compliments and suggestions by ensuring that standards and measures as set out by the National Department of Health, the Department of Planning, Monitoring and Evaluation in the Presidency and the Department of Public Service and Administration are adhered to. The Guideline sets out processes to ensure that patients/families and support persons are informed on how to lodge a complaint or record a compliment or suggestion and on what to expect subsequently.

This legal framework can be seen as good practices. However, these rights often do not exist beyond legislation and require adequate investment of state resources to be brought into action.

Additionally, several authorities with governing oversight, both binding and unbinding, are relevant for the particular problem of obstetric violence:

Health Ombudsman (established 2016). Has been created as an independent office in terms of the National Health Amendment Act 12 of 2013. The office is accountable to the Minister of Health and is assisted by the Office of Health Standards and Compliance. The office is mandated to investigate and make recommendations on complaints and ensure redress for malpractice in the health systems.

Office of Health Standards and Compliance (established 2013). Has been created as an independent body by (section 78) of the National Health Amendment Act 12 of 2013. The Office's objective is to protect and promote the health and safety of users of health services.

South African Nursing Council, (SANC) Nursing Act 33 of 2005 and the Health Professions Council of South Africa (HSPCA) Health Professions Act 56 of 1974. Both of these professional associations are independent statutory bodies established by law and reinforce South Africa's constitutional commitments by binding healthcare workers to its ethical principles and code of conduct.

An example of a major health response occurred when the CGE released its report, as discussed above.

The report made findings and recommendations to the National Department of Health, Health Professions Council of South Africa and South African Nursing Council. Currently, survivors and the Department of Health are undergoing settlements negotiations into material remedies, which include medical assistance and fertility services, amongst others.[34]

[34] G, Davis, 'Mkhize launches probe into illegal sterilisation of HIV+ women at state hospitals' *Eyewitness News,* 25 November 2020. Available at https://ewn.co.za/2020/11/25/mkhize-launches-probe-into-illegal-sterilisation-of-hiv-women-at-state-hospitals.

9. **Please describe State and other actors initiatives and measures to prevent these forms of violence, the specific budget allocated to prevention, and good practices in this regard.**

Currently, in South Africa, there are no national initiatives and measures to prevent obstetric violence, nor are there any specific budget allocations for prevention. However, there is a national budget allocation for GBV (see question 6 above).

Increased knowledge of what to expect from health care providers and during pregnancy and childbirth assists mothers to assert their rights. The ‘Mom’s Connect’ programme funded by USAID and implemented by the national department of health has been developed to increase access to reliable information about pregnancy.

Furthermore, CALS has partnered with Women affected by Mining United in Action, Embrace - The Movement for Mothers, Treatment Action Campaign who has set up public education initiatives to create awareness on this form of violence against women.