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Embodied Knowledge, Lived Experience: South African Personal Health Narratives

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Embodied Knowledge, Lived Experience: South African Personal Health Narratives

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Abstract

From a young age, I have been interested in health and how health affects various bodies within different spaces. More so, I am interested in how medical systems silences, rather than empowers the patients that it treats. This thesis focuses on various aspects of women’s health, specifically birth and pregnancy, within the context of post-apartheid South Africa. More particularly, this paper highlights the birth and pregnancy experiences of six women in Langa Township, Cape Town and how these women embody crucial knowledge to understanding South Africa's healthcare system. South Africa’s progressive constitution established new rights across various identities, including the implementation of healthcare for previously disenfranchised bodies. Though the constitution grants free healthcare to women, women still face multiple barriers in receiving maternal health in regards to affordability, accessibility and quality of care. Much scholarly research has been conducted surrounding issues of maternal health in South Africa; however, little academic research has used a feminist framework and an interdisciplinary narrative approach to explore these issues. Moreover, little attention has been given to the lived realities of the women who navigate South Africa’s healthcare system. In this paper, I address my standpoint as a white woman from the United States by sharing my own mother’s health narrative in order to center her health experience. Paralleling this concept, I center the conversations I had with six women who live in Langa to be the knowers and tellers of their own pregnancy and birth stories. This work seeks to assess how these women’s pregnancy and birth experiences play out in the framework of a country with purportedly progressive women’s health rights. From the six narratives, themes emerged in regards to upbringing, the context of South Africa, and pregnancy and birth experiences. In an attempt to address these themes, I further analyze unexpected costs, traveling for care, silences surrounding knowledge, perceived and received care, and the medicalization of birth. This paper highlights how these women’s maternal health experiences are highly politicized and gendered within the larger context of South Africa.
Dedication

I would like to dedicate this paper to the women who shared their pregnancy and birth stories with me, and to all the women who have navigated any healthcare system while pregnant and/or giving birth who have not had the opportunity to share their own stories.

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PROLOGUE

White walls and long hallways scare me. Whenever I walk down one, I can feel my heart racing, the blood pumping through my veins. Flashes of white fluorescent lights shout at me. I black out for what seems like hours, but in reality, it is just half of a millisecond. I know I am not in that hallway, the one where this anxiety formed.

As a kid, I have always been in and out of hospitals. Not as a patient, but as a visitor, visiting my mom. I remember playing with my mom’s leg brace—ripping the Velcro strap on and off, on and off until she would become peeved. Always a little upset because she couldn’t wear flip-flops or walk barefoot or run after me. I always wonder what it would be like to wake up one day paralyzed. Not from fear or anxiety, but from physical paralysis. My mom was in her first year of college when she woke up paralyzed from the waist down. Doctors diagnosed her with Guillain-Barre Syndrome, a neurological disorder that would leave her paralyzed for three months of her life and not being able to walk without a leg brace. That was the beginning—foot surgeries, complications, and multiple staph infections. Flash forward a couple of years. Things did seem better, until that one hospital hallway.

“Did you tell her?” She asked.
“No-no I didn’t.” My father replied.
“I have cancer.”

From there I can’t remember. I have only recently started to piece things together. My mom staying home and not picking me up from school. Finding chunks of hair in the shower drain. Having my grandma and aunts visit multiple times from out of town. I remember being embarrassed by my mom’s baldhead—I told her not to come to school without wearing her wig. Time went on. She had her ups and downs, and so did I. Eventually, she beat it. Her hair once
brown and curly grew back straight and silver. She lost the “cancer weight” and everything seemed back to normal. Nothing was said, and life moved on. One year to the next.

I tell this story because it is a story that was never told when it was actually happening. When my mom was diagnosed with stage III ovarian/uterine cancer, I did not know what was going on. I was told my mom had cancer, and that was it. Instead of conversation and an explanation of my mother’s illness, the only thing I knew and saw was how the disease affected her body. I saw her lose weight, gain weight, lose her hair, and cry because she did not want to shave her head. For my mom, my family, and I, it was simply easier to ignore her diagnoses instead of recognizing it. Though this happened to my family, it also happens to far too many people who navigate healthcare systems.

Society silences far too many voices—especially voices of people who are often found on the margins of society. I begin this piece with my mother’s own health narrative because it has influenced the person I am today, and the work I have pursued and I am interested in pursuing. Growing up, I always knew I wanted to go into medicine and, in turn, I went to Colgate thinking that I wanted to become a doctor. I started out on a pre-med track, but always felt something was missing from my coursework. I had the opportunity to work with faculty who showed me that medicine does not always equate to hard science, and I realized that social factors and determinants play just as large a role in health as biology and chemistry. I pursued courses that encouraged me to think critically not only about the scientific aspects of medicine, but more importantly, how the intersection of identity and medicine affect various facets of health. I am fascinated with the sociological and anthropological side of medicine and how our culture,
gender roles, and politics affect how we view and receive medical care. I now understand that our medical system often silences, rather than empowers, the patients that it treats.

Going into my sophomore year at Colgate, I was faced with a decision of deciding where I wanted to study abroad. I have always been drawn towards studying abroad in South Africa—given its complex history with race and colonialism that in many ways parallels the history of the United States. Once I made the decision to study abroad in Cape Town, I struggled with the idea of staying in people’s homes throughout the semester. Though I did not know how I would affect the space I was entering, I knew that I would need to constantly question my feelings and experiences. That being said, when my program required me to conduct my own research, I thought deeply about the ethical implications and tried to reflect this process in my research methodologies by utilizing a narrative approach that centered women’s voices instead of my own. After deciding that I was going to write on women’s health experiences, I wanted to ensure I was not establishing myself as a knower or an expert of women’s experiences with the South African healthcare system. Rather, through this work, I sought to emphasize the importance of personal narrative as a tool for change, healing, and growth for the six women who shared their stories with me. Furthermore, the six women whose narratives are incorporated in this piece are the knowers and experts of their own experiences.
INTRODUCTION

South African Context

Today in South Africa, legally all citizens are entitled to certain rights as established by the 1996 constitution passed by the post-apartheid government. The former oppressive apartheid government regulated, possessed, and exploited various bodies in regards to race, sexuality, age, and gender. The revolutionary constitution promoted rights that attempted to undo the wrongdoings of the previous apartheid government. Though race is at the forefront of many discussions of the post-apartheid period, the establishment of the new constitution in 1996, allowed for various intersections of identities to reclaim individual rights. In particular, for women, the constitution established specific rights in regards to reproductive health and maternal healthcare. According to Cooper et al., during the apartheid era, there were “no comprehensive reproductive health policies in South Africa” and “the greatest proportion of health resources were allocated to the delivery of healthcare for the white minority in urban areas” (2004:70-71). In an attempt to reclaim individual health rights, the post-apartheid government further expanded health laws through the establishment of various ministries dedicated to women’s and children’s health. These ministries sought to follow a number of universal guidelines concerned with protecting both women’s and children’s rights.

Though South Africa’s progressive legislation establishes multiple health rights for women, including free healthcare, there is a vast discrepancy between women’s granted health rights and how these rights play out on a day-to-day basis. According to the previously established literature, South Africa’s public healthcare system struggles to implement individual health rights due to a lack of funding. Further, according to Cooper et al. (2004), though only
twenty percent of South Africans utilize private health services, the private healthcare sector consumes nearly sixty percent of all healthcare resources. The largely underfunded public healthcare system has a direct impact on various South African identities, especially on women.

Though the South African government and various world health organizations have established certain rights and recommendations, there has been little research conducted on how these rights have played out in reality for South African women. Furthermore, no research has been conducted on women’s birth and pregnancy experiences within the context of Langa Township. The objectives of this paper are threefold: to understand how women in Langa navigate South Africa’s public and private healthcare systems, to understand how their established legislative rights play out in reality, and to better understand the institutional shortcomings and achievements of the South African healthcare system on both a micro and a macro level while utilizing a feminist narrative approach.

In this paper, I will begin by establishing my research within both primary and secondary sources by using scholarly articles and news articles. I will focus my literature review on the context of South Africa and Langa, private and public healthcare in South Africa, various literary themes including affordability, accessibility, and quality of care, and narrative approach utilizing a feminist framework. I will then validate my methodology both feminist and sociological, layout the themes from the six interviews that I conducted, and analyze my findings in connection with the previously established literature by interdisciplinary scholars to draw conclusions. I will consider the larger implications of women’s maternal healthcare experiences within the context of South Africa. Finally, for the last section of this paper, I will reflect on my experience in South Africa and how my time there has influenced my current and future work.

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**Ethical Reflexivity**

Before I continue with this work, it is essential for me to consider the ethical implications of writing on the topic of South Africa and women’s health, as there may be possible negative consequences. When looking at the relationships of power play dynamics for this work, it is important to determine how I entered a space, when speaking with these women in Langa, which was not mine. Consequently, the women who I spoke with may have felt uncomfortable by my presence. For instance, according to Slim and Thompson, a common limitation of interviews is that “the interview form has a tendency to put unnatural pressure on people to find ready answers, to be concise and to summarise a variety of complex experiences and intricate knowledge” (1993:62). Also, it is necessary to address the power dynamics between the women I had conversations with and myself. As a white and able-bodied American student, this work has the inherent ability to perpetuate the ethnographic gaze and the concept of othering. Jackson highlights the importance of recognizing the ethnographic gaze and the potentiality of othering as he describes:

> The discursive tension between a localizing ethnographic gaze and a generalizing theoretical perspective echoes the social and political tensions between societies at the margins of the modern nation-state and the centralized, bureaucratized structures of the state (2012:69).

More so, my research has the potential to perpetuate single stories and narratives of women in Langa that “creates stereotypes, and the problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story” (Adichie 2009). To avoid ethical concerns such as these, I used a feminist narrative approach by centralizing the personal health narratives of these six women. More specifically, I drew mainly on feminist theorists such as Bell (2009), Ross (2011), Gaskin (2003;2011), and Lorde (1987) who use narratives to
centralize the stories and lives of women who are often marginalized by society. I decided to do this in order for these women to tell their stories as opposed to dictating their pregnancy and birth stories as I saw fit.

Overall, I thought that for the most part, the women I interviewed seemed open and comfortable discussing the topics at hand. The women were allowed to share as little or as much information as they felt comfortable. Since they gave retrospective accounts of the pregnancy and birth experiences, I did not see them as a vulnerable population. In regards to consent, I had all the women sign an informed consent form in order to collect data in a proper manner and protect their identities and reputations. I gave each of my participants a pseudonym, and I will not reveal any personal information such as address, specific medical details, or information that may reveal their identities. In regards to reciprocity, I see my project as a space for these women to tell a personal narrative that they might not have the space to do so otherwise. Storytelling has the capacity for women to feel empowered because “through the art of story telling, women craft a unique space for empowerment” while simultaneously creating and claiming “space for empowering oracy to assert their basic and survival needs” (Njogu 2008:27). In addition, I gave my participants a copy of the project I completed in South Africa upon completion and if requested.
**METHODOLOGIES**

_Feminist Narrative Methodology and Epistemology_

“Stories teach us in ways we can remember. They teach us that each woman responds to birth in her unique way and how very wide-ranging that way can be. Sometimes they teach us about silly practices once widely held that were finally discarded. They teach us the occasional difference between accepted medical knowledge and the real bodily experiences that women have - including those that are never reported in medical textbooks nor admitted as possibilities in the medical world. They also demonstrate the mind/body connection in a way that medical studies cannot. Birth stories told by women who were active participants in giving birth often express a good deal of practical wisdom, inspiration, and information for other women. Positive stories shared by women who have had wonderful childbirth experiences are an irreplaceable way to transmit knowledge of a woman's true capacities in pregnancy and birth.”

~ Ina May Gaskin (2003:4-5).

When assessing health in any context, many individuals will turn to published literature, scholarly journals, and empirical data pertaining to a particular area of public health. Though I believe that this kind of methodology is essential in understanding health and health disparities, as seen through the extensive literature review below, I think that it does not tell the whole story of health—many times these methods exclude particular bodies across various identities. Through this work, I sought to challenge pedagogical discourse in which emphasis is placed on, and recognition is given to hard facts that can be ‘scientifically’ obtained in the context of a “health care system [that] privilege[s] the biology over the biography” (Charon 2009:121). It is crucial to hear the voices of those most marginalized by a particular health system as these narratives demonstrate how larger structures play out on an individual level. More importantly, however, for these six particular women, they allow a space to share, reflect, and heal with their pregnancy and birth experiences (Anand 2011).

The analysis below employs various frameworks from multiple interdisciplinary authors who utilize the intersections of health and narrative in order to develop feminist epistemologies.
in which the women whose narratives are incorporated in this work become the knowers and producers of knowledge. These women’s voices talk back to what Mishler (1984) labels the voice of medicine that understands health, illness, and disease through the framework of biomedicine. In an effort to deconstruct this overly emphasized model of medicine and the medicalization of women’s bodies, I have largely drawn upon the work of multiple feminist and sociological scholars who describe knowledge as being rooted within bodies and knowledge as embodied experiences. Through feminist methodology, I hope to critique and unpack the idea of what it means to be an expert and who gets to be an expert. Labov and Waletzky (1966) emphasize the importance of narrative and redefining what it means to be an expert. They note, “fundamental structures are to be found in oral versions of personal experiences: not the product of expert story tellers that have been re-told many times, but the original products of a representative sample of the population” (1966:12). As I spoke with Thandiwe, Sibongile, Nontle, Vuyokazi, Cebisa, and Phumeza, I began to question whose voices typically have the privilege and space to dictate the stories, lives, and experiences of women?

Through this work, I sought to emphasize how personal health narratives are a tool for challenging the rhetoric of academia while creating a space for truth, change, and healing for individuals who are so often on the margins. As Bell notes, “narrative approaches counter traditional models of knowledge by stressing that there are multiple truths, constructed by knowers who are socially and historically located, about a world that is neither fixed nor independent of knowers” (2009:8). As Bell (2009) posits and I believe, these women serve as representatives of the physical, social, and political worlds they occupy. More so, “their stories are not simply representations or explanations of events that took place in their lives or reports of feelings that these events evoked, but indications of the settings in which they were produced and
the regimes of practice in which they were “lived” (Bell 2009:7). Loretta Ross (2011) expands on this notion by describing the inherent connection between reproductive justice and reproductive oppression. Ross notes:

Reproductive Justice is a movement-building framework that identifies how reproductive oppression is the result of the intersections of multiple oppressions and is inherently connected to the struggle for social justice and human rights. A woman’s societal institutions, environment, economics and culture affect her reproductive life (2011).

Price further explains how the use of narrative analysis is used as a “pedagogical tool for consciousness-raising” (2010:44). Similarly, as noted in the Oxford Handbook of Feminist Theory, the act of storytelling takes into account how institutional structures affect knowledge while simultaneously instituting storytelling as a form of critical insight (Disch and Hawkesworth eds. 2016). As established by Bell (2009) and others, narrative has the capacity to undo established thought, knowledge, and theory. However, the use of narrative can do more as it provides a space of healing for the storytellers.

How can these narratives not only be used to understand the broader political and social landscape of South Africa but also, how can these narratives heal women and allow them to reconcile with their own experiences? From the literature, it is clear that for women, the act of telling one’s own story has the capacity to centralize one’s own experience. As Novitz notes, “stories about ourselves, in which we figure as central subjects, and to which others attend imaginatively, invite the sort of empathy we most desire” (1997:148). For those who are too often on the margins of society, the process of centralizing the self is important in understanding personal experience and individual identity. Similarly, Rowland-Serdar and Schwartz-Shea explain, “women can move from powerlessness to empowerment by reclaiming the stories of their lives” (1997:213). When speaking with the women and listening to their stories, the
question that was most elaborated on was “tell me a little bit about yourself and your life growing up.”

Even after some of these interviews, the women shared with me how they had never had the opportunity to share their own stories growing up or the stories of their pregnancies and births. Though this may have been the first opportunity for these six women to share their lives, their bodies have been holders of these stories long before they had the chance to share them. Charon explains, “narrative medicine reminds us that illness unfolds in stories, that our bodies, being more than machines or vehicles, live through our lives with us, perform our lives, carry our scars, our bliss, and our memories, simultaneously both limiting and expanding our lives” (2009:120). Williams elaborates on this notion of healing by explaining, “narrative reconstruction is an attempt to reconstitute and repair ruptures between body, self, and world by linking up and interpreting different aspects of biography in order to realign present and past and self with society (1984:197). Through this work, I hoped that the telling of narrative and the speaking of truth for these women would be beneficial to them in an attempt to heal their bodies through the telling of their own narratives.

Stories must be told to both understand health and larger society, but more importantly, women’s stories need to be told to and heard by the global community. These stories and women are agents of change within society as they have the power to disrupt and challenge the dominant narrative. As Bell postulates, “these movements have become important sources of change in health care as well as major forces advocating change beyond health care by posing “collective challenges to medical policy and… based on lived experiences”” (2009:5). I believe these women’s narratives are indicative of patriarchal structures that affect these women’s and other women’s lives within the context of South Africa. However, it is important to remember that
these women’s stories are each unique and demonstrate the choices they made based on their own circumstances while pregnant and while giving birth. For the specifics of this study, I focus on women’s narratives on pregnancy and birth because as Ina May Gaskin once said, “the way a culture treats women in birth is a good indicator of how well women and their contributions to society are valued and honored” (2011:6).

*Sociological Methodologies*

Though the women I spoke with all resided, were pregnant and gave birth while living in Langa, their lives differed in various ways in regards to family structure, socio-economic status, race, and medical experiences. Though I used narrative methodologies to re-center these six women’s experiences, I also used this method because I believe that micro-level experiences are indicative of macro-level structures. Further, interviewing women allowed for more telling experiences of South Africa’s gender and health stratifications and hierarchies. More so, I sought to better comprehend women’s lived maternal health experiences on a more personal level that was not situated within academia.

Before interviewing any of the women, I utilized an interview protocol in order to establish a standard set of questions. (See Appendix A). I asked an open-ended question such as “tell me a little bit about yourself” to learn about the women’s history, education, class, and family structure. From there, I asked about their knowledge of the constitution and specifically their knowledge in regards to maternal health rights. Next, I asked open-ended questions surrounding health, such as, “if you or a family member fell ill, what would you do?” I asked similar open-ended questions surrounding their pregnancy and birth stories and how and why
they made certain health decisions. Depending on what the participant talked about, I probed for specific sub-themes including accessibility, affordability, and quality of care. I then asked the participants if they knew anything about South Africa’s maternal mortality rate and why they might think it is so high. Lastly, I asked the women if they wanted to add anything else to the conversation on maternal health, pregnancy, and birth within the context of South Africa that they had not already discussed.

When looking for women to interview, I started with asking people I knew in Langa if they knew any women who had given birth within the last twenty-one years. I initially reached out to my host mama in Langa because we knew each other well. Our previous relationship allowed for some level of comfort during the interview while asking questions that could be perceived as personal or uncomfortable to ask. After my first interview with my host mama, I asked her if she knew anyone who would be willing to be interviewed. I decided to utilize a snowball sampling approach because of the intimate and personal nature of my questions. I thought that if a woman had briefly spoken to another woman who spoke with me that they might feel more comfortable sharing their narrative. My host mama from Langa was able to refer me to two relatives of hers who both allowed me to speak with them. The other three women I spoke with were contacted through connections with other School for International Training (SIT) students. The other three women were either host siblings, people living in student’s host homes, or friends of host mamas. When interviewing the women, I allowed them to choose a location that would be most comfortable for them. I did this in order to allow for an open conversation and dialogue in a relaxed and neutral space. All but one interview was conducted in the homes of the participants. The other interview was conducted at a park of the participant’s
choosing. Before each conversation, I informed the woman of the purpose of the study and that it was their choice to participate in the study. Before any interview was conducted, each woman signed a consent form informing them of privacy and confidentiality rights (See Appendix B). I informed all the participants that the interview should take no longer than an hour, depending on how much they chose to share. The lengths of the interviews ranged from about fifteen minutes to fifty minutes. Five of the six participants allowed me to audio record the interview and all of the participants allowed me to take notes while conducting the interview. Since this paper focuses on pregnancy and birth post-apartheid, I focused my analysis on the women’s pregnancy and birth experiences that occurred after 1995; however, the women were able to share their narratives from all their pregnancies and births.

*Participants (Note that names have been changed to protect the identities of the participates)*

1. Thandiwe- Interviewed on 9 April 2015 in her home. Birth year not disclosed. Has given birth to five children. Her fifth pregnancy/birth narrative in 1997 was used for the purposes of this study. Has used both private and public health facilities for maternal care.

2. Sibongile- Interviewed on 10 April 2015 in her home. Born in 1966. Has given birth to one child. Her first pregnancy/birth narrative in 2002 was used for the purposes of this study. Has only used public health facilities for maternal care.

3. Nontle- Interviewed on 12 April 2015 in her home. Born in 1950s. Has given birth to three children. Her third pregnancy/birth narrative in 1997 was used for the purposes of this study. Has used both private and public health facilities for maternal care.

4. Vuyokazi- Interviewed on 14 April 2015 in her home. Birth year not disclosed. Has given birth to four children. Her fourth pregnancy/birth narrative in 1995 was used for the purposes of this study. Has only used public health facilities for maternal care.

6. Phumeza- Interviewed on 18 April 2015 in a park. Birth year not disclosed. Has given birth to three children. Her third pregnancy/birth narratives in 1998 and 2002 were used for the purposes of this study. Has only used public health facilities for maternal care.
LITERATURE REVIEW

The apartheid period in South Africa was marked by a myriad of inequalities for various identities, in particular for women. Before 1994, there were little to no reproductive health rights for women, and further, the white apartheid government often exploited women’s reproductive systems. As described by Cooper et al. (2004), contraception was used as a tool to control black population growth during the apartheid period. The healthcare system, like so many other systems in apartheid South Africa, served to benefit whites in mainly urban class areas while simultaneously controlling bodies who did not fall into a white racial category. Connecting these ideas to the cited feminist literature, these structural health inequalities reveal racial hierarchies, two-tiered structures, and the social, economic, and personal costs of such systems. According to Van Niekerk (2012) and Cooper et al. (2004), the apartheid government allocated various resources on the basis of racial hierarchies. London emphasizes the idea of a segregated and highly racialized society in regards to health during the apartheid period:

The systematic insertion of race ideology in the planning and delivery of health services resulted in vast numbers of black South Africans receiving healthcare that was grossly inferior or absent, depriving a whole population of its rights of access to healthcare, to dignity, and to equality (2004:3).

Dambisya and Mokgoatsane (2012) argue that the disparity in healthcare was also seen in the discrepancy of private and public healthcare users across race. When looking at health disparities and the intersection of race, according to Ruiters and Van Niekerk (2012), in 1985, eighty-five percent of whites were privately insured compared to eight percent of blacks. Though a small percentage of black South Africans were privately insured, Ruiters and Van Niekerk (2012) argue that the private healthcare the black population received was less comprehensive compared to the private healthcare that a majority of the white population received. When specifically
looking at maternal healthcare during the apartheid era, according to Cooper et al., “services were characterised by overcrowding, understaffing, and a lack of privacy,” coupled with a multitude of access problems (2004:71). Further, Cooper et al. (2004) note that prior to 1994, there were no comprehensive health policies concerning women’s reproductive rights. With innumerable problems in regards to women’s health, the newly formed post-apartheid government was faced with a challenge when establishing purportedly revolutionary reproductive rights for women.

*Post-Apartheid Healthcare Policy*

In 1994, the South African government implemented a primary healthcare approach in which, as described by Justus-Hofmeyr et al., “the majority of people with less serious conditions [would] receive care in a primary care setting” (2014:2). This primary healthcare approach, as defined by Cooper et al. (2004), aims to expand access, to decentralize services, and to provide preventative care, while simultaneously offering free healthcare for women and children. In their research, Cooper et al. (2004) lay out a comprehensive timeline that is essential to understanding women’s granted and legal health rights in South Africa. In 1994, the Department of Health established a partnership to process and review HIV and AIDS policy that mainly focused on the prevention of HIV infection and treatment of AIDS-related infections. In conjunction with this partnership, women and children under the age of six were granted free public health services while fees associated with healthcare facilities were eliminated. In 1995, the government ratified the United Nations Convention of the Elimination of All Forms of Discrimination Against Women (CEDAW) in a step towards greater gender parity within the country. In 1996, the government established the Choice on Termination of Pregnancy Act that
put into place a legal structure for abortion services. In 1997, South Africa’s Maternal Mortality Rate (MMR) was made a notifiable condition, and the Patients’ Rights Charter was enacted to address quality of healthcare services. In 1998, the New Population Policy was introduced, the National AIDS Council was formed, and the Domestic Violence Act was passed. While in 1999, the Prevention of Mother-to-Child Transmission (PMTCT) was introduced in the Western Cape Province, and in 2000, the National Guidelines for Cervical Screening Program was launched. In 2001, the PMTCT program was introduced in the Gauteng Province. In 2002, the Treatment Action Campaign and Children’s Rights Centre won a court application ordering the government to implement comprehensive PMTCT programs and services across the country. Further, the National Contraception Policy guidelines were launched, and the government approved the provision of HIV post-exposure prophylaxis to survivors of rape in public sector facilities. In 2003, the government approved a plan to provide antiretroviral drugs to people with AIDS through public sector health services. More recently, in 2004, the sexual assault legislation went under review in order to amend the definition of rape and enforce more substantial sentences for offenders. The above legislation is extensive and further attempts to improve the health services and care of women in post-apartheid South Africa. Though the above legislation is promising in establishing seemingly progressive health rights for women, there are many discrepancies regarding the way the above legislation plays out in reality.

Context of Langa

When assessing how certain health rights play out for women in South Africa, this research focuses on women’s maternal healthcare, pregnancy, and birth experiences in Langa.
Township. According to the South African History Online Website, Langa was established in 1927 in response to the Urban Areas Act. Langa, located in the Cape Flats in the Western Cape, was designated as a space for the ruling white apartheid government to control black Africans. When looking at Langa today, according to the Cape Town Government (2013), the population of Langa was 52,401 in the year 2011. When looking at maternal health and research within the context of Langa, no previous research could be found. What is known, however, is that Langa has one city healthcare clinic, and according to the Western Cape Government (2015), there are no Midwife Obstetric Units (MOUs) within the township in which women can give birth. The disparity of health facilities is even more shocking as Ruiters and Van Niekerk (2012) note that it is impossible to find a private hospital in a township. When looking at the Western Cape Government Website (2015) and assessing the geographic locations of MOUs in the province, the closest MOU is located in Heideveld, which is 6.3 kilometers from the center of Langa. Various literature notes how spatial arrangements of cities have the ability to cause inequality through access problems to certain facilities. As cited in Ruiters and Van Niekerk (2012), according to Jeremey Cronin, the Deputy General Secretary of the South African Communist Party, spatial arrangements within cities continue to perpetuate exclusion and inequality. Ruiters and Van Niekerk, further their thoughts on spatial arrangements by describing, “re-segregation between black townships and informal settlements [are] subject to faltering public services on the one hand, and the largely white suburbs marked by the growing privitisation of services and space on the other hand” (2012:7). Though no formal academic research exists in connection with health in Langa, the literature that does exist describes townships as spaces of social and spatial inequality.

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Public and Private Healthcare

South Africa’s current healthcare system is based on a structure in which citizens receive primary healthcare services through either the public or private health sector. The literature concludes that South Africa’s healthcare system reflects the country’s social inequality across race, geographic location, and social class. According to Dambisya and Mokgoatsane (2012), South Africa’s public health sector is categorized by state departments and other institutions that perform public functions in accordance with health legislation. While consequently, Dambisya and Mokgoatsane (2012) describe the private health sector as those services outside the public health system that aim to treat illness outside the public sphere. Though private and public health options exist, Brown et al. (2007) describe how South Africa is marked by a largely under-resourced healthcare system.

When looking at the private sector, Ruiters and Van Niekerk (2012) cite South Africa as possessing one of the largest private medical sectors in Sub-Saharan Africa. While the country has one of the largest private medical sectors, according to Cooper et al. (2004), only twenty percent of South Africans have private healthcare and those who have private insurance use sixty percent of all health resources. Ruiters and Van Niekerk elaborate on this discrepancy by explaining how “the South African health system is divided between a well-resourced private sector serving a minority of the population and a poorly resourced public sector serving the majority” (2012:2). This notion parallels demographics cited earlier during the apartheid period, even though new and progressive health reform exists. Ruiters and Van Niekerk further explain:

The current two-tiered health citizenship reflects South Africa’s ongoing social fragmentation, lack of national social cohesion and residual apartheid mentality. It also reflects a continuing bias towards privitisation as well as continued support for
the idea that the state is incapable of sound service delivery. The implicit message is that the poor majority should continue to seek (inferior) healthcare from the state, while the wealthy majority should avoid that state and purchase (superior) private health services (2012:5).

Other academics agree that the current state of the South African health system is largely inequitable, especially across racial lines. Dambisya and Mokgoatsane (2012) explain how those who identify as white and Indian are more likely to be covered by medical aid and use private health services as compared to those who identify as African or coloured.

It is important to note the discrepancy in private and public health as evidenced by the quality of care reported at public versus private healthcare facilities. As noted by Ruiters and Van Niekerk (2012), the South African public health sector is becoming more dysfunctional while the private health sector it becoming less affordable. Dambisya and Mokgoatsane (2012) explain how people who have private healthcare are more satisfied with services as compared to those with public healthcare. They conclude that this is due to various structural downfalls of South Africa’s public health system, which is heavily underfunded and under-resourced. Cooper et al. further this point by describing how “weakness in the broader public health system have resulted in significant shortcomings in public health sector capacity to plan and institute the new policies and services” (2004:73). The lack of staff in public healthcare also exemplifies the shortcomings of the public health sector. According to Ruiters and Van Niekerk (2012), the public sector employs about 250,000 people, but there are severe shortages. According to the 2014-2015 South African Health Survey, within the Western Cape, there are 3,969 doctors to every 1 patient. However, according to Dambisya and Mokgoatsane (2012), there are a minority of health workers across multiple specialties working in the public sector (See Graph 1).
According to Cooper et al. (2004), these shortages result in the compromised delivery and implementation of services within the public health sector.

**Graph 1. Health Professionals by Public or Private Sector, 2006. Source: Dambisya and Mokgoatsane (2012:127).**

When assessing maternal care in public versus private facilities, researchers have noted women prefer to give birth in a private facility rather than a public facility because women perceive private health facilities to provide better quality of care. Though South Africa provides maternal and prenatal care that is generally free, Oi (2015) notes that public maternal healthcare is quite a basic service. In order to obtain purportedly better care, Justus-Hofmeyer et al. (2014) describe how women who don’t have medical aid or cannot afford private healthcare, will arrive late in labor at a private facility in the hopes of not being turned away. The quality of care is thought to be of a higher standard in these facilities, and thus, the cost is relatively expensive compared to free healthcare at public facilities. According to Oi (2015), the average cost to give birth in a private facility in South Africa is around $2,000 USD. The article further expands on the lack of resources public facilities have and cites to a report of six newborn babies dying in a
public hospital in Johannesburg due to a lack of antiseptic soap. The current state of South Africa’s public healthcare is highly critiqued and criticized throughout the literature due to a lack of resources and social inequality as perpetuated by legislation. According to Van Niekerk (2012), South Africa’s current dual system of health is not politically or socially maintainable. Van Niekerk notes that the current health system’s “continued existence reflects the persistence of class apartheid in this supposedly post-apartheid society, with the affluent, mainly white, but also increasingly black middle classes continuing to receive and defend inequitable privileges” (2012:78). Overall, the literature cited above is critical of South Africa’s purportedly revolutionary healthcare system. Though progressive and innovative legislation exists, there are many flaws within a system marked by the inequality between the private and public health sectors.

Maternal Mortality

Notwithstanding governmental health reforms, there still remain multiple issues with the implementation of health legislation that has adversely affected the country’s maternal health as a whole. One of the most prominent maternal healthcare concerns for South Africa and the global community is the high incidence of maternal mortality. According to Alvarez et al. (2009), half of all maternal deaths happen in Sub-Saharan Africa. Specifically, in the context of South Africa, according to Wabiri et al. (2013), the MMR in South Africa is 289.1 per 100,000 live births. However, academics contend that this number is inaccurate due to under-reporting. According to a study conducted by Silal et al. (2012), that uses personal narrative to address barriers women face while navigating South Africa’s healthcare system, South Africa’s MMR
may be as high as 625 per 100,000 live births. In comparison to other countries, according to Solarin and Black (2013), most developed countries’ MMR is around 10 per 100,000 thousand live births. Further, Solarin and Black (2013) state that compared to countries with similar income levels, South Africa has a MMR that is on average five times greater. Though there seems to be concerted efforts to decrease the MMR, according to Silal et al. (2012), the country recently fell short of reducing the MMR by three-fourths, and there is still a lot that needs to be done to change the current rate. As cited by Silal et al., South Africa’s minister of health admitted to parliament that “with regard to curbing child and maternal mortality and improving maternal health, we are in deep trouble” (2012:2).

Interestingly, much of the established literature describes a connection between the failings of South Africa’s healthcare system and the high rate of maternal mortality. Many researchers point to access to services and the level of care received by pregnant women as factors that contribute to the high rate of maternal mortality. In regards to access, Wabiri et al. (2013) conclude that insufficient access to maternal health services, during both pregnancy and birth, makes a critical contribution to maternal death. Cooper et al. (2004) similarly establish that there is a correlation between MMR and women’s access to healthcare. Further, Pacagnella et al. (2014) found that there is an apparent association between the delay in access to obstetric care and maternal death. Access to care is essential because as according to Guliani, Sepehri, and Serieux (2012), prenatal care and delivery care are critical for maternal health. In regards to level of care, Alvarez et al. (2009) note that an efficient and effective health system during pregnancy and delivery are strongly related to maternal death. Magoma et al. (2013), corroborates this notion by citing that skilled care during and after delivery plays an essential role in decreasing
the MMR. While the literature has established certain factors affecting South Africa’s high MMR, researchers also note that maternal death is largely preventable. For instance, Pacagnella et al. (2014), Silal et al. (2012), and Alvarez et al. (2009) conclude that women die from preventable causes during childbirth, and thus most maternal death can be avoided. South Africa’s MMR is an important factor to assess because as according to Alvarez et al. (2009), a country’s MMR reflects gender imparity and is an indicator of gender inequality.

There is still much research that needs to be done regarding how various health factors impact maternal mortality. Researchers, such as Wabiri et al. agree that there is “little detailed information… about the distribution of access to maternal health services across the country’s population” (2013:2). Further, according to Justus-Hofmeyr et al., there “is an urgent need to re-evaluate the models of birth care available to women” (2014:2). When looking at South Africa’s healthcare system as a whole, Human Rights Watch describes, “there are serious administrative and financial management inefficiencies at all three levels of the South African public healthcare system, and at the health facilities level, that hamper quality healthcare” (2011:14). Though the established academic literature attributes the shortfalls of women’s reproductive and maternal healthcare to various factors, affordability, accessibility, and quality of care seem to be at the forefront.

**Affordability**

When looking at how the constitution and other healthcare related legislation plays out in reality for South Africans, researchers have highlighted multiple legitimate flaws with the system, including affordability issues. Though women were granted the right to free health
services under the constitution, women still pay for some aspects of care, such as transportation and medical supplies. Academics agree that for rural women in South Africa, one of the greatest barriers in regards to healthcare, in general, is the cost of transport to and from hospitals and/or clinics. The government does not provide transport services for women who are pregnant and in turn, some women are unable to see a doctor for prenatal care. In a study conducted by Myer and Harrison (2003) in rural South Africa, the researchers found that fifty-nine percent of their sample had to take taxis to get to a clinic that women had to pay for out of pocket. Though about ninety percent of women were able to see a doctor before delivery in this study, Silal et al. (2012) highlight how there are variations across race, urban and rural residence, and socioeconomic status in regards to access to these services.

The healthcare system, like so many other systems in South Africa, favors those who are wealthier and can afford private health services. Silal et al. (2012) further explain that in addition to transportation, women must pay for certain medical supplies for delivery if the clinic is not furnished with the necessary medical equipment. This is a result of underfunding that manifests itself in other ways throughout the healthcare system. Rotheram-Borus et al. describe, “low and middle income countries such as South Africa... cannot afford nurses, and will not be able to train the personnel necessary to mount such support until at least 2050” (2014:2). The South African healthcare system is largely underfunded and has detrimental effects on the way in which women receive medical care. While women have been granted free health services, there still remains a financial burden that is not easily overcome in regards to transportation and supplies, which ultimately denies some women access to care during pregnancy.
Accessibility

Another downfall of the healthcare system for pregnant women is that many women have trouble or cannot access health services based on various barriers and social determinants. For instance, when looking at race, Wabiri et al. (2013) describe how more white women have access to antenatal care as compared to black women. Further, Silal et al. describe how “poor and black African women were less likely to have a skilled attendant at delivery than their wealthier or white counterparts” (2012:2). Guliani et al. (2012) corroborate this point by noting that care is more accessible for wealthy people. Women in rural areas have a more difficult time accessing clinics due to geographic location and the fact that there are simply fewer hospitals in these areas. According to a study conducted by Wabiri et al. (2013), only thirteen percent of rural women delivered their babies in the presence of a doctor. Further, in the study conducted by Myer and Harrison (2003), only forty-one percent of their sample lived close enough to access a clinic by foot. Silal et al. (2012) found that access to transportation can be problematic as well. In their study, the average travel time to clinics was twenty-three minutes or less as compared to hospitals. The lack of access to the medical field for pregnant women, as suggested by a report quoted by Silal et al. (2012), significantly contributes to maternal death.

Lack of access, especially for pregnant women who are black, poor, and live in rural areas, according to Wabiri et al. (2013), could be indicative of why only about forty percent saw a doctor before twenty weeks of pregnancy, despite having near universal antenatal care coverage. Though a copious amount of literature on access to health facilities and services exists, there is a gap in the literature surrounding access to knowledge of health rights. Mkhwanazi (2014) notes that there are multiple silences surrounding discussions on sexual reproduction.
They establish that much of the information surrounding knowledge on maternal care is learned through rumors that can be entirely negative and can cause women not to seek out services. The problem of accessibility is not linear and clear-cut, various intersections of identity, race, class, and geographic location contribute to how easy or how hard it is for women to access proper maternal healthcare and knowledge of maternal health rights.

**Quality of Care**

If women are seeking antenatal care, within the public health sector, can overcome barriers such as affordability and accessibility, it does not necessarily mean that the quality of care they receive will be comparable to the quality of care women in the private health sector receive. According to Ruiters and Van Niekerk, “South Africa aims to provide all South Africans, regardless of socioeconomic status, with…good quality healthcare,” despite the fact that much research has reported instances of negative care experiences (2012:3). As described by Brown et al. (2007), maternal care in South Africa is far from ideal. This is due in large part to the fact that the public healthcare system is highly underfunded—resulting in medical staff being put into stressful environments. Reproductive legislation in South Africa, though ideal on paper does not play out in such an idyllic manner, and according to Silal et al. (2012), causes a decline in staff morale due to the high workload. In this particular study, researchers found that all but one of the women they interviewed were dissatisfied with the quality of care they received during pregnancy and at the time of birth. Some women described how nurses insulted them, mocked them, and screamed at them during child labor. Brown et al. furthers this point by explaining how “women are often left alone for long periods during childbirth, and in some
instances women are shouted at, struck or slapped” (2007:2). Further, Brown et al. (2007) report that women are not given food or water during labor and are encouraged not to move around during labor. Human Rights Watch drew similar conclusions noting:

Women described being turned away from clinics without examination while in labor, bring ignored by nurses when they called for help, waiting hours or even days for care, being denied referrals to specialized care, and being told to walk with their newborns between wards immediately after delivery while weak and bleeding heavily (2011:24).

Similarly, Silal et al. (2012) note how staff was reported as being inattentive and turning away women in early labor that compromised quality of care.

The experience women have when seeking healthcare for prenatal, birth, and post-partum services can have larger effects on the way women perceive and receive other health services. Human Rights Watch explains that the “abuse of maternity patients in health facilities can have indelible psychological effect, and discourage women from seeking care” (2011:36). Brown et al. (2007) and Silal et al. (2012) corroborate this point by explaining how women will not utilize a particular health service or facility if they judge it to be of poor quality or if they had a bad experience there. The literature concludes that the environment in which women experience prenatal care and birth in South Africa is unhealthy, and is a violation of basic human rights.

A Comparative Perspective: Birth in the United States

To better comprehend this research topic, it is essential to understand South Africa’s political landscape, and how policies impact accessibility, affordability, and quality of care in regards to women’s health. However, it is equally as important to understand how these policies,
the way play out, and how they are recorded in the literature are a direct reflection of a patriarchal society that is not exclusive to South Africa. Before I continue with this paper, it is essential for me to highlight that pregnancy and birth are not ideal in the context of the United States, where I stand as a U.S.-based researcher. I emphasize this because the literature often neglects how Western systems such as globalization, capitalism, and colonialism have directly impacted countries such as South Africa. More so, I want to note that the way in which patriarchal structures dictate women’s health is not particular or unique to South Africa. The trends and themes described above are indicative of a transnational phenomenon that does not necessarily parallel women’s experiences in the United States but has clear connections. In *Our Bodies, Ourselves*, the contributors describe:

A survey of women who gave birth in U.S. hospitals in 2005 found, for example, that most women had unnecessary medical and surgical interventions, did not walk or move around in active labor, and gave birth on their backs; and nearly half of babies spent the first hour after birth with hospital staff” (Boston Women’s Health Book Collective 2011:399).

The contributors of *Our Bodies, Ourselves* illustrate what birth looks like today in the United States—a once natural process that has become a medical one (Boston Women’s Health Book Collective 2011). As a result, women in the United States have a 1-in-1,800 chance of maternal death—the worst of developed nations according to the Save the Children’s 16th annual state of the World’s Mothers report (Robeznieks 2015). More so, these numbers vary across both race and class. For instance, “the maternal death rate is 42.8 per 100,000 live births for black women, compared with 12.5 for white women and 17.3 rate for women of all other races” (Robeznieks 2015). Pregnancy and birth are not ideal in the context of the United States, but how do we know this?
Looking at the literature, most authors point to statistics and empirical data to explain pregnancy and birth as both a tragic and medicalized process. However, some groups are talking back to this discourse by creating space for women to tell their own birth stories—stories that both parallel and contradict the literature. One such example is The Birth Narratives Oral History Project (BNOHP) which aims to:

Document and disseminate true stories about childbirth. This project aims at representing the dynamic variety and individuality of giving birth while recognizing the history and universality of bringing babies into the world, however they get here. By making a space for these stories to be heard it is my hope that we will focus not only on the methods and outcomes of childbirth but also consider and respect the process” (Weatherby 2011).

BNOHP highlights women’s voices to re-center women’s experiences through the process of understanding multiple facets of pregnancy and birth in the United States. In one of the audio stories, Tricia describes her miscarriage experience:

As soon as I lost my baby, I—I started crying. An-and that was really hard. And um we buried it in the backyard. We put some tulips over it and decided okay you know that’s what happens. You know, it’s gonna happen. That’s fine. Um, I was very sad. It’s a lot of lost time because you know you want to have a baby…I’m sure there are a lot of other mothers out there like me who didn’t have an opportunity to have a baby ‘til they were thirty. And now you’re racing the clock. And you’ve had a miscarriage so you lost those many months of being pregnant and now you’ve lost the time you need to recover…. It’s a very slow long car crash… It’s a lot of pain that is drug out over a long period of time (Tricia).

This project illustrates how women’s pregnancy, birth, and even miscarriage experiences differ from one woman to another. Further, this particular project illustrates how silences surrounding pregnancy, birth, post-partum, and loss are not specific to one location. Though this paper focuses on pregnancy and birth in the context of South Africa, the way in which birth has become a medicalized process in very much so present in the United States. The method of narrative and storytelling needs to become a universal method that generates counter-narratives
to the dominant discourse. However, though I think sharing these stories are essential in unpacking and redefining healthcare systems, it is important to note that all voices are not heard to the same degree. In a world in which males, whites, the able-bodied, and the upper class (among many identities) are often heard, it is important not to equate these voices as those voices that matter most. Systems of oppression for too often silence certain bodies based on gender, race, class, etc.

As seen from the literature above, much research has been done on understanding various aspects of healthcare policies and practices in South Africa. Though extensive literature exists, according to London (2004), health as a right remains elusive in the context of South Africa. Many gaps in the literature remain, and more so, the cited literature does not adequately assess the status of maternal health and pregnancy and birth narratives within the context of South Africa through a feminist framework and personal narrative. With a large focus on HIV/AIDS in the literature, there is not enough information on awareness of particular birth rights and whether or not women do or do not exercise their given rights. Further, within the established literature, there is a lack of personal narrative and interviews from the women themselves who go through the healthcare system while pregnant and giving birth. Additionally, most studies do not focus on a particular geographical location; instead most research focuses on large rural areas and general urban areas. In my Independent Study Project, I sought to fill these gaps by interviewing women from Langa on how they navigated South Africa’s healthcare system while pregnant and giving birth, and why they chose to make the decisions they did.
DESCRIPTION OF DATA

The objective of this research was to incorporate women from Langa’s personal narratives to better understand their lives and their pregnancy and birth experiences within the context of the post-apartheid South African healthcare system. Through the conducted interviews, I gained access to various personal narratives surrounding women’s health and maternal healthcare experiences in the context of Langa. Though none of the women were able to give birth in Langa because there are no facilities capable of handling a birth, all of these women lived in Langa while pregnant. The women’s experiences and their responses to my interview questions were telling of various factors of these women’s lives. Though each one of the six women had a unique story, themes emerged across their narratives including upbringing, the context of South Africa, and pregnancy and birth experiences. Within the framework of upbringing, certain patterns emerged including socio-economic status and education attainment. Within the framework of the context of South Africa, themes such as knowledge of rights, health education, and perceptions of the healthcare system emerged. Finally, within the most significant and telling category for the purposes of this study, pregnancy and birth experiences, themes such as prenatal care, location of birth, instances of poor quality of care, unexpected costs, and rate of caesarean sections emerged. Though the above themes are insightful in establishing patterns among these women’s experiences, it is important to consider that there is no single story in regards to these women’s pregnancy and birth experiences. These findings are from too small a sample group to generate findings applicable in a large-scale context. Rather, they assist in better understanding how these six women perceive South Africa’s healthcare system and how they navigated through the system while pregnant and giving birth.
Upbringing

When telling their stories, the women whom I interviewed were first asked to tell me a little bit about themselves and how they grew up. While speaking about their upbringing, a lot of the women discussed certain aspect of their lives such as socio-economic status and education attainment. This background information is instrumental in establishing a foundation for understanding how the women navigated South Africa’s healthcare system. Further, this initial part of the interview allowed the women in this study to tell their life stories and have a space to share their experiences as an important part of the narrative approach.

i. Socio-Economic Status

When discussing their upbringing, most of the women expressed their socio-economic status while growing up and/or currently either explicitly or implicitly. Out of the six women, three expressed financial struggle while growing up. Thandiwe discussed how her older brother had to stop his schooling in order to find a job to support the family. She also talked about how money was scarce when she was growing up. She recalled that she never had proper shoes for school because she could not afford them and that she purchased a majority of her clothing from second-hand clothing stores. Thandiwe also recalled how her family could not afford to give her food to bring to school and how she often had to ask her friends for money in order to eat. Similarly, Thandiwe’s sister Vuyokazi also noted how while growing up her family went through a lot of financial struggles. She discussed how her father was not employed while she was growing up and how her family could often not afford to buy food. Phumeza was the last of the women to discuss her financial struggles while growing up. She mentioned how when she first moved to the Western Cape, at a young age, she always felt that people were concerned with
money and the need to have cash. She commented on her financial situation by discussing how while growing up it was difficult, and she felt and still feels like she doesn’t have a lot of money. Consequently, only one woman, Nontle, noted how she did not feel her life was financially difficult while growing up. Nontle discussed how her life was not difficult, and she was never hungry for food because she grew up in a coloured area, and her family was supported by various organizations. She also discussed how her husband struggled financially while growing up and how she never knew those burdens. The other two women, Cebisa and Sibongile, did not touch upon their socio-economic status while discussing their upbringings.

(ii. **Education Attainment**

When looking at the amount of education the women received, all six of the women received some form of formal schooling in their lifetime. Though the women all received some form of education, only two of the six women had the opportunity to do their matric years. Sibongile and Cebisa completed their matric years in Langa. The other four participants either failed a grade or were forced to drop out of school due to various reasons. Thandiwe started school at eight years old only when her father passed away. She studied until grade eight and shortly after dropping out, due to financial reasons, fell pregnant with her first child. In 1981, Thandiwe wanted to go back to school but was told by her mother that their family could not afford to do so. In 1987, Thandiwe went to night school and finished standard eight. Nontle did her schooling in Gugulethu up until grade eight. She expressed how she did not go to high school because there were no high schools for blacks that she could attend in the Western Cape. She noted how many of her friends and family members traveled to the Eastern Cape to attend high school, but she did not. Vuyokazi was able to finish grade ten; however, she could not continue.
going to school due to financial reasons. Phumeza went to school up to grade ten but failed her grade ten exams. Phumeza did not give a reason for not continuing her education. Overall, though only two of the six women finished their matric years, the other women were able to receive some level of education throughout their lifetime.

South African Context

After learning a little bit about the women’s backgrounds, I asked them to share their knowledge of the constitution and women’s health rights and their experiences navigating South Africa’s health system. From these discussions, themes emerged surrounding knowledge of rights, health education, and perceptions of the healthcare system. These themes give insight into how these women understand and have knowledge of their rights, and how these rights did or did not play out for them in the context of South Africa.

i. Knowledge of Rights

When discussing the constitution and women’s health rights, the women whom I interviewed all had something to say regarding their knowledge and own experiences. In regards to the constitution, all six of the women noted some aspect of South Africa being a democracy, specific rights people hold, and/or flaws of the constitution. Thandiwe noted how she was not very educated on the topic of the constitution, and she was not very interested in politics in general. She further noted that the youth have new rights in the new South Africa, but those rights and others are not upheld by the police. Similarly, Vuyokazi noted that South Africa is a democracy now, and there are new rights, but she did not explicitly state any specific rights. Sibongile discussed how things are much better now as compared to the apartheid era.
that people have the right to get a job whether they are black or white, and people have the ability to go anywhere they would like. Phumeza had similar feelings about the new South Africa, in that she discussed her experiences and struggles with apartheid and how she feels things are much better now than the past. When asked about constitutional rights, Nontle explained how she thinks everyone has the right to a good hospital. While Cebisa mentioned how she felt she knew a lot about rights and mentioned that there are now lots of rights concerned with the well-being of women and children.

When looking specifically at maternal health rights, only two of the six women explicitly mentioned maternal health rights in comparison to the other four women who made some comment on the topic or did not feel like they had anything to say on the matter. When asked about maternal healthcare rights, Thandiwe initially mentioned she was not sure and could not remember specific women’s health rights. However, upon thinking deeper, Thandiwe mentioned how she knows a little bit about HIV/AIDS rights. She discussed how women with HIV have the right to preventative medication if they are pregnant in order to not transfer the illness to their child. She also felt that though women who have HIV have this right, a lot of women do not practice it. When I asked Cebisa about women’s health rights, she mentioned how women have many rights including the right to have an abortion, the right to have kids, and the right to contraceptives. The other four women were not able to think of specific maternal health rights. However, Sibongile noted that women are doing well with their new medical rights and gave an anecdotal story about her own daughter’s navigation through the healthcare system. Though I asked all the women about maternal health rights, none of the six participants explicitly mentioned how women have the right to free reproductive and maternal healthcare.
ii. Health Education

When discussing healthcare in the context of South Africa, another theme that arose was the concept of the lack of knowledge surrounding pregnancy, birth, and sex. Four of the six women discussed this theme in some way, specifically in regards to access and availability of knowledge. Nontle noted how within the space of townships, she felt that there was no knowledge and access to health information. Vuyokazi corroborated this point by expressing how she felt there was no access to education surrounding birth and Cebisa expressed how women just do not know much information about sex. Phumeza elaborated on this theme by speaking about how nobody talked to her about pregnancy when she was growing up and that there was no readily available information on such topics. Nontle further explained how if there is health information in townships, it is usually located in clinics and is written in English. For Nontle, she felt that there is power in being educated on the topics of women’s health. Though these women have had experiences in regards to maternal health, reproductive health, and sexual health, a majority of the participants noted how there was a lack of education on such topics while growing up and even for girls and women today.

iii. Perceptions of the Healthcare System

When discussing the healthcare system outside of their pregnancy and birth experiences, four of the six women directly compared the private and public health sectors in South Africa. Overall, the women who compared the healthcare system, perceived to favor the private sector over the public sector. In regards to the public health sector, the four women described how there are often long lines, a lack of staff, and overpopulated clinics. For example, Thandiwe noted how at government hospitals, people have to wait in long lines. She explained that to see a doctor
people get to a clinic as early as 6:00 am and will wait until 4:00 pm. Cebisa also mentioned something similar by expressing how people will have to get to the clinic at 7:00 am just to see a doctor by noon. Thandiwe, Cebisa, and Sibongile all noted that you must be prepared to wait at government facilities. All three of these women also noted that at government hospitals, there is a lack of doctors and nurses. Nontle and Cebisa also noted that hospitals are overpopulated with people, and Cebisa noted that it is because there is not enough money allocated to public facilities. In contrast, these women perceived private healthcare facilities quite differently than public health facilities. For instance, Thandiwe, Sibongile, and Nontle thought that private hospitals treated patients better because patients are paying for care. Thandiwe also noted that patients do not have to wait for appointments at private facilities. Though not all the women discussed their perceptions of public and private facilities, among the women who did, all of them highlighted flaws of the public healthcare system.

Pregnancy and Birth Experiences

The primary interest of this study was to better comprehend how women navigate the South African healthcare system while pregnant and while giving birth. When discussing each of their pregnancies and births, under South Africa’s new constitution and reforms, many themes came up surrounding the use of prenatal care, the location of the birth, instances of poor quality of care, unexpected costs, and the rate of cesarean sections. These five themes are useful in understanding various parallels and contradictions between these women’s experiences while pregnant and giving birth. Further, these themes are helpful in better comprehending these six women’s lived health experiences.
i. *Prenatal Care*

When looking at receipt of prenatal care, all six of the women in the study saw a doctor at some point during their pregnancy. While pregnant with her child in 1997, Thandiwe described how she saw a doctor every month for prenatal care. Sibongile also noted how she saw a doctor several times while pregnant with her first daughter in 2002. The other women also mentioned at some point in the interview that they sought out prenatal care regardless of being on medical aid. When receiving prenatal care, the women in the study used both public and private facilities. Thandiwe, Nontle, and Cebisa (for her second pregnancy) all went to private health facilities to receive prenatal care as they were all on medical aid. While in comparison, Sibongile, Vuyokazi, Phumeza (for her second and third pregnancies), and Cebisa (for her third, fourth, and fifth pregnancies) received prenatal care in public health facilities, as they were not on medical aid and/or could not afford to pay for care at a private facility. Though all of the women in this study had access to prenatal care, they sought such care at both public and private facilities.

ii. *Location of Birth*

When looking at the location of these women’s births, though all of the women lived in Langa, none of them gave birth in the township. Two of the eleven births were in Pinelands, two of the eleven births were in Somerset, four of the eleven births were in Mowbray, one of the eleven births was in Observatory, one of the eleven births was in Belville, and the location of one birth was only specified to be at a private hospital (note there are no private hospitals located in Langa). Out of the six women, two women reported having to switch hospitals while in labor. For her third birth, Phumeza was transferred from a health facility in Somerset to a health facility in Mowbray due to lack of private health insurance. Similarly, Cebisa, for her sixth birth, was
originally booked at a health facility in Mowbray but was transferred to a health facility in Observatory because the hospital felt they could not handle the birth due to complications from diabetes. Though all of the participants resided in Langa, none of them gave birth within the location; they each had to seek out maternal health facilities outside of the township.

**iii. Instances of Poor Quality of Care**

When looking at the quality of care women received during pregnancy and birth, all six of the women reported at some point during one of their pregnancy and birth care that they received good quality of care. However, three of the six women reported some aspect of poor quality of care while giving birth or after giving birth. Though Sibongile felt her overall care during birth was positive, she did note the care she received was about seventy percent and not one hundred percent. She thought this to be true because she gave birth at a public facility and not a private facility. Sibongile’s feelings on public facilities mirror the above literature in which private health facilities are often perceived as providing better healthcare to its patients as opposed to public health facilities. After giving birth, both Thandiwe and Cebisa reported negative experiences with staff at the hospital. Thandiwe fell ill after giving birth and had to remain in the hospital for a short period of time. During her time, she saw a psychiatrist who told her she was “crazy” which made her very upset and uncomfortable being at the facility. After having her fourth child, Cebisa felt that she experienced some racism at the facility at which she gave birth. She discussed how she felt slightly uncomfortable at the facility because it was a mainly Afrikaans-speaking hospital, and her first language is isiXhosa. In addition, Cebisa noted how after being discharged from the hospital she waited four hours for lactation medicine. She eventually left the hospital because she was irritated by the wait time. The nurse later called her,
questioned her, and told Cebisa that she could be arrested for not waiting for her medication. Overall, the women whom I interview were satisfied with the level of care they received; however, Sibongile, Thandiwe, and Cebisa all had encounters with staff that negatively impacted the way they received healthcare.

iv. Unexpected Costs

Though, under South Africa’s constitution, pregnant women are granted the right to free healthcare access, five of the six women reported having to pay for some portion of their pregnancy and/or birth care. Five of the six women reported having to pay for public transportation in order to attend prenatal visits and to reach a hospital while in labor. Only one of the six women reported having access to a family car while in labor. In addition to the cost of transportation, two of the six women reported having to pay for prenatal care, food, and linens while staying in the hospital. Vuyokazi noted that she had to pay an initial fee of about twelve rand per month in order to have access to public prenatal care. She also noted that she had to pay for food while staying in the hospital after giving birth. Similarly, for three of Cebisa births, she reported having to pay about one hundred and sixty rand per birth for linens while staying at the hospital after giving birth. Though women are granted free healthcare under South Africa’s constitution, a majority of the women whom I interviewed reported having to pay for some part of their maternal healthcare.

v. Caesarean Sections

When looking at how women physically gave birth, a majority of the sample had undergone a cesarean section in order to deliver at least one of their babies. Out of the sample of women, four women reported giving birth via cesarean sections. As compared to Cebisa, who
had all six of her children vaginally, and Phumeza, who also had two of her children vaginally. When interviewing the women who gave birth via caesarean section, each woman cited a different reason as to why they were told they needed the procedure. Doctors told Thandiwe that she was in labor for too long, and she needed to deliver. Sibongile noted how the doctors advised she opt for the caesarean because her baby was in a breech position. While doctors told Vuyokazi she had to deliver via caesarean section because her baby was too small to be delivered vaginally. Finally, Nontle noted how she did not know why she had to have a caesarean section and thought that it was maybe because doctors told her that her baby was in distress. When looking at the sample as a whole, a majority of the women underwent caesarean sections and did so for various reasons.
FEMINIST ANALYSIS

The purpose of this work was to not only better comprehend South Africa’s seemingly progressive healthcare system as it affects women during pregnancy and birth, but more importantly to provide a space for these six women to heal through the act of sharing their narratives as their narratives represent their health experiences as embodied experiences. Though I was unable to measure empirically how and to what extent these women were able to heal through storytelling, Lorde (1980) reflects on her health narrative and the importance of speaking on the transformation of silence into language and action. Lorde notes, “I began to recognize a source of power within myself that comes from knowledge that while it is most desirable not to be afraid, learning to put fear into perspective gave me great strength” (1980:20). I can only hope that Thandiwe, Sibongile, Nontle, Vuyokazi, Cebisa, and Phumeza had the same empowering and healing experience through sharing their pregnancy and birth stories.

While listening to their personal health stories, I sought to answer particular questions surrounding how women navigate the healthcare system, the lived realities of these women while navigating the healthcare system, and the institutional shortcomings of South Africa’s healthcare policies. I hypothesized that though women’s health rights and maternal rights are explicitly stated in a legal manner; those rights do not play out as dictated by the constitution and other legislation within the context of post-apartheid South Africa. When analyzing my hypothesis within the context of my findings, it is quite clear that women are being denied their maternal health rights. Though women did have experiences in which they felt they received good or adequate care, the women whom I interviewed faced adversity in regards to affordability, accessibility, and quality of care. In order to better analyze my findings using a feminist
framework and within the broader context of South Africa, I will focus on the previously established themes of affordability, accessibility, and quality of care. Specifically, I will focus my feminist analysis on unexpected costs, traveling for care, silences surrounding knowledge, perceived and received care, and the medicalization of birth. My analysis of these findings will include multiple quotations from the conducted interviews in order to allow the women’s personal stories to be shared in this research as a means of feminist narrative methodologies. The below analysis will be helpful in better understanding how and why the women whom I interviewed navigated South Africa’s healthcare system while pregnant and giving birth.

Affordability

i. Unexpected Costs

When telling their personal narratives and the stories of their lives, all six women discussed the theme of cost in some way. Among the women’s narratives, cost was largely discussed in regards to paid care, unpaid care, and/or care that was not expected to be paid for. When analyzing the concept of unexpected costs, as stated above, five of the six women noted having to pay for some aspect of care that caused their care to not be free. The most prominent aspects of care women paid for included transportation to facilities, prenatal care, food, and bed linens. Most of the women noted how the additional costs were a financial burden if they were not working and/or not on medical aid. Despite the free healthcare women are guaranteed by the constitution, there are additional costs involved in accessing ‘free’ healthcare within South Africa that are not taken into consideration by the established legislation.
When looking at transportation, five of the women had to pay for public transportation to health facilities using their own monetary means. When discussing mode of transportation to prenatal visits with Thandiwe, she noted, in regards to “taxi, public transportation, you pay for whatever” (personal communication, April 9, 2015). While similarly, Vuyokazi said, “I have to pay the transport” when seeking prenatal care (personal communication, April 14, 2015). When looking at unexpected costs in relation to the literature, my findings parallel Myer’s and Harrison’s (2003) findings because they note how a majority of their sample had to seek out public transport to access health clinics. However, though Silal et al. (2012) discuss transportation as being a barrier to accessing a health facility, they do so only in regards to rural women. My findings show that though the women I interviewed live in a more urban setting, as compared to the sample in Silal et al. (2012), they still face affordability issues in regards to public transportation. Though the women in my study have the right to free healthcare, the way in which they access that care is not necessarily free. Further, when looking at the cost of care, some women whom I interviewed reported instances of paying for certain aspects of prenatal care and birth care.

In regards to other affordability issues and unexpected costs, women reported having to pay for prenatal care, food, and bed linens. For example, according to Thandiwe, in “the government hospital…when you go for the first time, you [have to] pay [a] certain amount. That certain amount is for you when you go every month, for, for check-up” (personal communication, April 9, 2015). When interviewing Vuyokazi, she corroborated this point by describing her financial experience with prenatal care. Vuyokazi stated, “I have to pay every time I [went] …every week I [went] to the clinic…They send you the amount you have to pay. Let’s say if you are not
working, then you [have] to pay, let’s say twelve rand a month” (personal communication, April 14, 2015). Besides paying a monthly fee for prenatal care, Vuyokazi recalled how she stayed at the hospital for about a week after giving birth and often sought food from outside of the health facility. When looking at other unexpected costs, Cebisa discussed how she paid for bed linens while spending time at the hospital after giving birth:

[The] only time you have to pay is when you go and deliver because you sleep in a ward, you use bed linens… You have to pay for the… that’s the only thing you have to pay for…At that time I think…It would’ve have been let’s say one-hundred and sixty rand for the whole procedure (personal communication, April 14, 2015).

When looking at the previously cited literature, no research discussed payment for care outside of transportation costs. However, Silal et al. (2012) note that women in rural areas may have to pay for medical equipment if a clinic does not have the necessary tools for pregnancy and birth. Interestingly, though the women I interviewed did not live in a rural area, they still had to pay for some aspects of care that they originally did not expect to pay for.

ii. Who Determines Free

Overall, when analyzing the finding of affordability as it relates to health, it is important to understand how these women’s maternal health experiences are not free as dictated by the South African constitution. South Africa’s constitution establishes that women have a right to free healthcare; however, women still face financial barriers to receiving maternal healthcare. When understanding this notion within a transnational feminist framework, one must look back to the inception of the legislation—as it was fist established in 1994 (and in subsequent years) as a result of South Africa’s new constitution. During the years of 1994 and 1995, President Nelson
Mandela appointed eleven members to the constitutional court, 9 males and 2 females, who ultimately approved this particular piece of health legislation. Though colonialism heavily influenced the structure of the newly formed post-apartheid government, when institutions are largely comprised of men, the state has the capacity to “arm men and disarm women” (Connell 1987).

Thinking about the patriarchal and colonial history of South Africa, I question who determines what is free? The six women whose narratives were included in this piece demonstrate how patriarchal forces control and maintain power over the female body through seemingly progressive and gender equal legislation. In turn, this form of control places a financial burden on women. According to Van Wijk, Van Vlie, and Kolk, “women use health care services more often than men do, and have a lower income. Women, therefore, carry the major burden of budget constraints in health care systems all over the world” (1996:708). The women who shared their stories for this research helped to uncover larger issues surrounding the definition of ‘free’ regarding women’s health in South Africa. More so, further research must be conducted in South Africa in order to assess how affordability of health changes across different bodies, in particular for women and women who are not white.

**Accessibility**

**i. Traveling for Care**

As described in the above literature and by women who participated in this study, there are no current facilities in which women can give birth to in Langa Township. The women who shared their narratives gave birth in a number of health facilities located in Pinelands, Somerset,
Mowbray, and Observatory. Looking at the literature, there is a lack of research surrounding women’s access to maternal healthcare in Langa. When connecting the fact that none of the women were able to give birth in a facility in Langa to the existing literature, it is important to assess arguments found in Van Niekerk (2012). Specifically, Van Niekerk (2012) discusses how inequality, in regards to health, is perpetuated through the concept of space. For the women whom I interviewed, they faced access problems due to their geographical location that in turn perpetuated health inequalities.

When assessing my findings in conversation with the literature, two women explained how they had used friends’ and relatives’ addresses in order to access facilities that they would not be able to access otherwise. Cebisa illustrated this point by describing, “with maternity hospitals; it depends in the area where you live” (personal communication, April 14, 2015). Similarly, when speaking with Sibongile, she discussed how “you can’t go [to a particular facility] unless you’ve got an address. If you stay here in Langa, you can’t go there. Because you must have one of your relative’s address” (personal communication, April 10, 2015). Cebisa also shared a personal anecdote when speaking about her use of a facility in which she could not access. Cebisa stated, “I go to the Green Point Clinic; they ask me where I lived. I told them that I live in Bantry Bay because my aunt had a house in Bantry Bay. So I have to use her address when I go to Green Point Clinic” (personal communication, April 14, 2015). These two women described seeking out other clinics, using addresses that were not their own, in order to access care that they perceived to be of better quality.
ii. Accessibility as Gendered

The fact that all the women in this study gave birth outside of Langa, coupled with the fact that two women reported accessing other clinics using family or friends’ addresses, demonstrates how these women faced accessibility issues while navigating South Africa’s healthcare system. In an article by Doyal, the researcher notes, “it is generally males who have a significant advantage over females…[while] access[ing] health-related resources” (2000:933). Health, in itself, is a gendered topic, and for these six women, this notion affected how they navigated South Africa’s healthcare system while pregnant and giving birth. It is important to question why there are no facilities for women to give birth at in Langa, and how these women had to manipulate the system in order to receive maternal health services. As of now, no literature exists on how traveling to give birth may affect women’s health experiences in Langa. However, one study conducted in Washington State found that women living further away from health care facilities are “more likely to have complicated labor and premature deliveries, and their infants are more likely to have longer and more expensive hospital stays than the children of their rural counterparts who deliver in local facilities communities with greater access to care” (Nesbitt et al. 1990:817). Conversely, it has been shown, and will be discussed below, how birth within health facilities has become a medicalized process, as opposed to a natural one. The six women I interviewed are a small sample of how inequality within maternal health has real life consequences on a micro-level scale, and more so, their narratives demonstrate how “access alone…does not guarantee the care we receive will be medically…appropriate or even effective (Boston Women's Health Book Collective 2011:651).
iii. Silences Surrounding Knowledge

Many of the women discussed how they felt their pregnancy and birth experiences were heavily shaped by what they knew about sexual, maternal, and reproductive health. Furthermore, the women discussed how they felt other women in South Africa did not have access to knowledge surrounding their health and health rights. When assessing the cited literature on knowledge of maternal rights and knowledge of maternal health, there is not much discussion on the topic. When further evaluating the literature, researchers and scholars do not address the structural downfalls in regards to educating women on birth, pregnancy, and sexual health. These silences within the literature and academia parallel silences these women faced in regards to health knowledge.

When speaking with Nontle on other peoples’ knowledge surrounding prenatal care, she described, “most of the people….they [don’t] go to prenatal clinic. So no one knows what’s going on with that child and then they will come last minute and give birth” (personal communication, April 12, 2015). Nontle furthered this point by assessing access to knowledge within townships. Nontle noted:

You will find people in the townships, that will die of things that could have been [prevented]…There is no knowledge…It will be women in the townships and places where there is not much information. It’s not readily available. Even if it is available maybe it’s written in English and nobody is going to translate that for them (personal communication, April 12, 2015).

When interviewing Cebisa, she also discussed her feelings of the lack of education concerned with reproductive rights and sexual health. Cebisa noted:

I want to say that, I think that a lot still needs to be done in educating us women on birth, on birth control, on… sexual health… I say this because I find that with my generation, people my age, we don’t go for pap smears. A lot of people my age
suffer from cancer of the cervix. We need to be educated on such things (personal communication, April 14, 2015).

Both Cebisa and Nontle discussed how there is a lack of access to information, and more importantly how this lack of information has real life consequences for women in their community. When speaking with Phumeza, she offered a personal anecdote regarding her lack of access to reproductive information as a child. Phumeza explained, “no one talked to us about pregnancy, no one talked to us about sex” (personal communication, April 18, 2015). These women’s ideas surrounding access to health knowledge, coupled with their personal experiences, serve to better understand taboos and silences surrounding maternal health, reproductive health, and sexual health in the context of South Africa.

iv. Understanding Silence as Gendered

When looking at the women’s perceptions of health knowledge as a whole, I believe Nontle describes the importance of knowledge best. She notes, “but in the end it’s knowledge, knowledge is power because if you know you can do this to help yourself things won’t be as difficult as it is” (personal communication, April 12, 2015). The importance of knowledge of health rights and maternal rights is largely under-researched. More research needs to be conducted that addresses how silences surrounding such rights have bigger implications in regards to patriarchy, gender, and taboos surrounding sex and women. In Our Bodies, Ourselves the authors note:

A woman’s body and her sexuality have traditionally been understood and presented as the property and business of everyone but the woman herself. Many of us have been made to feel that knowledge about care for our bodies—particularly those parts considered primarily sexual—are unnecessary, maybe even inappropriate (Boston Women's Health Book Collective 2011:30).
From my own experiences, discussions of sex, gender, sexuality, reproductive health, pregnancy, and birth are largely neglected and swept under the rug within the context of the United States. It is apparent that there are similar sentiments among these six women from Langa Township. For most of the women I interviewed, they were unable to explicitly state their maternal rights, and as Boston Women's Health Book Collective (2011) notes, this knowledge is necessary in order to navigate and access a healthcare system. Even the women themselves noted how they were never able to receive knowledge on maternal health rights, and they felt something should be done to change that.

**Quality of Care**

1. **Perceived and Received Care**

When analyzing the literature, there were some parallels between the women’s perceptions of healthcare and the care they experienced during pregnancy and birth. For instance, within the literature, Brown et al. (2007) describe the South African public healthcare system as highly underfunded, while the private health sector as being only accessible to certain identities across race and social class. Further, the above literature categorizes public health facilities by a lack of staff, overcrowding, and overall poorer quality of care compared to private health facilities.

When discussing their perceptions of various health facilities in South Africa, the women whom I interviewed had similar perceptions of health as compared to the literature. The women tended to perceive private healthcare facilities as being of better quality compared to public healthcare facilities. For the most part, the women described public health facilities in regards to
a lack of staff, wait times, decline in staff morale, and poorer quality of treatment. For instance, when speaking with Thandiwe, she described her feelings on waiting to receive care:

Senior people are told their appointment is this day at eight o’clock. If my appointment at the private hospital is at eight o’clock, then I will be there at eight. But in the government hospital, they cannot be there at eight. They must be there before that, and now the doctor attends the person, the patient, one o’clock. And at one o’clock the doctor will say I’m going for lunch. Then still that person did not have something to eat at home, never had anything. They don’t even look at those things. They were supposed to have food during the day for people who had nothing (personal communication, April 9, 2015).

When speaking with Sibongile, she discussed various aspects surrounding quality of care including staff morale, wait times, and underfunding. Sibongile described:

The thing is that the nurses working now in the public hospital, they are just working for the money… to get paid. It’s not like they love what they are doing. Like you can see when you are in hospital. Sometimes you wait in a queue, a long queue. Sometimes they tell you, you must go back if there is no medicine (personal communication, April 10, 2015).

Nontle also had similar views of medical staff as she described, “the problem is that… the people inside [hospitals] who are supposed to uphold rights, that you find that—maybe it’s also because they don’t know that much, that’s why they will treat people like they don’t deserve to be there” (personal communication, April 12, 2015). Nontle also spoke about the quality of care women receive while giving birth at public health facilities. She described, “the public hospitals, they will kind of force you to push or they will force you, I mean they don’t understand you when you are in pain. It’s like you’re acting up or something” (personal communication, April 12, 2015).

The women also noted how they thought people received better care at private facilities because they were paying to be there. Furthermore, most of the women noted how they would prefer to receive care at a private facility if they had access to the financial means. Nontle described how at a private facility “the experience was very nice because you are treated like somebody that [is]
here because you paid your money to be here. So the treatment is also of that standard” (personal communication, April 12, 2015). While Sibongile described public hospitals as “not so good… because maybe because you don’t have to pay for that” (personal communication, April 10, 2015). Similarly, Cebisa described, “the differences are in the care itself. It is because in private hospitals you pay a lot of money… medical aid is very expensive” (personal communication, April 14, 2015). Overall, the women whom I interviewed perceived public facilities to be of lesser quality, while simultaneously expecting better care from private facilities due to the fact that treatment is paid for out of pocket.

When looking at the literature, in regards to pregnancy and birth in the context of South Africa, the Human Rights Watch (2011) discusses how women are often shouted at, struck, or left alone for long periods of time during both labor and birth. Further, Silal et al. (2012) found that all but one woman in their sample was dissatisfied with the maternal healthcare they received. Though the literature depicts many women having negative experiences during labor and childbirth, when analyzing the quality of care the six women received while giving birth, for the most part, the women were satisfied with their experiences. The women who I interviewed reported that they felt their birth and pregnancy experiences were fine, and that both doctors and nurses treated them in a neutral manner. However, two participants, Thandiwe and Cebisa, reported specific instances of receiving poor quality of care after giving birth. When speaking with Thandiwe, she described, “I think two, four days after [he] was born I got sick. And then after that [I saw] the psychiatrist—like they thought that I am going crazy, and I was like [I’m] not going crazy” (personal communication, April 9, 2015). Thandiwe further explained how she felt uncomfortable and misunderstood by the staff at the facility because they diagnosed her with
having a mental disorder. Interestingly enough, Thandiwe gave birth at a private health facility but was still unhappy with the care she received. When speaking with Cebisa, she discussed how she experienced racism at a public health facility while giving birth to her child in 2005. Cebisa described:

That is where I experienced a little bit of racism, at [a particular hospital in Cape Town]. The hospital is usually... is dominantly Afrikaans speaking. It is predominantly—there are a lot of coloured people employed, and I sensed... a lot of racism from the nurses who were there... The fact is when you are there and when you are in labor you expect to be given help, first hand. I was not actually. To the extent when I gave birth on the second day I had to leave. I had to go home; and I was made to wait for.... lactation [medication]. I was discharged by the doctor ... as early as eight in the morning... and I waited from that time, the time I was discharged, until eleven—waiting for the lactation tablets. I got irritated because I kept on asking one of the nurses who were there. They kept on answering me in Afrikaans. I understand Afrikaans very well, telling me that I was going to wait, and I could not understand what I was waiting for. I got irritated. I eventually left at a quarter to eleven. I walked away because I had been discharged by the doctor. I walked away... As I was driving out of the hospital, I received a phone call from the nurse who was rude to me saying that—asking where I am... she said, “Listen, you cannot leave without the lactation tablets.” I said, “you can shove them where the sun doesn’t shine.”... I am not going to sit her just having giving birth. I need to get home and rest. I need to go and get a nice warm bath then I need to go look after my baby. I’ve been sitting there for three, almost four hours. After I had been discharged, and the doctor said that I should take my folder straight to the pharmacy and give me the tablets, I don’t need to sit and wait because I needed to get home. And she said to me, “you know that you can be arrested?” I said, “Call the cops on me, you’ve got my home address, do whatever you want to do with me” (personal communication, April 14, 2015).

Cebisa faced this sense of racism and poor quality of care at a public facility while giving birth. Her experience at this particular facility is marked by racism, wait time, and poor treatment from a nurse at the facility. When analyzing Cebisa’s experience in the context of the cited literature, there was no mention of the importance of language and medical care. However, upon further investigation, researchers have established an association between language and quality of care in health facilities. For example, Ponce et al. (2006) note that
language barriers within health facilities have the potential to reduce the quality of care received by a patient. Though both Cebisa and Thandiwe reported negative instance of quality of care, it is important to note that only two women of the six women reported being unsatisfied with their medical care while giving birth.

ii. How Women Receive Care

When looking at the concept of quality of care, it is essential to consider not only how these six women experienced maternal care, but also why they experienced the care that they did. Though the literature establishes that public health facilities are largely underfunded and under-resourced, women experienced both positive and negative encounters in both private and public facilities. When assessing this concept in a larger context, it should be considered how different identities and bodies had different experiences at various health facilities within the context of South Africa. In regards to gender, Van Wijek et al. (1996) point to two reasons for why women receive poor quality of healthcare: women are underrepresented while making healthcare decisions and there is a lack of recognition to gendered aspects of healthcare. Though these six women experienced different quality of care at different facilities, their experiences reflect how female bodies and voices are often not considered the standard in health and medicine. These women’s narratives further unpack how they were made to adhere to a healthcare system that was not necessarily made with their wants or needs in mind.

iii. Medicalization of Birth

When looking at the birth experiences of the six women I interviewed, four of the six women underwent a caesarean section for at least one of their births. Though cesarean sections in
the context of South Africa are not discussed in the above literature, there is much important research on the topic. For instance, according to Dumont et al. (2001), three-quarters of women from hospitals in sub-Saharan Africa delivered by means of caesarean section. Dumont et al. (2001) further note how the rate of caesarean sections has been on the rise since the 1970s in most developed countries. Furthermore, the literature also establishes how it is important to consider how the rate of cesarean sections varies across different bodies. For instance, Matshidze et al. (1998) describe how whites and coloreds were more likely than blacks to receive caesarean sections in South Africa. Further, Matshidze et al. (1998) describe that there is evidence that the use of caesarean sections is often influenced by inappropriate and non-medical factors. Additionally, Matshidze et al. (1998) found that the rate of caesarean sections was twice as high at private facilities as compared to public facilities. In all, the literature establishes that there is a need to better assess the increasing rate of caesarean sections across various bodies within the context of South Africa.

When looking at the four women had caesarean sections, they each cited different reasons for receiving caesarean sections. When speaking to Thandiwe about her delivery she described:

When I was about to deliver, I could not. I could not. I just, I don’t know whether I fainted or something like that, but my doctor had to be like, “wake up, wake up, wake up. Wake up you must push now you must push.” I could not push. Then the doctors are checking the time. Okay, and then they said, “no, no straight to the theater.” Then I was transferred straight to the theater (personal communication, April 9, 2015).

When I spoke with Nontle about her reasoning for having a cesarean section, she stated:

I don’t know because they said the child is distressed. I’m sure if I was not on the medical aid maybe they would have wait until the child came out. But because you are on the medical aid they like to take short cuts, but they will pretend … if they
would have waited, the child would have come out deformed or something like that. So they opted for the cesarean (personal communication, April 12, 2015).

Additionally, Vuyokazi discussed how she was scared and weak while giving birth. She felt that she could not push and explained how the baby “did not want to come down” (personal communication, April 14, 2015). Sibongile also received a caesarean section and described that she went to the theater because her baby was in a breeched position. All four women noted how their doctors suggested, encouraged, or told them that they needed a caesarean section. Though it might be easy to draw conclusions, such as how a specific population group may have a higher rate of caesarean sections, Matshidze et al. (1998) argue otherwise. Matshidze et al. describe that “the differences in section rates may reflect the effect of bias in clinical decision-making, and/or differences among women from different ‘population groups’ in their attitude towards assisted delivery, and their capacity to negotiate with clinicians” (1998:71). Though this study uses a small sample, it is essential to consider power dynamics between doctors and patients and how this affects women’s birth experiences. Furthermore, women should have the agency to make informed decisions during both birth and pregnancy in order to receive the highest standard of care.

iv. The Medicalization of Birth and Feminism

Overall, birth and birth options were not clearly laid out or explained for the women who participated in this study. When considering that four out of the six women in my sample received a caesarean section for at least one of their births, it is important to consider themes such as medicalization of birth experiences, agency these women did or did not have in making birth decisions, and the possible adverse consequences of caesarean sections. More so, according to Shaw, “the medicalization of childbirth raises the argument that freedom of choice in
childbirth is not possible within the confines of medicalization because medicalization is based on the patriarchal control of women’s bodies” (2013:523). I believe that the idea of ‘negotiating with clinicians’ is in some way connected to access to information. Women may or may not question the authority of a doctor or nurse if they do not know their maternal rights and/or legal health rights. For example, when looking at birthing position, according to the Western Cape Government Website, women have the option to “request a birthing position (e.g. squatting) that makes them feel the most comfortable.” When discussing knowledge of maternal health rights, none of the women in the study brought up this particular possibility while discussing birth. I wonder how access to certain maternal health knowledge would have affected or changed these women’s experiences. Would their access to knowledge affect their birth experiences? The six women who shared their narratives demonstrate how patriarchal control of women’s bodies affects women, women’s maternal rights, and women’s health experiences on a personal level.
CONCLUSION

Through this work, I sought to better understand the complexity of South Africa’s maternal healthcare system through personal narratives from women living in Langa. From what I gathered from the literature, I anticipated women to face various barriers in regards to access to maternal health including affordability, accessibility, and quality of care. The women who were so generous to share their stories were all from varying backgrounds, socioeconomic statuses, and races; however, they all had at some point navigated the healthcare system through pregnancy and birth. Before conducting this research, I initially anticipated that the women whom I interviewed would all have similar negative experiences while receiving maternal care at health facilities. Though most of the women faced preventative barriers as found in the literature, women did also have positive experiences while receiving maternal health. They expressed how they were thankful for the care received from doctors and nurses through means of both private and public healthcare. However, through this research, it was found that women still have complications in regards to affordability, accessibility, and quality of care. Specifically, in regards to unexpected costs, traveling for care, silences surrounding knowledge, perceived and received care, and the medicalization of birth.

When assessing the findings from this study, it is important to analyze them within the context of South Africa. The post-apartheid era has been largely marked by access to new rights across previously disenfranchised bodies. In regards to health, as established by the literature, there is still a long way to go in achieving an ideal healthcare system for women in accessing affordable and acceptable maternal healthcare. From this work, it is quite clear that the political macro level systems in place within South Africa have very real effects on women’s personal lives. As Carol Hanisch once noted, “personal problems are political problems” and “we all need
to learn how to better draw conclusions from the experiences and feelings we talk about” (1970:4). Through this feminist work, the women whom I interviewed were given space to tell their embodied narratives. Further, through this narrative approach, I sought to unpack how society disproportionately silences women and women of color. As Lorde once noted:

My silences had not protected me. Your silence will not protect you. But for every real word spoken, for every attempt I had ever made to speak those truths for which I am still seeking, I had made contact with other women while we examined the words to fit a world in which we all believed, bridging our difference. And it was the concern and caring of all those women which gave me strength and enabled me to scrutinize the essentials of my living (1980:20).

These six women’s narratives are examples of how women’s health decisions, pregnancy experiences, and birth experiences are heavily dictated by legislation. More so, this work demonstrates how women are holders of their own knowledge and experiences. I hope that, through this paper, these women were able to talk back to their experiences as women navigating a highly complex and deeply patriarchal system in a post-apartheid state.
EPILOGUE

Looking back on my experience in Cape Town, South Africa, and more specifically Langa, I can say I will never forget the moments I shared with these women and other women in the community. Though it was a privilege to hear these six women’s birth and pregnancy stories and share them in this feminist piece, I realize that these experiences are not mine to manipulate or dictate—they belong to these women. From my work and studies at Colgate, my time in Santa Fe, New Mexico, and while coming back home to the United States from South Africa, I realized that birth and pregnancy play out in similar ways across borders. More so, I realized there needs to be a space for women to heal through health narratives within the United States as well. I began to think more critically about questions including: how is birth conceptualized in the United States? Who dictates pregnancy and birth narratives? What does a “normal” birth look like and why? How can others and I create space and talk back to the dominant discourse surrounding birth and pregnancy within the United States?

I have always been interested in becoming a doula, or birth companion, but never really knew how to become involved. It was by chance that I met Jessica and Steph, two doulas themselves, at the Gathering for Mother Earth Festival in Santa Fe. After speaking with them, they invited me to participate in an upcoming doula class hosted by Tewa Women United. Tewa Women United is an organization that aims to “provide safe spaces [for] indigenous women to uncover the power, strength, and skills they possess to become positive forces for social change in their families and communities” (Tewa Women United Website). Through a four-day course with the International Center for Traditional Childbearing (ICTC), I became a certified doula. The course was very intensive, but I felt at home with the group of ten other women from

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different backgrounds who took the course with me. The space of the class itself was healing—
new moms taking the class brought their month-old babies, we cooked together, ate together,
cried together, and grew together.

Coming back to Colgate, I knew I wanted to practice as a doula in Hamilton, as I learned from
my Women, Health, and Medicine class, that birth options were not the most readily available in
the area. I decided to reach out to a local midwife, to not only to work with her as a volunteer
doula for her clients but also to see how homebirth plays out in the context of Hamilton, New
York. I have only had the opportunity to work with two women so far, and both of their stories
are quite memorable. However, Lila's birth story resonated with me as her experience was telling
of the downfalls of our own medical system.

I can remember being anxious the whole week, as Lila’s due date was only a couple days
away. I knew the birth would happen soon because the week before she thought she was going
into labor—but it was really just Braxton Hicks contractions. I was with friends doing work
when I got the call that I should start heading towards Lila’s home. Besides me, Lila’s birth team
was made up of a midwife, an assistant midwife, and another doula. We all had about an hour
drive to get to Lila’s house, and we knew we had to move quickly as her previous two labors
were both under five hours. Ten minutes into my drive, the midwife called me to tell me that we
all missed it—Lila had given birth at home within minutes of going into labor. Lila had called
911 and six paramedics got to her house as the baby was crowning. When Lila did not deliver
her placenta right after the baby was delivered, the paramedics were concerned and transferred
her to the local hospital.
Once the birth team made it to the hospital at around one in the morning, we were most concerned with getting Lila and the baby home as soon as possible. Upon speaking to the nurse, we were told that the hospital policy to have newborns stay for at least 24 hours and be checked by a pediatrician.

“Well, when’s the pediatrician going to be here?” Asked the midwife.

“He usually doesn’t start his rounds until ten a.m., but he could come in early or later. I really do not know.” Replied the Nurse.

Lila was stuck. Technically, she could have left the hospital; no one was physical holding her there. However, if she left, her insurance would not cover her stay because she would be leaving against medical advice. Even more concerning was the hospital’s policies on vaccinating newborns. Originally, Lila wanted her baby’s Vitamin K shot to be delayed; however, it is hospital policy to call Child Protective Services if a mother opts out of a Vitamin K shot. Once again, Lila was stuck and eventually had to permit the nurse to give her baby the vaccination.

Though I knew birth in the United States did not center women and their experiences, it was another experience to see it play out in front of me, especially for someone I care for greatly. When I first saw Lila at the hospital, I spoke with her about the experience—she was a little distraught, having wanting so badly to have given birth in the birth pool with the full birth team there. However, when speaking with her just a week later, she had a realization about her birth. She realized that though her birth did not play out the way she imagined, it strengthened her relationship with herself and her husband.

“Though I was upset at first—disappointed, I realized that the experience I had was empowering. Like we did this—I did this. It’s a great story.”

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All birth stories are different—they happen in different settings, under different circumstances, with different people present. Though Thandiwe, Sibongile, Nontle, Vuyokazi, Cebisa, Phumeza, and Lila had their own unique birth stories, their stories are indicative of two main themes. One, that birth rarely plays out in a way that centers women’s needs, feelings, and experiences, and two, more stories need to be not only told, but also heard in order to change the way birth plays out for all women.
APPENDIX

Appendix A: Interview Protocol

1. Tell me a little bit about yourself.
2. What do you know about the constitution and bill of rights? Do you know anything about what it (bill of rights) says about healthcare and maternal rights?
3. If a serious health problem were to arise in your family and you needed medical attention where would you go?
4. Have you (or a family member) ever had to go to a hospital or clinic?
5. Can you tell me a bit about your pregnancy with your kid(s) after 1994?
6. Can you tell me a bit about giving birth?
7. What could have made your birthing or pregnancy easier?
8. In comparison to other women in your family and other female friends, how do you think your birth experience was?
9. Looking back, how do you feel about your overall birth/pregnancy experience?
10. If you were pregnant today, how would you go about giving birth and why?
11. Is there anything else you would like to say regarding maternal health, pregnancy, and/or birth?

*Note: These questions serve as an outline for an interview. During the interview, certain questions may be probed further depending on the respondent’s narratives/answers.
Appendix B: Consent Form

CONSENT FORM

1. Brief description of the purpose of this study
Thank you for taking the time to participate in this study.

The purpose of this study is to better understand how women’s health rights in South Africa play out in reality for women in Langa. This study seeks to investigate if women in Langa have knowledge of particular maternal health rights. In addition, this study seeks to investigate themes within maternal healthcare surrounding affordability, accessibility, and quality of care.

With your permission, I will record this interview so that I do not miss any details. I will delete this recording after I finish my project.

Upon completion, this report will be available in the SIT library and potentially online in both English and isiXhosa. I may use this research for my major thesis at my home university (Colgate University) or for a future fellowship or grant. I may also share my final projects with friends and professors.

2. Rights Notice
In an endeavor to uphold the ethical standards of all SIT ISP proposals, this study has been reviewed and approved by a Local Review Board or SIT Institutional Review Board. If at any time, you feel that you are at risk or exposed to unreasonable harm, you may terminate and stop the interview. Please take some time to carefully read the statements provided below.

   a. Privacy - all information you present in this interview may be recorded and safeguarded. If you do not want the information recorded, you need to let the interviewer know.
   b. Anonymity - all names in this study will be kept anonymous unless the participant chooses otherwise.
   c. Confidentiality - all names will remain completely confidential and fully protected by the interviewer. By signing below, you give the interviewer full responsibility to uphold this contract and its contents. The interviewer will also sign a copy of this contract and give it to the participant.

_________________________________________  ______________________________________
Participant’s name printed                          Participant’s signature and date

_________________________________________
Interviewer’s name printed                          Interviewer’s signature and date

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