Improving access to maternal health care beyond health care policy: Pregnant women's experience of maternal public health care services in Cape Town, South Africa

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DPRBRO001

SUBMITTED TO THE UNIVERSITY OF CAPE TOWN
In partial fulfilment of the requirements for the degree

MPhil in Southern Urbanism

Faculty of Science
University of Cape Town

February 2023

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Plagiarism Declaration

I, *Bronwin Andrea Rhoda*, hereby declare that the work on which this dissertation is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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Abstract

Unequal access to maternal health care continues to be a concern in South Africa despite the efforts of government and health practitioners to make the system more inclusive and accessible to all women, especially for women who have been previously disadvantaged prior to and during Apartheid. Research in maternal health care has shifted and emphasized the delivery of quality care by medical staff to ensure that the goal of reducing maternal deaths is to improve maternal health care. Despite the global concern and interventions of the local government, many women still experience limited access to quality maternal healthcare services. Waiting for public health care services further highlights women's challenges. There is a need to understand further how waiting impacts the patients' experience and access to care. Acknowledging that gaps exist in the current literature focused on maternal health care, this study employs qualitative research methods to explore pregnant women's experience within the maternal public health care system in the Cape Town Metropole Region. Four specific objectives guided this aim: one, exploring the challenges pregnant women encounter when accessing state maternal facilities; two, exploring the bodily and physical experience of waiting on the delivery of public health care services; three, exploring the vulnerability in waiting through the lens of pregnant women; and four, exploring the relationship of government interventions through waiting.

The findings of this research demonstrate that public maternal health care is accessible for most women based on the effectiveness of government policies and interventions. However, medical personnel experience constraints that restrict access to *quality* care. The challenges associated with waiting and medical personnel continue to impact the perception that women create of the delivery of public health care services. Addressing the challenge of waiting requires policies and interventions to align with expanding human resources to deliver the highest quality services.

Key Words: *Maternal Health Care, World Health Organisation, Waiting, Embodiment, Access, Service Delivery*

This dissertation is dedicated to,

my children, Alec, Grace and Emily
and
my late grandfather, Rasool (Clement) Israel

Acknowledgements

It is to the following people that I owe an infinite amount of gratitude:

First and foremost, thanks be to God who has given me the strength and courage through these past months. The journey was definitely not easy and there have been many times of failure and stumbling but through His grace and mercy, the completion of this dissertation has been possible through every obstacle.

Most importantly, to the strong and resilient mothers who have been part of this research project, thank you for taking the time to embark on this journey with me, especially during this time of the pandemic and preparing to welcome your babies into this world. During this time, I had the opportunity to welcome 5 new individuals on this journey and I am so grateful to you all. To the medical staff who have also been part of this research, thank you for taking the time out of your busy days and family time to assist in the completion of my research and providing me with your knowledge and expertise.

My supervisors, Dr. Rike Sitas and Dr. Andrew Tucker, for your support and guidance. You have been the best support team I could have wished for. Thank you for cheering me from the moment this research journey began. Thank you for being so understanding and guiding me throughout this research journey to complete my dissertation to the best of my ability. To Dr. Anna Selmezci, thank you for being just an email or phone call away, your patience and compassion has been so comforting during this time. To every staff member in the Department, for the contributions and ideas towards my dissertation.

To my loving husband, Morgan Bentley Rhoda, thank you for your support, sincerity, understanding and patience especially through this important time in my academic journey. To my parents, Destiny and Charles Schoor. Your support, love and endless sacrifices have helped me to complete this degree. My siblings, Kirstin and Cade, extended family members and all that has been involved directly and indirectly, thank you for all your prayers, love and intrinsic belief in my abilities even when I doubted myself.

This dissertation is dedicated to you and your efforts do not go unnoticed.

Foreword

I remember the early mornings, getting ready for my routine antenatal checks. I would always pack and get everything ready the night before just in case my alarm did not go off or forbid I overslept the morning of my visit. I remember the car rides to the clinic: it was dark outside and the silence of the night was slowly fading as the roads got busier with morning traffic. I would pay attention to the reflection of the street lights as it hit the front window, the car was not moving too fast and the reflection of the street lighting hitting the front window created a calm effect and gave just brief moments of relaxation. Although I had always left home early on the day of my check-ups I was never the first in line. These visit days would involve a hasty jump out of the car, just to avoid another person joining the line. Watching cars pull up to the side of the road to drop off the patient; some old, some young and some accompanying others who could barely walk. Around 7:30, the guy would set up his stall, judging that it was a stall outside a clinic he did not sell any health snacks. By 8:15, after ladies had their fair share of conversations and held onto their bellies to support its weight; the first 10 ladies were let into the clinic. I remember prior to COVID-19 I would arrive early at the clinic and sit according to the arrival of patients. When the COVID-19 pandemic hit South Africa, despite the time you arrived, you waited outside until the gates of the clinic opened and until it was your turn to enter. I stood there surrounded by the cold morning mist along with other pregnant women patiently waiting for the gates to open while life around (and inside) me just kept moving swiftly.

On the morning of May 15th 2020, a day prior to the date that the private gynaecologist had predicated I would give birth, I had travelled to the local clinic where I had been receiving my antenatal care from. After arriving at the clinic, I was escorted by the security guard on duty to the emergency section. It was rather quiet and the passages leading to the nurses' room had no lighting. I informed the sister that I was experiencing extreme pains and some of the "signs" that comes before giving birth. With no hast at all, I was just instructed to get onto the bed while she went to fetch my folder. A few minutes had already passed, and I had observed every inch of the room, I saw two women in labour walking the passages, and I was still waiting for the sister to come back to check up on me. Once the sister had returned and she had already browsed through my folder, she conducted the examination to check that myself and my son was doing fine. Despite the pain that I was experiencing, nothing had alarmed her that anything was wrong. I was told that I had a "bladder infection" which resulted in the back pains that I was experiencing. With a pack of tablets in my hand, I was sent on my way back home.

Later, that evening the pains only grew stronger. Scared that I would be turned away again, I told my husband I needed to be rushed to the nearest hospital. After a detailed observation at the hospital, I was told that I had been in labour and had already dilated two centimeters. On May 16th 2020 at 04:35am, less than 24 hours since I went to the clinic, I had given birth to a healthy, beautiful baby boy.

This experience with the public health care system served as a starting point for months of research focusing on pregnant women's access to maternal public health care. This research draws on the experiences of pregnant women, as well as the experiences of professional medical personnel encountering public health care services. The focus of this research is to gain a better understanding of the constraints that contribute to the perceptions that women who utilize maternal public facilities in Cape Town have of the maternal health care services.

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1 Introduction

In the last decade, the focus of research and researchers, regarding access to quality maternal health care has shifted towards skilled medical professionals as the driving force that impacts the quality of care pregnant women need and receive from and within the public healthcare system (Silal, et.al, 2012). Scholars within this research field have been collecting data on how maternal health services can be improved, and the outcomes of these studies highlights how skilled medical professionals play a vital role in the delivery of services and can be seen as the tangible aspect of access to public maternal health care services. In the context of South Africa, there has been a growing demand for the State to intervene and improve the quality of services delivered by the maternity and obstetrics units in the public sector (Ismail, 2015). Previously, research on maternal health care focused on maternal deaths as an indicator; used to monitor the improvement of maternal health care services (WHO, 2017). However, with the new focus of research, the decrease in the number of maternal deaths has become evident as not the only way of ensuring that patients are receiving quality health care.

Furthermore in South Africa, maternal deaths are not an issue that the government has been trying to solve in the past 10 years but since the first democratic election held in 1994, whereby the ANC-led government recognised the injustices created during the Apartheid era. This led to implementing a programme of political, social, and economic transformation and aimed to develop a society based on democracy, social justice, and fundamental human rights (Penn-Kekana & Blaauw, 2002:8). Since 1994, maternal, child, and women's health has become a top priority for the government. Following the need for transformation after 1994, key legislative and policy milestones have been passed by policy makers, health professionals, and service users (Penn-Kekana & Blaauw, 2002:30). However, even with the high level of commitment from the government through its political and administrative leadership, and the implementation of key legislation and policies, maternal deaths remained an issue in South Africa (Penn-Kekana & Blaauw, 2002:30). This indicates that policies and interventions are not sufficiently effective and adequate in improving the quality of maternal care service.

Although the implementation of legislation and policy, which is led by government officials, health professionals, and policy makers is important; and significantly contributes to improving the current maternal health care issues, there are still other factors that affect the overall conditions of maternal healthcare (African Progress Panel, 2010). Accessibility, infrastructure, cost, quality and sustainability of care, information deficit, and the attitudes and behaviours of medical personnel have been recognised as important contributors to

ensuring improvement in maternal health care and reducing the maternal death rate (African Progress Panel, 2010).

The provision of policy and identification of challenges faced by women in accessing maternal health care services aim to improve the quality of these services. However, despite the availability of free maternal health care services in the public sector, women may still encounter challenges when seeking care. This therefore raises the question of why these challenges persist despite the existence of policies and efforts to address them? In addition, how do these challenges impact the perceptions of women of their access quality maternal health care services?

In order to better understand the challenges faced by pregnant women accessing quality maternal health care services in the Cape Town Metropole Region, this research focuses on the pregnant women's experiences within the public health care system. Through a qualitative approach, the research aims to understand how women build their perceptions and experiences of the clinics and services they receive from public maternal facilities. To gain a more comprehensive understanding of the issue, the study also includes the perspectives of skilled medical professionals who deliver these services within the public sector. The research therefore focused on engaging with pregnant women and medical professionals to explore the factors that contribute to women's experiences with public health care services and to identify ways to improve the delivery of these services.

Based on the aim of the research, this thesis draws on three bodies of literature. The first body of literature being, maternal health care. Literature on unequal access to maternal health care in many developing countries, particularly in Sub-Saharan Africa, is a well-established area of research. There is a significant body of literature on this topic, in which various challenges that women in these regions face have been identified when trying to access maternal health care services. The second body of literature being, waiting. Waiting is a common and often prolonged experience for pregnant women seeking care within the public healthcare system is also an area of ongoing research. In the context of maternal health care, literature on embodiment is important because pregnancy and childbirth are physical experiences that are shaped by social and cultural norms and expectations. Understanding pregnancy as an embodied experience can help to contextualize the challenges and barriers that women face when trying to access maternal health care services.

This thesis starts by reviewing the literature and theory surrounding these topics in discussion, followed by an analysis of participant interviews, which includes both the pregnant women (receivers of public health care services) and skilled medical professionals

(providers of public health care services). The analysis chapter focuses on three aspects: access, waiting, and experiences.

Section two (chapter 4) focuses on access, within the section access can be recognised as both a tangible and intangible aspect of maternal health care. Specific to my research paper, “tangible” factors refer to the physical building and means of transportation used to access maternal facilities. “Intangible” factors refer to the delivery of health care services by skilled medical professionals. Introducing these aspects of maternal health care will assist in gaining a better understanding of the complex factors that influence pregnant women’s experiences.

Waiting has been observed to be a dominant feature of basic service delivery, therefore section three (chapter 4) focuses on the waiting that takes place outside and within the facilities. The waiting that happens before and during the antenatal clinics highlights a constraint of access to quality care from public facilities. Following the examination of these two aspects of maternal health care, section four (chapter 4) focuses deeply on the experiences of the patients who utilize these public services. Experience is a multifaceted concept that encompasses a wide range of emotions and perceptions (Paulsen, 2020). This research recognizes that pregnant women may have both positive and negative experiences when accessing maternal health care services. Therefore, it aims to be inclusive of all types of experiences that participants may wish to share, whether it is positive or negative. By gathering a diverse range of experiences, it will provide a more comprehensive understanding of the challenges and barriers faced by pregnant women accessing maternal health care in the Cape Town Metropole Region.

Lastly, sections five (chapter 4) focuses on the experiences of the medical professionals who deliver these services to the public. It is important to include their experiences, to gain a better understanding as to why their delivery of services is brought into question and why the services they deliver are seen as poor quality of care.

Based on this analysis of the responses, the conclusion drawn from the research will indicate why access to quality public maternal health care services remains a challenge from the experiences of both patients and medical staff.

2. Literature Review

2.1 Introduction

First, in order to understand how pregnant women, interact with the public healthcare system, it is important to situate the study within the context of how maternal public health is being written about. The World Health Organisation (WHO) recognises that “99% of all maternal deaths occur in developing countries, of which Sub-Saharan Africa accounts for nearly 85%” (World Health Organisation Africa, 2021). South Africa does not only experience unequal access to maternal health care but many countries that form part of the Sub-Saharan Africa which includes: Ethiopia, Cameroon, Madagascar, Uganda, Zambia and Zimbabwe (Alam et al., 2015). WHO notes that Sub-Saharan Africa does account for a higher percentage of maternal deaths; however, as identified by Silal (2012) these are the “traditional” measure in which development of the health care system was monitored, and there is a great emphasis on the unequal access to maternal health care services. Therefore, as medical professionals become the focus of access to maternal health services, it is important to understand the current barriers faced within the system from both patients and medical staff.

As waiting is a common experience for many individuals seeking care within the public healthcare system, the second body of literature draws on concepts of waiting that have come to permeate studies of state-citizen relations. This can be especially true for pregnant women, who may encounter multiple stages of waiting during each clinic visit and may spend an extended period of time waiting at these facilities. Understanding waiting and its impact on the patient experience is an important aspect of understanding how individuals experience care within the public healthcare system. Jeffrey (2008) draws on Henri Lefebvre's (2002) notion and notes that ‘waiting’ is a prominent feature of modern everyday life’. Majority of the population that does access public health care facilities - waiting time has been identified as a problem to accessing health care services in South Africa and internationally (Mokgoko, 2014). Jeffrey (2008) also draws on the notion of ‘chronic waiting’ – many citizens who are marginalized and make use of the public health care system – remain on the systems databases for a long period of time. Literature on waiting is important as it further highlights the inequality of women’s access to public health care services.

The third body of literature connects the maternal health system with waiting as an embodied experience. When the need to access maternal health care services arises, there is a dominant feature of waiting: the bodily waiting for the arrival of the baby and the physical waiting outside and within these health care facilities. It is therefore crucial to understand that pregnancy is an embodied experience and during pregnancy, there are moments of

waiting. Waiting is something which both the body and mind experience during these 9 months. Much of the literature on waiting highlights how waiting on state services is as much embodied as a political issue.

2.2 Maternal Health Care

2.2.1The history of maternal health care and how the importance of maternal health care emerged

In order to understand why access to quality health care is important, it is significant to understand what the issue pertaining to maternal health was and what led it become a global concern. During the late 20th century, maternal health drew global attention and was classified as a public health issue. In 2000, leaders from 189 countries came together at the United Nations (UN) in New York and signed the Millennium Declaration, agreeing to achieve 8 goals known has the United Nations Millennium Development Goals (MDGs) (Millennium Development Goals, 2014). The MDGs, as agreed by the UN members, aimed to “eradicated extreme poverty and hunger, provide universal primary education, promote gender equality, reduce child morality, improve maternal health, combat diseases such as HIV/AIDs and malaria, ensure environmental sustainability, and develop a global partnership for development” (Millennium Development Goals, 2014).

In 1987, the ‘Safe Motherhood Initiative’ was announced and it contributed to the global interest in maternal health. In 1994, women’s rights to “safe pregnancy and childbirth were recognized at the United Nations International Conference on Population and Development, and it was then formally adopted within its programme of action” (Maclean, 1994). Maclean (1994) also goes on to state that “Safe Motherhood Initiative strived to reduce maternal morbidity and mortality by 50% by the year 2000” (Maclean, 1994). However, the goal of the initiative was not achieved by its agreed timeframe, but it did however contribute to the introduction of more implementable interventions and policies found today. Following the failure of the achievement of reducing maternal morbidity and mortality through the initiative, much attention globally was given to the introduction of the MDGs to improve women's reproductive health issues. The MDG 5 had 2 targets, *specifically “reducing the maternal mortality ratio (MMR) by 75% by 2015 (Target 5A) and achieving universal access to reproductive health” (Target 5B).* This goal and its targets are important because it has contributed to the fundamental goal of reducing maternal deaths through the Sub-Saharan Africa (Kyei-Nimakoh et al., 2016).

Following the MDGs, was the introduction of the *Sustainable Development Goals (SDGs)* or also known as the *Global Goals*, which exists as “a universal plan for all countries to end poverty, protect the planet and ensure prosperity for all” (Introduction to the sustainable

development goals, 2002). The Introduction of these global goals (2002) lists a “set of 17 goals which includes 169 targets, and it was agreed upon in 2015, that the SDGs set the global development agenda until 2030” (Introduction to the sustainable development goals, 2002). Although the MDGs improved many lives and livelihoods of people, there were many people who were “left behind” due to the challenges which made countries and people particularly marginalized and vulnerable faced such as “weak governance structures, history of conflict to being landlocked and susceptibility to climate shocks” (Introduction to the sustainable development goals, 2002). The major difference between the MDGs and SDGs was the principles which led to the changes needed to achieve the global goal of “reducing poverty, protecting the planet, and ensuring prosperity for all” (Introduction to the sustainable development goals, 2002).

In alignment to this research study, is the SDG 3; which focuses on good health and well-being. The goal targets relate specifically to pregnant women and their health care and aim by 2030, “to reduce the global maternal mortality ratio to less than 70 per 100 000 live births and by 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1 000 live births and under -5 mortality to at least as low as 25 per 1 000 live births” (The SDGs in Action, 2021).

In South Africa, the investment into women’s maternal health grew post-1994 as there were many inequalities associated with political rights, social rights, economic rights and even rights related to health during apartheid. Since the democratic transition, the main goal of the South African government, specifically with regards to women’s access to maternal health care is to become more inclusive in providing health care to all people of colour because during the Apartheid era the health needs of poor women of colour were neglected (Cooper et al., 2004). As women globally and mostly in Sub-Saharan Africa continue to die from preventable diseases during pregnancy, it remains a top priority to improve women’s maternal health care and the SDGs offer an opportunity to leverage commitments.

2.2.2 Why maternal health care matters

Identifying that there is a global concern, in order to better understanding this concern, it is significant to highlight why maternal health care is of the utmost important to all women; as well as their unborn child. WHO refers to maternal health as “the health of women during pregnancy, childbirth and the postnatal period” (Maternal Health WHO, 2022). To ensure that a newborn is born healthy, the health needs of the mother should always be taken into consideration and made a priority. In the 1990’s, a study was conducted in Peru that indicated that educating women on primary health care would increase their awareness of

preventive maternal health care services and it would improve the survival of their children (Elo, 1992).

Based on the maternal mortality statistics from 2000 to 2017, there has been a decrease in the number of deaths by 38% - from 342 deaths to 211 deaths per 100 000 lives globally. Maternal mortality refers to *deaths which occur due to complications from pregnancy and childbirth* (WHO, Maternal Mortality 2000 to 2017, 2021). This is similar to a reduction of 2.9% of the average annual rate. This rate of reduction is "less than half of the 6.4% annual rate which is needed to achieve the Sustainable Development global goal of 70 maternal deaths per 100 000 live births" (WHO, Maternal Mortality 2000 to 2017, 2021). Based on the *Trends in Maternal Mortality: 2000 – 2017,* the number of maternal deaths in sub-Saharan Africa and South Asia still remains the highest globally, compared to the statistics of Eastern Europe and Central Asia, Europe and Central Asia, North America, and Western Europe. It is evident that there are inequalities found across regions and those most identified between the richest and poorest countries (WHO, Maternal Mortality 2000 to 2017, 2021). In most cases, causes of maternal death are preventable if women seek and get the proper health care treatment. The leading causes which contribute to the maternal death rate include: *haemorrhage (27%), hypertension (14%), sepsis (11%), other direct (10%), indirect (28%), abortion (8%) and embolism (3%)* (Maternal Health WHO, 2021).

It is important for women to seek and register for maternal health care as soon as they find out they are expecting in order to prevent deaths or health-related issues for mother and child. Maternal deaths can be caused by pre-existing medical conditions which may or may not become worse during pregnancy. Complications may occur at any point in time during pregnancy and childbirth. These complications can be avoided if births and the ongoing health of women are attended by skilled health personnel, who can be either doctors, nurses, or midwives. When complications arise within the duration of the pregnancy or childbirth, there is a need which requires "prompt access to quality obstetric services that are equipped with life-saving drugs, including antibiotics, and the ability to provide blood transfusions needed to perform c-sections and other surgical interventions" (Maternal Health WHO, 2021).

2.2.3 Understanding what 'access' to health means and it's challenges

It has been highlighted in the previous sections that maternal health care and access to maternal health care should be a priority goal that needs to be addresses. However, before the challenges of accessing maternal care is elaborated on it is important to understand what access means and entails. Access to healthcare refers to having an equal opportunity to use healthcare (Bettercare, 2012). Understanding the term access, the term can be

further understood and categorised in terms of *affordability, availability and acceptability* (Bettercare, 2012). Affordability refers to “how much someone has to spend in order to utilise the health care services available” (Bettercare, 2012), and based on the cost of the services needed to establish whether or not the cost of this service will impact the rest of the household’s daily needs. Affordability also refers to and is inclusive of all costs involved when seeking medical healthcare services, which includes; the cost of travelling, the loss of income as a result of seeking healthcare and the cost of service for someone looking after dependents while visiting the health facility (Bettercare, 2012). In terms of availability, this refers to how close the services are, the stipulation of appropriate opening hours, employment of knowledgeable and skillful staff, allocation of equipment that is working and access to drugs and disposable medical goods (Bettercare, 2012). Lastly, acceptability refers to “the relationship between the expectations and values of the patient that is seeking medical help, the facility that is being visited and the healthcare professional that is rendering the health care services to the patients” (Bettercare, 2012).

Access to health care can be interpreted differently by different people. The challenges that women encounter impacts and contributes to the perception of their access to a health care system which is promised by the government, who is meant to be well functioning and aligned to global health standards.

As the world is making progress to ensure that women’s access to maternal health care services is easily available, there remain many barriers that most Sub-Saharan African countries face. Barriers such as “cost, access, infrastructure, quality and sustainability of care, information deficit and attitudes” (Africa Progress Panel, 2010).

With regards to cost, with the global concern to reduce the maternal mortality rate “some countries have made efforts to reduce or eliminate user fees for health services for women who access maternal health care facilities” (Africa Progress Panel, 2010). Public health care services in South Africa are dependent on funding and the government contributes to 50% of the country’s health expenditures and the other 50% is generated through the tax that citizens pay.

Based on the Health Budget Brief South Africa (2019), financial budgets prior to COVID-19 indicate that the government has been investing billions into the healthcare system. Key policy making coordination and delegation in South Africa are implemented by the National Department of Health (NDoH) ((National Health Act 2003). To ensure that the Department of Health meets its requirements and builds a uniform health system for the country, it takes approval from the National Health Act (2003). Apart from the National Health Act, “other legislation and emerging policies guide the work of the health care sector” (National Health

Act, 2003". Legislation related to the study of the NDoH includes "free health care for pregnant women and children under the age of six years" (National Health Act 2003).

According to key financial indicators of the health system (Health Budget Brief South Africa, 2019: 4-8), the government funds key intervention towards: HIV/AIDS, TB, and Maternal and Child programmes ((Health Budget Brief South Africa, 2019). In 2014/2015 the government spent a total of R12.8 billion on HIV/AIDS, TB, and Maternal and Child Health compared to 2020/2021 in which the government estimated to spend a total of R25.3 billion on this programme. Professional health care still remains unaffordable for many women in the Global South, and more specifically women in Sub-Saharan Africa. Surveys which have been conducted in West Africa found that more than half of the women listed cost as the reason for not seeking healthcare during their pregnancy (Africa Progress Panel, 2010).

The costs involved during pregnancy are both direct and indirect. Direct costs include fees associated with the use of facilities and their services and indirect costs refer to the cost of transportation to and from the facilities and the loss of wages if work is missed in order to attend clinic visits. The treatment for women with complications is often more expensive. Cost is only one of the many challenges which women face when trying to access the services they require during the course of a pregnancy.

The second biggest challenge which women face is the inability to access *quality* maternal healthcare services. Africa, which accounts for nearly 85% of global maternal deaths, battles a major health-worker problem; on average for every 10 000 people there is only access to 13.8 qualified nurses and midwives (African Progress Panel, 2010: 8). Due to the lack of human resources, the care which women need in cases of any complications is always not available. A study completed in Malawi indicated that,13% of the clinics had medical personnel working 24 hours shifts and this may become unsafe when dealing with patients and more seriously complex when there is a need to handle a patient with childbirth complications or neonatal emergencies at night. The limited access to quality maternal healthcare services is further complicated by the uneven distribution of trained and skilled medical personnel in rural areas where there are fewer trained and skilled workers than in urban areas. In South Africa, rural areas make up 46% of the population and for this population size, there are only 12% of the doctors and 19% of nurses available. This barrier further contributes to women not seeking and limiting access to healthcare which is needed to avoid preventable deaths of pregnancy and childbirth (African Progress Panel, 2010).

Related to the inability to access quality maternal health care services is the lack of infrastructure. In rural areas, the issue is poor roads and transportation. Clinics are not situated in close proximity, and this results in the inaccessibility to receive the required care

during the time of pregnancy. The inability to access these maternal health care facilities in time in cases of emergency can be severely dangerous for women who suffer from obstetric complications, and delays in accessing maternity clinics or hospitals can result in long-term or permanent consequences for both the mother and the unborn child. In South Africa, the hospital system operates according to a tier system and this means patients are located at public facilities according to their level of health risk, which contributes to inequitable access to health care services (Health Financing Profile, 2016).

Based on the arrangement of levels of the facilities in South Africa, the lowest level is primary health facilities (these include Maternity Obstetric Units) (MOUs), “followed by level one hospitals and then tertiary hospitals” (Horner & Mashamba, 2014). The function of an MOU is to provide antenatal care and assist with low-risk deliveries. MOUs is a link within the health care system, “and one of their main functions is the identification and referral of high-risk patients” (Horner & Mashamba, 2014). The establishment of MOUs in Cape Town dates back to the 1970s. With the growing population, the demand for the management of human reproduction in Cape Town was increasing. This led to the form of current hospital obstetric services and an alternative delivery solution was urgently needed. In January 1973, the first MOU was established adjacent to the Lotus River Day Hospital (Van Coeverden De Groot et al., 1978:706). MOUs were accommodated in existing day hospitals and their main functions were to provide comprehensive obstetric care in the communities in which they were based, educate medical and nursing staff, provide relief to teaching hospital workload and create career opportunities for midwives (Van Coeverden De Groot et al., 1978:706-708).

Based on the City of Cape Town 2017 Socio-Economic Profile, “Cape Town’s population is expected to grow rapidly across the next 5 years growing from 4 055 580 in 2018 to 4 232 276 in 2023” (Chakwizira, 2022). Focusing on maternal health, the delivery rate of women under the age of 18 years is increasing from 4.8% in 2015 to 5.0% in 2016. Taking into consideration the increase in the population and births there is a high demand for the 11 MOUs situated within Cape Town and its resources. The high demands that these MOUs experience may contribute to the waiting time.

Studies conducted on maternal health care services have shown a lack of data on the quality and sustainability of these health care services. It is important to improve the treatment of health care that pregnant women receive in both urban and rural areas, but more importantly, it is necessary for attention to be paid to the type of care which is actually provided to pregnant women during antenatal, childbirth and postnatal interactions with the maternal public health care facilities. The most important aspects of the quality of care are its

sustainability, this means that once systems have been improved and staff have been developed they can carry on providing the services that they need without much support from the government. With the global goal of the support of the SDGs to improve maternal health care, there have been improvements to access and coverage, and this has all been possible through the interventions of international donors and NGOs. However, in order to achieve positive health outcomes, once international donors and NGOs are no longer present, health care facilities need to ensure the development of a sustainable health system capacity.

There are many factors which contribute to women and unborn children not receiving the proper health care required to prevent preventable deaths and/or long-term consequences of pregnancy which are explored as part of this research. As seen through the literature, women's access to good maternal healthcare is important. Improving women's access to quality maternal health care increases the global standard of healthcare and its service delivery. Accessing quality health care is costly and many women cannot afford these costs during their time of pregnancy. Highlighted in this section, it can be seen that in order to access quality maternal healthcare services there are many challenges which women have to face. There is also the burden that state facilities have to endure to provide the services which cater to the majority of the population who needs the services which they can only access at no cost due to their economic status. It has become evident that not only are these services under-resourced, costly, and difficult to access at times when women are entering the maternal health system, pregnant women spend a lot of time waiting.

2.3 'Patient'ly waiting on basic service delivery

2.3.1 Access to maternal health care before and during the Apartheid era

Understanding the shortfalls of maternal health in South Africa today requires reflecting on the unequal systems established prior to and during apartheid. Prior to Apartheid (1948 – 1994) the history of nursing has played a role in the shaping of healthcare service delivery in South Africa (Abrahams et.al, 2001). Further exploring the history of nursing in South Africa, Marks argues that even through nursing, racial segregation had already stemmed through the system (Marks, 1994). The "ideal" persons within this profession were based on their race and their socio-economic status, this alluding that the ideal person within this role had to be white and from middle class. As noted by Abrahams (2001), prior 1994 before the government restricted their approach to "Healthcare for all" the training of nurses was systematic and discriminative. Despite the need to address the lack of resources that required in terms of nursing the training had strict measures in place from 1968 to 1986 (Abrahams, 2001: 241). Considering the strict racial segregation policies set in place the

training required by nurses and midwives were more applicable to women that were white and of a middle class, who was able to meet the requirements of being accepted within these strict training programmes as implemented by the government at the time. Introducing the Apartheid system, not only created racial segregation but contributed to a system through which a limited resource of healthcare was further exacerbated, and this became apparent through the allocation of access to healthcare facilities and resources that were unequally distributed and classified by racial groups (Baker, 2010: 79-80). During Apartheid, many women of colour had to find alternative methods to ensure the health of themselves and their unborn children; especially women who were located in rural areas which made access to maternal health care facilities challenging.

The racial systematic division further contributed to the quality of services received by patients. Due to the lack of resources, both financial and human resources; poor communities were most affected by this system of division (Chassin & Loeb 2013: 462). The poor quality of services which patients receive from state facilities impacts the perceptions in a negative manner (Ramani, 2004:208 and Mostafa, 2005: 516).

According to a study conducted by Warri and George (2020), there are a number of reasons women still register for and attend antenatal visits late in their pregnancy or only visit a medical facility when they are in labour. Women recognise pregnancy as a natural part of life and the only time when a healthcare facility should be accessed is when she is feeling unwell or observes any complication related to the pregnancy. Women are often still not receiving the correct information regarding the ideal time for registering their pregnancy at the local facilities in order to receive treatment and this information is received from family members or from inadequate health education (Warri and George, 2020:5). Other factors influencing women's decision to attend antenatal visits later in their pregnancy include the high cost - women delay the initiation of antenatal care in order to save money for the cost involved over the entire pregnancy - and pregnancy disclosure - women delay the announcement of their pregnancy publicly, especially if there is no spousal support and in cases of teenage pregnancy - and the negative reaction of society and their parents (Warri and George, 2020:7-8).

2.3.2 Access to maternal health care post-Apartheid

Post-apartheid, although women were encouraged to adopt new and improved maternal health decision-making, many women today still revert to following their own intuition and agency regarding their health and pregnancy. There have been numerous measures of development put in place to improve the quality of healthcare service delivery for both public and private patients of the state and to increase the basic standard of care and patient

expectations (National Department of Health 2012:4). However, there remains an inequality in the service delivery which patients receive from the government healthcare facilities. The inequality of public health care services is exacerbated by long waiting times, as a result of a shortage of medical staff, problems in the facilities such as poor hygiene and infection control from preventable mistakes, insufficient medical supplies and equipment, and inadequate record-keeping (Maphumulo & Bhengu, 2019:2-3).

According to the National Department of Health (2015) in South Africa, the expected time women are meant to spend is two hours during their antenatal clinic visits. However, this seems not to be the case as women wait more than 2 hours waiting within a primary care facility and this is viewed as Long Waiting Time (LWT) (Baron & Kaura, 2021:2). Other studies have been conducted on long waiting times within the antenatal clinics in the Global South and these indicated that in Nigeria, the average time was 3.8 hours and ranged from 1 to 7 hours (Nwaeze et.al 2013:25 in Baron & Kaura, 2021).

Research into the delivery of healthcare services within maternal facilities has been conducted to determine the factors that increase the delay women experience receiving adequate services during their time of pregnancy. Studies conducted in the Western Cape identified the following factors contributing to the long waiting time women experience when using antenatal clinics, these include: “staff factors, patient factors, operational functioning, communication, equipment and infrastructure” (Baron & Kaura, 2021).

Adequate, knowledgeable and skilled staff is a key factor in ensuring quality care is delivered within maternal facilities. Primary care facilities and Midwife Obstetric Units (MOUs) are “staffed with midwives, human immunodeficiency virus (HIV) counsellors and nurses” (Baron & Kaura, 2021). Contributing to the long waiting time is the amount of administrative work by medical staff during their time of training. During this time midwives and nurses are also facilitating medical students. Doctors attend to high-risk patients or in the case of severe emergencies patients are transferred to secondary care facilities. Doctors are not stationed at maternity wards and operate between the hospital and the wards; delays are experienced when doctors are needed at the hospitals during the time meant for them to provide their services at the local clinics. Staff attitudes and behaviour impact the extended clinic visits. There is no regulation of time management and pregnant women complaining of the medical staff often results in patients being treated badly (Baron & Kaura,2021:4). The number of patients attending antenatal clinic visits is not always the same: some days clinics will attend to a large number of patients, both first time attendees and regular attendees, and other days clinics will receive few patients visiting or attending their appointments. Women who are currently registered at the clinic often receive appointment dates prior to their visits and

will be attended to on the day of their appointment. However, women who are registering their pregnancy for the first time may be asked to return on another date depending on the capacity that the clinic receives for the day and is able to assist with the number of resources available (Baron & Kaura,2021:5).

Women who attend antenatal clinics for the first time require more activities to be completed compared to a woman who is visiting the clinic for a follow-up. These activities will include opening a medical record folder, blood test, physical examination and confirmation of pregnancy. During the first visit, women can be overwhelmed by the processes and the flow of processes within the clinic and become despondent by the amount of time it takes to wait to access the clinic and the amount of time used before seeing a medical staff member (Baron & Kaura,2021:5).

In a country as diverse as South Africa, communication is a big challenge which is faced on a daily basis. Local MOUs serve the majority of the population that stems from the middle-to-low-income communities, of which 88% is Xhosa speaking (Statistics South Africa 2020). The lack of communication results in women feeling lost, overwhelmed and confused, and this results in patients waiting until they can be attended to by someone who is able to understand them (Baron & Kaura, 2021:6). Lastly, the equipment and infrastructure of the clinics are not always up to standard, and a lack of certain equipment results in long waiting times. The size and capacity of the antenatal clinics also determine the number of patients a clinic is to assist and attend to at a time to not overburden the current resources being used (Baron & Kaura,2021:7).

As seen in the literature, the usage of government healthcare services comes at the cost of time and waiting, waiting in lines and waiting to see the midwife or nurse. As a citizen in need of this service which cannot be obtained privately, there is very little choice but to wait and endure the time needed in order to receive the services needed for treatment. There is a need for improvement from the past, as the past has contributed to unequal experiences. There is a much greater need for improvement in the governing of the current system used to attend to patients and to decrease the amount of time used to deliver essential healthcare services.

2.3.3 Impacts of waiting on vulnerability experienced in pregnancy

The injustices of the past and the lack of the challenges being addressed in the present has a direct impact and continues to contribute to women experience waiting. Given the history of South Africa, the lasting effort of Apartheid is still evident in the waiting times that patients experience when accessing public healthcare services. This is directly related to the uneven

distribution of resources and lack of staff as identified by Baker (2010), Maphumulo & Bhengu (2019) and Baron & Kaura (2021).

In waiting, there are certain unexpected and uncontrollable anxieties which arise, with vulnerability being an overwhelming emotion. According to Veno et.al (2021: 2) vulnerability in pregnancy can be defined as “psychosocial problems (i.e. history of anxiety or depression before or during the pregnancy) or social problems (i.e. young age, lack of social support, being single, unemployed, low education level, history of adverse childhood experiences, poor socioeconomic status, stressful life events during pregnancy, or a history of domestic violence or abuse)” (Veno et al, 2021: 2).

Iris Marion Young highlights the temporalities of pregnant embodiments and identifies pregnancy is a time of “waiting and watching” (Young 1984). Young further describes pregnancy for the pregnant woman as:

> *a temporality of movement, growth, and change [...] The pregnant woman experiences herself as a source and participant in a creative process. Though she does not plan or direct it, neither does it merely wash over her; rather, she is this process, this change. Time stretches out, and moments and days take on a depth because she experiences more changes in herself and her body. Each day, each week, she looks at herself for signs of transformation” (Young 1984 as cited in Rye et.al, 2018).*

According to medical practitioners, there are various indicators through which vulnerability in pregnancy can be monitored and this can be organized into three categories, namely: “social determinants of health, psychiatric diseases and somatic diseases” (Veno et al, 2021:4). Social determinants of health within the social system refer to factors such as the “history of being neglected during childhood, history of children being forcibly removed or known low intellectual or mental resources” (Veno et.al 2021:4). Other social factors refer to the socioeconomic status, being a single parent and poorly integrated women with an ethnic background (Veno et.al 2021:4). Psychiatric diseases refer to known psychiatric disorders such as depression, anxiety, schizophrenia, alcohol abuse, drugs or addictive medication. Lastly, somatic diseases refer to the history of severe obstetric conditions or chronic somatic comorbidity due to the risk of complicating the pregnancy (Veno et.al 2021:5).

During pregnancy, there is a major shift not only in a woman’s body but in her mental and emotional state. As a woman prepares her body to inhabit another human, her mind changes consciously and sometimes unconsciously for the process to take place as naturally as it should throughout the pregnancy. Through Raphael-Leff’s (1993) analysis of pregnancy, this research further explores why women become vulnerable through

pregnancy. Pregnancy is a disconnection of a woman and her body, as she is no longer the only user of her body (Raphael-Leff, 1993:16). The continuity of self is disrupted by the internal distractions and to further add to the disruptions there is a sense of formlessness with the due date being a form of structure (Raphael-Leff, 1993:17).

During pregnancy, a woman not only has to consider the physical and emotional changes that will take place in her body but also the external factors of her environment which changes daily, factors such as the waiting to receive treatment at public health care facilities or the attitudes of the medical staff of the healthcare facilities. All these factors contribute to the feeling of vulnerability in a time in which the woman and her unborn child are most vulnerable and at a time unable to control certain aspects of the pregnancy.

In the next chapter, we will explore more deeply the embodiment of pregnancy and what it entails in terms of women and their encounters with the delivery of public health care services.

2.4 Embodiment

2.4.1 Pregnancy as an embodied experience

Access to quality maternal health care is an embodied experience because maternal health consists of various factors that is connected to a woman's body and her reproductive health. The embodied experience of maternal health is impacted by various challenges and these experiences of the challenges influences the women's perspective of maternal health care services. These perspectives can be positive and empowering experiences or it can be negative and traumatic experiences. It is therefore important to understand the complexity of the embodied nature of maternal health in order to improve access to quality maternal health care.

Csordas (1999: 143) in Ribbens-Kleinchapter (2017) defines embodiment as an '*existential condition in which the body is the subjective source or intersubjective ground of experience'*. To further build on the definition provided by Csordas (1999) embodiment does not specifically relate to the physical body but focuses on culture and experience and how these can be understood from the point of the bodily being in the world. Embodiment can be further understood according to; the physical body: the body as a source of perception; and as the source of agency, practice, feeling, custom, the exercise of skills and performance (Strathern & Stewart, 2011: 389).

Many studies conducted with pregnant women have indicated that during pregnancy, women become more aware of their bodies, how their bodies are changing and how society changes around them as their pregnancy and pregnant bodies become more visible over the

nine months. As noted by McClean and Mitchell (2018) women can become more aware of their femininity, as well as their feelings of well-being and bodily pride (McClean and Mitchell 2018:2).

Research by Lucy Bailey (1999) on the embodiment of pregnancy reveals that pregnant women experienced changes in their sexuality, finding that as their bodies on showing and taking on a maternal role become less considered as an object of sexual desire. Similarly, to what has been identified by McClean and Mitchell (2018), women become less concerned with their physical body shape and become accepting of their changing and growing pregnant bodies. During this process of women and their bodies changing Bailey further explores women's self-identity. The changes which women experience are not a true reflection of their self-identity, and women, therefore, do not link their bodies to their identity to not feel total rejection from certain social roles (Bailey 2001).

The physical changes of a pregnant woman's body are one aspect of pregnancy embodiment, the other aspect includes the changes which are not visible to the naked eye. Iris Young (1984) is one of the few researchers who focuses on the sociological analysis of the embodiment of pregnancy. Taken from a research participant's experience, Young (1984: 48) describes this invisible experience of pregnancy as the following:

> *As my pregnancy begins, I experience it as a change in my body, I become different from what I have been. My nipples become reddened and tender, my belly swells into a pear. I feel this elastic around my waist, itching, this round, hard middle replacing the doughy belly with which I still identify. Then I feel a little tickle, a little gurgle in my belly, it is my feeling, my insides, and it feels somewhat like a gas bubble, but it is not, it is different, in another place, belonging to another, another that is nevertheless my body.*

Through this analysis Young highlights that the embodied experience of pregnancy and the ways in which a woman's body changes has become different from what has been previously identified by researchers. Furthermore, highlighting as sociological approaches are used, there is a better understand that women experiences are complex during there time of pregnancy.

During pregnancy, there are major transitions which take place all the time, from the physical body and mind. Research over the years has shown that researchers mainly focus on physiological experiences and neglect to focus on sociological experiences.

2.4.2 Women with the public health care system

As identified in the previous sections due to the numerous challenges which women face within the public health system, some women are moving away from accessing health care facilities and opting to do home-attended birth deliveries and alternatively registering late to health care facilities and only making use of these facilities when complications are experienced during the birthing process. The health care facilities and the treatment that women receive when pregnant play a vital role in their perception of access to maternal health care services. As stated by Girma et.al (2018) an individual's perception is an accumulation of experiences, expectations and perceived needs. In developing countries, the perception of individuals attending public health care facilities is often ignored or lightly taken into consideration and not valued. To improve the quality of maternal care, and for maternity morbidity and mortality to decrease; as well as to improve the overall health of the mother it is important to pay attention to the perception of the individual attending the health care facilities.

Previous research has shown the number of reasons why women register late to antenatal care or do not attend any antenatal care visits during their pregnancy which include “cultural norms, gender discrimination and lack of a right-based approach, inadequate knowledge of signs and symptoms of illness and services available, costs of services, lack of transportation options and poor quality of care” (Mannava et.al, 2015:2), however, the top factor which researchers are currently exploring is the quality of care. The reason for researchers conducting these studies is that previous research has found that improving the quality of care provided by health care workers can significantly decrease the rates of maternal mortality and morbidity (Mannava et.al, 2015:2).

As attention is drawn towards improving quality care, what does quality care mean? Quality care universally does not have a standard meaning but it is a concept that many researchers have attempted to define. Graham et al (2013) notes that quality of care should include the following: “clinical effectiveness, safety, and a good experience” for the patient (Graham et.al, 2013). In terms of facility-based maternal health services, Hulton defines quality care as “effectiveness, timeliness, as well as the upholding of basic reproductive rights” (Hulton et.al, 2000). In essence, quality can be broken into two components; the first is the quality through the provision of care in terms of the service and the system and the second is the care which is experienced by the patients who encounter the services.

Patients who encounter poor services and treatment will suggest that the quality of care is poor and vice versa, patients who encounter excellent services will suggest that the quality of care is of a good standard. Quality of care does play a vital role in improving maternal

health care and the services associated with maternal health care and it also influences the attitudes and behaviours of the patients as well as the health care workers who are responsible for the delivery of services within health care facilities (Mannava et.al, 2015).

2.4.3 Embodiment of public service through staff

From the perspective of the patients, there are many factors which hinder them from accessing proper maternal health care and these factors influence their perception of the quality of care which they receive. However, health care workers also experience challenges which influence the quality of care they can provide to their patients. Health care workers play a vital role in the delivery of adequate health care services. In essence, they serve as representatives of the state and the services which the states provide to patients who are unable to access private healthcare services.

The reasons why health care workers are unable to provide quality services and care include the following: health facilities are not prepared and lack readiness in terms of adequate access to treatment, drugs and medical equipment: the shortage of staff especially within rural areas; health workers are not adequately trained and are subject to inconsistent supervision; and health care workers often "work in isolated settings and is insufficiently supported for the tasks they have to perform" (Baker et.al, 2017).

From all the factors which have been identified as reasons why maternal health care workers are unable to provide quality services and care, the biggest factor which hinders maternal health is the shortage of staff which is a major concern and challenge that many developing countries experience. Gerein et.al (2006) identify two key players in the shortage of maternal health care workers in sub-Saharan Africa: one being HIV/AIDS and the other the issue of emigration. In African countries, HIV/AIDS rates in adults are among the highest and more recently the number of emigrations is increasing in countries such as Malawi, Nigeria, Swaziland, Zambia and Zimbabwe (Gerein et.al, 2006:42). These results in increased workload for staff working within facilities, increased waiting times which contributes to reduced good patient satisfaction, reduced time for the patient as the staff is unable to monitor patients closely to provide a correct diagnosis, and poorer infection control (Gerein et.al, 2006: 45-46).

2.5 Conclusion

Access to quality maternal health care is important in order to reduce the number of maternal deaths that is currently higher within sub-Saharan Africa to align to the global health standards and goals set out to be achieved by 2030. Through the literature is can be seen that for South Africa, access to quality maternal health care does not only mean that the country is working towards the global goals of the reduction in maternal deaths but rather

that the government is attempting to rectify the injustices of the past that had been created prior and during the Apartheid era, which led to the current “flawed” delivery of healthcare services being received by patients; who are reliant on the free health care services delivered by the State. However, there are still two major challenges, which has been highlighted and this includes the “waiting” of basic services and the quality of services received. During pregnancy waiting is a vulnerable time for pregnant women and as a guidance rely on the medical personnel, as support during this important time of their pregnancy journey.

What has become evident in the preliminary review of existing literature is that there are challenges that both the pregnant women and medical personnel face, this however does not address or relate to the experiences of the both pregnant women and medical staff who are utilizing and are situated within the public sector. For pregnant women these includes barriers which prevents them from receiving quality maternal health care and for the medical personal these include barriers which prevents them from delivering quality maternal health care services. This research study will further explore that challenges that has already been highlighted in the literature review through qualitative methods from the perspective of both pregnant women and medical staff within the maternal healthcare sector.

3 Research design and methodology

3.1 Qualitative research in the pursuit of quality health care

As shown in the literature, there is a gap in understanding the rich and varied perceptions of women within the maternal health system. This research, therefore, utilised a qualitative approach to gain a better understanding as to why public facilities are seen as inaccessible and to better understand how the current health care system can be improved to aligned to the SDGs. According to Denzin (2011) qualitative research is a form of research that rely on the use and collection of information from real-life experiences. These experiences may be shared through case studies, personal accounts, interviews, and cultural products. The result of these experiences shared in research aids to better understand the daily experiences and meaningful events in people's lives (Denzin et.al, 2011: 43).

To gain a better understanding of the research subject, qualitative researchers may apply a variety of interconnected interpretive practices. Each interpretive practice which is used within research shapes the world and the meaning which that the research subjects apply in different ways (Denzin et.al, 2011:43). A qualitative research approach is *descriptive, interpretive, subjective, and inductive* in nature (Steinberg et.al, 2010:18).

Accordign to Steinberg (2010) qualitative research aids the researcher to gain insight of complex textual descriptions of how people experience a given research issue. Compared to quantitative research, the use of the qualitative method allows more flexibility within the research which allows for greater freedom and change of the interaction between the research and the participant (Mack et al, 2005:4). Specific to this study, the utilisation of a qualitative research method enabled the identification of the relationship between pregnant women and their access to public maternal health care and how the challenges they encounter during their visit to maternal health care facilities.

The benefits of qualitative research are that it allows the participant/s to respond to questions in their own words. It has the ability to evoke responses that are *meaningful* and *culturally* relevant to the participant, responses that are unanticipated by the research and rich and explanatory in nature (Mack at.al, 2005:4). Qualitative research approaches provide the ability for the researcher "*open*" and build on the initial response given by the participant (Mack et.al, 2005:4).

3.2 Qualitative research and Covid-19

Prior to COVID, the envisioned method of collecting data was to visit local maternal clinics, asking women if they would be interested in participating in the research study. It also included recruiting staff members and being able to take images of the facilities and what

was being observed every time a visit to the clinic would be made. Over the course of the three months of data collection, the women would share their experiences after visiting the clinics and respond to any additional questions posed for further information needed for the research study. Pregnancy is a vulnerable time for women in which they experience a lot of emotions and changes. Due to the vulnerable that the women are in; the research was conducted over the course of the 3 months was to build a relationship with the research participants and to be part of their pregnancy journey.

Due to COVID-19 and government lockdown regulations at the time, a standardised approach to data collection could not be used within this research study. As the researcher, I was not able to recruit women or staff directly from the local clinics, and I was unable to capture moments of waiting and how waiting looked within the maternal health care facilities. The next step in my research was evaluating the best way to collect data, during the pandemic which would not compromise my health or the health of my research participants.

To start the research process, the first participant included in my study was a family member who was currently attending a local maternal clinic. With the restricted access to clinics and research participants, I applied a snowball sampling method. Snowball sampling or also known as chain referral sampling is a form of purposive sampling. In this method, the existing relationships or networks of the initial research participants are used. It is also a method in which the initial participants refer individuals who could potentially participate in or contribute to the study. Snowball sampling is used to find 'hidden populations', that is, individuals or groups that are not easily accessible to the researcher through other sampling methods (Mack et.al, 2005:5). Using this method, I was able to recruit more women as part of my research group. Additionally, I contacted women that I personally knew who had previously given birth in local clinics; to assist in recommending potential women whom they were aware of that was currently attending public clinics for their antenatal visits.

The goal was to have six pregnant women who were currently attending local maternal clinics and six staff members. Recruiting members online was not as easy as recruiting participants in person. With the restrictions of not being able to physically visit clinics and asking women to recommend another participant the number of participants in the study grew slowly. This led me as the researcher to extend my methods of recruiting participants, through social media platforms such as Whatsapp and Facebook to broaden the number of people my research study was reaching. Before the research commenced, a total of 6 women had agreed to be a participant in my study. The first, was a family member, two women through the use of social member, another a referral from a friend, and the last two women I has met during my time of attending my own visits at the clinic.

Due to not being able to visit any clinics and the limited time for the research to be collected the health care workers who were initially used as participants, I knew personally. A total of seven health care workers were asked to be part of the study and a total of five were able to participate and contribute to the study. Of the five medical staff which agreed to be part of the study, two were doctors, two were midwives and a nurse. The staff were well informed on what the research entailed. All staff members were also ensured that the facilities in which they work would not be mentioned to comprise their work, and this also allowed them as participants to share their full experience within the system.

Due to COVID and the strict guidelines stipulated in the ethical clearance received from the Ethics Committee; all data collection took place online via emails, Whatsapp messages (text and voice recording) or phone calls.

Due to COVID-19, I did not have the opportunity to meet my research participants in person. However, as a mother myself and having gone through this experience of antenatal care and childbirth via a public health care facility, I knew this could be a vulnerable yet also exciting time for these first-time mothers. For the month in which I was in conversation with the women, a relationship of support between myself and the women was built. To build this relationship, I would frequently check-in with the ladies, how their days were and how the pregnancy was going; these check-ins took place outside of the time when the interviews were conducted. Each woman was sent a newborn pack, as a token on appreciation that they were part of the study. Denzin (2011) and Steinberg (2010) describe qualitative research as a measure of personal experiences and a subjective research approach through which research participants are not observed as objects but as participants who contribute to research through various interpretative daily practices. The experiences of these women played a pivotal role in this research study. While examples of these experiences are present throughout the empirical chapters in this thesis, it is also important to give space to describe more about the women themselves. This will hopefully allow the reader a better sense of, and hopefully some semblance of familiarity with, these women – and how they wished to present themselves to me – when their experiences are described later. In this research, pseudonyms have been used to protect the participants' identities to ensure anonymity. Pseudonyms have been allocated through a random selection of names.

Patience

Patience was a 21-year-old domestic worker. She moved from Zimbabwe to Cape Town in 2018 to complete her schooling. At a young age, she lost her mother. In Cape Town, she was still supporting her grandmother in Zimbabwe, who provided for her and her brother after her mother’s passing. She described herself as a hardworking and driven individual.

Patience further described herself as an open and honest person who does not believe in misleading other people and always strives to be fair in everything she does. She said she was passionate about her work and always ensured that she completed every task to the best of her ability. As a young woman, she was passionate about learning new things and working on her personal growth. At the time of my research, Patience had spent three years in Cape Town, which had been challenging. It was challenging because as a domestic worker, her clientele was not always stable and that meant that income was not always stable. Her partner was also a driver for UberEats, and income was not always stable with a lack of tips. Since moving to Cape Town and calling it her 'new home', she had made new friends, and her future goal was to further her studies so that she could provide for her daughter, whom she was expecting.

Shenaaz

Shenaaz was 27 years old. When the research was conducted she had just been retrenched from her job and with the baby on the way, she was not looking for employment. During this time, she received financial support from her husband. Shenaaz described herself as an honest, strong-willed and creative woman. Given the pandemic's regulations, her husband could not join her for any of the clinic visits and was not permitted to be present at the time of giving birth. This was an experience that she felt "bad" about as it was their first child they would have liked to have welcomed the baby into the world together. Shenaaz was passionate about yoga and the outdoors. While preparing for the baby, she knew her ability to engage in these passions as frequently as before would change, but she hoped to continue them and enjoy them with her baby. As a couple, Shenaaz and her husband decided not to know the gender of the baby before it was born, and this was one of the exciting things they most looked forward to once their "little bundle of joy" arrived.

Tiana

Tiana was 22 years old and completing her undergraduate studies at the University of Cape Town in Social Sciences. She was born and raised in Cape Town, and at a young age, she also lost her mother. As Tiana prepared for the arrival of her daughter she wished that her mother was around to provide her comfort. Tiana's biggest passion was cooking; she enjoyed taking time out for herself and expressing herself in the kitchen. She mostly loved cooking meals for her husband and family members. During the pregnancy, her husband was also not allowed to visit or to be present at the birth of their daughter. Tiana described this as an extremely sad and frustrating time as it was their first baby, and as first-time parents, it would be a special moment they would never get back. Despite this sadness and

frustration, Tiana most looked forward to nursing her baby and, as she described, just the “natural birth” in general.

Donna

Donna was 23 years old at the time of the research and was employed and working full time from home. She described herself as an observant person She said she enjoyed a good conversation. Similar to the other women, her partner did not get to support her at the clinic visitations and or be present at the birth of their daughter they were expecting. This a process that Donna described as difficult; during this time, she felt alone in her pregnancy, and her partner did not experience the “realness” of pregnancy or childbirth. With the difficulty of this experience, Donna did not look forward to anything in the first trimester of the pregnancy as a soon-to-be mom. As Donna reached her last trimester of pregnancy, she reflected on what she was told by many women who previously had children and said that the community of motherhood romanticises the notion of having a baby. However, it leaves out the tangible cost of it not only financially but also emotionally, mentally and physically.

Amanda

Amanda was a 22-year-old and had just graduated from UCT. She was working part-time at a large financial service provider in Cape Town. Amanda described herself as a determined young woman, and her goal was to continue her studies once her daughter has been born. As a student, she resided in Observatory, and most expenses were paid through student funding; as she prepares for her baby, she was back home. Amanda had many anxieties during her pregnancy, especially with work and her goal to continue her studies, knowing that her baby would arrive soon. The primary uncertainty was whether work and the continuation of studies would be possible after the baby had arrived.

Joann

Joann was a 23-year-old at the time of the research and seeking employment to provide for her daughter, which she expected soon. Joann described herself as a hard-working young woman who always strived for new opportunities. She described herself as strong and never let anything get “under” her skin. She always tried to make the best of any situation, even when it is not ideal. She said that she always tried to learn from her mistakes and always to try to better herself. During her first trimester, Joann lost her partner in a tragic accident. This was a heartbreaking time for her, especially having to get ready for and attend visits with no partner and having no one to share the excitement with. What she most looked forward to once her daughter was born was holding her, hearing her cries, her scent and most of all, enjoying her.

3.3 Research methods

To explore and gain a better understanding of pregnant women's experience when accessing public maternal health care facilities, this research relied on in-depth interviews and the use of visual documentation. Interviews were conducted over the course of three months, from April 2021 to June 2021, with six pregnant women accessing local MOUs in the Cape Town Metropole. To gain insight from the health care professionals and their perspectives on access to maternal health care, interviews were conducted with five health care professionals. The 5 health care professionals included two doctors and three sisters and were selected because their roles as medical personnel who have worked within a local MOU and who are currently working as staff in MOUs provide invaluable insights into the experience of staff within the system.

3.3.1 Interviews

Online semi-structured interviews contributed to the corpus of the research materials. The use of semi-structured interviews allowed me to obtain additional information, from the interview questions set out. This method helped offset a sense of formality that can occur with structured interviews and facilitates a more comfortable atmosphere, in which participants are free to express their feelings or views as needed.

Prior to the interview being conducted, participants were made aware of the aim of the research and what each question entailed. Once participants agreed to partake in the research, they were asked to complete a form that stipulated their consent and that they understood the purpose of the research study. Participants were asked if the interviews could be recorded, and consent was received in the form of either written or verbal consent. Most of the participants were eager to partake and be part of the research study, as they saw this research as a platform to voice their opinion of their current experiences when visiting the local maternity clinic. Engaging with the women they felt that in most cases formal complaints which are made about the treatment they received are never heard or acknowledged. This research process allowed for the women to openly share their experiences of the public facilities. Through their experience's women will highlight the struggles that they faced. The motivation for the women was that by sharing their experiences, the quality of services provided by the state could be improved to the level that it should be.

All the participants were happy to share their stories. The pregnant women in this research were also first-time mothers. The use of first-time mothers within this research was important in order to gain first-hand experiences. The reason for this consideration was to avoid participants from providing insight that they are "accustomed" to the treatment from public

facilities and know how the system works. The inclusion of pregnant women in this study provides this study with qualitative experiences of the challenge's women encountered when receiving medical assistance within public clinics.

3.3.2 Visual research

The use of visual research is considered an ancient form of understanding (Margolis. et al, 2018: 600). As humans we rely on our sight to make sense of the material world and it impacts what we feel and experience in a current event (Margolis. et al, 2018: 600). Including this research method in the study also allowed the participants to share emotions and feelings which they were not able to verbalise. In order to build a more evocative dimension to the research, participants were asked to share visuals that depicted how they felt during their times waiting to receive the appropriate healthcare services they were seeking.

One of the components of the research study was to visually document the bodily and physical waiting which takes place within the maternal clinics. Bodily waiting refers to waiting for the baby inside the mother's womb and observing how the body changes over the months, and physical waiting refers to waiting outside and inside the facility and involved observing how women wait and what they do while waiting to see the nurse or midwife.

To visit the clinics, permission needed to be granted by the Western Cape Health Department. The time it would take for application and processing permission would exceed the timeframe of the research study. Secondly due to COVID-19 access to maternal facilities was only granted to the women who were attending the clinic. Therefore, the research participants were asked to share images of what they associated with their time while waiting at the clinic. To capture their experience waiting in the clinics, the women shared memes, selfies and even stock images from Google which resonated with them and how they felt in their time of waiting. Additionally, women were asked to provide a summary of what they meant by the image sent, as images can be interpreted differently by the observer.

4 Research Analysis and Interpretation

4.1 Introduction

This chapter explores the experiences of pregnant women encountering public healthcare services. It will explore the challenges that the women encounter by looking at how and why women access public health care services. It will become evident that when these women do access public maternal facilities there are episodes of waiting that they encounter contributing to anxieties and negative perceptions of the services that they are receiving. Through the sharing of their experiences, it will be revealed that waiting contributes to the negative perception of the public facility but the true experiences lie within the relationship shared between the staff and patients. The aim of this study is not to negatively label the staff of the public maternal clinic but instead through the sharing of their experiences to further explore why the services that they conduct on a daily basis are seen as a negative quality of delivery of an important service to both the mother and unborn child. Therefore, this chapter is important in laying the foundation for subsequent chapters that seek to provide an understanding why patients experience challenges and why staff are currently seen as inadequate in delivering these essential standards of healthcare services.

4.2 *"We couldn't afford to give birth at like a private hospital"*: Women's access to quality health care services

Looking at women's access to public health care in terms of affordability and availability, when the women I interviewed were asked how they came to know about the facility and how they travelled to the facility during their pregnancy, they said:

> ***Patience:*** *the day clinic, nobody told me about it because it is close to me, so I can see people going there, so I just went there …. I was referred to another clinic and did not know where it was. Sometimes my employer would take me, sometimes I went by taxi… When I was transferred to the big hospital, because they did not have those baby doctors. They asked me do I have transport and I said no, they said they were going to call the ambulance and the ambulance was going to take me to the big hospital.*
>
> ***Shenaaz:*** *my last appointment was on the 23rd of March at 9. Usually, there are a few ladies that get the exact appointment so just before 9 I get there (my own car) and they let me into the gate with the other ladies the general public has to stay outside of the gate.*
>
> ***Tiana:*** *I was referred to the clinic by the private gynae [gynaecologist] that I was seeing. I came to know about the clinic through family members who*

have attended the clinic before. I would either walk or drive as it was around the corner from where I stayed at the time.

Patience had not been advised by anyone of the clinic located in her neighbourhood but had become aware of the services being rendered by observing the people who would pass by her house on a daily basis to visit the clinic. Through her response, we can see that the clinic was within walking distance from her house and no additional funds were needed to travel to the clinic in order to receive the services she needed. During her time of labour, she was provided with an ambulance to be relocated to the hospital where she received the services she needed. Compared to Patience, Shenaaz did not have a clinic located in her neighbourhood but was aware of the clinic that she needed to attend for her pregnancy. Due to the location of the clinic it was necessary for her to travel making use of her own private transport. This cost of travelling to and back from the clinic however did not impact Shenaaz negatively although during this time that she was retrenched, her husband was employed. The distance from her home to the clinic was less than a 10 minute drive, and she needed to travel approximately 3.5 kilometres. Tiana, prior to being advised by the private gynaecologist that she needed to seek medical services from the public clinic, was aware of the clinic through the knowledge of family members who had utilised the public healthcare services previously.

Based on the responses from the pregnant women interviewed, findings show that the physical distance involved in accessing a clinic for respondents was not a key issue. While greater distance could imply extra costs in gaining access, this was not recognized as a factor affecting participants' access to health care facilities. In addition to what their responses show, the respondents indicated that they were in a position to access the healthcare facilities easily, by making use of their own transportation, making use of public transport or the use of the public services of the healthcare facilities. Compared to women who reside in rural areas, accessing healthcare facilities is easier within urban areas (African Progress Panel, 2010), this is evident from the participants responses. Due to the strategic placements of MOUs in neighbourhoods, women who reside in urban areas do have more of an advantage to access these clinics as it does decrease the amount of time and cost involved to reach the healthcare facilities that they are receiving adequate treatments for the course of their pregnancies.

Extending on women's access to maternal healthcare, in terms of affordability, the women elaborated on why they were utilising public services and not utilising the healthcare services from private facilities, they said:

> ***Donna:*** *the medical insurance from my work did not cover, uhm, what is this? The gynae appointments as well as the birthing of my baby, like the delivery, that was not added into the plan. So, I only had the antenatal and scans available and like after birth, like nurse coming to my home after birth.*
>
> ***Amanda:*** *the reason why I am not attending a private clinic is because I am not on medical aid anymore and also, I just feel like there is really, there is not much difference. Like you get the same care that you need at a public and private. Yes, maybe private nicer.*
>
> ***Tiana:*** *at the time I wasn't on medical aid at all, I didn't have medical aid, uhm so I was seeing like a private [doctor]. I first went to my GP and then he referred me to a gynae, uhm and we were also paying her privately and the cost[s] were just too much. So, she advised me to go to the MOU, she told me to make a booking… We couldn't afford to give birth at like a private hospital. I think at the time, they gave me, they told me it would be about like R36 000 if that's just like a natural birth. Uhm, and if it was a c-section you pay extra and you pay extra per day that you are at the hospital as well.*

Without medical aid, the cost involved is exorbitant to utilize private healthcare facilities for antenatal visits and the delivery of babies. The baseline cost, which includes the delivery of the baby and the fees of the doctor who is administering the procedure, is an amount which most women cannot afford and this excludes any complications which may occur during labour and the extended amount of days spent in the hospital post-delivery. Although private healthcare is the type of comfort that any woman would want during her time of pregnancy, the cost involved is an additional financial burden.

Accessing public healthcare facilities is a more cost-efficient option for most women, as most of the hospital costs of government funding. However, based on what the women have said during their interviews, their responses indicate that there is a false interpretation of the private healthcare system, where women assume that they need medical aid to access the facilities that are available. Contrary to this, private clinics and hospitals accept cash payments, however, it still proves to be the costlier option. According to statistics, an estimated 16% of the country's population has medical aid (Rensburg, 2021). With inflation rates rising, and the cost of living increasing in South Africa (BusinessTech, 2022), medical aid is not affordable to everyone and the costs of utilizing private services are unaffordable to many citizens. Access to public healthcare does mean government-funded healthcare but these services can be limited which leads women into seeking additional medical resources which they can afford to ensure the safety of their unborn children.

Looking at the women's access to health care in terms of acceptability, findings from the interviews indicated that the majority of women within the research study were still attending and visiting private gynaecologists while attending their appointments at public clinics. When the women were asked if there were any treatments that they required outside of the current treatment and services that were rendered by the public clinic, they said:

> ***Amanda:*** *I have been to one of my appointments at a private clinic but I did not see much difference, so I just thought I should continue going to the public clinic that I have been going to. The services that I required outside the clinic was scans because I know that they only send you to one scan at the public and mine they only sent me to my first scan when I was about 7 months. So. I was going on my own like way before by myself to a private place.*
>
> ***Tiana:*** *I would prefer more resources such as the scans… I went for additional scans that the clinic did not provide.*

Based on the responses of the women, the number of resources which were available at public clinics was perceived to be limited. Any additional scans or in-depth scans were done through private gynaecologists, as the public facilities only offer 1 scan per patient during their time of pregnancy. The need to seek and utilise external services from private facilities shows that the women are not accepting of the limited resources received from the public clinics and as a result add this financial burden to ensure the health of their unborn child.

Reflecting on what the women have shared, public health care facilities are accessible. They are within travelling distance, women can either access these facilities by private transportation, walking or even public emergency transportation. These indicate that women are not limited to the availability of public maternal clinics within the Cape Town Metropole region. In terms of affordability, private care is not affordable for these women which have led them to seek the medical assistance of public healthcare facilities to ensure that their pregnancy is well monitored. Besides, public maternal healthcare services being free these women still seek additional scans due to the limited resources of scans. These additional scans which the women do outside of the public facilities do imply that they increase the amount of money they are spending to ensure their health and the health of their unborn child. To further examine women's acceptability the question, of whether or not these women trust the current information they are receiving regarding their pregnancy was asked. Based on the responses of the women, some were not accepting of the treatment at the facilities. there is a lack of adequate services that they are receiving therefore they seek additional scans and private consultations. The next section will explore waiting within public maternal

care facilities in order to gain a better understanding of what is contributing to inadequate services which has been discussed within this section.

4.3 *"Waiting is the name of the game"*: Women's experience of waiting on service deliver within maternal facilities

There are different emotions experiences in these times and spaces of waiting. When asked to share how they felt waiting within the public facilities, Donna said:

> ***Donna:*** *With all due respect, I understand it is a public hospital/MOU and as it is known waiting is the name of the game. Waiting for hours on end to get assistance is no excuse at all when the amount of people at present is forecasted by appointments set by the staff itself. I felt, tired, exhausted and despondent while waiting at the MOU. It is utterly unnecessary for the wait time, when it is caused by the staff itself. You don't just come to the MOU without an appointment, they forecasted we will be there.*

Donna was prepared for the wait as she mentioned it was the "name of the game" because this is what using public facilities meant. When she was booked to visit the clinic for check-ups she was always given the time of 7am but this time was not adhered to by the clinic staff. During the interview Donna shared the observations that she made every time that she would visit the clinic, she would arrive at the clinic just after 5 in the morning and already at that time of the morning there was a line of pregnant women stretching around the corner of the clinic. She had mentioned that:

> ***Donna****: most of the women would get there at 5am or even earlier than 5am in order to be first in the line to get helped and go home. Sadly, even if you got there at 5am the midwives and doctors only start to help at 8am.*

Examining the time of Donna, the clinic would assign her the time of 7am, although the clinic only opens at 8am. She arrives at the clinic at 5am because there is not a ticket system or a tracking system to the order in which women arrive at the clinic. Arriving at 5am at the clinic, does not guarantee that she would be attended to first but that she would avoid spending an entire day waiting at the clinic. Given the fact that she arrives at clinic to the time that she enters the gates already 3 hours has passed and these hours are not inclusive of the time that would be spent inside of the facility. Expressing a similar experience to that of Donna, Tiana also shared that complications which arose during her pregnancy led to her being referred to the hospital to receive treatment, where she also experienced arriving early at the hospital and having to wait:

> ***Tiana:*** *I was high risk because of my anemia and stuff, I had to be moved to a hospital for my routine check-ups; which I had hated because I had to*

wake up at like 5 to be like number 10 in the line and even being like number 10 or whatever, I still waited long and I would be there for the whole day and this was towards the end of my pregnancy.

As a high-risk patient due to chronic anemia, during the time of her pregnancy Tiana was transferred from the local MOU and referred to a hospital for her check-up and during this period as her conditions improved and stabilised she was transferred back to another local MOU for her delivery. As noted from Tiana's experience shared when asked about her access to the clinic, she indicated that the clinic was in walking distance and the amount of time spent in this facility was not as long as the time she spent when referred to the hospital for treatment. To ensure that she was early at the hospital she had to be at the hospital by 5 and even arriving at the hospital at this time did not mean that she would be the first to receive her medical services that she needed.

Through the women's observations during their times of visiting the clinic, findings show that they spend majority of time waiting due to arriving early to ensure that they are the first to receive the services. Women were then asked how they spent their time waiting to receive the medical services. Shenaaz reflected on this and said:

Shenaaz: *I didn't feel anything while waiting because I think I got to a point where it was you know, this is something I have to do so unfortunately, I have to wait. I knew like if I had an appointment tomorrow, like I have to pack snacks for myself or a book or just something to keep me occupied for the hours that I was going to be there. The waiting wasn't really an issue for me, as long as I had something to do with my time. It was more like waiting then someone will see you to do some kind of test and then you'll wait a bit more and then you'll go in to see the nurse and then after that then you go home.*

Each visit Shenaaz physically prepare by packing snacks or a book to endure the time that she would wait to see the nurse or the doctor during her antenatal visits. Mentally preparing herself all the time, made the time waiting manageable for Shenaaz as long as her time was spent wisely. The times that Shenaaz would vary at each antenatal visit. Shenaaz said that:

Shenaaz: *On a day of visiting the clinic, I would arrive at the clinic at 9am based on the time that was given to me by the nurses who booked me visitation and after arriving that time would only leave the clinic at 13:30 in the afternoon. On days when I was given an early time slot such as 7am she would leave the clinic at 10:30 in the morning.*

As seen in Donna experience, the time given to the women would not be adhered to by the staff. The amount of time spent in the public facilities are unpredictable and this impacts their perception of the efficient of services received from the public facilities.

The time that women spent in clinics is not only experienced during their clinic visits but also during their time of labour. Patience shares her experience of waiting on service deliver during her time of labour:

> ***Patience:*** *In the morning around 10 o' clock, I was in pain and then I called another lady and she is from Parow North and I also work for her. I called her and told her you need to take me to the hospital, to the clinic and it was around 11 o' clock. Then I went there, I didn't know that the person that is with you won't be allowed to go inside so I went by myself with my bags. When I got inside there were other ladies and they were screaming, screaming. I was like is that what I am going to do, is that what I am going to go through. I was like oh, no! I was there I was in pain but I wasn't crying like the other ladies. Then I got assisted after 2 hours of being in pain, 2 hours waiting. Then, it was around 1 o' clock that I was assisted then they told me your baby is too small; you cannot give birth here.*

Patience was referred to the hospital due to complications and the clinic not having all resources needed for the safe delivery of her baby. The day prior to this experience Patience had visited the clinic due to the pain that she was in and was turned back home because she was not showing the most obvious signs of being in labour according to the clinic nurses. Even in a moment of bodily urgency, Patience had to wait and follow the protocols of the system.

It is evident from the women's responses that with each visit they had become complacent with the amount of time waiting in and at the clinic. The amount of time spent has become so normalized as a standard process within the system. The assigning of times for visits was also viewed as unhelpful because as the women have indicated through their experiences they would still arrive at the clinics early enough to leave the clinic as soon as possible and to avoid leaving the clinic in the afternoon.

As indicated in chapter 3, for the initial proposal of this research, I would have observed and visualized how waiting looking with the facilities, instead due to COVID-19, I had asked the women to share images of what they felt best described their time waiting in the clinics to depict how they felt during their times waiting to receive the appropriate healthcare services they were seeking. The aim of the image was not only meant to show or described what they

did during their time waiting but also to serve as additional information about their experience of the public health care system. Along with the image shared, the women were also asked to share a short description of their image and why this image resonated with time during their time of waiting. The images shared by Jo-Ann and Donna, were memes visualising how the time they spent waiting felt.

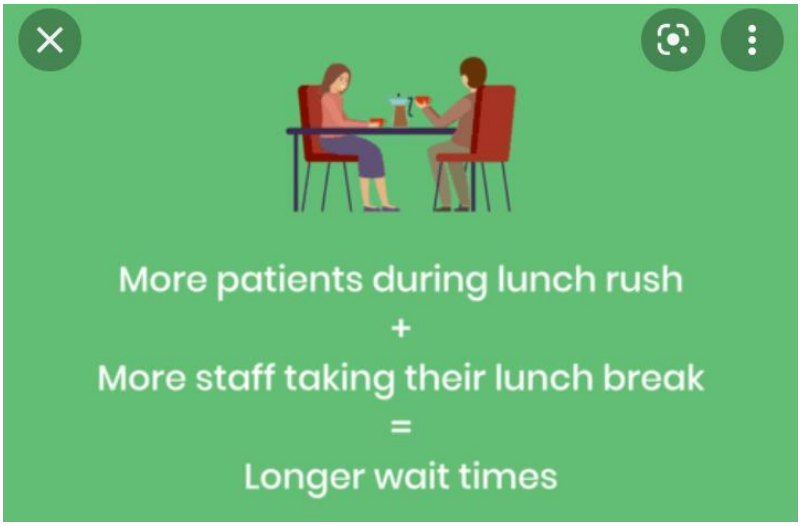

Figure 1: Joann meme representing her time waiting

Describing her image Joann said *"This picture reminds me of how I used to sit at the clinic before any of the nurses attend to me because they are on lunch"*.

Memes are captioned images intended for elicit humour. Memes have been trending on social media as a way of expressing a culturally-relevant idea. The meme Joann shared showed that the staff at the clinics didn't care much for the women waiting, but rather it was more important that they stayed on track with their lunch schedule even if it meant leaving women waiting to be assisted. It cannot be assumed that the staff didn't care because as humans they too have to maintain their health whilst working in a high pressured working environment. Neither does this diminish the reality that pregnant women felt uncared for. Perhaps what it shows again is that the staff become the representative of the state and in this case, the state may not care for either staff or patient as a solution could have been found. Similar to the image that Jo-Anna has shared, Donna also shared an image which ridicules the time they spend waiting for the medical attention of the nursing staff.

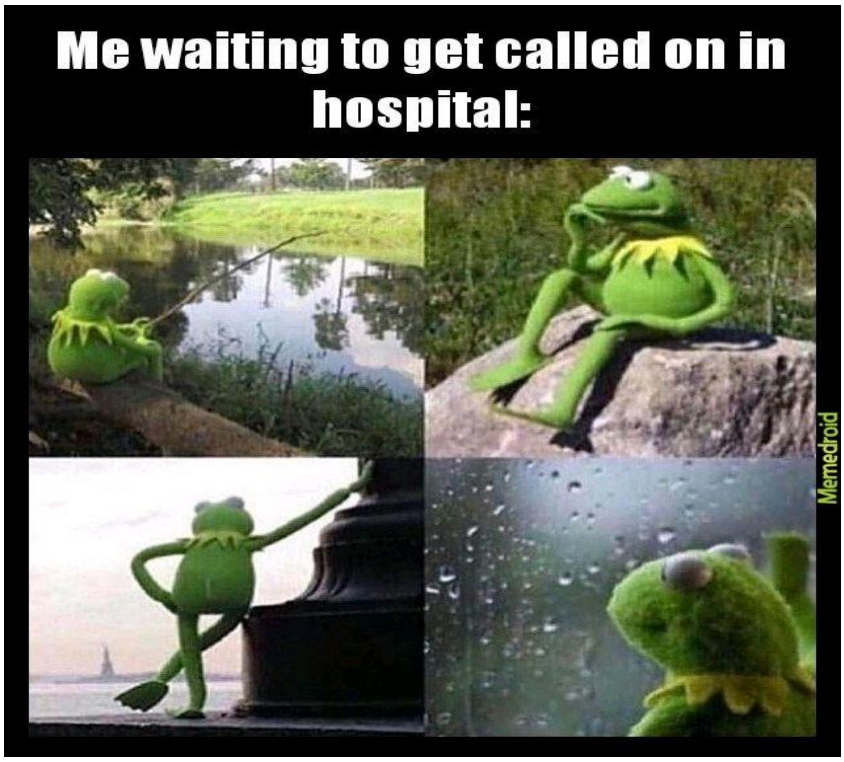

Figure 2: Donna's comical take on waiting for assistance

Adding to the meme shared, Donna said: "*The photo is a meme but it describes how I feel waiting at the MOU/Clinic every time I go there. It's not a joke to wait for hours, but if I don't make a joke about it I would lose it".* The meme that Donna shared shows Kermit the frog, on social media has become known as a meme expressing sarcasm, a cheeky comment about others or encountering social awkward moments. The sharing of this image shows that although Donna did not show any frustration towards the time she spent wait, this was not the expected standard of services that Donna expected when utilising public services but it is not the experience she hoped for.

The images and experiences shared by Amanda and Tiana, highlight how in this time of waiting they experienced hopefully moments know that this time spent waiting was part of the pregnancy journey. To show this hopefully moment of waiting, Amanda shares a picture of the ECG monitor show her heart beat and the heartbeat of her baby.

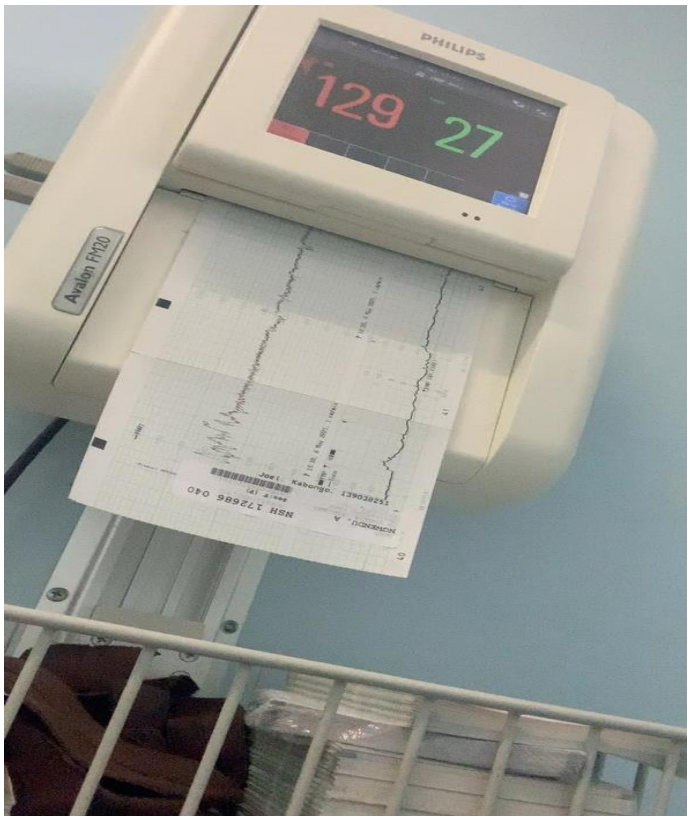

Figure 3: Amanda connected to the monitoring machine waiting

Asking Amanda how this image resonates with her in her time waiting, she said "*This image reminds me of the long early morning waits in the clinic. Where I would be at the clinic as early as 7:30am and still wait in a long line but my comfort laid in knowing I was going to hear my little one's heartbeat. That of course made the long waits worthwhile!"* Being able to see and hear the heartbeat of her baby, brought comfort to Amanda, distracting her from the moment of waiting that she was encounter.

Tiana shared an image of herself while in labour and waiting to give birth, which she had posted to social media platform (Instagram) adding captions to the images, describing how she is patiently waiting to give birth, accrediting herself for being strong through this moment of waiting and highlighting that her husband not being present during this time due to COVID restrictions.

Figure 4: Tiana in labour for the delivery of her baby girl (image cropped for respondents' anonymity and ethical considerations)

Tiana describes this time in this image as "*This one I think is the best one. It was during my labour and I was at the local MOU. I remember going in at 5am and having to wait until change of shift to be seen to. It was painful and really the worst feeling. But what carried me through was the fact that I knew would be giving birth soon and meeting my baby."*

Clear from the images shared by the women, there were different emotions present during the times of waiting at the clinics for a regular antenatal check-up and while in labour. The images shared describing the times waiting alludes to moments of anxieties, frustration and vulnerability. However, these negative emotions did not influence that behaviours of the patients as through their familiarisation with the public services normalised the time they spent waiting. The images shared showing the moment of waiting during later alluded to moment of anxieties, pain but also an awaited moment of happiness. Happiness and excitement, knowing that following these painful moments in waiting there will be an arrival of the baby which that had cared for, for the past 9 months. Reflecting on the women's responses, findings show that despite the waiting, the motivation of their unborn child brought more joy then the unpleasantness of their surroundings.

Echoing Auyero's (2010) notion, as these women wait within these clinics they become 'patients of the state' because the research shows that assigned time to the pregnant women are not adhered to, and that waiting time has become normalised as a standard process within the public healthcare services. The amount of time the women spend when using the clinics continues to show that there is a gap in the existing healthcare policy that stipulates that women have access to effective and efficient healthcare services. Despite the issue of time spent in the clinics being similar experiences that the women shared during their encounter with the public facilities, each woman shares different experiences of their service encounter in the clinics and how they truly feel as a pregnant woman in the system. The representation of this experience was shared with the images shared by the participants. This section highlights one of many challenges that women face when utilising public health care services, it also highlights the feelings and perceptions that women have

of the public health care system. The following section will further elaborate on these feelings and perceptions through the sharing of their experiences as patients of state health care services.

4.4 *"I was nervous of the treatment because I am young"*: Experiences as patients of the state

In this section I will explore how women's experiences are shaped through their encounters with the medical staff. I examine the type of treatment and the manner in which pregnant women receive this treatment, focusing on the influence of their age and the influence of stories shared by friends and family about the service public maternal healthcare facilities. Within this section, I will also observe that there is both negative and positive experience shared by the patients who are currently receiving these public services.

Conversations with the pregnant women alluded to that there was a pre-perception created of the public facilities that they were visiting. As noted by Girma et.al (2018) in the literature review chapter, a general perception of a person, object or environment is built and drawn upon through an individual's experience, expectations and perceived needs. For many of the respondents their perception of the local clinics they attended was not only influenced by how they came to access the clinic or how long they waited within the clinics, but rather also by their encounters with the medical staff of the local clinics, and the experiences of other women who had encountered or made use of the same public services before.

When asked about their experiences of their interactions with the local MOU staff and how this has affected their perceptions of the clinic, the level of professionalism rendered by the staff was a common theme. Concerning the treatment received from the staff, pregnant women shared their experiences, saying:

> ***Shenaaz:*** *At my first visit the nurse had been speaking to me then all of a sudden turned around and stuck a needle in my arm (which hit the bone) and gave me a tetanus shot which I did not like as I was not asked or told what the shot was until I had asked what it was and why I was being injected.*

Donna shares a related issue to that shared by Shenaaz:

> ***Donna:*** *In a nutshell, my observation is the following – MOU's are understaffed and the space reserved for it is very small. SARS [South African Revenue Services] is even more spacious, and I have been there before. During my visits, medical students were present to assist us and the student that took my blood bruised my arm so bad it was purple and ached for 2 weeks.*

For Shenaaz the incident she described created a bad impression of the treatment she received because she was not asked permission for the tetanus shot to be given, nor was she advised that she would receive this tetanus injection or what was the reason for her needing to have a tetanus shot. According to the American College of Obstetricians and Gynecologist (ACOG, 2022) all pregnant women should receive the tetanus vaccine during each pregnancy because receiving this vaccine helps the women's body make antibodies to protect her baby from neonatal tetanus. The antibodies formed are then passed to the baby and can protect the baby until he or she is available to receive their next tetanus shot at 2 months. This treatment that Shenaaz had received show that the staff failed to pass on the knowledge and educate her on the kind of treatment that she needed for her well-being and the well-being of her unborn child.

For Donna, due to all senior staff being occupied and attending to other patients, the injection administered by the student left Donna bruised and in pain for weeks after also receiving her tetanus shot. The guidance from a senior staff member, to assist and educate the student staff member failed to happen in that moment that the tetanus shot being injected. Through this experience, it can be observed that student staff still rely on the mentoring and physical guidance of the senior staff working in the facilities.

Baker (2017) identified that there are several reasons why healthcare workers are unable to provide the quality of services and care (reasons that relates to the experience that Shenaaz and Donna both shared) that include that health workers are not always adequately trained; receive inconsistent supervision; and work in isolated settings with insufficient support for the tasks they have to perform. Medical staff within the public facilities treat their patients poorly due to the immense work load delegated amongst the limited number of staff members who need to carry out all the services to the public. The frustration and stress of overworked staff members affects the empathy and compassion of staff members.

Upon further discussions with respondents, some also highlighted that their age influenced how the staff would treat them. When asked how they were treated because of their age, the women said:

> ***Tiana:*** *With the treatment, I feel that because I was young they treated me like, I don't want to say with no respect but they did treat me differently to how they treated the older ladies. They just wanted me to be done quickly and it was like if I was sick they had no sympathy. They were like you chose to be in this situation, so you deal with it.*

Compared to Tiana, Anna was aware of her age and because of this, she was going to be a young mother. She had a fear that she would be treated different by the staff because of her age. When ask how she felt about visiting the clinic for the first time, she said:

> ***Anna:*** *I was nervous because I am young. They obviously way older than me. You know the stigma of young people being pregnant. I was nervous to the reaction that I was going to get and the comment and all of that. I was nervous of the treatment because I am young.*

From what is already known, in South Africa, teenage pregnancy is a major issue to which a certain stigma is attached (Sewpaul et.al: 2021). Linked to teen pregnancy or pregnancy in young women is their increased rate in maternal mortality (Sewpaul et.al: 2021).

Pregnant teenagers receive unfair/unequal treatment from the staff because staff lack the necessary skills for adolescent sexual and reproductive health care and staff also have negative social norms towards adolescent sexual practices (Jonas et.al: 2016). This is important to note because although the women in this research are not teenagers, as the ages from the respondent ranges from 20-29 and teenage pregnancy ranges from 15-19 (Sewpaul et.al: 2021) they were still treated in the same manner in which the nurses and midwives would treat a teenage mother; as if they were teenagers who were seeking maternal health care. Tiana saw the difference in treatment between herself and older women through the perceived haste in which the staff wanted her to give birth and leave the facility. As for Anna, she was aware of her age and of the facilities age stereotypes, and therefore was nervous with her encounter at the clinic.

The women included in this study being young mothers to be feeling they were being treated unfairly for being young created a negative perception towards services rendered at public facilities. Based on the experience shared by these women we can identify that there is a double perception: women perceived being treated negatively because of their age which as a result led to a negative perception of staff in general. The assumption cannot be made that they were always treated badly, but as humans we tend to remember the negative moments more than the positive ones and that can taint our perception of everything.

For some of the respondent some of their perceptions were also influenced by stories which they have heard from other women who have used and given birth in public clinics before. Respondents had the following to say:

> ***Donna****: I understand this next part has nothing to do with my experience but my best friends and I had lunch the weekend before [what? This interview? Before going into the clinic?]. My best friend, who has given birth at this MOU, shared her experience with me and another pregnant*

best friend. She spoke of how cold and dismissive the midwife was during her labour and how the room was packed with nurses and other mothers with their newborn babies. The shower had no warm water, only cold and the door could not close therefore a lack of privacy.

Listening to the experience of her best friend and the treatment that she received during her encounter with the maternal clinic, Donna did not want to share this same negative experience of her friend during the time of pregnancy. The thought of this negative experience led Donna's anxiety and fear for herself and her baby to grow. Furthermore, Donna said:

> ***Donna**: This MOU is notorious for its horror stories and quite frankly, I do not want to become a victim of this toxic cycle. If I have to lie, I will lie to give myself and my baby a better chance. Not having to sign a document after giving birth, excluding any blame from the hospital, if anything does happen to my baby. Because at the end of it, the means influence the cause.*

The experience that Donna's friend had shared was linked to the specific maternal clinic that she was also receiving treatment from and because of this experience shared she became anxious that she would share the same experience as her friend. Donna therefore lied that she had moved and needed to be transferred to the clinic in the new area in which she had moved to.

Similar to Donna, the stories that Shenaaz heard about the clinics indicated that women would be physically abused by the staff:

> ***Shenaaz**: Basically, with birthing stories, at government establishments, what I have heard is that some of the nurses or midwives hit you. It is not specific to one MOU that I have heard but just government facilities in general; where they'll like hit you if they feel like they don't approve of what you saying or doing. Especially, in labour when people are in pain and people tend to be a little unnecessary with the screaming. Then also being ignored, when you really need help from someone.*

Drawing on the responses from the women, it is evident that the public clinics have a reputation of being classified as "scary" places that are not welcoming. This I consider ironic as this is the very place in which a new life is welcomed into all the time.

In spite of the poor treatment some of the women received and deeply troubling stories the women have heard about other births, not all have received this treatment from the staff during the visits to the clinics. Some of the women found the treatment of the staff to be friendly, supportive and welcoming. As the following respondent shared:

> ***Jo-ann****: They treat you nicely, they ask you questions, they consider everything in your pregnancy. I was happy with the doctors that I saw every time that I went. I basically saw the same doctor every time. I was comfortable with her, it was not every time someone different.*

Due to complications Jo-Ann did not give birth in a local MOU and was transferred to a tertiary hospital. The warm and comforting service she had received at the MOU, she also received at the hospital while in labour. She described the service of the staff at the hospital to be positive as well:

> ***Jo-Ann:*** *They were nice yes. The doctor she came to see me the Friday, and she came to tell me that she can understand that I am very irritated already of laying there the whole time and nothing is happening but she is going to see what she can do now but she cannot give me a c-section because I am still so young. She explained all the complications it could lead to in the long term for me, so I understood and I was like okay. I am actually grateful for her, for the extra mile that she went.*

Like Jo-Ann, Anna also shared a good experience of the services she received despite her initial anxieties of visiting the clinic. Anna referred to the services as being good and friendly service from the staff at the clinic she was attending, saying:

> ***Anna****: The first experience with the clinic, was actually good. All the nurses are quite friendly and if you stick to your time, you get your appointment over and done with by 8 o' clock in the morning or half past 8 in the morning. Yes, otherwise the staff is super friendly where I attend and they always so keen to help and answer any question.*

Like Jo-Ann and Anna, all women who seek medical attention during their pregnancy need to experience support and friendly service of staff especially during such vulnerable times of a women's pregnancy journey. For these women the good service they received brought them comfort during their time of pregnancy. Jo-Ann, although she had the support of her family, was a single mother, as the father of her child had passed on months after finding out they were expecting. The sharing of the good experiences that these women had shown that within the system there are complexities and that not all experiences are negative.

Besides the anxieties and fears created through personal experiences from the staff and hearing experience from other women who had previously receive medical assistance from the public clinics; the uncertainties of the pandemic also increased the concern in these women who were attending the public facilities. Most of this research had taken place during the COVID pandemic and the worry of contracting the virus created a sense of distress and vulnerability, while pervasive for many groups, was especially acute in pregnant women who

were categorised as high-risk to the virus (CDC COVID-19, 2022). As noted by Veno et.al (2021) during pregnancy there are many uncontrollable and unexpected anxieties that arise, the fear of also enduring this journey alone created anxiety for the women.

As a South African government COVID-19 regulation, the partners of pregnant women were not allowed in the public health facilities to help minimize the spread of the virus. The comfort of partners or a loved one was therefore not available to these women. Especially for the first-time mothers this meant relying on the comfort and support of public clinic staff which their responses indicate some did not always receive from the staff during their antenatal visits.

This is not a conclusive point that can be made but the experiences that the women have shared plays a valuable role in showing lack interpersonal skills that the staff sometimes showed. This relates to the challenges which have been identified that hinders women's access to maternal healthcare services. The lack of resources that the staff have within these facilities impacts the knowledge which needs to be shared with patients to ensure that they are educated on their health and the health of their unborn child.

As identified by Hulton (2002) in order to improve access to healthcare services there is a need to improve the employment of staff and provision of equipment to deliver the quality care that patients need in times of seeking medical assistance. The continuous poor and inadequate service which is received from staff is repeated among individuals who may need to encounter these services due to their inability to afford to access private health care services. This alludes to that there is a gap within the implementation of policy that suggest women should have equal access to public healthcare services.

Hearing the perception that the women have of the public services and staff, there was a need to delve deeper in the circumstances that surround the services which are being rendered to the public by interviewing public clinic staff to gain their insights and perceptions of the current challenge within the public health care system.

4.5 *"It was like a sausage factory"*: The experience of medical staff as the givers of the health care service

Within this section I will identify the varied experiences shared by medical staff. These experiences shared will also provide why and how patients experience the public health care system Focusing on the research themes, similar questions were posed to the staff to receive their insight existing as the frontier of the government public healthcare service. When the pregnant women were asked how easy it was for them to access the local clinics, most of the them responded to accessing the clinics as not a challenge.

Building on this research question of accessibility to maternal facilities, the medical professionals were also asked their perception on how accessible local clinics are. In response the medical professionals said the following:

> ***Dr Christina****: Yes, everyone comes. There may be transport issues and financial barriers for sure, there are many barriers to health seeking behaviour, but once they arrive they will eventually be helped. Most doctors, at least those with a measure of integrity will try their best to deliver the best care they can in a constrained and strained system for each patient. Of course, this is a very biased statement.*

Within this response it is clear that Dr Christina is aware of her own positionality. Based on her own experiences maternal facilities are accessible but there are barriers which patients may encounter. In agreement with what Dr Christina has shared Sister Lee-Ann also acknowledges the easy access to the maternal facilities, and goes on to say:

> ***Sister Lee-Ann****: Yes. The primary health care institutions are as they are usually within the community but the secondary and tertiary hospitals are not as accessible to the poor as they are usually outside of the communities they supposed to serve*

What Sister Lee-Ann highlights is that healthcare facilities that are located within the neighbourhoods are easily accessible and the secondary and tertiary hospitals that patients are referred to which risk occur is not that easily accessible due to their location.

Identifying that there are complexities, not all medical personnel agreed accessibility to be easy for pregnant women, another medical professional said:

> ***Dr Stella:*** *Yes and no. With regards to maternal health, "normal" or what we call, "uneventful" pregnancies will go on to be delivered at an MOU (primary healthcare facility). If any problem is picked up at that level during the antenatal checks, the patient will be escalated to a secondary facility, or even a tertiary facility. This process seems easy at face level because we do put so much emphasis on maternal health care. However, the barriers are often financial strain. Patient's now having to travel further using public transport that they cannot afford, in order to go and to these secondary and tertiary facilities. Sometimes they miss appointments because of lack of finances.*

Building on the reasons given by Dr Stella, Sister Rebecca's echoes the issues of clinics outside of the patients residing communities, identifying the reasons for clinics being not easily accessible as follows:

> ***Sister Rebecca:*** *I don't think it is always accessible. With a catchment area system in place at government facilities, clients are often shown away from facilities and often referred back to the area they fall under to seek medical care. In this instance, some of the very few clients who comply to this often need to spend more time and money travelling to visit a facility in their area.*

Sister Rebecca's comment supports the study that has been conducted by Chassin & Loeb (2013) which states that, patients who are impacted the most are those that needs to seek and travel further in order to receive the adequate health care that they cannot receive within their neighbourhoods. The responses of the medical personnel resonate in what has been identified in 'waiting' on the delivery of public basic services. Clinics are physically accessible but factors such as financial constraints, transportation and attitudes of medical staff make the clinics difficult to access and creates tension between patients and medical staff (African Progress Panel, 2010).

Researchers have observed that there is a divide between the Global South and the Global North which is created by poverty and underdevelopment. With a greater population residing in the Global South, examining on a comparative basis, infant mortality, life expectancy at birth, maternal health, and child health is vastly different to that of the Global North (Aginam, 2000). when the medical staff were asked what the common challenges are that they encounter working in these public facilities they said:

> ***Dr Stella****: The South African, obstetric patient – things like poverty, abuse, lack of adequate nutrition, obesity, teen pregnancies and chronic diseases. It's very different to treating a first world patient. These issues take a long time to address and there are often multiple, however, there are huge time constraints and lack of resources to do so adequate[ly].*

The reflection that Dr Stella has shared shows that the patients who are being treated within the facilities have different socioeconomic circumstances compared to a patient of the Global North. These socioeconomic circumstances do impact their health and the level of treatment they require from the medical facilities. Also reflecting on the socioeconomic conditions of patients in South Africa, Sister Rebecca adds that it is important for patient to utilise these services due to the lack of knowledge regarding their health and pregnancy:

> ***Sister Rebecca****: Every MOU comes with challenges. Because this MOU is a state facility, often patients comes from poor socio-economic backgrounds. Although doctors from the MOU have outreach days where they attend facilities to see to patients, there are still a large number of clients who miss appointments due to a lack of funding for travelling*

purposes. Not only are these communities poorer, but a lot of women aren't as educated and lack understanding with regard to their health and that of their babies. Often these women need to attend up until delivery, it becomes an expensive visit with moms coming in as often as once a week.

In her response Sister Rebecca highlights three challenges, firstly patients who utilise state services come from poor socio-economic backgrounds. Secondly, although doctors are assigned to dedicate hours to service within the clinics, a few patients still do not have access to utilise these services due to financial burdens. Lastly, women lack the education they need regarding their health. If risks are identified within a women's pregnancy she will attend more clinical visit than per usual in order to monitor the baby. These number of visits can contribute to the patient experience additional financial cost.

***Dr Christina**: Patient load, it never ends, you easily become overworked and that's why I saw my seniors at the time resort to harsh treatment of the patients. It can be a highly stressful environment, you're managing multiple patients simultaneously, and each at different points of their labour. Keeping high patient load in mind, the facilities are just not coping, there are never enough beds, you can have a patient give birth on a chair. Limited expertise at the MOU's can also result in a high stress environment and suboptimal care of the patient.*

What Dr. Christina highlights is important, because she highlights why staff resort to harsh treatment towards patients. This is a result of the high volumes of pregnant women seeking medical assistance with limited staff to attend to these needs. She also highlights within some facilities there is a lack of equipment to attend to all the patients seen on a daily basis.

The experiences that the medical professionals have shared echoes what Gerein et.al (2014) focusses on his study. He notes that maternal health care workers are unable to perform and provide quality and services and care as a result of staff shortages. The African Progress Panel (2010), estimate that there are 13.8 qualified nurses and midwives who are responsible for 10 000 patients in Africa. However, doctors are not included in this statistic, as they are not located within the MOU clinics and perform their duties mainly at the secondary and tertiary hospitals. As Sister Rebecca has indicated, doctors are present at MOUs on their outreach days.

Based on the medical staff's responses, as the provider and employer who delegates staff to these facilities, the government is responsible and should be held accountable for providing sufficient funding and deployment of the correct amount of medical staff to serve the public who are making use of public clinics (National Department of Health, 2012). The MOU clinics

still lack the human resources to serve the large population that does seek professional health care that they cannot afford in the private health care sector.

Despite these challenges as medical staff they still strive to provide the best assistance the patients who entrust them as the experts with their health and that of their unborn child. In light of this staff were asked what their experience is like within the system that does not support the work they need to carry out to the public. They said:

> ***Sister Lee-Ann****: At the MOU I found it rewarding but the patient load was high. Because of this I felt patients were not given much education of they were treated disrespectfully.*
>
> ***Dr Christina****: Obstetrics is very overwhelming, at whatever level you may encounter it, as a student being exposed to an MOU for the first time. On one particularly busy call, I remember thinking and feeling like it was a sausage factory. I thought it was a totally undignified place to bring life into the world, and remember experiencing the sisters running the unit particularly cold and cruel. I didn't expect patients to be shouted at but they were, for the most menial reasons, they were insulted, remarks like "open your legs, it wasn't an issue when you got yourself in this position" particularly with the teen moms. It was extremely unsettling.*
>
> ***Dr Stella****: The patient load has always been tremendous. Neonatal units always seem to be very organised and well run, due to immense funding and technological advancements. Maternity units however, are slightly chaotic, partially due to patient load but also lack of funding and the complexities that come with the South African, obstetric patient.*

Based on the response that Dr Stella has given, neonatal care refers to the type of care a baby born prematurely or sick receives in a neonatal unit and maternal care refers to the health of women during pregnancy, childbirth and the postnatal period. The management of patients in these divisions are different due to the funding and support. The lack of funding within maternal care contributes to the challenges within this unit of healthcare.

From these questions asked to both the patients and staff, it has become evident in the research that there is a social stigma, evident in the way staff treat patients, especially young mothers to be. Noting from the responses of doctors was that amongst nurses and midwives the treatment of young woman is different to women who are older, or in their own opinion considered a suitable child bearing age. In South Africa, there is a high estimated number of teenage pregnancies, estimated at 68 births per 1000 girls (Sewpaul et al, 2021). The cold and dismissive treatment towards the young women from the staff is the reason women fear

visiting antenatal clinics. As a result, pregnant women arrive unbooked to facilities and labour wards in hopes of avoiding intimidation by the staff.

The above finding also indicate that staff members working in these public facilities are aware of the financial implications that patients have to endure if and when facilities are not easily accessible (referred to seek help at alternative clinics) but this does not mean that the facilities are inaccessible. In addition, financial implications limit the number of attendances that pregnant women can make to the public facilities, especially to those women that require professional health care during their time of pregnancy.

Medical personnel were also asked the following: In which way can the system be improved to ensure that all women receive the adequate services they seek during their pregnancy? In response to the question the staff said that the following could be possible solutions:

> ***Dr Stella**: Approaching every patient with empathy and not judgement is also massively important for them to feel comfortable and thus increase the chances that they will return. There should be staff meetings that deal with this topic, as well as debriefing and spaces for staff to go when they need help too, due to things like burnout.*
>
> ***Sister Barbara**: Short term: the mass population seeking health care should take more responsibility of their health. Long term: the population pool that day hospitals or MOUs have to service is so large, so public institutions should consider streamlining or changing the process of admissions and attendance and also invest in career development programmes.*

What Sister Barbara is implying is that women should educate themselves on appropriate health measures during their pregnancy and visit clinic earlier in their pregnancy. Women should seek healthcare services once she finds out that she is pregnant in order for her health and the pregnancy to be monitored for any risk or underlying conditions. In most cases women would attend antenatal visit late in their pregnancy or only when they are about to give birth. Secondly, as patients have mentioned waiting within clinics can be as a result of admin processes not being adhered too. Therefore, Sister Barbara is reiterating that this is a process that needs development to allow efficiency of services to be conducted.

The suggestion that Dr. Christina provided to improve the system she said:

> ***Dr Christina**: We can go closer to the patient, make mobile ANC clinics, that would be a revelation. This will help alleviate pressure in the hospital setting to deal with menial complaints.*

In this response, she is highlighting that although antenatal clinics are easily accessible due to its location in neighbourhoods. For women who do not have this access there can be the implementation of mobile clinics to alleviate the current challenges experienced.

Evident from the response of the staff is that the attitudes towards patients are a result of the work environment stress that they encounter daily. They have to conduct work on unpredictable cases such as the baby being too small to be delivered in the MOU or the women needing an emergency c-section; with limited resources.

It has become evident from the responses of the staff that the major impact causing the negative perception to patients lies within the lack of human resource to attend the large number of people seeking assistance from the facilities. Due to the lack of human resources, staff are unable to devote time to educate and engage patients, and advise them appropriately. Although the suggestion provided by the staff to build of more facilities seem an ideal solution the insufficient amount of educated and knowledgeable staff will be an issue which the government will face.

As indicated by the medical professionals interviewed in this study, there is also a need for them to receive more training and guidance on how they can and should be more empathetic and compassionate towards the patients they are treating on a daily basis. Based on the experiences shared by the medical professionals within these facilities, it shows that more attention is needed to ensure that the services provided by the public facilities is optimal. This has implications for the government to make the necessary improvements to ensure that the SDG's, specifically SDG 3 is met by 2030.

5 Ensuring access to quality maternal health care for all

This study explored pregnant women's experiences within the maternal public health care system in the Cape Town Metropole Region. This research was admittedly, broadly speaking, located in an urban centre and contributes towards research on how women build their perception of public health care services based on their access to quality health care as pregnant women in cities. The thesis concludes with four reflections on the following: the challenges that pregnant women encounter when accessing state maternal facilities; the bodily and physical experience of waiting on the delivery of public health care services; the vulnerability in waiting through the lens of pregnant women; and lastly, the experiences of medical staff who deliver these services on a daily basis and the challenges that they face.

First, the thesis sought to explore the challenges that pregnant women encounter when accessing state maternal facilities, and the findings revealed that state facilities were not inaccessible for the respondents in the research. As noted by the African Progress Panel (2010), inaccessibility to maternal facilities is the second biggest challenge for pregnant women in Sub-Saharan Africa. The women who experience the impact of this challenge the most are those women who reside in rural areas. The women in this research reside in urban areas, making access to maternal facilities less of a challenge for them. Based on the study conducted by Van Coeverden De Groot (1978) discussing how MOUs were established, it can be seen how accessibility has also increased within the urban areas through the establishment of various facilities throughout the city to alleviate the pressure of the tertiary hospitals. Respondents, fortunately, lived in neighbourhoods in which the facilities were within close travelling distance for them to access when they needed to visit for their antenatal check-ups. As indicated by the respondents, they could either access the facilities by walking. If the facility was not in close proximity they would make use of their own private cars. One respondent, even indicated utilising the public taxi service for her clinic visits. In cases where the women's pregnancies (months prior to labour), or even in the time of labour, showed any form of risk, they were referred to tertiary hospitals in which they received the required treatments for their pregnancy. Two of the respondents indicated that they were referred to tertiary hospitals due to risks during labour, in which the clinic provided the transport to the hospital. Access to public health care becomes inaccessible when individuals have to seek professional healthcare in outlying areas and they are not financially able to travel to and from to receive the treatments that they need during their pregnancy. As also noted by the African Progress Panel (2010) cost, infrastructure and skilled staff are also a challenge that pregnant women face when accessing maternal facilities. The respondents did not encounter major financial challenges. The MOUs that the women visited was well

established but did not have adequate equipment, however, the facilities that they visited had trained staff who could attend to the individual needs of their pregnancies.

Cooper's (2004) study identifies that the South African government has set the goal to address improving access to maternal health care, especially for women of colour post-Apartheid. This goal ensures that women can access the required healthcare services freely. The women interviewed gave insight into why they were utilising public services and not private health care services with finances being the barrier, where choosing public services proved to be an affordable alternative. The cost of utilizing private health care services was a cost that these women could not afford making private health care inaccessible to them. Based on the perception of the women the use of private services meant having medical aid. Majority of the respondents were not only medical aid, while one of the respondents could not access the maternal benefits of her medical aid scheme.

Secondly, exploring the bodily and physical experience of waiting on the delivery of public health care services, the study found that the sheer volume of people using public services meant waiting in lines outside of the clinic and waiting patiently to see the doctor once they entered the facility. Based on the respondent's feedback this waiting could range from 2 hours to waiting a whole day within or around the facility. The number of hours that the respondents indicated waiting echoes the study conducted by the National Department of Health (2004) and Baron and Kaura (2021) which indicates that the issue of waiting at public maternal facilities is still an issue that women continue to experience when visiting these facilities. No effective measures have been implemented and during COVID-19 the number of hours the women have experienced has only become a bigger challenge that women who utilise public facilities encounter. Knowing that they were using public facilities, the women interviewed knew that each visit meant waiting, because at these facilities, this relates to the fact that there are a limited number of staff members who have to attend to large groups of women on a daily basis. These aspects that the respondents identified about how they spent their time reiterates what has been highlighted in the study conducted by Baron and Kaura (2021).

Due to the perception that the women had of the clinics and having encountered the clinics on multiple occasions, based on the women’s responses they were resigned to the reality with the time that they spent waiting within the facility as the facilities had become known to be a “place of waiting”. On a day that they would have a visit to the clinic, they would prepare themselves for the day as the time they would spend in the facility was not pre-determined despite having received scheduled times for their appointments on the day. Despite mentally and physically preparing by packing in reading materials and food for the long waits, the

women would still be frustrated and felt vulnerable. However, the women are not in a position to voice their frustration and the vulnerability which they felt. The frustration, anxieties and vulnerability that the women felt, is a clear indication that there needs to be steps in place for the system to be changed; so that the women are treated as patients, and not as “objects” utilising these free services rendered by the state.

Thirdly, focusing on exploring the vulnerability of waiting delved more into the women’s experiences within these facilities. Although the waiting time women spent in the facilities was the same in different facilities, their experiences were different. Responses from the women show that there were varied experiences and encounters of empathy towards them. Some women felt supported and that they have been receiving the necessary treatment they required; while some felt mistreated and therefore sought second opinions from medical staff within the private sector. Baron and Kaura (2021) highlights the importance of access to *quality* health care by medical professionals. As seen by the responses of the respondents, this focus is not being entirely achieved as they still experience inadequate service delivery by the medical professionals. For some of the respondents, their age even impacted how they were treated by the staff and for some of the women they received good treatment from staff which left a good perception of the staff at the facilities. For the women that were treated poorly because of their age, initially, there was a fear surrounding their first encounter making them vulnerable to attending antenatal visits. The horror stories such as women being screamed at or hit by the staff also created a feeling of worry for these women, and this led to anxieties that this treatment of patients they heard of would also be the same experiences that they shared during their time of pregnancy or even labour.

Finally, exploring the experience and perspective of the medical staff and how these challenges they face further exacerbate the challenges that women who utilises these facilities face. It has become evident from the research that the staff cannot be seen as the government exerting its power on the patients through the staff who operate the facilities daily because as indicated by respondents and Baker (2017), there are challenges that even the staff experience to deliver quality health care services and these challenges impact the service that they deliver to the patients daily. The waiting that patients experience is linked to the lack of human resources within the public sector which needs to attend to the large number of the population who seek professional health care but public institutions. The harsh treatment that patients receive is also linked to the shortage of trained and qualified staff within these facilities. Burnout and inadequate training of staff members to communicate when they are experiencing burnout due to working in a highly stressful environment also contributes to the challenges. The experiences that the staff interviewed highlighted reflect what Baker (2017) argues.

As the staff indicated in the research, yes, public healthcare facilities are easily accessible, but this does not mean it is accessible to all. Especially for those individuals who do not have facilities available in their neighbourhoods as the respondents in the research have indicated.

There is a continued need for government to align with global goals to reduce the number of maternal deaths and to increase access to all women in need, the government does need to align its policies and what is taking place within the maternal facilities.

5.2 Conclusion

Based on what has become evident in the findings, post-apartheid South Africa has aligned with the SDGs to ensure that all pregnant women have access to public maternal health care, especially those who still continue to experience the lasting effects of the Apartheid system (Cooper et.al, 2004). Based on the strategic locations of MOUs in neighbourhoods to alleviate the pressure on hospitals, the physical accessibility to clinics is no longer the problem (Van Coeverden De Groot et al, 1978). This has been echoed by the responses of the women interviewed in this research as they are able to walk to the clinic facilities or in some cases make use of their own personal transportation to the facilities. The responses of the medical staff also agree that facilities have become more accessible due to their availability within the various communities. This solution, however, only speaks to addressing the physical accessibility of facilities. Women who do reside in urban settlements has more accessibility but those who reside in rural areas and are financially able to access these free services. This is an indication that in its entirety the issues that relate to accessibility have still not fully been addressed by the government, although policies and programmes has been implemented to address these more pressing issues that South Africa faces daily. As indicated by the medical professionals in this study, challenges arise when women have to seek medical attention at facilities when they are referred to MOUs in a different area/community. The challenge is not locating the facilities, but the cost involved to get from one facility to another. If patients are unemployed or financially unable to make use of public or private transportation to travel this challenge will impact the accessibility of the women who do require these services.

Furthermore, although women, have access to the facilities there is limited access to the quality care that they require to be delivered by the staff who work within these facilities. As previously noted in the literature, the allocation of resources was hindered prior to Apartheid and today this still seems to be an issue that maternal healthcare facilities face with the high number of population that still seeks and requires medical attention from the public healthcare system. As indicated by the staff, this is an indication that the government policy

does not align to the number of staff assigned to the facilities throughout the Cape Town Metropole Region. The human resources allocated to these facilities does not correspond to the the surplus of people attending which is contributing to women experiencing “abuse” from overworked, understaffed and limited supplies within the facilities that is required to deliver quality care to the patients. This challenge speaks to bigger issues than what has been set out as achievable goals and policies by the government itself.

Another problem that remains a challenge for the women who attend these clinics is the amount of time they spend waiting to receive treatment. Based on an analysis of the literature, the study conducted by the National Department of Health was completed in 2004, and the study conducted by Baron and Kaura was completed in 2021 in which waiting time has still been identified to be a persisting issue that women still experience when utilising public health care services. This is confirmed by the women I interviewed as part of this research. To effectively streamline the administrative process within the facilities proper systems needs to be put into place to ensure that staff have more time available to attend to patients and to decrease the time patients spend waiting. The lack of effective administrative process also relates to the shortage of professionals who are not allocated within the facilities to ensure that nurses, midwives and doctors could fully attend to the patients seeking medical care.

Furthermore, there needs to be a focus on staff training and retention within the system. The lack of trained and qualified staff reiterates that there is a misalignment of the policies and goals that the government has intended to achieve a decrease in the number of maternal deaths and to improve the quality of services delivered to the patients. As Hulton et.al (2000) suggest, to improve the quality and efficiency of service there needs to be an investment in the staff who carry out these services. Women’s perception of the health care system relies on the staff within the system, if the staff conduct poor work they create a poor and negative image of and experience within the system to its patients.

Considering the general lack of research that has been conducted on the experiences of pregnant women utilising public maternal health care services, this thesis hopes to contribute to the partial fulfilment of this gap by focusing on the challenges that the women have identified within this study. This research has highlighted that this is not an inability to physically access facilities but challenges linked to waiting times, vulnerability within the system and lack of empathy from some of the staff who work within the system. This research has also highlighted the importance of medical personnel to these patients who are at a vulnerable stage of their pregnancy journey. Further, the research also indicates that the medical personnel rely on the appropriate resources to make these global goals achievable

and to deliver the quality care that is required for both the mother and child during the time of pregnancy; as well as after pregnancy itself.

Fundamentally, the state has a good policy but struggles to implement it beyond tangible infrastructure. Often the delivery of the tangible and technical infrastructure surpasses the people and programming is needed to optimise it to its full potential. It is also when these intangible aspects are considered by the State, that major improvements can be seen within the public maternal healthcare sector that overall, the number of maternal deaths will decrease significantly and that the perceptions of women who receive these services change and become more positive. These changes will also speak to bigger changes, such as staff retention and staff being more disposable in their roles with the support and resources that they require.

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