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1000 Risks and Birth-and-Death in Cape Town

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By Greg Clinton

"I was willing to die," Terri told me, "I just didn't want to have another caesarian." She referred to her vaginal birth after three c-sections (a VBA3C), which took place at home, since no Cape Town hospital would allow her what is termed a trial of labour – an attempt at vaginal birth – for fear of uterine rupture. It is widely agreed that the risks for planned VBACs are far less than that of planned repeat c-sections (RCOG 2015; Curtin et al 2013). Yet, all the obstetricians that Terri consulted in this pregnancy and the last two (in both the public and private healthcare sectors) preferred planned c-section risks to the risk of uterine rupture. One doctor told her that waiting for spontaneous onset labour was like running blindfolded across a busy freeway. Terri came to disagree profoundly with the doctor's risk assessment. Now, most medical caregivers agree that the risks are far higher for VBACs taking place at home, not because there is a greater risk of uterine rupture at home, but because in that extremely rare case it may take too long to reach an operating theater. However, Terri could not find a hospital that was willing to support her attempt at a VBA3C. In addition, at a previous attempt at a VBAC in a private hospital, Terri was only allowed to labour for seven hours before being told she must have a repeat c-section. This time, with her husband's wholehearted support, she prepared carefully for home birth, where she would have more control. She would go to a nearby public hospital if she needed emergency surgery. She gave birth at home vaginally to a healthy infant after forty hours of peaceful labour, during which regular hand-held Doppler heart rate measurements indicated that her baby was never in distress. Terri says that once labour got going she could feel there was no weakness in her caesarian scar, and so was never scared of rupture.

Though "I was willing to die" was a shocking statement, in my ongoing ethnographic investigation since 2014 of how perinatal risk is defined in Cape Town, I have found Terri's conviction was far from singular. In my observation of independent midwifery consultations in Cape Town, antenatal classes, births, social media interactions, in my own doula training, and in conversations with pregnant women and their partners, public hospital authorities, doctors and midwives, it was clear that for everyone the stakes were high in what counted as an indication for a c-section. I want to unpack here some of the terms of reference for assessing Terri's risk – this is to juxtapose some very different ways in

which her or her child's death could signify in post-apartheid South Africa.

"I was willing to die" sounds careless of risk, but Terri made a very careful risk assessment. It was the conclusion of many years of evaluating multiple modes of defining personal and generic perinatal risk. So, "I was willing to die" also meant: "I judged uterine rupture was less likely than in-operative and post-operative c-section complications." It also meant: "I thought running the small risk of uterine rupture was worth it because I knew for certain I would not be allowed another pregnancy after a fourth c-section." More broadly, it meant: "I trust my body and God." Terri read medical research on VBAC risks, consulted with experienced midwives, drew on the experiences of her three other pregnancies and on the experiences of acquaintances on social media for women considering VBACs. In addition to all this research, Terri also had a deep faith in a God-given ability to birth vaginally.

Terri, and many others like her, often find themselves occupying a position somewhere outside of both the private and public South African healthcare systems. In South Africa notions of working and middle class status, and along with that emergent redefinitions of race, are often mapped onto the almost free public healthcare system and the exorbitantly priced private sector. Terri would have been classified as "Coloured" during apartheid, and so would not look out of place among almost exclusively black patients in the public maternity sector. However, VBAC-seekers like Terri are not easy to place in terms of class, exposing the extent to which this category has become increasingly shifty in post-apartheid, millennial South Africa. In a millennial economy, as Jean and John Comaroff describe it, people are less likely to identify themselves in terms of class, though "frequent flyers and frequent fryers" become more and more separate from each other, and the middle classes lose exactly the income security that established them as middle class (300-303). In a biopolitics of public health risk management, Terri is not easy to place, either. In some ways she represents a risk to the biopolitical endeavor of securing the first 1000 days of life: her VBAC is too risky for a public hospital in a country judged by the UN to be failing at reducing maternal and infant mortality. However, as someone who could consider using a private hospital (with personal savings or credit rather than medical aid), her VBAC could also been in a very different category of risk assessment: that of malpractice insurance.

As cultural analyst Mary Douglas wrote in 1992, "risk is always political" (44). While not denying the reality of danger – "always horribly real" – she argues that the notion of risk is a euphemism for danger. Risk, with a nod to probability mathematics, simply sounds more scientific (24-9). In a post-millennium context of highly influential global NPOs, the value of risk discourse lies not only in its connection to science, but in its connection to national population, judged globally. So, in 2013, the WHO could find

South Africa as failing to reduce perinatal infant and maternal mortality rates. In the countdown to "the first 1000 days of life," now believed to be a crucial window for intervention for optimum life-long cognitive ability and well-being, the perinatal period is considered an important time for public health interventions. While there were no explicit references to "the first 1000 days of life" in my field work, it was very clear that perinatal deaths were highly significant of postcolonial South Africa's health as a nation-state. So, for instance, the *Mail & Guardian*, a must-read paper for South Africa-based policy-makers, researchers and intelligentsia, wrote that "Giving birth in SA gets riskier," and "Birth [is] a measure of progress".

It is tempting to see death's proximity at birth in terms of national developmental pathology, physical risk or as the pathology of birth itself. However, birthing spirituality suggests an alternative view, one that was important as part of Terri's risk assessment toolkit. Stellenbosch midwife Sr. Robyn Sheldon writes that "[n]ew life entering this world feels fragile, not because newborns die easily – they are remarkably resilient; but because the baby is still hovering on the brink between fully entering life and leaving behind a more cosmic consciousness" (75). This view would seem counterfactual to many more mainstream South African medical caregivers invested emotionally and epistemologically for many years in a narrative of saving babies and mothers through medical risk assessment. Yet many birth workers I spoke to believe that medical risk is linked directly to what might be termed soul work. They believe, for instance, that it is essential to mourn for lost children in order to avoid prolonged labour (and so avoid c-sections), since it is their experience that in labour unsurfaced fears cause the release of adrenaline, negating the oxytocin that prompts the cervix to stretch open. Sr. Marianne Littlejohn, drawing on thirty years of midwifery experience in South Africa's public and private hospitals, explained to me that "birth involves grief and death. You have to be able to let go, of your body, of how you look, of your plans, your dreams. A woman who can't grieve is a woman who will have a hard time in labour."

I present here different kinds of death apparent in Terri's risk assessment of her VBA3C. The first is the statistical danger of death. Then, Terri's or her child's death would have signified also in terms of population – of women seeking VBACs, of women registered in a public sector facility. Such deaths would be significant of national development (or lack thereof). Terri also considered death in terms of her religious beliefs, and in terms of what I would term "soul-aware life-giving", a mode of birthing preparation that makes reference both to medical concepts and to spirituality. If, as Sr. Littlejohn suggests, a woman who can't grieve is a woman who will struggle with labour, a woman who cannot face down the threat of her own death (in multiple modalities) cannot attempt a VBA3C, as things stand now, in the Cape Town birthing sector.

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