Mothers Matter: Developing the ‘Waiting Mother’

2017-09-18 13:18:13

By

“Waiting indicates that we are engaged in, and have expectations from, life; that we are on the lookout for what life is going to throw our way” (Hage, 2009: 1).

Waiting is an inevitable part of human existence. Whether we are waiting for the bus, waiting to heal, waiting to give birth, or waiting for the day to begin or end, waiting manifests for a variety of reasons, durations, and may be accompanied by a wide range of emotions. Waiting can be regarded as subjective or objective (Fujita, 1985); modal, relational or active (Auyero, 2011); or as political, social or cultural (Hage, 2009). Waiting can also be perceived as a fruitful process, providing one with time to think; “waiting can be a rewarding experience, eliciting reflection on time and human existence (Schweizer, 2008: 126). On the contrary, for Javier Auyero (2011), waiting implies ideas of powerlessness and helplessness, which does not affect everyone in the same way. Waiting, according to Auyero, can be interpreted as stripping the waiting person from his or her agency. However, while it is common to assume that “waiting is a passive modality of being where people lack agency” (Hage, 2009: 2), waiting can also be agentive in nature. Waiting, can thus entail “passive activity” (Crapanzano, 1985) or “active passivity” (Hage, 2009). Both versions imply waiting as a form of activity, action, or something we do. Ultimately, waiting offers many lenses through which to understand and make sense of the complexities of everyday life.

In my research, which sought to evaluate the feasibility, efficiency, and sustainability of a video card intervention that was aimed at educating waiting pregnant women and mothers in a local state antenatal clinic about early childhood development (ECD) and maternal and child health (MCH), waiting emerged as the activity that took the most time in the clinic. As an analytical tool, the concept of waiting proved useful in understanding my research process, as well as how time affected pregnant women and mothers in the clinic. Since waiting affected all pregnant women and mothers in the Community Health Clinic (CHC), where my research was conducted, this paper shows how the time that women spent waiting in clinic was normalised for the sake of development. More specifically, I will argue that (waiting) mothers were made to matter within the clinic space

via development interventions supplied by the state and external development agencies. This was done by reframing the waiting time of women as 'wasted time' and as an 'opportunity' during which to educate specifically pregnant women and mothers about ECD and MCH developmental issues.

Waiting as Wasted Time

"When we wait in the doctor's clinic, for example, we surrender our time to another. This is willingly done, except when it takes *too long,* when we start to feel out of synchronicity with the time that we think it should take. Waiting, then, becomes a waste of time…" (Tan, 2009: 73; italics in original). When waiting is perceived as wasted time, it can evoke subjectively negative emotions within the person who is expected to wait; as Crapanzano states, "waiting produces in us feelings of powerlessness, helplessness, and vulnerability — infantile feelings — and all the rage that these feelings evoke" (1985: 45). The lengthy periods of waiting experienced in South African public spaces – especially in the waiting areas of public services institutions, such as "home affairs for birth registration, SASSA offices for grant applications and collections, primary healthcare clinics for antenatal visits and immunisations" (NGO Pulse, 2014) – were normalised and perceived by those with power, such as the state and development agency, as time that was 'wasted' and as time that patients should make available in order to access state resources. In other words, they viewed waiting as time that must be 'endured' and simultaneously as time that must be used 'productively'. When this occurs, waiting can be seen as an 'opportunity' during which to achieve certain goals.

This was the case for my research project which was aligned with and supported by the "Waiting Room Project", launched by The Innovation Edge in November 2014 (NGO Pulse, 2014), that called for creative and innovative ideas to transform various 'waiting places' into 'engaging spaces'. As I will show, however, the assumption that 'waiting places' are not necessarily 'engaging places' is somewhat erroneous since a great deal of activity happens in waiting spaces. The video card intervention was supported by The Innovation Edge because it was imagined and anticipated that the intervention would be able to 'transform' the CHC antenatal clinic and MOU waiting places into engaging spaces. In particular, it was expected that the video card would enable (working class) pregnant women and parents to learn about foetal and infant care behaviours via the video as they sat in waiting areas of the public CHC. Three assumptions consequently rendered this project possible: (1) waiting in public healthcare facilities was inevitable and normal; (2) waiting places were not necessarily engaging spaces; and (3) waiting time and waiting spaces were wasted opportunities. It was

therefore as a result of these assumptions about waiting that the 'waiting mother' was produced, developed and made to matter within the CHC waiting rooms.

Waiting for Something

"Waiting is always waiting for something. It is an anticipation of something to come — something that is not on hand but will, perhaps, be on hand in the future" (Crapanzano, 1985: 45). I entered the clinic with a narrow idea of what, and how long, pregnant women waited for: to give birth (spanning over several months) and to be assisted by nurses (ranging from minutes to hours); however, my observations revealed that the "object of waiting" (Crapanzano, 1985: 45) for the pregnant women in the CHC extended far beyond these two simplified forms of waiting. Furthermore, the waiting time and appointment lengths varied for each woman, ranged from twenty minutes to three hours. During these minutes to hours that pregnant women spent waiting in the CHC antenatal clinic, it can be argued that the women were "always waiting for something" (Crapanzano, 1985: 45). Whether pregnant women waited for the clinic to open, for their clinic cards to be checked, for their names to be called, for their appointment dates to be issued and to arrive, for their appointments to begin or end, or for their test results, the process of waiting for and in between these standardised procedures, was always presented as 'inevitable' and 'normal' in the public healthcare facility. The notion that waiting is 'inevitable' and also 'beyond our control' is explored by Ghassan Hage (2009). Within its (albeit ambivalent) capacity to be agentive, waiting can also be political, as there is a politics around *who* has to wait, *what* waiting entails, *how* to wait, and also how waiting is *organised into a social system* (Hage, 2009: 2). In this regard, waiting is linked to power, an idea supported by Pierre Bourdieu who states, "the all-powerful is he who does not wait but who makes others wait" (2000: 228). Waiting is thus not only shaped by the person who is waiting, but is also determined and shaped by those providing whatever it is that people are waiting for (Hage, 2009: 3). This is the case for public healthcare facilities, where the lack of efficiency, poor services and the scarcity of specialised medical professionals is measured by the duration of waiting time. Nursing staff at the CHC therefore experienced waiting differently to pregnant women.

Analysing waiting in a welfare office in Bueno Aires, Javier Auyero's (2011) research represents the subjective mode of waiting (see Fujita, 1985) and demonstrates how the waiting experiences of poor people in the welfare office were grounded in (subjective) feelings of confusion, uncertainty and arbitrariness. Auyero argues that "these waiting experiences persuade the destitute of the need to be patient, thus conveying the implicit state request to be compliant clients" (Auyero, 2011: 6). As found by Auyero, the welfare clients often compared their

waiting time at the welfare office to the waiting time in public hospitals: “in both places they have to (silently) endure; they have to act not as citizens with rightful claims but as patients of the state” (Auyero, 2011: 23). Auyero (2011) further categorises waiting as modal, relational, and active. First, waiting is a modal experience; patients “have to wait for almost everything (e.g. housing, health services, employment)” (2011: 9). Second, waiting is a relational experience; “they create or mobilize a set of relations or networks that allow them to spend long hours there. While there, they often meet with friends and relatives who help them tolerate and make sense of those boring and tiring hours” (Auyero, 2011: 14). Third, Auyero’s ethnographic observations revealed that welfare clients kept themselves active while they waited, by playing with their children, feeding and changing their infants, walking around, leaving the building to buy snacks, playing games on their cellular phones, or occasionally reading the newspaper (Auyero, 2011: 15).

Based on my observations, the waiting periods for the pregnant women in the CHC antenatal clinic can also be categorised as modal, relational and active. While most of the women sat alone and in silence, waiting for their names to be called by the nurses and for their antenatal appointments to begin (i.e. their waiting time was modal); some were accompanied by their partners or fathers of their babies, family members, friends, and younger children (i.e. their waiting time was relational). Moreover, some women browsed through the *Mother, Child Health and Nutrition* booklets and breastfeeding pamphlets that were provided to them by the nurses; some listened to the peer counsellors’ educational talks; some were busy on their cell phones, either playing games, texting, making phone calls, or browsing the Internet; and some waited by eating food or not eating at all (i.e. their waiting time was active). Nevertheless, while many of the women managed to occupy themselves while they waited in the antenatal clinic waiting areas, and thus had ‘some’ control over their waiting time, this was not always an enjoyable experience for all.

For Zara, a twenty-three year old woman from Rwanda, who was six months pregnant with her second child at the time of the interview, the process of waiting in the CHC antenatal clinic was “very boring”, adding:

Because, like you sit here like, I’ve been here from half past six till now [13:00] and I’m sorry, there’s like people that didn’t bring food, my husband brought me food, but then, I mean imagine like for a pregnant person from six o’clock until now and you did not have something to eat then that’s not really good.

Zara’s period of waiting was the longest I had encountered during my fieldwork. Even though her appointment was for 07:00, she arrived thirty minutes beforehand to ensure that she would be assisted “on time”. In

total, Zara spent seven hours at the antenatal clinic, of which more than six hours were spent ‘waiting’. In another example, Robyn, a twenty-five year old woman, who was nine months pregnant with her first child at the time, found waiting at the antenatal clinic to be tiresome. However, since her medical aid scheme had ended after her work contract recently expired, Robyn was prepared to wait because she valued the free healthcare services offered by the state clinic, even though the duration at the public clinic far exceeded the waiting time at the private clinic she previously attended. Her stance is revealed as follows:

Kylie: How long have you been waiting?

Robyn: Yoh, ok, no I can’t lie [laugh], what time is it now?

Kylie: It’s half past one (13:30).

Robyn: Yoh, I came here… Say, an hour, say an hour.

Kylie: So half past twelve? How long do you usually wait at the private clinic?

Robyn: No, they do appointments, when I get here they see me, when they’re busy, it’s like 10 minutes max.

Kylie: Ok, so this is long?

Robyn: [laugh] No, this is long! But rather be patient and get good service than get help quick quick and next patient. No, I trust government.

The feelings of boredom, exhaustion, and frustration that accompanied long durations of waiting at the CHC were also revealed to me in other unexpected situations. Shortly after interviewing Robyn, I went outside for a short break, where I was approached by a young man. Making small talk, he said to me: “*Yoh! Hie’ wag ‘n mens tot jy dood is*” (“Gosh! Here, one waits until one dies”). All I could do was sympathise. As I stood outside, Robyn passed by me on her way back from buying a snack from the informal trader; she, too, suddenly commented:

“*Yoh!* I must still wait long… Probably until tonight!”. Robyn was eventually done with her antenatal appointment and left the clinic at 14:40. Having arrived around 12:30, she had spent over two hours at the clinic. While some working class pregnant women found waiting to be “boring”, others were content with waiting, provided they received free and adequate antenatal services from the clinic, and that they had something with which to occupy their waiting time.

The way that ‘time’ is rationalised, counted, and materialised in our contemporary world, and especially as it is materialised within public healthcare facilities, means that some people (patients) are constituted as having enough or even a surplus of time and others (staff) as not having enough time. Pregnant women, in particular, spent many minutes to hours waiting in the CHC antenatal clinic. The power to make pregnant women (and other patients) wait rested not in the hands of the state who was in control of public healthcare resources. As such, (working class) pregnant women who wanted or needed to access free antenatal services and other state resources were not only expected to ‘make time’ to attend their scheduled antenatal appointments, but once they were in the clinic, the women were also constituted as having ‘time to waste’. Instead of reducing the time that pregnant women spent waiting or improving the speed and quality of antenatal services offered by public clinics, the state capitalised on their waiting time. The state, together with the development agency supporting the video card intervention, consequently sought to normalise ‘waiting’ by implementing interventions within the clinic waiting spaces. As a result, the ‘waiting mother’ was produced, developed, and made to matter within the clinic as a way to distract from the long durations of waiting time that had become normalised in the waiting areas. In particular, she was made to matter in a way that would reframe her waiting time as an ‘opportunity’ to learn. By choosing to view waiting time as ‘wasted time’ and as an ‘opportunity’ through which to transform ‘waiting places’ into ‘engaging spaces’, the implementation of the video card intervention in the CHC waiting areas not only contributed towards the normalisation of waiting, but also resulted in the devaluing of all patients’ time, but particularly women’s time. This was primarily because the creation and implementation of the video card rested on the assumptions that firstly, women had sufficient time to spend/waste waiting in the clinic during their antenatal clinic visits, and that secondly, they had nothing to do while they waited, and that the waiting areas were not engaging spaces. My research, however, found the opposite to be true. For instance, none of the pregnant women explicitly referred to their waiting time in the CHC antenatal clinic as ‘wasted time’ because they knew they were “waiting for something” that would benefit their own health, and the health of the babies. Pregnant women thus attended their antenatal appointments at the public clinic for specific reasons, and willingly surrendered their time for the sake of their unborn babies. Moreover, while some women spent far more hours waiting in the antenatal clinic than others, all women were relatively busy during their ‘waiting’ times on antenatal visits, either moving between nurses’ examination rooms, or occupying their time as they pleased. While many women valued the video card intervention, the video card was introduced into the CHC waiting areas under numerous false assumptions.

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AMA citation
. Mothers Matter: Developing the 'Waiting Mother'. *Somatosphere*. . Available at: . Accessed September 18, 2017.

APA citation
. (). *Mothers Matter: Developing the 'Waiting Mother'*. Retrieved September 18, 2017, from Somatosphere Web site:

Chicago citation
. . Mothers Matter: Developing the 'Waiting Mother'. Somatosphere. (accessed September 18, 2017).

Harvard citation
, *Mothers Matter: Developing the 'Waiting Mother'*, Somatosphere. Retrieved September 18, 2017, from <>

MLA citation
. "Mothers Matter: Developing the 'Waiting Mother'." . Somatosphere. Accessed 18 Sep. 2017.<>