The new era of democracy in South Africa is meant to be enjoyed by all citizens of the country wherein justice, equity and human dignity are core values. However, twelve years down the line, access to health care seems to be far-fetched especially for the poor majority, with women being at 'the bottom rung of the pile' (Flood et al. 1997). This arguably brings the issue of equity and human dignity to the forefront of our discussion in our attempt to highlight the gaps created by an unequal distribution of resources in the country. The first section of our chapter gives a brief historical exploration of the causal factors for the continual inequalities in accessing health-care facilities in South Africa, specifically for black South African women we examine the colonial and apartheid interface and argue that historical factors have greatly contributed to black women's ill-health and poor access to quality health-care. This sheds light on why health-care is still more easily accessible for the rich, including while females who can afford a healthy lifestyle and good medical care, backed by their ability to take out medical insurance. The long history of apartheid means that there is a huge gap between the rich and the poor that generates inequalities in wealth and access to basic services for the majority, the poor black people. The most affected people in all of South Africa's disadvantaged groups are black women who still live in poverty anti lack access to the basic human rights of education, clean water and sanitation, proper housing

and health care (Haddad 2001: 9). This is largely because gentler imbalances in South Africa's colonial and apartheid history have subjected women to a triple oppression, which is based on class, race and gender. This triple heritage means that they are worse off and suffer the brunt of poverty and neglect as they are under-resourced. Their lack of financial power means that they cannot afford the medical insurance that would guarantee them accessing better-equipped and well-maintained health-care facilities. Although there are some free medical services in die country, the queues are agonizingly long and service delivery is slow, so that gravely ill people will spend more than e.gh; hours waiting to be attended to. This is indeed worrisome and a cause for concern since firstly, women are child-bearers and need ante-natal and post-natal care. Secondly, they are more vulnerable to being infected by HIV and AIDS because of their physiological make-up. Thirdly, most black women are dependent and therefore lack access to resources that can assist them in obtaining good medical care. This has far-reaching repercussions especially in view ill the current HIV and AIDS scenario. This is what the first section discusser. The second section examines the strength and significance of the African ethic of *ubuntu* which entails notions of care and interrelatedness, highlighting how *ubuntu* informs and influences women's role in care-giving. However, the predicament that sets in is that these major care-givers are also being infected by the HIV virus at a very high rate and the question that

arises is: who cares for the carers? Consequently, we critique the application of tile *ubuntu* ethic by raising the issue of who belongs to who. Nevertheless, we propose not to reject this valuable ethical tool in our attempts to construct an ethical and holistic health-care package. The third section examines black women's agency in health-care. We use the term agency to mean 'empowered to act' or 'taking action' when cur fronted with a crisis. By emphasizing women's agency in care-giving developing and sustaining their communities we highlight the meaningful role that women continue to play in their impoverished communities .Even, amidst the prevailing HIV and AIDS crisis, women have remained resilient in their caring and nurturing for life. Their empowerment is not based on financial resources, but on African humanist values that mirror Christian values: a resource that is indispensable to humanity. We conclude our argument with the suggestion that women could be more effective agents of care for themselves and for others if more resources are allocated to them in development programmes. Our conclusion emerges from the information provided to us by our dialogue partner. Zandile Myeni, who works for a health-care organisation that aims at providing services to poor black people with a special focus on women and children in Soweto In light of the above conclusion, we suggest that African values espoused in *ubuntu* are a cornerstone on which women's resilience is anchored; therefore society needs 10 continue tapping into these resources. The major challenge we raise for policy

makers both in the South and the North is that in spite of some of the limitations of *ubuntu,* African values which continue to bind us together and care for each other should be preserved and nurtured.