

Enduring “lateness”: biomedicalisation and the unfolding of  
reproductive life, sociality, and antenatal care

Nicole Ferreira

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Supervisor: Prof. Fiona Ross

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This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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## Abstract

The dissertation examines how pregnant women seeking antenatal care at a state facility in the Southern Peninsula of Cape Town conceptualise and experience their pregnancies in relation to the biomedical model that informs state practices of care. I specifically explore the experiences that contribute to the state's definition of 'late' presentation at antenatal clinics (i.e. after the first trimester). The antenatal care model advises that pregnant women report "early", at 12 weeks, and have regular follow up visits up until 40 week period, yet recent public health research showed that women present "late" to the antenatal clinics, with only 40.2% of first antenatal visits occurring in the first trimester in South Africa. The women who were a part of the research were chosen in the clinic space, in waiting rooms, booking rooms and while waiting for ultrasounds. The women were selected based on age (17 upwards), and gestational age at first antenatal booking. I examine the ways biomedicine frames temporality, and the way that health policy enacts this through antenatal care. I contest the brackets of 'lateness' and biomedicalisation of pregnancy, and the state's version of the female reproductive body as I describe the unfolding experiences of a reproductive life, showing how pregnancy and health care seeking are enmeshed in social worlds. The discursive framings of antenatal attendance exhorts women to seek antenatal care at 12 weeks gestation, to "be responsible" "good women" managing their sexual and reproductive lives with a mode surveillance that presumes a certain way of knowing and counting the body. I explore the other ways of experiencing, knowing, and counting, showing how pregnancy experiences and healthcare seeking behaviours are influenced by social, economic, political, and historical factors, and by the moral and religious values that shape daily life for women. My thesis is grounded in the growing literature on anthropology of reproduction and the biosocial. In doing so, I examine what it means to have and experience a reproductive body within the unfolding events of everyday life, where moments and 'quasi-events' (such as structural inequalities, and the daily bouts of gang violence and domestic violence) become enmeshed, such that they influence temporality, differing perceptions of trust, distrust, risk and testing, and differing social values of testing. I further show how maternal kinship networks of support are valued, yet precarious as are intimate partnerships, which both influence experiences of care, neglect, abuse, punishment and shape antenatal attendance. In contesting temporal boundaries of biomedicine I show how women's bodily and relational experiences, their everyday lives and quasi-events within them are inseparable in shaping antenatal health seeking practices and how pregnancies are imagined.

## Glossary of terms

*ANC*: antenatal care

*Geelsug*: understood as something that makes your baby yellow, likened to jaundice.

*Jirra*: A colloquial Afrikaans term used as an expletive, and commonly understood as an expression of frustration, annoyance, and excitement.

*Moffie*: a derogatory Afrikaans term for a homosexual man.

*MOU*: Midwife Obstetric Unit

*Naartjie*: tangerine

*Ordentlikheid*: decency, respectability

*Senuweagtig*: working on one's nerves; nervous.

*Skaam*: shame (no skaam – no shame)

*Skeeming*: think, opinion, reckon; from scheme

*Skelling*: scolding

*Stoep*: Stoep is a small veranda or set of stairs outside of a house.

*Symphysis-fundal height (SFH)*: measurement used to assess foetal growth. Measurement is taken with a tape measure starting from the highest point of the uterus (the fundus).\*

*Vermaak*: amusement; for one's amusement

\*See state maternal care guidelines for details of antenatal first booking tests and examinations (**appendix 1**)

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## Preface

### Tracing the pathway to the clinic: space, site, and research focus



Image 1 Retreat MOU

*During the first visit to the clinic to meet the staff, I sat waiting on the side benches surrounded by about 70 pregnant women, they were accompanied by partners, and their children (who were fidgeting on the benches). The benches that I too would begin to fidget on in discomfort while I waited for the nurses. It was an Autumn March day and despite the early chill in the air, the clinic felt claustrophobic, the apartheid era, military industrial fans on the top of the walls provided a time warped feeling, but no relief from the mugginess as they remained switched off. Once research began in July, the atmosphere was different, the rooms less full, and there were no children around - a newly stuck sign indicated that no children were allowed in to the clinic hung over the chairs. Women were called by number to the front of the waiting room to get their blood pressure taken, height and weight in the back room next to the toilets (missing seats), and called into examination rooms, the HIV testing room and the history taking room. The women were called into the separate rooms (history taking, HIV testing, physical examination). Over the course of the research faces would become familiar as women came in for follow-up visits throughout their pregnancies and I could continue an ongoing conversation with them. Rose, from Malawi, always smiled the most when she saw me, it was a warmth of familiarity as I saw her from her first booking appointment, during one of my first fieldwork days where I had made small talk about her home language Chichewa, to which she had looked pleasantly surprised that I knew this linguistic fact, through to her waiting close to labour. I would check-in where the nurses were for the day and who was doing history-taking information, followed by checking the outside wall of*

*the examining rooms that had an A4 page of names of the women who were there for their first antenatal visit, written in numerical order followed by their gestational age (if they had already had the first physical examination done by 7:30am). The page was a standard page, hand written by the nurse in charge for the day and photocopied for any nurse needing to call and tick off names for women on their first visit to the clinic. The list of names included 15+ women who had booked a space for the day. The gestational ages on the list usually ranged from 8-25 weeks (occasionally some were over 25 weeks), marking many on the list as past the recommended “early 12 weeks”.*

There is a public health imperative that pregnant women arrive for their first antenatal visit at 12 weeks and before 20 weeks to prevent and reduce risk and attend to health concerns including diabetes, HIV, STIs, high blood pressure (Antenatal Care Guidelines, 2007; Maternal Care Guidelines, 2015; DoH, 2014: 39-42). Many staff members at the clinic recognised and tended to question why women may have exceeded 12 weeks gestation age before booking. I aimed to establish the various reasons surrounding “late” reporting through highlighting the range of state and health discourse influencing antenatal care and the framing of “early” arrivals, or efforts to reduce “late arrivals”, observing the clinic staff tending to the continuous flow of pregnant women of various gestational ages, and in speaking to pregnant women themselves. I settled on this research question as it allowed for research that examined state organisation of pregnancy, and ethical conduct. Previous studies (Masuku, et al., 2012; Abrahams and Jewkes, 1998) have shown that women who report for ante-natal care ‘late’ are accused by nursing staff of being ‘bad mothers’, and cases of maltreatment have been reported. In contesting temporal brackets of antenatal attendance, I am interested not only in the experiences of pregnancy, but also social, economic, political, and historical processes that shape women’s lives within spaces of financial and physical precarity, and how events of violence in the everyday weave into reproductive experiences. I focus on how biomedical definitions of ‘lateness’ as envisaged in reproductive healthcare policy make specific assumptions about the female reproductive body. These include assumptions about knowledge, counting and marking of menses; knowledge and surveillance of pregnancy ‘signs’ and menopause ‘signs’; taken-for-granted notions of trust in biomedical intervention; and assumptions that context and individual are separable, such that individuals bear responsibilities that are assumed to be independent of the context that shape understandings of pregnancy and care. As I show, these contexts of structural inequalities, violence, kinship obligations among others, shape how and when women begin to access state-provided reproductive health care, complicating the picture of temporality that underlies medical regimes. I show that biomedical temporality focuses on a linear notion of pregnancy, health care and self-regulation. This underestimates how deeply enmeshed pregnancy is in the social and the

everyday that shape differing forms of knowing and rhythms of reproductive knowledge and healthcare seeking. Drawing from contemporary ideas about events and the everyday (see particularly Povinelli, 2011; Das, 2015), I examine how different dimensions of everyday life intersect with the medical imperative to care for oneself and one's foetus. A bracket that has consequences of ill-treatment and social judgement as it is laden with the discourse of "a good woman" and her "responsibilities" as a mother within the state care.

## **Background to state antenatal care in South Africa**

Antenatal care in South Africa is structured as a three tier referral system with an emphasis on primary health care<sup>1</sup>, as adopted post-1994 by the National Health System. This model seeks to improve access to free primary health care (Dlakavu, W.F, 2012; Abrahams, Jewkes and Mvo, 2001: 241). The reproductive sector is highly medicalised in South Africa where most births occur in a medical facility, and 84.4% of women have a skilled attendant assisting at their delivery (Tlebere et al 2007; Rogerson, unpublished 2016). In terms of provision for reproductive health, Midwife and Obstetric Units (MOUs) make up the first tier that provide care services by midwives for "low-risk", "uncomplicated" pregnancies (Dlakavu, W.F, 2012). The secondary and tertiary units deal with referrals of "high risk" patients and are formed by the regional or provincial hospitals (Dlakavu, W.F, 2012). The MOU's started between 1973 and 1980, and were structured within the apartheid segregation system and located in the "non-white" areas in Cape Town (Bishop Lavis, Elsies River, Gugulethu, Hanover Park, Heideveld, Khayelitsha, Kraaifontein, Macassar, Michael Mapongwana, Mitchell's Plain and Retreat) (Thompson, 2007). Nursing in South Africa has also been shaped by colonisation and the apartheid system as the profession was racially segregated and discriminatory with the disenfranchisement of African nurses (Abrahams, Jewkes and Mvo, 2001: 241; Rogerson, unpublished 2016). The weight of the historical framings of segregation and inequality are worth noting as the effects of such inequalities are still present in the structure and location of the MOUs. The inequalities are present in the unequal distribution of resources, skilled workers, unequal access to public healthcare facilities (that serve 70% of the population), overburdened and underpaid staff, and poor working environments, which have been shown to add to the stress felt by staff

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<sup>1</sup> Comprehensive Primary Healthcare (PHC) approach is in line with global recommendations based on the 1978 Alma Alta Declaration. The PHC approach is based on a preventative system rather than curative, and goes hand in hand with a District Based Healthcare system in order to better utilise resources, and improve access to and quality of healthcare (Dippenaar, 2009:8).

(Dippenaar, 2009:3, 41; Bhaga, 2010). The resource inequalities and overburdened staff were factors that were still present during my fieldwork, however, Retreat MOU was still considered by the staff and pregnant women to be in better condition than surrounding MOUs.

Ante-natal care is “designed for the early detection of deviations from normal pregnancy, and the early treatment of medical conditions that can have an unfavourable effect on the mother and/or the infant” (Wedin, et al., 2010:389). The antenatal care model advises that pregnant women report “early”, at twelve weeks gestation, and have regular follow up visits up until 40 week period (four visits for “low risk” patients) (DoH, 2007:28). In the first visit, a history is taken, risk factors are assessed, and routine procedures are performed, including checking blood pressure; abdominal palpitation to assess size of the uterus, foetal position, discomfort, previous surgical scars; and foetal heart auscultation, examination for oedema, weighing, urinalysis, HIV testing(See **Appendix 1** for antenatal guidelines for the first booking visit). An antenatal card is created that carries the record of these assessments (Mathole, et al.,2005: 386; Solarin and Black,2012:364; DoH, 2007:20-27; Pattinson, 2005: 5-11).

The importance of the “early” check-up is emphasized in South African health care guidelines, policies and strategies such as in the Department of Health’s *Basic Guidelines for Antenatal Care* (2007), as well as in international policies and public health strategies and initiatives.<sup>2</sup> South Africa has put in place strategies such as the *Strategic Plan for Maternal, New Born Child and Women’s Health and Nutrition in South Africa 2012-2016 (MNCWH)*; and *South Africa’s National Strategic Plan for a Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA 2012)*. One of the key points of the strategies has focused on the “advocacy and health promotion for early antenatal care and attendance/booking” (CARMMA in Masuku, et al., 2012). Across the studies and guidelines, there has been a general consensus that the quality of antenatal care is significant in maternal and new born health and survival. That this is an issue is clear from maternal and infant mortality rates, and lowering these is a key indicator in South Africa’s Millennium and Sustainable Development Goals. The maternal mortality ratio in South Africa (2015) were reported at 138 per 100, 000 (down from 154 in 2010) (WHO, 2015: 96; Day and Gray, 2012/2013: 208; Michalow et al., 2015:2). It has been reported that non-attendance and late attendance for antenatal care are “among the top five avoidable causes of perinatal deaths... and patient related maternal mortality” (Solarin and Black, 2012:359). Within South Africa, HIV

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<sup>2</sup> African Union’s initiative; the Abuja Declaration; African Health Strategy and the Millennium development goals 4 (Reduce child mortality) and 5 (Improve maternal health).

and mother-to-child transmission are major additional factors in mortality rates and are seen as avoidable through early detection and antenatal care attendance (Solarin and Black, 2012:359).

Despite the emphasis on “early” antenatal care booking, studies have increasingly shown that women present “late” to the antenatal clinics, with only 40.2% of first antenatal visits occurring in the first trimester and before 20 weeks gestations in South Africa (Day and Gray, 2012/2013: 241; Masuku, et al., 2012). Researchers offer a range of reasons, including: women not knowing about their pregnancies; differing ideas, beliefs and fears about acknowledging pregnancy in the first trimester; perceptions of “right time”; pregnancy as unwanted (or unplanned, or mistimed); lack of access to state health care and costs of accessing health care; lack of childcare options for existing children when mothers go to the clinic; fear of HIV diagnosis; ideas about intervention in ‘normal’ pregnancy; differing expectations about responsibilities for care (state versus family and individuals); the quality of treatment women receive (which is greatly affected by scolding from staff); the confusion of the bureaucracy of booking; waiting for appointments, and the systematic following of protocols (Masuku, et al., 2012; Abrahams and Jewkes, 1998).

As “late” attendance is seen as an avoidable cause of maternal, perinatal and infant death, those factors that contribute toward late attendance have been considered “avoidable factors, missed opportunities and substandard care” according to the assessments by the National Committee on Confidential Enquiries into Maternal Deaths (Moodley, J, et al., 2014:58). The enquiry involved assessing and dividing the factors into areas where they occurred, namely at the “patient/community level”, or within the healthcare service provider level and within its administrative and managerial systems (Moodley, J, et al., 2014:58). It was noted that the “institutional nature of the enquiry means that it does not explore the patient/community-related factors adequately”, and that narrative reports that illustrate these factors beyond their statistics were a good way to capture problems and inadequacies, and have become useful tools for education, discussion among health care workers and advocacy (Moodley, J, et al., 2014:58). My research built on the gap identified in this report, as I explored the nexus of reasons for women’s late reporting to MOUs, and traced these intersections of pregnancy, healthcare, well-being (and its other) in individual lives. I aimed to gain a fuller understanding of the features through which a pregnancy is recognized as having claim on the social.

## Research Question

*What are the experiences of women, such that these are contributing to 'late' presentation at antenatal clinics (i.e. after the first trimester); and how are women's reporting behaviours shaped by social experiences, including their own understandings of bodily states, geographic locations, and within kinship relations?*

Within this, I further explored core concepts in the organisation of state management of pregnancy, organisations of power, and questions of ethical conduct:

- What knowledge systems and social worlds intersect and collide in terms of how pregnancy is imagined during the first trimester?
- How do women experience and understand pregnancy?
- How does social tense (Povinelli 2011) frame these imaginings of pregnancy?
- How do the state's antenatal care policies and its medical institutions and staff envisage the temporality of pregnancy and understand 'lateness' and 'responsibility'?
- How do pregnant women understand the concept of 'time' during pregnancy? What does time for pregnant women mean in relation to their bodies and 'signs', and where mobility, access to, and timing of antenatal care is shaped by precarity and violence.

## Fieldsite context

Retreat MOU is situated within the Southern Peninsula in Cape Town. Previously identified as a "black and "coloured" area in terms of the Group Areas Act, it was subject to racialized regulations and restrictions of housing location, mobility, and job opportunities. As I drove through the back roads of Retreat and the mid-90s greying architecture, passing 1<sup>st</sup> -11<sup>th</sup> Avenues, there were many houses with corrugated iron sheets and remnants of wood and steel materials, all extensions, and there were also wooden houses (referred to as 'Wendy houses' rented out for extra household income, or occupied by extended family) in backyards (see Spiegel, 1987) (*Image 2*). Passing Heathfield High school between 7 and 8 am, on the way to the MOU, the roads had school children walking along them on their way toward the school. On my first trip to the clinic to establish relations in early March 2015, I got lost on the wrong side of 11<sup>th</sup> avenue and Retreat Road, which meant I circled between 11<sup>th</sup> and 9<sup>th</sup> avenue, before pulling up to an older woman for directions, to which she happily responded and excitedly asked 'who

was in labour' - easing my discomfort in an unfamiliar area, with a familiar excitement about life and birth at the MOU.

There is parking inside the space for the MOU and the Day clinic behind closed gates guarded by security guards with a sign in sheet. (Image 3, 4 and 5). Entering the MOU, my usual day begun after I spoke to the administration staff, and proceeded to the antenatal care section of the clinic, greeted by women waiting in the chairs who I would speak to throughout the day (Images 6-9). I spent many mornings in the room allocated for history taking. A small roughly 2.5 by 1.8 metre room with one desk pushed against the length of the wall, a desk chair for the nurse, and one chair on the side of the desk positioned at the width of the desk facing the nurse. Through that consultation room I could see a block of faded yellow apartment blocks with a line of informally set up structures in front of them, one particular structure appeared to be approximately 2 stories high with a vibrant array of flags and a small propeller picking up the wind; these living spaces peered through the barbed wire of the MOU wall (*Image 10*). Thus became my site and routine over the next six months.



*Image 2 Back roads of Retreat, Heathfield, and Wendy houses*



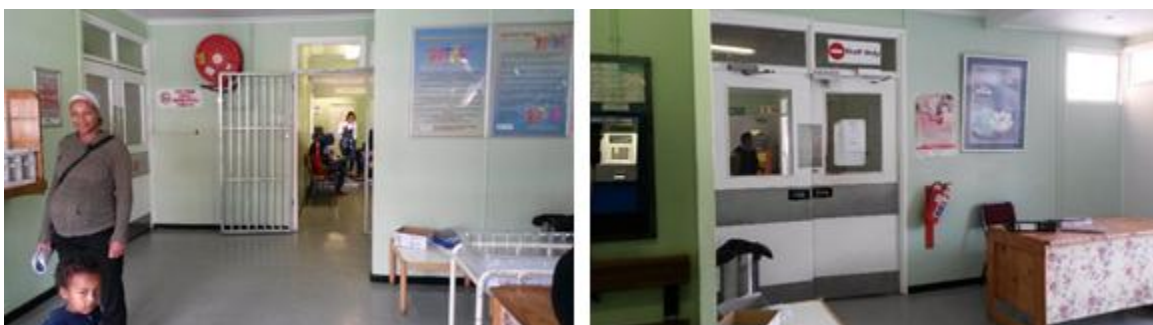
*Image 3: Entrance to Retreat MOU and Day clinic. Pedestrian gate on the right guarded by security. Signs: 'no guns' 'no knives'.*



*Image 4: Clinic parking lot*



*Image 5: Entrance to MOU; tuckshop with items such as crisps, fruit and juice; Retreat Day clinic on the right.*



*Image 6: Clinic entrance. Left: administrative offices, post-natal maternity ward, showers, and labour ward. Right: security desk, staff wing.*



*Image 7: Maternity wing and labour ward.*



*Image 8: maternity wing*



*Image 9: Maternity ward*



Image 10: MOU on the right, apartment blocks and informal houses on the left.

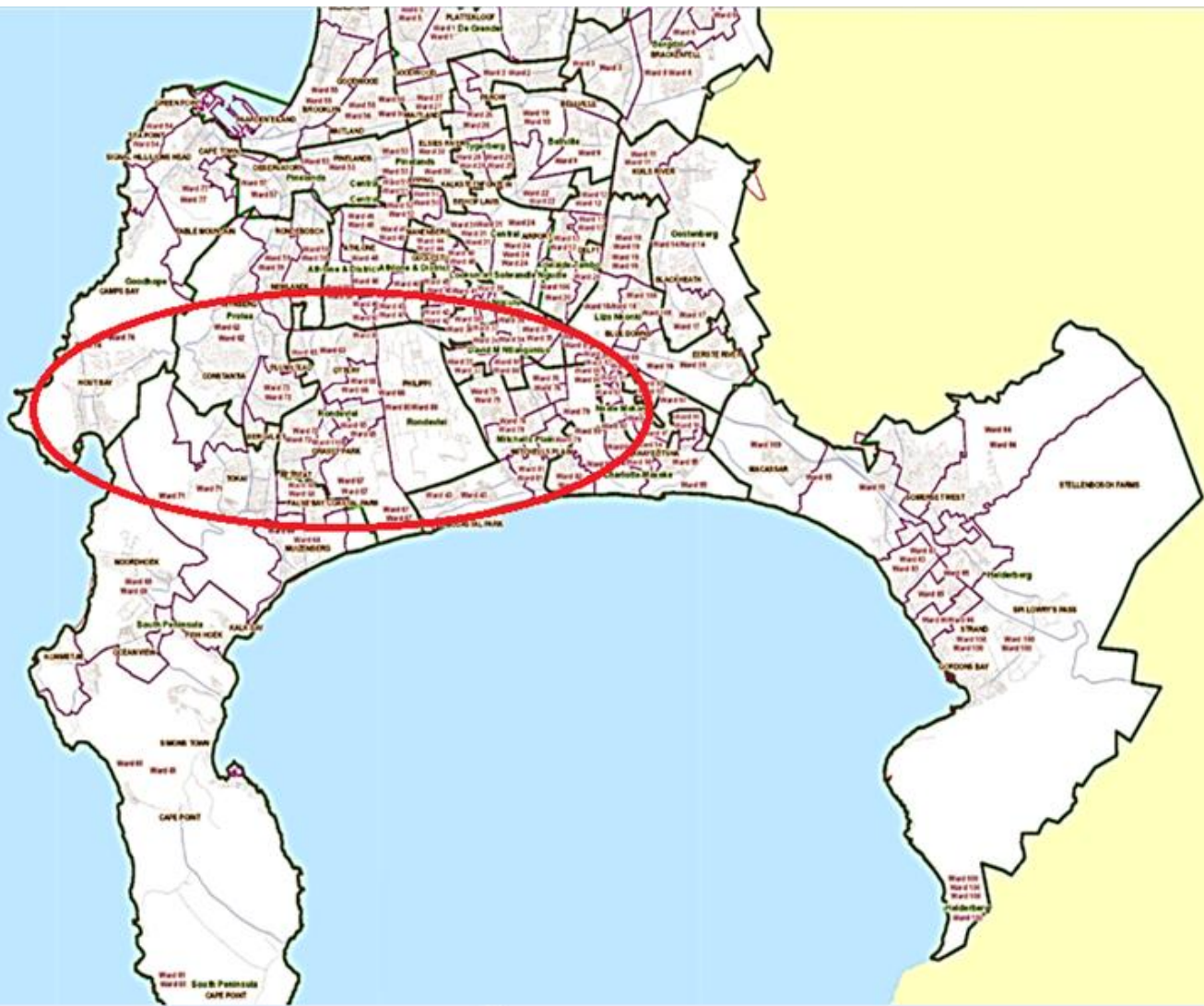
<http://emap.capetown.gov.za/egisviewer/>



Map 1: Cape Town

Participants were from the surround areas of the Southern Peninsula:

- Hout Bay,
- Steenberg,
- Lavender Hill,
- Montague,
- Retreat,
- Parkwood,
- Capricorn,
- Overcome,
- Lotus River,
- Ottery,
- Grassy Park,
- Sea Winds,
- Athlone,
- Phumlani,
- Pelican Park,
- Hillview,
- Mitchells Plain.



Map 2 Southern Peninsula areas detailed

## Chapter One

### Biomedicalisation, responsabilisation, and the everyday: subject formation in antenatal care

#### Literature overview

##### History of antenatal care and biomedicalisation

Antenatal care as an idea of “pregnancy as a condition warranting professional supervision” has grown over the centuries (Oakley, 1982:1). In the rise of antenatal care, during the 18th and 19th centuries in Britain, doctors offered advice for relief of symptoms during pregnancy and focused on the diet and life-style of mothers, however, there was no specification that women should visit their doctors during pregnancy (Oakley, 1982:1-2). The minimal antenatal supervision was related to an inability to detect and correct problems and avoid maternal deaths (Oakley, 1982:2). It was only throughout the 1900s that developments in understanding the physiology of pregnancy and the causes of maternal and foetal death occurred through advancements in medical technology. For example, the foetal heartbeat was first heard in 1918, signs of preeclampsia were recognised through urine analysis in 1843, and from 1896 onwards, x-rays and reasonably reliable methods of confirming pregnancy became available (Oakley, 1982:2). Emphasis was placed on professional care of the mother during pregnancy (Oakley, 1982:5). This was true to an extent in the context of South Africa, but it was stratified in terms of race and class, with white women (hierarchized between English and Afrikaans) tending to have more biomedicalised care, many black and Afrikaans women tending to have tradition birth attendants (Rogerson, unpublished 2016; Thompson, 2007). Fordyce (2013) analysed three editions (1941, 1951, 1961) of a leading obstetric journal in the United States, and found that after the twentieth century routinisation of antenatal care, by 1941 it was recommended in *Williams Obstetrics* that women be “taught” to register early in pregnancy and return to the obstetrician for consistent follow-up appointments (Fordyce, 2013: 126-129). This emphasis on professional care shaped notions of maternal and foetal death being seen as preventable through medical supervision (Oakley, 1982:6). The medical gaze and the advancement of technology intersected in shaping the routinization of antenatal care visits with a focus on risk assessment and prevention.

The historical context of how pregnancy and birth became construed as a medical problem can be understood as parallel to the growth of biomedicalisation. Biomedicalisation has been understood as a process by which human conditions are placed within a medical domain to be assessed, diagnosed, and controlled by biomedical understandings. The biomedicalisation of

childbirth and pregnancy “involves interpreting pregnancy as a disruption to health that necessarily requires expert medical intervention, and thinking of pregnancy as primarily about health and illness” (Zola, 1983; Muller, 2005:54; Ginsburg and Rapp, 1995). Clarke, et al. (2003: 161-162) describe biomedicalisation as the “increasingly complex, multi-sited, multidirectional process of medicalization, both extended and reconstituted through the new social forms of highly technoscientific biomedicine”. Fundamental to biomedicine and the management of health has been the focus on individual responsibility to be fulfilled through “improved access to knowledge, self-surveillance, prevention, risk assessment, treatment of risk and the consumption of appropriate self-help/biomedical goods and services” (Clarke, et al., 2003: 162). I observed these forms of ‘responsibility’ throughout my fieldwork, and I will contextualise them below, as they serve as key introductory moments between pregnant women, the clinic space, and public health recommendations.

In contextualising the present models of antenatal care as imagined by the state,<sup>3</sup> Dippenaar (2009:42) claims that in public healthcare, politics is the most influential factor that shapes structural and regulatory decision-making. In 1978 The World Health Organisation supported the idea of a “risk-approach” in monitoring pregnant women in an effort to improve perinatal and maternal outcomes (Zanconato et al., 2006:16). The risk approach was developed to improve the quality and delivery of maternal and child health care and is based on approaches that maximise utilization of resources as part of primary health care (WHO, 1978: v). This approach to primary health care is a result of the 1978 Alma Alta Declaration that was aimed at improving the health of populations in an effort to achieve “health for all”; these approaches influenced strategies for achieving the Millennium Development Goals for maternal and child health and gender equality (Schaay and Sanders, 2008: 4). Both national and international health policies and strategies illustrate how the biomedical view of pregnancy care is built into public health policy recommendations for early attendance to healthcare institutions offering prenatal care (DoH, 2007).<sup>4</sup>

In South Africa the emphasis has been on improving accessibility, quality, and utilisation of emergency obstetric care through functioning referral systems that incorporate a risk approach (the three tier system) (Zanconato et al., 2006:16-17). Early attendance was seen as beneficial and

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<sup>3</sup> States including South Africa that adhere to the WHO maternal recommendations, and public health policies.

<sup>4</sup> African Union’s initiative; the Abuja Declaration; African Health Strategy and the Millennium development goals; DoH Basic Guidelines for Antenatal Care (2007); Strategic Plan for Maternal, New born Child and Women’s Health and Nutrition in South Africa 2012-2016 (MNCWH); and South Africa’s National Strategic Plan for a Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA).

necessary for early interventions (Myer and Harrison, 2003:268; Hofmeyr, G and Hodnett, E. 2013: 1-2; Mathole et al, 2004: 123; Lindmark, 1992; Villar et al, 2001). Based on these studies, it was clear that social research alongside medical criteria was important to include in research into antenatal care and quality treatment (Sanders et al., 1999; Mathole et al., 2005). Social research was needed to determine healthcare seeking practices, reporting behaviours, experiences of treatment of care and relations between pregnant women and clinic staff, and perceptions of “quality”. Previous studies that have incorporated qualitative and ethnographic methods in researching late attendance have not only shown that “cultural” knowledge about care during pregnancy can differ to that of biomedical knowledge, but also that practice and policy differ within healthcare organisations due to different working conditions and resources, different community dynamics, and political economic factors (Mathole et al., 2005:387; Supanich, 2009; Abrahams and Jewkes, 1998; Myer and Harrison, 2003). These factors highlighted the complexity of care giving when there are differences in how pregnant women and biomedical professionals understand pregnancy (Mathole et al., 2005:387). As I will show, the nuances of such contextual factors were observed throughout my research within the Retreat clinic.

### Anthropology and biomedicalisation of reproduction

By contrast to the medical concern with early involvement in reproduction, there is a powerful critique within Anthropology of the biomedicalisation of reproduction. Anthropological studies of reproduction and pregnancy observe “the complex and diverse social contexts within which pregnancies occur and are carried to term”; observations that have anchored my framing of ‘biosocial’ in reproduction during the research (Santelli, et al 2003; Mukhopahyay and Higgins, 1988; Ginsburg and Rapp, 1995; Petchesky and Judd, 1998; Davis-Floyd and Sargent 1997). Anthropological studies have contrasted commonly used measures of healthcare and technology with “the culturally variable ways of thinking about sexuality, relationships and fertility among different groups of women and men around the world” (Santelli, et al 2003). For instance, it was reported that some women in South, West, and North Africa were not attending antenatal care in the first trimester because of beliefs about being vulnerable to witchcraft, as well as conditions of needing to speak to ancestors and in-laws first (Mathole et al, 2004; Ngomane and Mulaudzi, 2012; Myer and Harrison, 2003:270; Feldman-Savelsberg, 1999). Anthropological studies have also focused on the complexity of relations and contextual political economic factors that highlight gender inequality, economic inequality, culturally constructed ideals about relationships and sexuality, interactions with partners, kin and peer groups as well as healthcare providers and

new reproductive technologies (Santelli, et al 2003). These studies offered critiques of the positivist accounts of sexual and reproductive experiences, illuminating the social, relational, and political economic dimensions that come to bear of pregnancy. This focus drew my attention to multiple interwoven relationships and factors that shaped pregnancy and care, as well as how differing knowledges intersect and collide.

Ethnographic evidence shows the multiple ways of “knowing” what to do when one gets pregnant (Supanich, 2009:52; Davis-Floyd and Sargent 1997). One of the reasons that the construction of the “fewer visits” model had been considered was due to the acknowledgement that translating healthcare models in “local” contexts is complicated by socio-cultural, historical, and economic factors (Zanconato, et al., 2006:15). In considering factors outside of “medical criteria”, public health studies often incorporated “culture” into their repertoire in a way that constructed “culture” as a barrier to women’s use of antenatal care; as an interference for satisfactory implementation of antenatal programmes (Adamu and Salihu, 2002; Zanconato, et al., 2006:15-19). Culture was often seen as an obstacle in public health discourse, which problematically frames “culture” as static and “obscures other historical forces that shape the landscape of healthcare” (Levine, 2014:82). This view neglected the everyday entanglements of knowledge and meaning making, and the forms of life that shape understandings and actions. I focus on these shaping ‘forms of life’, exploring the textures of everyday life and how experiences and meaning making were grounded in everyday life. I argue that lateness is not “cultural” and nor should it be individuated through laying the blame on “transport”; rather, it is a combination of factors that are underpinned by political economy.

#### Time as a technique of power

I considered the history of organisations of knowledge, questions of power, the temporal modes of biomedicine and state antenatal care discourse as key concerns when doing anthropological work on reproduction. Organisations of knowledge such as the above mentioned biomedical and public health models shape conceptions of time in relation to pregnancy and antenatal care, and reassert a biomedical hegemony of knowledge (Davis-Floyd and Sargent, 1997:114).

Authoritative knowledge in relation to antenatal care carries a structural superiority that legitimates one kind of way of knowing over others (Jordan, 1997[1978]: 56-57). The studies from South, West, and North Africa have shown the process of authoritative knowledge in action as it related to conflicting ideas of time where women arrived after 12 weeks to the clinic due to: reliance on bodily signs such as menstruation stopping at least three times; differing perceptions as to what the ‘right time was’; differing beliefs about pregnancy care in the first 3

months; confusion over fixed notions of due dates; ‘unwanted’ pregnancies; and the socioeconomic factors influencing lack of access to health care and lack of existing support structures (Abrahams and Jewkes, 1998:8-12; Myer and Harrison,2003:271; Ngomane and Mulaudzi, 2012; Zanconato, et al.,2006:18; Mathole et al.,2004:124; Bledsoe and Banja, 2002). These examples show that pregnancy as an event is understood and acknowledged in an embodied way within a given political economy that differs from biomedical and clinical notions of an event (Davis-Floyd and Sargent, 1997:114-115). In the medical model, fertilization is taken as the measure and beginning of life, the point from which measurement commences. The biomedical and clinic notions of the event of pregnancy take ‘knowing’ one’s body and the monthly regularity of menstrual cycles for granted. In assuming a mode of knowing and self-surveillance and counting the body, knowledge of fertilization and pregnancy signs (such as lack of menstruation), biomedical recommendations assume pregnancy is known about and acted upon in a linear manner. This assumption does not take differing bodily experiences into consideration, nor does it consider the political economy where socioeconomic factors influence access and timing. While these analyses highlight an anthropological lens of taking into consideration social, cultural, and economic factors, and the necessity to include women’s experiences in accounts of quality antenatal care (Mathole et al., 2004:124; Myer and Harrison, 2003:271), I will extend this further by understanding how time can be seen as technologies of power in the Foucauldian sense of ‘biopower’ which aims to discipline knowledge, bodies and practises (Foucault, 1990[1978]). Antenatal care policies, as well as practices in the clinic, can be seen as the state in action as it administers and crafts life within its borders, and inscribes normalising interventions on pregnant women. Timing becomes a technique of power as it is used to discipline activities of pregnant women (Foucault, 1990[1978]). The inscription of normalising interventions has detrimental effects for knowledge and behaviour deemed outside of the norm. This is reiterated by Jordan (1997[1978]:57) who explains that authoritative knowledge within the clinic space appears natural and reasonable, but in appearing that way it creates forms of power over knowledge that can socially exclude and become coercive. This is seen in the studies in South Africa in accounts where women’s own knowledge was ignored or recognised as ignorant by the clinic staff and midwives and resulted in scolding (Abrahams, Jewkes & Mvo, 1998; Villar et al, 2001). My own research suggests that in addition to these, we need to take account of the ways that biomedical models of the responsible and knowledgeable woman stand in complex relation to the ways that women attending antenatal care in lower income areas of Cape Town understand their bodies, locations and relationships. I show that

these factors are critical in the ways that women access healthcare and shape the timing of their attendance.

### The work of time

*“Time is not purely something represented, but is an agent which ‘works’ on relationships” (Das, 1999: 67)*

Biomedicine produces new forms of ethics, expectations and subject-positions as interactions between staff, clinic protocols and biomedical knowledge intersect at differing levels and juxtapose differing forms of ethics (Jain and Kaufman, 2011:183). In these interactions, clinic situations offer insights into how futures are brought into the present (Jain and Kaufman, 2011:183). The articles in the special edition *“After Progress: Time and Improbable Futures in Clinic Spaces”* focus on time as a conceptual “problem”, and therefore reassess biomedical progress in the contexts of “how and when lives matter, interpersonal obligation, and the organisational pressures that bear on clinical work” (Jain and Kaufman, 2011:183). The articles seek to understand the “stakes of future thinking for the present and how these imaginings shape contemporary struggles over care” (Jain and Kaufman, 2011:183; Brodwin, 2011; Lovell, 2011). They analyse how conceptualisations of the future (such as ideas of progress, efficiency, and patient longevity) constitute present medical practices and how this is negotiated in different ways with different interests, sometimes to the detriment of patient care (Jain and Kaufman, 2011:183). I have viewed this in relation to how the structure of public antenatal care is enmeshed with politics and bureaucratic requirements for efficiency, and improving access to “health for all”. The symbolic framing emphasises “how rhetorical and discursive uses of time are harnessed to legitimate certain positions over others”, reiterating Povinelli’s (2011) notion of social tense<sup>5</sup> as a technology of power that shapes recognition and forms of life. These primary healthcare ideals in relation to antenatal care construct what futures are viewed for mother and unborn child. Narrative constructions of pregnancy and care can be analysed to demonstrate political and social discourses of blame, responsibility, and belonging (Supanich, 2009: 55; Jordan, 1997; Fordyce, 2012:119).

### Discursive and social placement of the “good woman”

The above state and biomedical framings of timing to antenatal care place “women” at a centre of state regulation, with additional expectations to be “good” women, and “good” mothers. This moralistic rhetoric is part of the biomedical trajectory – bad mother if you are not “on time” –

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<sup>5</sup> Social tense is the social and political context and use of grammatical tense (Povinelli, 2011).

where the discursive structure articulated with material consequences for not adhering to temporal framings (scolding by nurses, neighbourhood gossip, and family neglect). The state, as well as localised formations of gender roles, came to bear on how my participants understood and experienced the world, their pregnancies, how they made decisions and navigated social relations. As Butler argues,

In social interaction throughout their lives, individuals learn what is expected, see what is expected, act and react in expected ways, and thus simultaneously construct and maintain the gender order... be given gender takes place through discursive routes: to be a good mother, to be a heterosexually desirable object, to be a fit worker, in sum, to signify a multiplicity of guarantees in response to a variety of different demands (Lorber, 1994; Butler 1990)

These gendered moralistic values placed on women can be seen throughout the chapters of my thesis, with particular attention to the dire consequences of transgressing these expectations.

#### Anthropology, ambiguity and the work of words

In approaching political, economic, and medical institutions as experienced by pregnant women in everyday life, I took to the framing of “forms of life” as a theoretical lens through which to view my fieldwork. In drawing on late Wittgenstein, and Veena Das (1998), I focused experiential and linguistic attention to ‘forms of life’ that shaped my participants’ understanding of reproduction and pregnancy.

As I methodologically approached the *work of concepts* such as time and notions of lateness and unwantedness, I sought to understand the capturing words and ambiguity through Das’s (1998) reading of Wittgenstein’s philosophical questions on meaning as they relate. Das (1998) uses Wittgenstein’s *Philosophical Investigations* to pause and introduce “hesitancy” in the way anthropologists have dwelled on concepts of culture, everyday life, and the inner life (Das, 1998:172). Language games is a philosophical concept that refers to language use and the actions into which language is entangled; concepts do not need to be clearly defined to be meaningful; speaking is part of an action and ‘form of life’ that gives language meaning (words have meaning depending on the uses made of them) (Wittgenstein, 1953: 7; Das, 1998). Based on Wittgenstein’s idea of language games, Das suggests that meaning and understanding are possible because of an incompleteness of meaning in words and instructions. She argues that “hesitancy” as an approach to understanding meaning and ambiguity enables anthropologists to dwell on everyday contexts in which words are used, and in so-doing, to render a more particular account of language and the forms of life to which it gives rise (Das, 1998: 172-175). Das and

Wittgenstein describe culture as more than “inheriting a set of rules or a certain capacity to obey orders” (Das, 1998:174; Wittgenstein, 1953:para. 7). Cavell (1989) and Das argue that this “agreement” in forms of life is more complicated, in which there is “an entanglement of rules, customs, habits, examples, and practices” (Das, 1998:176). Das speaks of this in relation to ethnography and anthropological text as being “marked” by “excess” or “surplus” (Das, 1998:179). This excess “expresses equally the distrust of formal rules and obligations as sources of social order or moral judgement”, and thus an understanding of meaning can be gained through an excess of description that captures entanglements and the context of meaning (Das, 1998:179). Cavell explains that one needs “to learn not merely what the name or label is, but what a name is and what forms of life make the words what they are and do what they do” (Cavell, 1979: 177). I sort to understand the work that words did in relation to the social consequences of naming pregnancy in a specific way (late, or unwanted). For example, ‘unwanted pregnancy’ was a reason given by women for ‘late’ arrival (Abrahams and Jewkes, 1998). During my research, the term ‘unwanted’ carried ambiguity of meaning (at times synonymous with unplanned), and often changed meaning for pregnant women throughout their pregnancies. A complex term and sensitive topic to talk about, it complicated experience and attendance. Pausing on this concept allowed for a practical engagement with the work of words and meaning. As I show, rich ethnographic description within these contexts aids in capturing meaning of these words and what forms of social, political, economic, cultural and moral structures shape meaning and action as it relates to pregnancy and antenatal care.

### **Methodology and introduction to research participants**

I conducted six months of fieldwork, including: participant observation consisting of observations and conversations within the waiting room and maternity ward; observations in history taking bookings (82), in the 20 week ultrasound scan (106); interviews with 37 pregnant women; continued conversations with 7 participants; observation of social media groups such as “Retreat and Steenberg News” and “gang watch”. I also developed a journal method, taking core concepts that materialised from the discourses I heard, I operationalised them into a method in an effort to understand the “work” of words in different contexts. Included in the journals were small body maps outlining bodies where women drew or wrote their understanding of their pregnancies and bodies over 9 months. I have used these to further understand my participants subjective experiences of their pregnancies, bodily changes, understandings of time, and what they drew focus to during the 9 months.

### Participant observation

I opened up introductions to the clinic and staff in late March 2015, and remained in contact while I awaited ethics clearance.<sup>6</sup> My relations with the staff lasted the year, with my fieldwork beginning in mid-July. I conducted 6 months of ethnographic research in the clinic space from July – December 2015. The ethnographic research consisted of qualitative methods: participant observation; note-taking; informal and semi-structured (recorded) interviews; life history information within the interview sessions; participant journals; body maps; photographs; participant mapping. I conducted participant observation in the waiting room and clinic space. I introduced myself and research to all of the women who entered the rooms and gained their consent before the nurses/doctor began their quick session. I often left to further talk to the women and interview them based on something they had said in the session. It was a space where I had to be attentive to my presence and vigilant of discomfort. At times I had become a part of the nurses examination as I was asked for help calculating back menstrual dates, keeping women company as they waited, sharing laughs with the women, reassuring some anxious about the blood taking, helping with translation issues as I picked up cues of language from the main translation aid, Gemima, the HIV mothers to mothers Zimbabwean woman who got called many times to translate for Malawians. My translation abilities minimal at best, I mainly observed that they functioned as support buffer in a space where impatience might have escalated.

Journals with key words that were drawn out of current discourse to establish the “meaning” in different contexts. I chose the words that appeared repeatedly in current sexual and reproductive discourse and these were the core concepts that materialised and were operationalised within a journal method.

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<sup>6</sup> Humanities Faculty Research Ethics Committee: Ref. No.: HUMREC201506-04 ;  
Faculty of Health Science Human Research Ethics Committee: HREC Ref: 596/2015

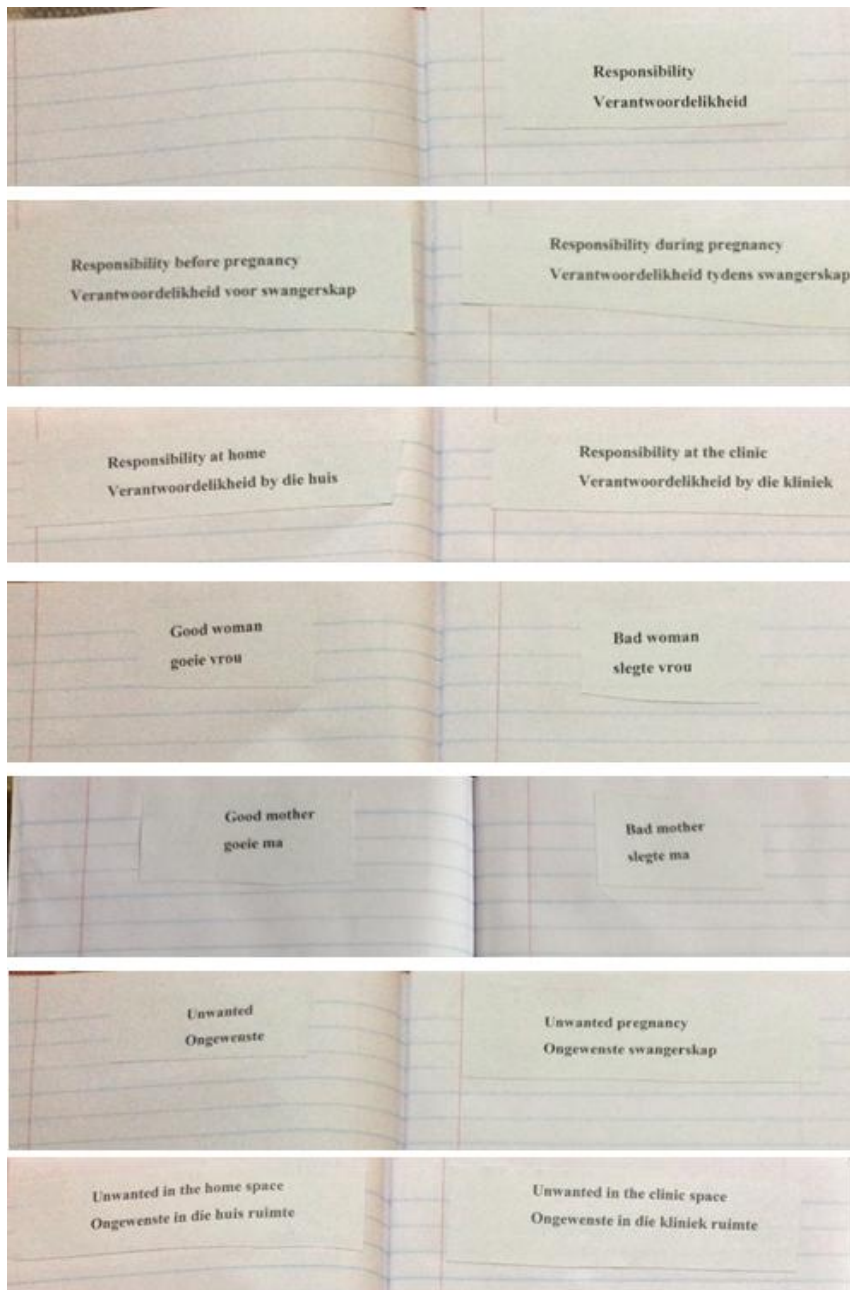


Image 11: Journal

### Body mapping

Body maps are created to visually represent aspects of people's lives, their bodies and their ideas of health and illness. It is used as a way to tell stories and represent experiences – here to gain fuller understandings of subjective bodily experiences of pregnancy and conceptions of time (Gastaldo, et al. 2012).

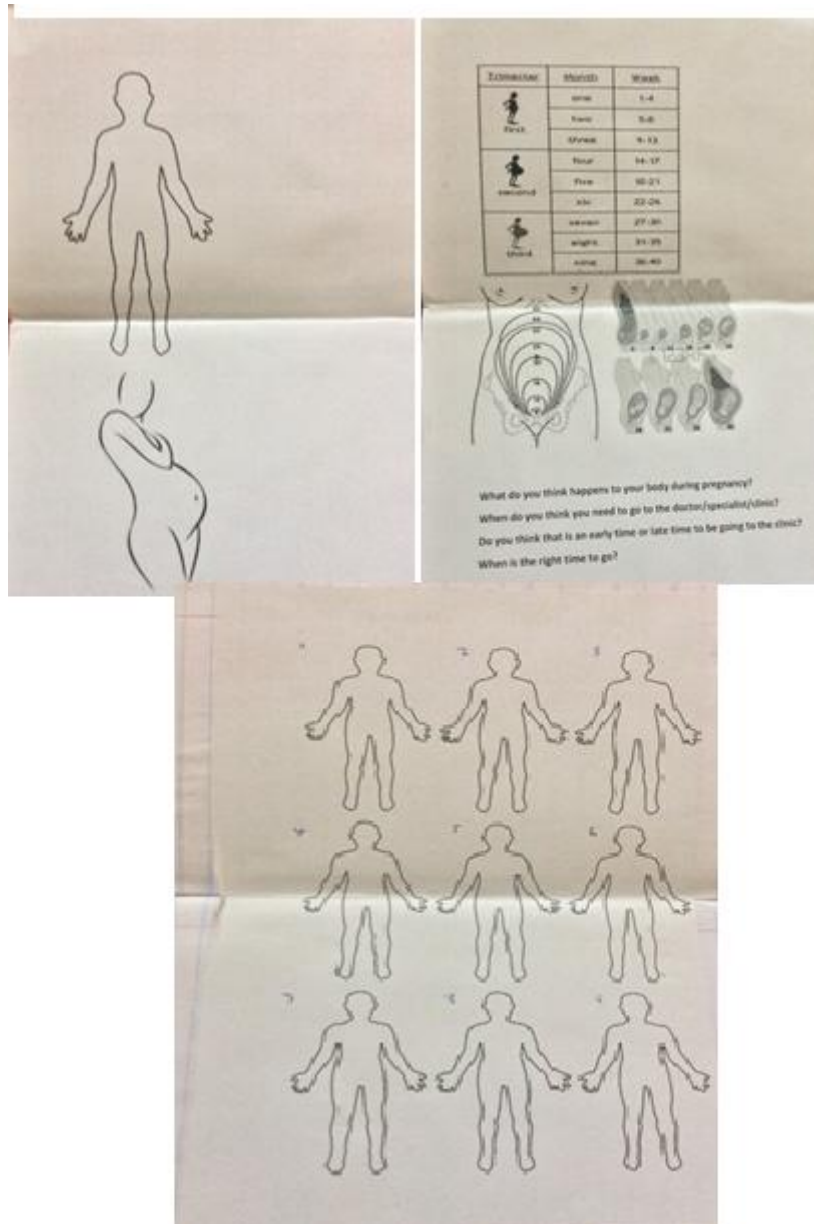


Image 12: Body Maps

## Interviews

I conducted formal interviews with 37 women who were unbooked, “late” or experiencing their pregnancies as “unwanted”/”unplanned”. The ethical implications of such sensitive material were addressed by being attentive to hesitancy, tone, emotions, finding a private space to speak, and keeping the conversation and interviews open to what participants wanted to talk about at moments where questions were sensitive such as abortion, adoption, and gender based violence. The types of interview questions were asked can be found in the information sheet (**Appendix 4**). Life history information was incorporated into the interview questions as it related to temporal framings of my participants present positions within Cape Town and any past

movements, as well as women's kinship histories, household formations and community dynamics. This method was used as a way to understand the social, relational and historical shaping of experiences of pregnancy and belonging.<sup>7</sup>

The 37 participants in the table in **appendix 2** are introduced and described throughout the chapters as their stories emerge in relation to the themes of knowing, trust, violence, and social relations. I met them all in the waiting room of the antenatal care unit, during history taking consultations, or in the recovery ward after they had given birth. I shared small moments of excitement over their pregnancies, how they were feeling, changes to come in their lives, the joys of closer intimacy with their partners and family. Other times I paused with them during emotional moments where they described financial and family precarity, HIV+ diagnoses, domestic violence, drug use, devastation about shattered future plans because of unplanned pregnancies, and the weight of making decisions for the lives they now carried.

The women aged 18-21 brought many themes to the fore as they faced family and community stigma and punishment for not meeting expectations of respectability. As **appendix 2** shows, 12 of the 37 women were between 18 and 24. With this finding it needs mentioning that the 2016 South African Statistics showed the highest number of births (years 2000-2013) was within this 20-24 age group of women at 233, 323 births/year (**appendix 3**). The attention to the age group of women 18 and upwards allows for richer understandings of sexual and reproductive life, gender and family dynamics, and social experiences of pregnancies.

In public health studies, it has been recorded that women between 18 and 25 years of age were “more likely to attend late as compared to those older than 25” (Mametja, 2009:20). Well my sample size was small, it must be noted that women aged 25 and older were as likely to attend “late” to antenatal care. This will be considered in relation to age perceptions and life-cycle experiences.

Generally participants lived with extended family members, in backyard Wendy houses, or in 2-3 bedroom houses shared by 3-12 people (see example in chapter two). Few were married, fewer lived with their partners or children's fathers, and some maintained long-term partnerships. Many of the women's children had different fathers (a maximum of three different fathers), where most were still in contact, maintained levels of child support and access to fathers'

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<sup>7</sup> Life history information derived from previous studies examined the fluidity of household dynamics, the importance of kinship and community ties to care and support for children, and the dynamics of violence, poverty and mobility (Spiegel, 1987; 1996; Ross, 1995; 2010).

extended family for childcare. Household food consumption consisted mainly of: bread, tea, polony, cheese, potatoes, and pot meals on weekends (these were the highlight of family gatherings where meat was cooked into a stew or curry).



Image 13: 'Daily meat specials' "polonies" "chicken" "beef"; "superette: Gatsbies, samoosas, koeksisters"

Continual conversation through journals, WhatsApp, phone calls, and meetings with Stacey, Danielle, Sharnaleigh, Deniell, Shantay; Nondumiso, M\*, and S\*.

Three of the five participants who completed the journals - Stacey, Danielle, Sharnaleigh - , remain in contact with me. I had seen them since their first clinic booking, and had the pleasure of watching them through their pregnancies, and finally watching them settle into their new roles as mothers and their unfolding relationships with their babies and family. These three women were all between 18 and 21, and were dealing with the weight of changing relations, futures and bodies as they came to terms with their 'unplanned/unwanted' pregnancies.

Danielle I met on my third fieldwork day - we were both beginning new journeys. Danielle was calm despite the family tension over her pregnancy. She had strong religious values, and an untainted desire to finish her matric year. As time passed, we met in the waiting room of the clinic multiple times, each time she looked a little more tired, each time her stomach a little bigger. I anxiously awaited her labour as she was given the due date of December 24<sup>th</sup> – my birthday. However, a very uncomfortable Danielle, in the peak of Cape Town's heat, was still pregnant on the 30<sup>th</sup> of December. Danielle went into labour, but was "taking too long to dilate" and the baby's heart rate was increasing so she was referred for a C-section on the 3<sup>rd</sup> of January, and had her son Cairo.

Sharnaleigh was also among the first women I spoke to. She was at the clinic for her first booking with her boyfriend. A young man, 9 years older than her, and not approved of by her father. I had first seen him during the antenatal talk in the waiting room where he decisively

walked up to the centre blue chairs with the pregnant women waiting, and gave Sharnaleigh a cup of water and some fruit, which got the attention of the whole waiting room as he was given flattering remarks about his involvement and spurred on by laughter. Sharnaleigh, rolled her eyes later when talking to me about her boyfriend always bringing home fruit after work for her. Sharnaleigh was happy about the pregnancy because of her stable relationship. She was preparing for her birth by watching television documentaries on pregnancy and birth. By the time I saw them both again, it was in the waiting room of Mowbray maternity for her 20 week ultrasound. The imagery on that scan was clear and the foetus' facial features could be detected. Unlike the round fuzzy image at Retreat. She too had a baby boy – Jake.

Stacey, the participant that touched me the most as she shared her feelings at the newly formed rift with her grandmother (who she lived with and was her maternal figure) after she revealed her pregnancy. Not yet 21, she had to shoulder the “disappointment” from her grandmother who eventually evicted her. Although she understood the reasons behind her grandmother’s “disappointment”, Stacey maintained a stern sense of values of “fairness” and was angered by her grandmother’s treatment. Stacey, further coming to terms with her new life, had been wounded by a rejection letter from the University of Cape Town. Her journals had an ache of emotion to them as she “came to terms with everything”; it helped that she had a ‘get on with it’ attitude to life. I met with Stacey throughout her pregnancy, and each time she looked a little more settled with the pregnancy, and making amends with her grandmother. She gave birth to a baby boy too – Mason.

Nondumiso, who did not complete a journal, and I maintained a relationship since her first booking where she had received an HIV+ diagnosis that shattered her reality and led to ongoing partner therapy sessions throughout her pregnancy. I met her when offering an ear and shoulder as she broke down in the back room – taking guidance from paths illuminated by Patricia Henderson (2011), an approach to an ethics of solicitude (Levinas, 2001), and an emphasis on the kindness of acknowledgement in a caring touch. Nondumiso was distraught at life, and often called me for guidance on calming down. I usually advised, if it was safe outside, that she take a walk to clear her mind and wait for her other children to return from school. Throughout her short time with follow up visits to the clinic for both her pregnancy check-ups and her therapy with the NGO, she was stable in her relationship again, and excited to have another child. Her daughter was born on the 22<sup>nd</sup> of January, and by mid-June I was receiving pictures of a full faced baby with an azure blue head wrap – Nondumiso looking tired in the picture.

Nondumiso’s experience throughout the time spoke to a multitude of themes that women face when pregnant: ‘unplanned-ness’, illness diagnoses (concerns of her death while simultaneously

life was growing in her), tumultuous intimate relations, navigating her fear of community gossip and family shunning and stigma, yet needing desperately a support system, and battles with depression.<sup>8</sup>

There were a few participants who brought the dire issues of intimate partner violence to the fore when they arrived at the clinic with shades of purple marking their bodies, or their hands clasped tightly while sitting after household fighting. Some are spoken about throughout the thesis, but one woman (to remain unnamed and experiences limited in detail here) left a haunting story of her life experiences of repeated bouts of multiple forms violence and trauma, drug use and family neglect, that will remain with me like a shadow. This woman, after my guidance when we met, and months later a middle of the night call for details, sought shelter at a women's care centre and remains there with her son. She remains the shadow within this thesis as moments of everyday violence women live with shape the forms of life before and after the boundaries of the "first thousand days of life".

### **Ethics: on positionality and partiality, proximity and privacy**

My research was shaped with an understanding that research and knowledge creation are historically, temporally and politically situated, and influenced by positionality, partiality and selectivity (Clifford and Marcus, 1986; Fabian, 1983; Mafeje, 2001). Positionality in research can be understood as it is a set of positions such as race, class, gender, sexuality, religious orientation, education, and language that intersect and continually shape interactions with different people in different spaces. I reflected on the my own positions as they related to my participants, especially in terms of my race, class, language usage, and not being a mother (or pregnant) myself nor heterosexual (queer in sexuality and gender). I engaged with the dynamics as they spoke to broader conversations in anthropology on reflexivity, alterity, representation, writing, power dynamics, issues of translation and how anthropology's subject has been constructed in relation to uses of time (Clifford and Marcus, 1986; Fabian, 1983; Mafeje, 2001).

My positionality as a white researcher, and a woman who was not pregnant in that space, often played out with women in the clinic mistaking me for a nurse or doctor - I was quick to tell them I was neither. The Zoe Project which is situated within the MOU was the entry way into the clinic space for me. The Zoe Project offers counselling and doula services, educational

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<sup>8</sup> Nondumiso's depression and relationship with her partner were luckily somewhat tended to with the NGO counselling at Retreat.

assistance, provides food through a soup kitchen initiative, and works within the community (especially on issues relating to teenage pregnancies and drug abuse). I was not conducting fieldwork with or for the Zoe Project, merely under the guidance of the founder for the project as she knew the staff and the clinic space well. As the Zoe project is situated within the clinic space, I was also mistaken for being a counsellor there. These descriptors and assumptions about my position prompted an immediate transparency of my position as a researcher NOT doctor, nurse, counsellor. Due to the small space and the sensitivity needed as it related to health and privacy, and stigma and status within communities, I negotiated the use of rooms that were private when speaking to women. All participants were given the information sheet and consent form and given time to read and consider if they wanted to partake (**Appendix 4**). I gave further explanation of the research verbally along with their rights to withdraw at any stage, and a means of contacting me should they want to withdraw or withdraw any information. Negotiation over consent and data used was continuously negotiated throughout the research and write-up, especially in relation to ongoing communications. My attention to positionality, and concerns of consent and privacy highlight ethical codes relating to *confidentiality, anonymity, protection of participants*. The information sheets, consent forms, and contact sheets (**Appendix 4, 5**) were created in acknowledgement of the UCT code of ethics as well as Anthropology Southern Africa's code of ethics, with a focus on *protection from harm* as it related to physical, psychological and emotional harm of my participants and myself as a researcher.

What unfolded practically was a continual balancing act within the clinic space. There were limited rooms available for interviews which meant negotiating spaces with the nurses while they worked. It usually worked out that I conducted interviews during the mid-morning tea break. I not only negotiated appropriate timing for interviews to minimise interrupting the nurses, I also negotiated the waiting room space which was dauntingly full. I was aware of taking up too much of the women's time if it was not a tea break, as they might get called into an examining room while talking to me.

While the above markers of positionality made explicit the power relations that were layered with whiteness, class, and authority, there was another intersection of my identity that I remained silent on despite feelings – my sexual and gender queerness. I was mistaken for a man twice during fieldwork, standing as moments that amplified my queer position in a space where conversations quickly revealed a strong heteronormativity and conservative ideals about women, men, gender roles, and marriage. There were explicit comments by mothers teaching boys 'not to be' "moffies" (seen by certain haircuts, clothing, and 'female' domestic duties). There was the

strong religious orientation among staff of the clinic and the NGO, a point that first concerned me if I revealed any personal information, but as fieldwork progressed I was pleasantly surprised to withdraw my guard (but not my position to remain silent about my sexuality deflecting questions about relationships and marriage) as I saw religion is action as care. So while I was under no threat or any explicit homophobia, I remained only half in view. This is a negotiation many queer researchers face (Hames-Garcia, 2009) and brings to light questions around the strived for ‘two way process of research’, where intimate revealing in this instance was never going to be two way. A fact that was a pity, because the subjects of intimacy, relationships, and pregnancy, and the long-term interactions with participants warrants a back and forth.

### Clinic as a liminal space

The fieldwork, considered a ‘waiting room’ project, sets up boundaries of “a fieldsite” and temporal limits of “fieldwork” within such a liminal space, pregnancy itself also considered a liminal process. The concept of liminality sets up boundaries of “entry” and “exit” in spatial, temporal, relational, and spiritual senses. In taking an approach that calls forth attention to the “everyday”, I view the clinic as a point in intersecting networks of support and relations as it is embedded in surrounding area politics and community relations, and subject to the ever present violence. I consider how boundaries of “fieldsite” and “fieldwork” relations were displaced through the continual contact with participants; I became a part of how some women sought support networks. The clinic became the site of intersecting relations and new formations of relational support. This led to negotiating boundaries, and questions of the limits of reciprocity in fieldwork in spaces where financial inequality and drug use are present, and at times go hand-in-hand. This ethical and practical stance aligns with an ethics of response and responsibility (Levinas, 2001).

### **Forms of responsibility, surveillance and regulation**

Responsibilising discourse, and forms of regulation were seen throughout my fieldwork and grounded at key introductory moments between pregnant women and the clinic. The discourse can be understood as being constructed through the state policy and public health strategy aimed at women’s reproductive and sexual health that focuses on “empowerment” and health “rights” (Kaufman, 1997).

Over the course of my observations I listened to the morning antenatal care talks and the HIV talks that were given to the women waiting at the antenatal clinic. 15-25 women generally arrived for their first time booking each day (image 15).



Image 14 Antenatal wing waiting area

Clinic functions and formalities initiated the HIV talk as emphasis was placed on the importance of women sitting in their allocated seat, and listening for when their numbers were called. Numbers assigned to pregnant women waiting, and the technical terms such as “first time bookings”, begin stripping away individuality from women making them into patients. The nurse stated the protocols that structure how women are seen to each day:

*“you need to phone and book and come at that time...We work according to a schedule; we don’t just do what we want...Booked names are on a list”* (this list of names gets photocopied and given to each of the nurses doing the various examinations for that day). *“You’re only seen if you’re on the list. Sit on your own chair (blue chairs). The prisoners come here too. We want you gone before they come here. But if they come speak to the warden if they are in your seat. No giving them your phone even if they say ‘but their parents are close by”*”.

The women carried their medical files. These were completed during visits and returned to staff. They were given a pregnancy card that was marked with a returned dates that they would keep throughout their pregnancy. The women I spoke to at various points during their pregnancies never knew how many times they were meant to come in; they just tried to come in when they were told to do so.

On the first visit the nurse explained that they need to have their pregnancy confirmed from a clinic and have the letter of confirmation with them, or have brought a pregnancy test, and their HIV test results if they have them. The nurse stated that the women are tested 5 times

throughout pregnancy for HIV (at the day clinic, first booking appointment, 20 weeks, 7 months, and during labour). “Irrespective of your faith [religious beliefs about not giving blood] and [fear of] needles *if your blood is flowing, we will test*”... we don’t want to see your status change during your pregnancy, so use condoms... *a marriage certificate does not make you immune to HIV and infection*”. The nurse explained that if they “catch an STI while pregnant” it could lead to a miscarriage, premature labour, physical deformities, and premature death. These factors she said were “*something that can be avoided so use CONDOMS! Use them during pregnancy, after pregnancy, and while breastfeeding... You need to take responsibility for yourself*”.

During the antenatal talk reproductive health was covered by showing on a cardboard image of a female reproductive system, what happens during menstruation, ovulation and conception. It was always a point of humour for the group waiting when the facilitator said that most of the women are here at the clinic because it was “*unplanned*” and that women “*don’t know about their bodies*”. At this point staff highlighted that “it is important to know what is happening in your body” and advised that “*you must teach your daughters to know their periods*”, so that they know when they are ovulating, can count their menstrual cycle, and can better understand, prevent and plan pregnancies. The women interacted by nodding, laughing, or vocally agreeing to the information and interacting when the facilitator asked questions. Further discussed was the importance of eating specific foods during pregnancy such as vegetables and fruit, dispelling the common assumption given by at least one woman during each ANC talk, that ‘naarjtjies’ and oranges cause ‘*geelsug*’. The importance of being ‘responsible’ during pregnancy and mothering by not drinking, smoking or taking drugs, and attending the clinic was emphasised. “No *skaam* anymore, it’s time to be *responsible*... First three months are important for health”. The terms ‘responsibility’ and ‘taking responsibility’ were repeatedly used in ways that related to: knowing the biological reproductive cycle; knowing menstrual cycles and the dates of when they start and finish; knowing how to navigate intimate relationships, condom usage and contraception; knowing and controlling what to eat and drink; stopping cigarette, drug and alcohol usage; knowing the signs of pregnancy (lack of menstruation, breast sensitivity, nausea, fatigue) and the danger signs during pregnancy (“severe headache, abdominal pain, vaginal bleeding, reduced foetal movements” Maternal Care Guidelines 2015).

Family planning and contraceptive methods were explained throughout the HIV talk. The nurse emphasised that the women have the duration of their pregnancy to decide on a family planning

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<sup>9</sup> Periods are a short language version of “menstrual period” or “menstrual cycle” indicating a period of time menstruation occurs, and that menstruation is understood to occur periodically (typically every 28 days) (Nordqvist, 2016).

method that they will be put on after they have given birth. The women were told that they “*need to choose one*”, they cannot leave after giving birth without being placed on a family planning method. This statement about having to use contraception after the birth was also emphasised during the history taking sessions, where at one observation the student nurse said to a woman who was unsure of what family planning she would go on and if she wanted to at all, to which the student said “*you cannot be discharged without it; it’s illegal<sup>10</sup> ...do you want to be here every year for 10 years...*”. The emphasis here relates to the biomedicalisation of women’s health and the surveillance and control over female reproductive bodies; the public health stance that pregnancies should be spaced with at least 2 years between children; and that people should limit the number of children for health and economic reasons.<sup>11</sup> The comment was framed with a concern for the women, but also within a responsabilising discourse that places women and mothers at the centre of responsibility and blame for health and care.

The localised meaning of morality and behaviour was understood as the Afrikaans term “Ordentlikheid”, which Ross defines as, “*decency, respectability*” (2010: 233). The gendered constructions of *ordentlikheid* and the “good woman” and “good mother” give a moral heaviness to the discursive structuring of biomedical temporal framings of “early” and “late” arrivals. The historical context of colonialism, Christianity and Apartheid give weight to the “good mother” and “good woman” within the context of South Africa. Re-ordering and regulation of morality based on notions of cleanliness, appearance, behaviour, household cleanliness and gender roles are at stake in these framings (Comaroff and Comaroff, 1991, 1997; Ross, 2010: 36-37). Anna Versfeld (2012:4) in focusing on the role of generation changes and cultural practices, drew on the dynamics of “social change” for her analysis. In describing female personhood in Manenberg, an area under the same siege of gangsterism and drug use as the areas I focus on in the Southern Peninsula, Versfeld re-emphasises “*ordentlikeheid*” as a critical feature of *female personhood*. Citing Salo, (2003, 2004) who defines personhood as, “about who the individual is in relation to society and how they fit in”, Versfeld builds on this to operationalise the phrase “positive personhood”, utilised “as the general social consensus on an individual as a valuable being” (2012:4). *Ordentlikheid* was built on three factors during apartheid according to Salo: “women’s privileged access to work, welfare, and housing”, which influence the construction of female personhood (2003, 2004; Versfeld, 2012:4). I seek to build on previous work in South

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<sup>10</sup> Maternal Care Guidelines (2015:139) “Contraception must be offered to all women before discharge”. It is not “*illegal*” as stated by the nurse. It must be noted that some participants explained that they choose the injection after birth because they “have to”, but they do not return for follow-up injections in an exercise of agency.

<sup>11</sup> Timing, number and spacing of pregnancies (Maternal Care Guidelines 2015, Basic Antenatal Care Handbook 2007. WHO 2015) “women who have more than 4 children are at increased risk of maternal mortality”. WHO, 2005 “Spacing pregnancies by at least two years increases the chance of child survival”.

African anthropology in which “ordentlikheid” is a critical and gendered feature of daily life. For my participants, to be a good woman required attention and regulation to gendered norms of decency, virginity, and respectability, and to be a good mother centred of the same self-regulation and surveillance of conduct and gendered ideals of respectable marriage relations before child-bearing, and centring of women as “responsible” for the health of the children. These expectations and discursive framings are centred on discourses of blame. The resultant moral discourses filter throughout my chapters, as they were seen to shape both the “right” time to become pregnant and the “right” time to come into the clinic.

### “Lateness” and access –concerning political economy

Women were continually concerned about present and future finances, education and work opportunities after making their pregnancy public. Roughly 10% of my interviewed participants spoke of concerns about work positions once pregnancies were public, or gaining employment during pregnancy. The women in desperate situations for employment, like Merlody, expressed concern about not getting work while pregnant, and how she would have to see the time period of the pregnancy through before “things could get better” and she could find employment. Women who had employment stated that they could not book earlier at the clinic because they could not get time off from work. During the 20 week ultrasound examination, women frequently asked the doctor for a note to get time off from work, but the doctor was clear that unless their health was in risk, they were required to work up until 36 weeks.

Despite the state pregnancy leave provision, pregnant women were not taking time off from work to come into the clinic. For example, Shantay was a supervisor at Shoprite, where taking a day off meant the people working under her had to rearrange their day which often could not happen. A similar experience with Libby in her explaining what it was like to work as a cashier at Supersave, where she explained being “*treated badly*”... “*My manager was not flexible to time being taken off*”. Long working hours ensured there was not time to make it home at a ‘decent time’ to cook dinner, feed, and bath her son. Another case was Deniell, working at the front desk at China Town in Ottery during her first pregnancy, she had to go back to work “*just two weeks after giving birth... there were no maternity benefits and the owner needed me to communicate because he didn’t speak English*”.<sup>12</sup> It was because of these working relations that women did not know how many days

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<sup>12</sup> No maternity benefit or leave is illegal. State labour law states that:

they were legally allowed to take off and were under the stern expectations of employers in an economy where unemployment is high and the promise of a kept job position is precarious.

The dynamics shaped by the political economy and geography of Cape Town, where transport, housing placement, and employment, were strong factors for late arrival, and infrequent follow-up visits. This geography will be taken up further in chapter two in relation to violence(s). As I show, the nuances of access are important. Previous studies tend to subsume difficulties of location as “transport difficulties” or “no money for transport” (Abrahams and Jewkes, 1998). I show, the matter is more complex. As seen in map 1 and 2, a geography that spans a large portion of the Southern Peninsula requires at most four commuter taxi’s to get there, leaving on average at 5am taking up to 2 hours to travel and switch routes in different taxis (especially from Hout Bay). The earlier you arrive on the day the more likely you will be closest to booking number one and more likely to get out by noon. The waiting room was always full throughout my six months of research, a time period that extended from the downpours of July winter into the humidity of summer in Cape Town. Given the multiple taxis needed, distance from the train station, and ‘the trek’ to the allocated clinic (all involving avoiding violence and mugging), it needs highlighting that arriving at 7am requires prior hours of travel and waiting, as few women arrived with the luxury of being driven in a car. Many women did attribute their inability to get to the clinic to insufficient money for a taxi. A few women had the problem of not having childcare for their other children; children are not allowed in the clinic, unless they are being watched outside by someone accompanying the women. Deniell had been turned away on her first clinic visit because her other child was with her (she was already 18 weeks pregnant then); she could not make her rescheduled appointment because she did not have taxi fare from Lotus River; she finally had her first booking appointment at 27 weeks.

There are *exceptions* and *negotiations* that take place as to who gets allowed in or not when booking protocol is breached. There is usually space for extra bookings each day (5-8) that the staff accommodate if the clinic it is not at full capacity. The other hierarchy of exceptions are if women are from Hout Bay, Phumlani or areas that are far away from the clinic, or if women are HIV+. I further observed that women who had missed their appointments the day before and

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*“Female employees have a right to four months maternity leave when they are pregnant. By law your employer is not obliged to give you paid maternity leave, but you are entitled to four consecutive months of maternity leave” (Wage Indicator 2016, 2016) (Department of labour, 2014).*

Workers on maternity leave can claim from unemployment insurance fund (UIF) for 17 to 32 weeks, and further: *“a contributor who has a miscarriage during the third trimester or bears a still-born child is entitled to a maximum maternity benefit of six weeks after miscarriage or stillbirth”.*

had come a day later due to lack of money for transport were allowed to stay for a booking. Others who did not make the “exceptions” for those taken in without a booking were turned away. For instance, Mersell was 6 months pregnant at her first booking appointment. Her account of coming to the antenatal unit illuminates the layers of access complications. She explained that she had come to Retreat MOU when she was 4 months pregnant, but they were too full ‘to squeeze her in’. She had not called and booked ahead, she had ‘just arrived’. After that attempted visit she was unable to return soon because she had no money to come. She has to take a taxi from Ottery to Lotus River then to Retreat, or from Ottery to Wynberg then to Retreat which costs R26 per trip. She explained that her husband does work, but “*didn’t pay proper money*”. I asked what she meant by proper and she said permanent work would be proper. He works in gardening and paid R500 fortnightly. She had previously worked at a store where she ran the potato chip frying machine in Ottery and stopped because she was pregnant. There were many women who relied on their partners’ income to access transport, and a lot of the time their partners were working contract jobs as bricklayers, mechanics, security guards or gardeners. The precarious financial situation women were living in and the reliance on male partners, other family members, and state grants complicated access to the clinic.

In considering the price of transport, the amount of time it takes to get to and from the clinic, the waiting process at the clinic and the difficulty of getting time off from work, a few women stated that they if they came in later for the first booking visit (20 weeks+) then they would not have to come in for appointments as many times, thus saving time and money. The desire for fewer visits to the clinic, was not only related to access, work, but also was tied to common assumptions about a “good mother”, where, as long as you are seen by “the community” to have attended the clinic, the “lateness” of arrival was not questioned unless women were well into their third trimester, and the frequency of visits did not factor into this perception.

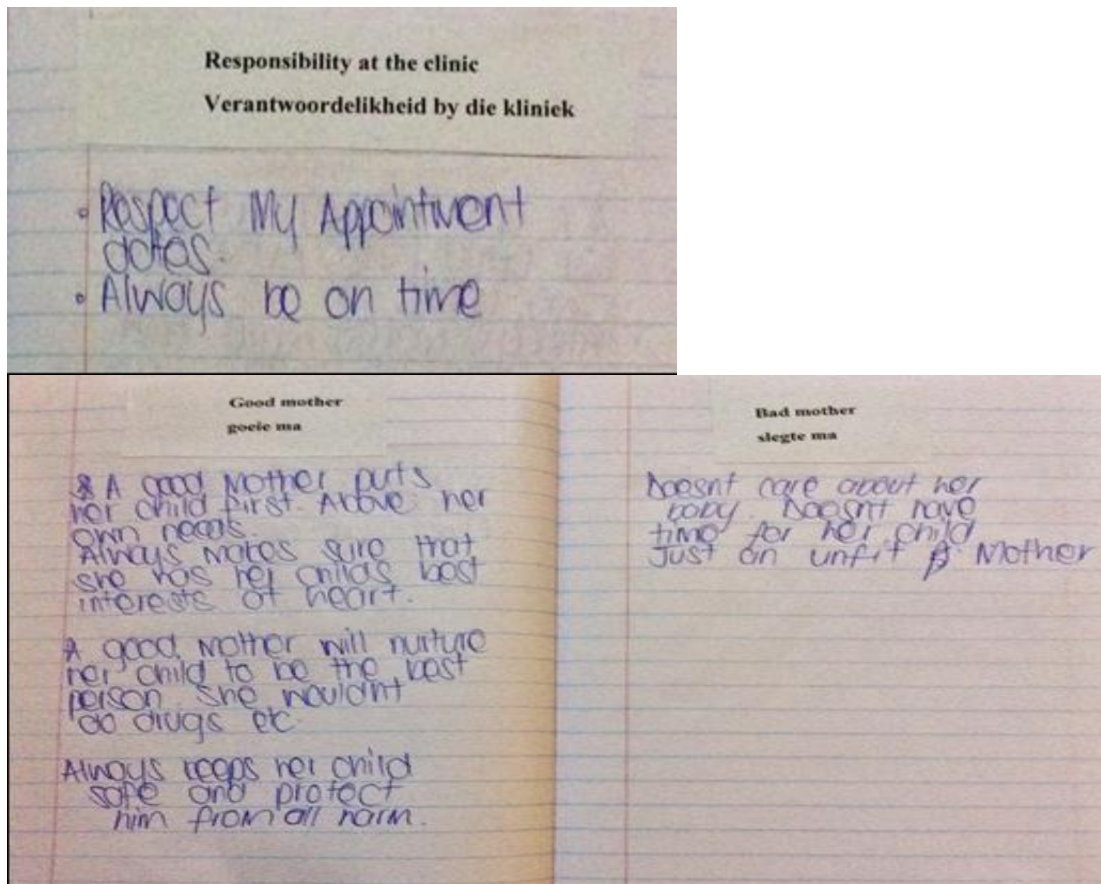


Image 15 Danielle Journal pages on what she understands the word responsibility and the labels of “good” and “bad” mother mean.

## Chapter outline

The thesis consists of six chapters. Chapter two, *Space, violence and temporality: the embodied dimensions of subject formation* explores what goes ‘uncounted’ in the statistical capturing of ‘lateness’ by giving ethnographic descriptions of life in spaces of violence and inequality. In focusing on space and experiences, the chapter shows how space is defined and remapped in relation to gang violence, vandalism, theft, and threats of sexual violence that affects flows of people, organisation and healthcare access. In looking at violence and its temporal and social effects, I further analyse how intimate partner violence/domestic violence, and household dynamics influence clinic access and timing. Geographies and histories of violence, and experiences with harsh intimate partner violence are to be considered as shaping values, not merely ‘qualitative explanatory’ ones. Space and the violences in it come to shape forms of life, movement and temporality.

Chapter three, *Knowing and counting*, follows on from the introductory discussion of biomedicalisation. In analysing the governing rationalities and biomedical discourse that frame conceptions of women's bodies and reproductive experiences, I show the tensions that arise in the process of biomedicalisation and the assumptions of a "knowing" body that neglects multiplicities of bodily experiences. Self-regulation and surveillance of bodies, contraception and sexual relations, and attentive surveillance of bodily signs of 'absent menstruation' and 'symptoms' of pregnancy are premised on universalised assumptions about bodily experiences and emphasise 'knowing' within models of 'rational individualism'. I rather show through tensions in knowing and counting, that 'knowing' one is pregnant and gestational age is a process in which one *comes to know* through bodily experiences, and relationally through engagements with partners, kin, peers, clinic staff, technology and bureaucracy.

Chapter four, *The social phenomenology of trust and uncertainty: unsettling the parameters of biomedical "lateness"*, disrupts biomedical boundaries of temporality in antenatal care, clinic attendance and labels of "lateness" by analysing the social phenomenology of trust and distrust. I show how beliefs and experiences of different kinds of failings (state care, contraception, tests, foetal sexing) shape trust and distrust at varying thresholds in pregnancy and life, and complicate relations to medical authority.

Chapter five, *Navigating pregnancy's social life: 'sitting with', speaking, punishment, and repair*. In following participants throughout their pregnancy, I show the series of social events and consequences that follow after "speaking" as women experience stigma in action, and the social importance of the 20 week ultrasound scan for the repair of kinship relations and in garnering support. I take a guiding focus from Rapp's position that "women are moral pioneers", as I show how women "sit with" pregnancies ("unplanned" and "unwanted"), and the moral, religious, financial, emotion and personal dilemmas that are navigated alone; "speaking" and 'revealing' to partners and kin once pregnancies are accepted. I then explore the social consequences of speaking and the devastating punishment experienced by young women by older female kin; and finally moments of the social work of "repair" between family and pregnant women as the foetus is given material and affective placement in the world through the 20 week ultrasound scan. In moving through these unfolding experiences, I show how the linear recommendation to "arrive at 12/20 weeks" to the clinic ignores the ways pregnancy has a claim on the social in which existing networks of obligation, responsibility, and exchange constitute persons and relations and influence when and how women seek antenatal care.

The concluding chapter six, I encapsulate the key findings of the thesis with an emphasis on “the social”, “events” and the “everyday” that positions the findings within broader anthropological literature on health and the attention to forms of life and “local social worlds”. Through attention to forms of life, events and the everyday, I focus on how the personal, environmental (spatial), political economic, historical, experiential, and relational shape how pregnancies are experienced. Beyond the discursive and political framings of subject formation that individuates pregnancy and health care seeking practices within a positivist model; I bring the social to the fore as I show how the biomedical is experienced by pregnant women. In doing so I show the individual is enmeshed in complex relations over time; I offer a temporality of events and their placement that is relational and experiential.

## Chapter Two

### Space, violence and temporality: the embodied dimensions of subject formation

Thursday 15 October:

Cape Town radio stations report of 2 dead in taxi shootings in the early hours of the morning. The situation was still believed to be “tense” in Lavender Hill, Seawinds, Vryground and the surrounding areas of Retreat and Steenberg at 7am. The violence escalated after taxi protests in Vryground on Wednesday morning saw the burning of tires by protestors, and the use of stun grenades and rubber bullets by police to disperse crowds. Protests were linked to ongoing taxi feuds over taxi routes. The people in the areas affected in the South Peninsula had been walking around in groups to get their children to school, or remaining inside their houses. By 9am streams of comments on the Retreat Facebook news page said that gun shots were still being heard, and they confirmed the taxi violence had prevented people from getting to work because they were being assaulted.

The taxi violence followed on from a weekend which saw the Capricorn youth centre vandalised and set alight. The response from people living in the areas showed a loss of hope for the situations they live which are saturated with gang violence and shootings, taxi violence, robberies, sexual violence, domestic violence, drug abuse, and vandalism of community sites. Earlier that Thursday morning two trains were set alight at Cape Town Grand Central station, further adding to the delay in public transport.

I had cancelled my trip to the clinic that Thursday after speaking to my participants who did not leave their houses out of fear, two of whom had had antenatal bookings scheduled for that day. The clinic staff had trouble getting to the clinic, as they too live in the South Peninsula areas and some take the taxis to work. The nurse had said that many of the women scheduled for clinic visits that day could not make it in. The Retreat Day Clinic next door had continued to receive people with gunshot wounds on the following days.

## What goes uncoun ted: on quasi-events, violence and space

In understanding space and the everyday experience of it, De Certeau (1984) examines the production of urban space, and how it is experienced through the everyday practices of a city's inhabitants. The embodied act of walking in urban space reveals how space is organised (De Certeau, 1984: 117).

*“A space exists when one takes into consideration vectors of direction, velocities, and time variables. Thus space is composed of intersection of mobile elements. It is in a sense actuated by the ensemble of movements deployed within it. Space occurs as the effect produced by the operations that orient it, situate it, temporalize it, and make it function... Thus the street geometrically defined by urban planning is transformed into a space by walkers”* (Collie, 2013: 1).

Through movements in spaces - navigating, rerouting, orientating, sensing, and pausing - pedestrians speak. Spaces become meaningful through these movements, stories, and histories (De Certeau, 1984: cited in Collie, 2013: 2). Everyday spatial practices and tactics produce a second geography of the city, one in which gives dimension to the urban maps that “render geographical knowledge as an abstract, ahistorical *place* that erases the spatial practices that are the condition of its possibility” (De Certeau, 1984: cited in Collie, 2013: 3). Ordinary inhabitants of the city live “below the thresholds at which visibility begins” (De Certeau, 1984: 93). In using De Certeau's framework for understanding the subjective and embodied experience of space through my participants' everyday habits, movements and engagements with violence, I will highlight the “quasi-events” of everyday that go uncoun ted in the statistical capturing of late reporting for ante-natal care, as well as the layered weight of historical, structural and spatial inequalities that add to experiences and forms of life (Povinelli, 2011:13).

For Elizabeth Povinelli, events are “things that we can say happened such that they have a certain objective being”; they are crisis-laden and can be measured and “politically and ethically responded to”; quasi-events though never quite achieve the status of having occurred or taken place” (Povinelli, 2011:13). Quasi-events are not aggregated, and thus apprehended, and evaluated – they do not reach a status of eventfulness that is to be grasped as an ethical and political demand in the same way crises and catastrophes are responded to (Povinelli, 2011: 13). One can see this in operation in the case of women reporting for antenatal care in South Africa. The state aggregates the variety of ways that women approach antenatal care in terms of time (“late” or “on time”), discounting the reasons that might lie behind whether or not, and when, women seek care. The resultant statistic – 40.2% of women arrive late for their first trimester check-up – becomes a social fact and a political and ethical imperative: the state must ensure that

more women report 'early', and does so through interventions in strengthening education on family planning and antenatal services. What is not "counted" in the statistical capturing of lateness, are the quasi-events in the everyday lives of the pregnant women and how they shape how, when and whether women take up the state's offer of care. I am referring for example, to examples of inability to access clinics on time, intimate and kinship negotiations that take place, life in communities of violence and drug use, lack of child care support and ability to take time off work to wait in the clinic all day (Abrahams and Jewkes, 1998). In examining some of these aspects, I begin with Libby's account of arriving at the clinic.

### Libby

I met Libby on a cold winter morning at the clinic. She was a short woman with a strong voice and slow walk. She was the participant that had mistaken me for a man – we laughed about this as we walked to the car. Libby was 35 years old and taken by surprise at being pregnant again. She had one child, a son who was already 17 and whose presence filled the two hour conversation as Libby returned to stories of him. I got my flask of tea from the car for us to share. We decided to stay outside to talk in the fresh air despite my concern for the quality of the audio recording. Libby described her morning to me as she prepared to come to the clinic for her first booking appointment on August 6th 2015. The sun only rose at 7:30 that day. She had left her house at 5:30am to get to the clinic, and had walked nearly two kilometres from her home in Lavender Hill (an area notorious in Cape Town for gang violence) to Retreat MOU in the dark. It took about 20 minutes.

*The time I woke up it was half past 4 so I told myself 'just another few minutes' and then the alarm went off quarter to 5, put on the kettle, wash my face, wash my private parts, finish breakfast half cornflakes on the stoep, see what people is walking around, brush my hair, brush my teeth, then I came here twenty past 5, half past went out of the house and came here... When I looked up it was quarter to 6... my sister actually asked if she can walk me, and I said no it's fine, I will just pray. And when I came here by the corner, I said 'jirra dankie, god thank you' ... because I was walking alone, there were two ladies coming, and one guy he was still looking at me and the other one was there by the shop, and there was the other dirrrty one, jirra man, my heart is pump for him because he must grab you, very scared of him... and when I came here I said god thank you for bringing me safe here\_and as I entered I threw my card in and went to sit and I see I'm number two, I always want to be number 1 or 2 that is my aim when I come to this clinic because I want to be out early because I have stuff to do...*

Libby also explained that she had to remind herself not to walk fast or do anything too strenuous because “*when I walked from Lavender hill till here, if I walk fast I get pains here \*points to lower stomach\*, then I must walk slowly...*”

Libby’s aim to be first in the queue for the day is common among people dealing with public services such as public health services and Home Affairs, as people need to arrive to the buildings from 6am and before 8am to get a place in the top 100 for the day. Libby rather walked to save spending money on taxi fare as she was recently unemployed. Walking not only caused bodily fear and stress as her heart ‘pumped’ in fear for her safety, but also caused a pain in her lower stomach now that she was pregnant. Libby’s experience serves as a case that emphasises the relationship between bodies, space, violence and structural inequality.

### **Construction of space and the everyday: clinic access, remapping, rerouting**

Space and experiences in it as this chapter opened with, are defined and remapped in relation to violence in the areas that effect flows of people, organisations, and healthcare. (Das, 2008; Mbembe, 2000). Libby, like many other participants, only leaves her house to get groceries, go to work, to the clinic, and to visit family members. Most women expressed maintaining an emotional and physical distance from other people, and thus have very few friends they trust and rely on. They attribute this to the ways gang violence shapes public spaces, and to the social effects of drugs and gossip. For many participants, sisters and maternal kin form an important supportive relationship, and are key in strategies against domestic violence and social unrest. Women described themselves as ‘isolated’. I take up this issue as it relates to spatial dynamics, economies of violence, physical, structural and temporal isolation. These further influence perceptions of ‘hopelessness’ and offer grounds for a consideration for a theoretical understanding of forms of life where endurance frames daily experience (Povinelli, 2011). Secondly, isolation as it relates to patriarchy and domestic violence, precarity of household dynamics, notions of household and safety, and changing relations of care. For pregnant women, the clinic space is implicated in the wider political economy and geography of violence, and so becomes embedded in the dynamics that influence clinic access and arrival to scheduled visits (Muller, 2004).

The clinic spaces have become targets of gang violence. Clinics and patients have been robbed and buildings vandalised. All of these add to the precarity of life and care the women experience. I argue that the geography of health seeking and the temporalities are interrupted by actions and

fears about gangs and public violence. Additionally, domestic violence and intimate partner violence, I argue, are the uncountried “quasi-events” in how, why, and when some pregnant women access the clinic. The state’s definitions and assumptions about pregnancy assume that context and individual are separable, such that individuals bear responsibilities independent of the context. Where context is factored in it is understood to be an explanatory value rather than a shaping one. Space and the violence in it come to shape experiences and bodies - specifically pregnant bodies. Context’s as “shaping” value will further be shown in relation to kinship dynamics; use of the clinic as an axis of support, as well as how the clinic staff themselves tend to the social. Experiences with arriving at the clinic “on-time”, maintaining clinic schedules, and engagements with the clinic and staff I argue are implicated in subjective experiences of layers violence, production of space and the relation between violence, temporality, and sociality.

Forms of violence in the areas from which the clinic’s clientele are drawn are layered with gang violence, taxi violence, robberies and vandalism. These events often influenced how pregnant women would navigate access to the MOU and other clinics, if they left their houses. Other times women had to reroute to a new clinic altogether due to shut downs, as was the case with Lotus River clinic. Lotus River clinic was used by some of my participants as the first clinic that they visited to confirm their pregnancies (or illness symptoms), and receive referral letters for Retreat MOU. Vandalism and robberies had led to the clinic in Lotus River being shut down.<sup>13</sup> This meant that all people seeking healthcare in the area were directed to the next nearest clinic which was on Klip Road (map below). Both clinics are situated between Lotus River, Ottery, Parkwood, and Grassy Park. My participants from the areas explained that they had to walk a further 2km to get to Klip Road clinic, which meant walking passed a known gang territory inhabited by the gang called the Mongrels.<sup>14</sup>

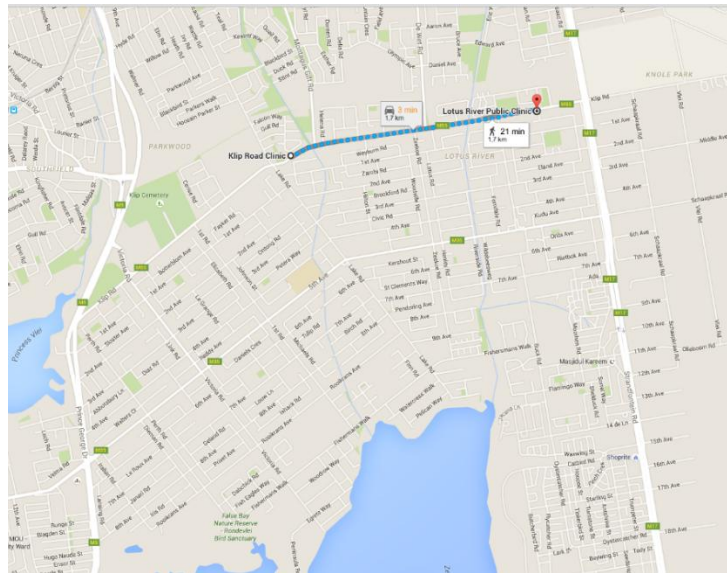
Rehana spoke about her access to the clinics, which included Lotus River clinic and Klip Road clinic as the primary ones sought before being directed to Retreat MOU. Due to Lotus River clinic being shut down, Rehana had to go to Klip Road clinic. She explained that “*it is very busy*

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<sup>13</sup> “City Health spent more than R150 000 on repairing infrastructure at the Lotus River Clinic... despite spending more than R40 000 a month on security” (Lewis, 2014). The clinic closure was permanent with plans to build a new clinic in Pelican Park.

<sup>14</sup> The Mongrel are “one of the oldest gangs in Cape Town and operated in District Six before the area was bulldozed in terms of apartheid’s Group Areas Act. Its membership is spread across the Peninsula... the gang’s stronghold was in Lotus River” (IOL, 2003). For more on present gang information see Don Pinnock *Gang Town* 2016. In 2013 South African Police Service statistics 12% of the 2,580 murders in the Western Cape were gang-related. An 86% increase from 2012. “there are 12 recognised street gangs and three prison gangs in the Western Cape... however, an estimate from the early 90s lists the total gangs in Cape Town at 130” (Swingler 2015 Daily Maverick; SAPS)

*since they stopped Lotus River...now I must pass by the mongrels” so she takes a taxi to bypass that if she has the money, because “if they know your face, and know your family and what side, they hurt you... that’s why I don’t walk anywhere”.*



Map 3: Reroute to Klip Clinic from Lotus River Clinic. (Google maps, 2016)

Space in relation to gangs in the areas was mapped according to the understanding that shootings, stabbings and robberies are constant. There were specific spaces mapped by my participants as being ‘gang territory zones’ and boundary markings for different gangs. These zones and boundaries were spoken of as being open grass areas, parks, fields, bridges, and rivers. As Rehana explained, in rerouting to the Klip Road clinic, she had to pass a known gang territory. In accessing the clinic, she had to refigure her access and make funds available to take a taxi to the clinic rather than walk passed the gang.

Rehana continued explaining what living in Ottery meant with the gang violence, not just having to access Klip Road clinic. She described that:

*“There are bad shootings in Ottery... There are people getting shot - a guy on Thursday got shot and the woman with him. He died, but she is in hospital. She got shot 7 times in her arms and legs and probably won’t walk. He was not a gangster. The gangsters know their faces. You are categorised by the territory you live in and if they recognise you as someone’s family member. The gangs are called Mongrels and Euro cats. They knew her face*

because she used to live that side [Mongrels side]. The River cuts the two sides apart... Fighting just go on, on, on".<sup>15</sup>

Her description of the environment and the recounting of a recent shooting was a familiar way that participants spoke of gang violence in the areas. They would explain that it was bad, and then move to narrating a story of a recent shooting that happened in the last seven days. Their recounting of events was told with a narrative that highlighted the everydayness of shootings in the areas. A description given by Jemima recounting violence through a recent story of a shooting, echoes with the everydayness of the violence and threat of being shot.

*"I don't really feel safe. They shoot here, especially drug dealers. I had a friend drug dealer, 18 years old, got shot in a shop buying cigarettes... I saw the body after. In Lavender Hill, they shoot a small boy there, I just had to cry... for the mother... shooting is death here..."*



Image16: Facebook Steenberg and Retreat Group update November 13 2015 following the attacks in Paris.

There were episodes of revenge attacks between rival gangs (Mongrels and Euro cats) over the course of 2015 (image 16).<sup>16</sup> The attacks were a part of the long-standing battle for territory in Ottery. Despite the gang violence being episodic, the effect was such that people were constantly afraid and alert, experiencing an environment that is constantly threatening. When speaking about experiences of gang violence, participants did not believe there was an end in sight for the violence, they did not trust the police to putting an end to the violence, illegal use of firearms, and drug manufacturing, selling and using. There was an everydayness to the description of

<sup>15</sup> The 2015 flare ups between the Mongrels and Euro Cats were part of the long-standing battle for territory between these two gangs. Ottery residents had been living in fear since early shootings in 2015, and continual shootings flared up throughout the year, reaching a peak again in October and November. (Malgas,2015; Isaacs, 2015)

<sup>16</sup> Cape Times reported visited "63 bullet holes" at the recently refurbished Russel Court flat block in Ottery. (Petersen, 2015).

violence, as indicated by experiences as well as in the affective description of “hopelessness” to “escaping” the violence and living in the Cape Flats Southern Peninsula area. The range of affects in the description of violence and space were hopelessness, sadness, and anger.

Hopelessness in not being able to move house, affordable areas being just as bad as each other in the Southern Peninsula, violence not having an end in sight, continued bouts of vandalism on spaces of “community upliftment” and “youth spaces” such as Capricorn youth centre. Sadness, as Jemima expressed by weeping for a young boy’s mother after he was shot. Anger was expressed in plenitude on the Facebook sites when killings and shootings were announced (usually with a graphic image); it was also expressed in the form of religious revenge/justice narratives. The result was that my participants’ experiences and affective responses (fear, loss of hope) were placed within what Elizabeth Povinelli (2011) calls a ‘social tense’ of the present continuous, where violence and its affective responses had a durative aspect.

Their fears were not only for themselves, but also their children. For them, good parenting meant restricting children from leaving the boundaries of their homes for fear of gang violence. Rehana, as with other participants, expressed fear when thinking about the future of their children; they did not want their sons to join gangs, and their daughters to have teenage pregnancies:

*“I’m very scared because they are all boys. I keep them indoors all the time”.*

Veronica, like Rehana, and the other mothers, explained that her children “*know they must stay and play inside*” she said that she is “*honest with them*” and explains to them “*what goes on and not to join gangs*”. Or, as Nadine put it, “*I have two boys and I don’t want them involved... I want them to work one day for their wives and be good fathers because the environment we live in now...*”

These dynamics of violence and space affect mobility of my participants and their children and add to the actions that isolate and insulate the house. These barriers broken with stray bullets through windows (image16). These barriers are gendered, as clearly expressed by Libby, who lets her son and nephew outside to see select friends, go to school, and run errands, but does not let her 13 year old niece outside alone. The niece goes from home to school, or to the Newer Foundation. Libby said that:

*“when she wears tight pants... I tell her to wear a sweater that covers her bums because she is very well built, pretty girl... and where she goes I ask her ‘where are you going, the shop?’ then I will stand by the gate and watch her walk down the road... if she must go to Newer Foundation I will take her ...because the people always look at her down the road, especially the boys they go looking for trouble with her because she doesn’t play outside*

*because she goes straight from school to aftercare. She's 13 years old and goes on functions with newer foundation club. I am very precise with her because she is a girl"*

Nuuran illuminated the subjective gendered experience and added fear of walking around when she explained that she does not walk around, especially at night. While I asked about her experiences as a women walking, Nuuran brought up the additional concern of being targeted when walking with children.

*"They tend to target women, especially if you have a child because you can't run...I've seen them rob an old lady... sad because in the past gangsters seek out other gangsters. Now they want to take it further, and hurt you... get beaten up or raped... if they rob you and decide they want to now rape you, they will".* This consistent fear of the potential for grave violence against women affects accessing state care as many women walk to the clinic at varying times, in darkness as Libby had to.

Gendered experiences of restricted mobility were spoken about in relation to policing young women, or by self-policing due to fear of public violence and being "targeted". There was the perception that women, children and the *"weak and sick"* coming in and out of the clinic were *"targets"* for robberies. This further added to the precarious and violent spatial dynamics of and around the clinic spaces. Ardener (1981: 12) argues that the "division and hierarchies of social structure are depicted... through small scale spatial metaphors... space reflects social organisation". While there is a fear of gang violence across the genders, my participants as women, and their policing of nieces' and daughters' mobility and dressing illuminated the power relations of gender and fears of violence in spaces. The vulnerability felt by women can be attributed to the constant violent experiences they hear and witness, as well as the perception of gender where "female vulnerability is taught", and women are stereotyped as being weaker (Ardener, 1981: 29). This perpetual fear was also compounded by social isolation that promoted mistrust of others and gossip. In regulating dress as well as mobility, women's bodies become a centred focus of control, violence and discipline, as Hatton (2011: 76) explains in his inverted model of Foucault's analysis of power and punishment in the panopticon. Where the centre controls the bodies on the periphery, Hatton (2011:76) inverts this to view the body as being at the centre as the target of control, and those who control the target are located at increasing levels and distances in the periphery "depending upon their kind of participation in the direct physical coercion of the targeted body". In using Hatton's inverted model, I further argue that forms of power relations experienced by my participants, namely patriarchal violence, were not only in the form of surveillance, internalisation of gender norms and regulation, but also gravely experienced as direct physical and sexual violence, and intimate partner violence. Drawing on

Povinelli's idea which is that quasi-events are events that never reach the status of having occurred or taken place, and do not rise to the surface of what can be accounted for in political evaluations – they do not reach a status of eventfulness in the same way catastrophes do. From the perspective of my participants it is not about their pregnancies and bodies per say, but about the conditions that make for particular kinds of bodily experiences and possibilities. Structurally they are not 'quasi-events', but eventedness in the sense that gang violence and other forms of violence may have eventedness. However, the fear is *always* there; the potential of violence was constantly anticipated.

### **Violence within the clinic**

As initially stated, the clinic spaces themselves become sites for violence. Nurses from the MOU and the Retreat Day clinic described how unsafe they feel in the clinic space due to the threat of violence. In one case, known gang members were admitted to the Day clinic with stab wounds after a fight. The separation of the MOU and the Day clinic was only by a few metres, and during that day one of the gang members was brought into the MOU so he could get water from their facilities. A nurse from the MOU remembered how scarred they all were because he should not have been allowed into a space that jeopardised theirs and pregnant women's lives. The fear of violence erupting in the presence of male gang members within the clinic space was not an imagined concern, as the Day clinic and ambulance staff have had to deal with numerous situations of violence in the space such as the shooting or stabbing of staff. The staff at the day clinic explained that the security gate that separated the waiting room and their offices and wards was recently broken. That broken gate had yet to be repaired which led to a following incident where a group of men came through and were "*walking up and down the corridor with guns*" explained a trauma nurse. The nurses reiterated the perception that robberies are occurring more frequently outside the clinic space as patients leave, because they are "*easy targets*". The clinic staff are also robbed on route via taxi to and from the clinic. The staff also see to the wounds of the community. In the trauma log book there was a range of 100 – 170 patients in the trauma unit per day, with (2-10%) of those being violent crime injuries. The main areas these incidents occurred in were logged as: "Lotus River, Lavender Hill, Ottery, Montague Village, Grassy Park, Parkwood, Retreat, and Muizenberg" – precisely the area that was served by the antenatal clinic. News reports following clinic shut down, such as Lotus River Clinic, have brought to light the experiences staff who find it difficult to work in these environments, and the concerns about their patients "defaulting on their treatment because of safety concerns" (Anel Lewis IOL

August 2014). Lauren Muller, in earlier research in the primary health care facility of Clareview in the “Cape Flats” Cape Town argues that:

*Government health policy and legislation tend to neglect the specific significance of place and space in its conceptualisation or articulation of power. Local primary health care is grounded, however, in particular facilities and communities (2004: 54).*

In observing the clinic space, I aim to further my argument about the production of space that is not a neutral and apolitical, but woven with material, relational and symbolic realities that orientate around experiences of violence (Lefebvre 1991). The presence of violence in the form of physical attacks with weapons and the various injuries, outside of the clinic and within it shape the experience of health care, access, the timing of visits and the possibilities. The skelling and physical abuse experienced in state institutions is an additional factor in considering violence not only outside of the clinic, but also within it. To understand the presence of violence in the Southern Peninsula, I take a step back and look at the historical processes through which urban social conditions were made.

### **Gangs, violence and space – historical shapings**

*‘One might breach a city wall or kill a king, but how could one...break a wall of isolation?’ (Mumford, 1961: 605 in Pinnock, 1989: 168).*

*“The pre-apartheid city’s apparent racial integration overlay a cruel class structure that apartheid re-rendered in crude racial terms. Despite massive post-apartheid change, Cape Town remains South Africa’s most segregated city” (Ross, 2010: 2).*

The insulating and isolating that my participants experienced due to violence, I argue is also owed to structural inequality as a result of colonial and apartheid racial and class restructuring and zoning, and the rise of gangs during this era (Pinnock 1984; Standing 2006). Pinnock (1984), explains that street gangs were largely the result of and reaction to the apartheid Group Areas Act of 1950, and the forced removals created social disorganisation, break-up of social support and informal neighbourhood and kin support systems (Pinnock, 1984; Standing, 2006). Gangs were a response to “apartheid’s massive social engineering” (Pinnock, 1997:5).

The isolation and feelings of hopelessness about the gang violence, and drug use and the inability to move outside of gang saturated areas can be analysed in relation to the spatial dynamics and

1950s urban planning and rezoning. The 1950s planning literally built isolation into the “townships” and the “Cape Flats” by leaving a green belt of empty “buffer strip” around these compulsory cluster developments (Pinnock, 1989:150-168). The Cape Flats had been separated from the mountain suburbs by a vast expanse of “empty land and a freeway” (Pinnock, 1989:159). One of the features of this planning was an *isolation* “for those who could not afford motorised transport, the distant township was to become a trap... imprisoned by poverty in environments which were both hostile to the only form of transport they had – walking” (Pinnock, 1989:159). Space is not neutral, it is ideological, and in this instance space and violence are not bounded in the Cape Flats areas, but are in relation to the whole of the city, including the histories of the production and distribution of violence (Gillespie, 2014: 203; Povinelli, 2011; Mbembe, 2001).

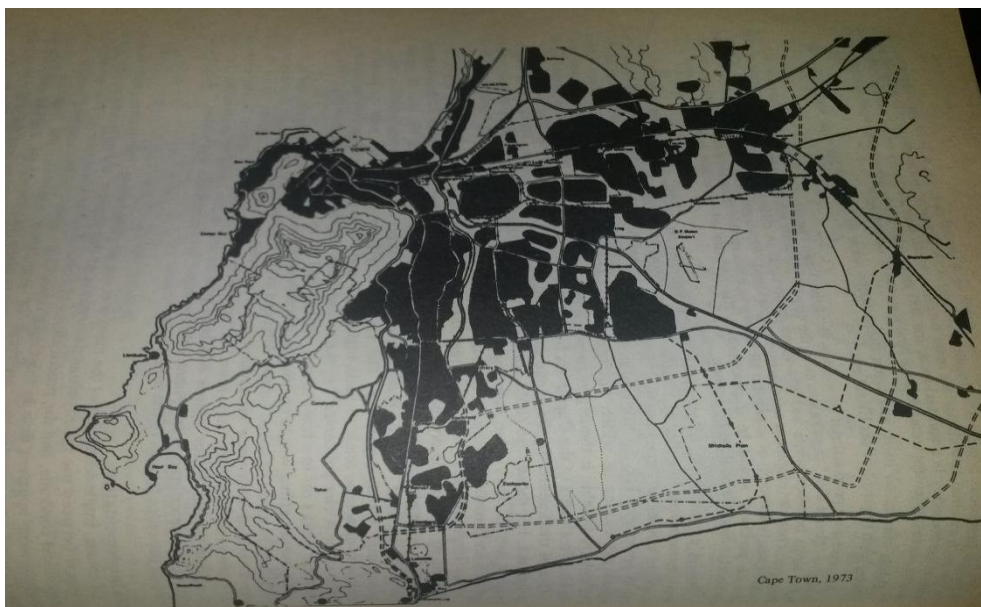


Image 17. Apartheid isolation planning Cape Flats (Pinnock, 1989)

Some of my participants could remember growing up and being forced to relocate, or having their living experiences and household security hinge on failures of waiting for council house relocation. Nadine was one such. She remembered living in Kenilworth and then being removed to Parkwood. She, as a young girl, had felt isolated because she did not speak Afrikaans well; in time that changed.

I argue that the literal spatial and ideological isolating of the Cape Flats adds to the feelings of “hopelessness” my participants have in being able to “escape” living in the Southern Peninsula areas saturated with gang violence shown above. This lens shows an approach to understanding ‘violence’ and the ‘everyday’ as assessed through the spatial, temporal and affective dimensions

of descriptions of constant violence (Das, 2008). Most comments from the pregnant women, even those that had moved between areas, felt that nothing was going to change, and that the violence was the “*same everywhere*”. Jessica, a 35 year old mother of 3 spoke of the shooting in Steenberg where she lived, and how the gang shootings had been in all the areas that they had lived in:

*“Seavinds, Muizenberg, Steenberg... ‘Everywhere you go it’s the same thing, no escape... The children get used to where they live in and I have to be okay because I can’t go with them everywhere’”*

Shantay lives in Athlone and 5 minutes away from Manenberg, she explained that:

*“I don’t want a child growing up there... Can’t walk anywhere because too many gangsterism going on ...no matter where you go you’ll find it...”*

Despite explained boundaries and areas likely to have constant gang presence, my participants spoke in a way that emphasised the spatial saturation of gang violence, shootings, and drugs as Shantay did. Veronica said that in Lotus River there was, “*hectic shooting every night...run through the road with guns open... They shoot at night, and are around in the day, and shoot on the weekend too, because they know that some of the gangsters will definitely be home during the weekend*”. In speaking about Lotus River and Ottery, Renesia similarly affirmed the constant presence:

*“I don’t think you wanna walk in Lotus River because the violence and the drugs is all on the street there... it’s basically all the same because there’s also violence that side [Ottery] with the shooting, and the drugs and everything. The whole of Lotus is like that... WHEREEVER you walk, you walk into a gang”. In leaving her house everyday she explained that she felt “*very unsafe*”, and hauntingly stated that “*you don’t know if you gonna come back tonight*”.*

In asking Renesia about the temporality of the gangs and if there were fluctuations in violence at different times throughout the year, she responded with an exasperated:

*“It just happens all year. Every year, every day, every second. There was a man just shot down on Monday”*

Mersell a participant who lived in Ottery, had explained how she wanted to leave the place due to violence and drugs in the area. In recounting a shooting from the previous night, Mersell called the place “the battlefield”, as it was commonly known, because that was where eruptions between the gangs occurred.

*“There is a lot of gangs and violence... it’s not well... I want to get out of the place... they shoot a lot there; they don’t worry about children or anything... last night shoot by us at The Battlefield... I have to fetch them [the children from outside] when they shoot...”*

She is scared to walk around because you “*don’t know what time they’ll shoot*”. Shooting also occurs within the flats as gang members enter to find each other. A news article gives a description of how flare-ups unfold on a field:

*The Mongrels lined up on one side of the field and the Euro Cats on the other. They started firing at each other non-stop. It was madness. They were using R4 rifles and AK-47s - it was like a war zone (Petersen, 2015).*

In speaking about wanting to move, Mersell had followed it with a tired “*I want to move - but everywhere is the same*”. When reflecting on having children in this environment she said: “*it works on me... on my stomach and head... especially when they shoot children...*”<sup>17</sup>

Not only does she feel everywhere she could go would still be saturated with gang violence, she also feels isolated because of it and the drug usage. These shape her experience as it did the other participants when she spoke of spending “*every day in my house*”, with her neighbour as her only friend, because “*it is not safe and the rest are drug addicts... the people she knew from school*”. This was similarly described by a few of my participants, including Rehana, who had noticed the physical effects of fear on her body when there were shootings going on, and her explanation that she is inside her house “*a lot of the time*” and said she had few friends only her “*neighbour in the next flat, and cousins*”.

The naming of the ‘battlefield’, orientating oneself in relation to landscape cues of gang territories, presence of gang members and men, and the embodied experiences of heart racing, stomach turning effects of violence on the body, my participants experience of mobility, sociality, sociability and motherhood were infused with the violence in those spaces. Events of violence are woven into the fabric of everyday life, where space, bodily experiences, naming, orientating, insulating/isolating, and parenting constellate around expectations of everyday violence. Veena Das (2007) claims that violence as it descends into the ordinary not only interrupts it, but also changes it.

### **The clinic, the social, and spiritual guidance as responsive to society’s demands.**

Despite the narratives showing an othering of violence and fear of public spaces, the observations and experiences spoken of by my participants also brought attention to the violence within domestic spaces and between intimate partners. At times the narrative line between the

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<sup>17</sup> Her expression is a reference to the common term “working on one’s nerves”, in Afrikaans “*senuweeagtig*” (Ross, 2010: 6).

'outside' of gang violence and drug use, and the 'inside' home were blurred not only by stray bullets, but also by domestic violence which was exacerbated by male partners' involvement with gangs, drugs and infidelity. The theme of isolation again re-enters as it relates to patriarchy and gender based domestic violence, and the strategies that keep violence at bay. Some of the strategies for support in bouts of domestic violence entered into my participants' experiences of choosing to go to the MOU clinic to seek help after such violence. Such power relations between couples, domestic violence, or domestic unrest with partners or in-laws, created obstacles to receiving antenatal health care and help. The antenatal clinic not only served a biomedical function during pregnancy for women, but it became a space where staff tended to the layers of the body, the social and spiritual as will be elaborated below. The placement of the NGO and its counselling services within the Retreat space further added to the dynamic where women returned for help after having created networks of trust with the long term clinic staff and NGO.

It must be noted that there is a history of recorded abuses and scolding of pregnant women by clinic staff around South Africa (Masuku, et al., 2012; Abrahams and Jewkes, 1998; Villar et al, 2001; Atkinson, 1993) and I observed some underlying fears of seeking treatment from the staff by participants. Despite this consideration, I observed the clinic site and staff to function as part of women's strategies against domestic violence and various other social issues that were concerns for the pregnant women.

The clinic staff throughout the first booking day often read women's bodies, moods, gestures, facial expressions, and reactions, and noted "signs" of relational disturbances with parents, family and intimate partners. As one nurse explained, on her informal booking sheet for the day, she takes note of things to bring up again when she sees them later that day. She spoke about this after seeing a woman who she thought "looked depressed and quiet", as well as another woman who said briefly that she had relationship problems and her husband had recently left her. In examining these two women, the nurse took note of these emotional and relational disturbances so that she could bring them up again when she had more time. The nurse emphasised that the women usually 'open up' if they have more time and this usually occurred in the history taking section of the day. The same nurse recounted a devastating story from a 22 year old woman when she found out the reasons behind her excessive smoking. The nurse asked how much she smoked a day, to which the young woman told her 'about a box and a half'. The nurse well knowledgeable about the medical issues of smoking while pregnant, was still attuned to the social issues that may lead a young woman to smoke so much a day. In noting this, the nurse further asked why she smoked so much, "*what was making a 22 year old that stressed*" she had wondered. Later that day, the young woman had time and opened up to the nurse that her step

father had raped her. The devastation of turning to cigarettes as the only option for coping with such violence and violation is immense. As the NGO that offers counselling is situated in the clinic space, the young woman was directed to the counsellor if she was open to talking further, which she was. The influence of both the concern and intuitive questions from the nurses around 'social issues', and the placement of the NGO counselling services in that space work to offer guidance, care and response to more than just physical, biomedical concerns during antenatal care and pregnancy.

Other nurses, doing the history taking spontaneously asked questions to the women about their relationships, especially young women who were pregnant and at the mercy of their parents' household, women who had physical signs of abuse with bruises and cuts, or women who were explicitly emotional about their financial and relational problems. I observed an immediate understanding from the nurses in cases where abortion was had previously or was considered for a present pregnancy, especially if financial reasons were at the fore. There was a concern about how the women would cope with their decision, and counselling and other options such as adoption were offered if need be. Most of the time an additional layer of guidance was offered in the form of spiritual and religious guidance. One nurse explained that she *"likes to bond with the women and it is important for later on when they come back... Give them help and advice, and spiritual guidance, just a bit"*. She explained that the spiritual side was also important for her and the staff because *"we can't always do it alone... and they [the pregnant women] need to know there's something more too"*.

Spiritual guidance was offered in the form of promoting relations with God; resorting to 'prayer as comfort' in times of distress around decisions; and prayer as a means toward relieving any feelings of guilt about decisions on abortion or adoption that the pregnant women may have been feeling. Pregnancies that were labelled "unplanned" and hesitantly expressed as "unwanted", were reframed within a religious phrase of the pregnancy being *"a gift from God"* which seemed to ease fears and offer calm in the face of unpredictability and financial precarity. With the presence of spiritual and religious guidance, and religion as a form of care in these instances, there was also a framing around the *"bad things"* such as drugs and shootings as *"the devil making them do it"*, which offered a space of blame to be placed on spiritual absence, where women could 'turn their lives around' (especially prisoners seen to) and *"find God... because God works in the body and mind and heals"*. This spiritual encouragement did not saturate encounters, but merely cropped up at moments where concern was garnered around social and relational problems (Comaroff and Comaroff; 1997). Given these critical moments of reading bodily and emotional 'signs' for social concerns of abuse or ill treatment, I argue that religion in these

moments served as a form of care, and can be understood as “guidance” as being “responsive to societies demands” (Bulger, et al., 1995: 362).

The reading of ‘signs’ of relational violence, abuse, and unrest by the clinic staff, brought the reality of domestic and sexual violence to the fore as women not only navigated gangsterism in public spaces, but also the stark volatile abuse by male partners.<sup>18</sup> Clinic space and staff guidance on such matters became a part of the strategies some of my participants used to keep violence at bay. At other times, if the relationship with the male partner was seen as ‘stable’ without violence or upset, and more than one child had been had between the partners, then a suggestion for marriage was given in an effort to solidify security and stability for their children. This advice was in contrast to the more discussed concerns by the nurses about male partners not “*staying around*”, and the how the pregnant women should “focus on themselves and their child”. These observations show a tension between the lived reality of violence and precarious social and intimate relations, and the societal discourse idealising marriage and home as ‘security’ due to notions of ‘ordentlikheid’.

### **Constructions of the home, domestic violence, temporality, and clinic attendance**

*“...sometimes there is a very fine line between intimate relations and terrible abuse...” (Ross, 2010: 7).*

*“Prevalence of women physically abused by intimate partners at least once ranged from 8.7% to 17.8%, Western Cape at 16.9%. Other studies have reported higher rates at 42% and 50% (Jewkes, 2002; Dunkle, et al., 2004 in Abrahams, et al., 2006).*

In considering these violent disturbances in intimate relations that shape interactions with and attendance at antenatal clinics, and experiences of pregnancy and motherhood, I consider a question from Veena Das, on “what is intimate violence?” she answers that “the place to consider in addressing this question is ‘the home’...” (2008: 291).

Isolation did not only come up in relation to gang violence and having to stay inside ones house, it also came up in relation to household dynamics with in-laws or male partners and intimate violence. As shown above, there is a tension between giving advice on becoming married to maintain ordentlik ideals versus the lived reality of marriage drawing women in to closer proximity to intimate partner violence and isolation. Often women I spoke to who were not

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<sup>18</sup> Jeremy Vearey, Provincial Commander of Operation Combat, “on the Cape Flats, your first experience with violence is not on the streets, it’s in the house... by the time that you’re 14, 15, 16, you’ve seen a hell of a lot more than what you’ve seen on the street when it comes to gender based violence” (Swingler, 2015)

married but had a long term male partner and children with him, had chosen not to get married, and not to live with their partners. This was one strategy that kept violence and the unpredictability of such violence at bay. Social science research over the last decade has focused attention to questions of gender based violence and the relationship of such power dynamics on adverse health outcomes for women, specifically HIV infection (Jewkes, et al., 2006; Gupta, et al., 2008). Researchers can measure and analyse data by applying the Sexual Relationship Power Scale (SRPS) that is aimed at showing how “gender-based structural inequalities manifest themselves in individual relationships” broadly looking at control in relationships (mobility, education, communication), and decision-making such as condom usage (Pulerwitz, et al., 2002: 791). The research takes into account the “quasi-events” of which I focus on as forms of everyday violence, here domestic violence from intimate partners and abuse by in-laws, which shape interactions with healthcare and health risks for mothers and children. The previous research, (Jewkes, et al., 2006; Gupta, et al., 2008; Pulerwitz, et al., 2002), showed how intimate partner violence and domestic violence, can be aggregated and evaluated in a response to HIV concerns and taking “gender” seriously in health outcomes. This section seeks to expand on this recent research attention by illuminating the differing forms of domestic violence encountered by pregnant women and their intimate partners, as well as extended family. How these worlds of violence and precarity shape how women access health care and social support, timing to clinics, relations with clinic staff, and risks to their health.

#### Household dynamics, formation and violence

Candice gave context to the precarious intimate relationships when she explained that she was not married or living together even after having five children together.

*“I want to live by my aunt... you don’t know how to love with other people... maybe he is not nice, maybe you argue or something, and you think you made a mistake. I lived with my aunt since I was a baby – it’s better for me there”*

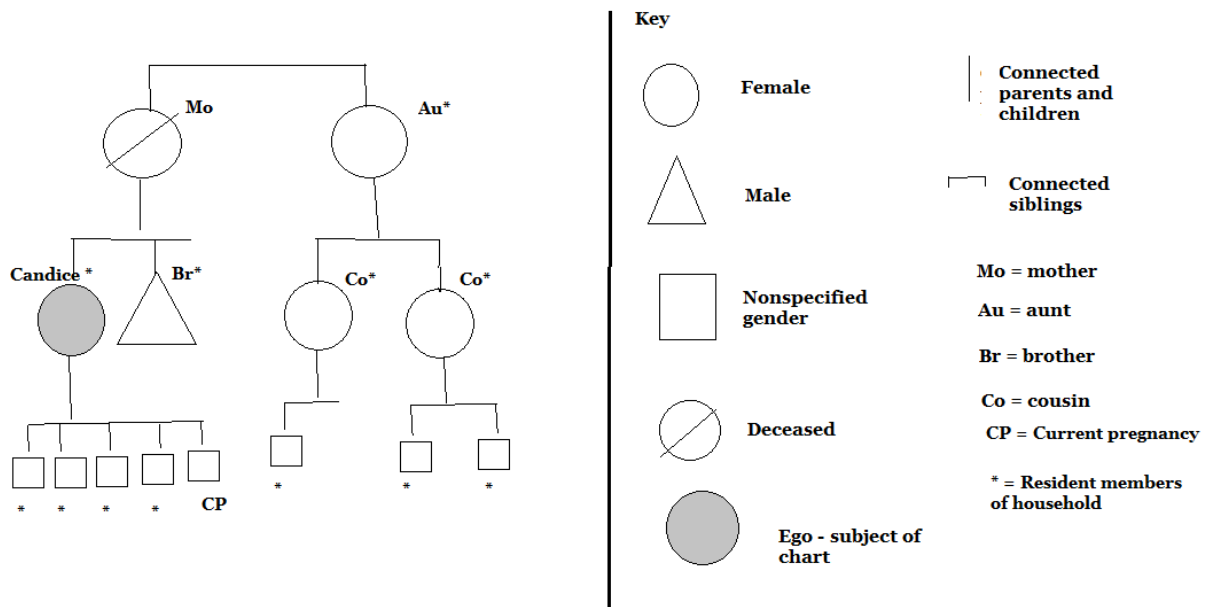


Image 18: Kinship diagram Candice's household composition. Residents are marked with \*.

Candice, and her 4 children were living with her aunt (and her two daughters and grandchildren), and her brother - 12 residents in total, in a two bedroom house.

Candice's partner lived around the corner in the backyard of his family's house. Candice said that she was "used to living together no matter what". There was a trust and support in familiarity of kin. She had brought up concerns about choosing to stay unmarried and live apart because her aunt's house was getting too small and she would have to consider moving in with her partner to his backyard bungalow. She was worried about moving as she said:

*"how is my boyfriend's people going to treat me... I'm not their family, I'm just their niece and nephew's mother... if we fight, maybe they take his side not mine maybe... better to live apart and don't see problems, it's the small problems that make trouble. It's not like living with your own family, if you fight then later it will be fine..."*

Candice was worried about how she would be treated, and how any small issues might break the fragile household and relationship. She would rather have the maternal support which was familiar and she could trust. Candice's experience and attempts to keep relations echoes what Ross writes in relation to research with residents of 'The Park', an informal "shantytown on the outskirts of Cape Town",

*"where life is punctuated by loss, disruption, violence, abjection (Kristeva 1982) and what Achille Mbembe describes as 'the distress of experience deprived of power, peace, and rest' (2001: 12), people must put much*

*effort into developing and maintaining relationships and ordinary rhythms of everyday life. This does not mean that there is no regularity to life, but rather that it is achieved against great odds... and often holds only temporarily” (2010:5).*

For some participants, maternal kin networks of support and housing were temporary strategies against domestic unrest or violence. If women were living with partners, but not married, they utilised these maternal kin networks for support in the form of providing a space to live if they left the partner (temporarily), food security, income sharing, childcare, and fluidity between these households. When I met Libby during her clinic visit for the 20 week ultrasound, she was staying with her sister to avoid her partner and the fighting between them. Libby had not married her partner as he stayed in his house with his family when she was pregnant with her first son (now 18), and she stayed with her family and raised the son. Libby would often speak of going to her sister to get away from her partner who she shares a house with their son. She would also help take care of her sister’s children as the sister would her son.

#### Marriage, family relations, violence and clinic engagements

*“The complexity of household relations [in the Park] was compounded by domestic violence, which rendered relationships precarious and social institutions, such as the family, vulnerable (Ross 1996), and cause considerable movement between different units in the ghetto as women and children sought refuge” (Ross, 2010: 92).*

The lived reality of intimate partner violence being exacerbated in marriage was brought devastatingly to light when I met Nadine, and which shaped her interactions and visits with clinics during and after pregnancy. Married for two years, she had two children from a previous relationship that ended when her partner was selling drugs. Her first pregnancy in her marriage miscarried. She bore a daughter, and, a year later, was pregnant with their second child. Her husband’s child from a prior relationship also lived with them. Her first two children were living with extended family, one with her mother, and the other one with his father. Nadine was experiencing severe domestic abuse, and had sought help from the clinic staff even though she was not pregnant then. She had gone to the clinic because she had developed a trusting relationship with one nurse during her previous pregnancies and bouts of domestic abuse. Nadine had needed help on that particular day because her husband had not only physically abused her, he had also coerced her into trying to take two pills that he would not tell her what they were. She had pretended to take them, and managed to hide them away till she went to seek

help at the clinic. The nurse saw the pills and said one was an “anti-retroviral, the other an antibiotic”. This was not only an informal distribution of anti-retrovirals to suit particular understanding of health control/maintenance by an adulterous husband, but it was also a story of the coercion she faced. She was convinced he was not faithful because of this experience and numerous others, one experience being where she had previously contracted an STI from him while pregnant with the child she subsequently lost. Nadia, had suffered physical abuse even during pregnancies as she stated that when pregnant with her daughter: *“he hit me in my tummy”*. The physical abuse had begun when Nadine had confronted him shortly after they had married about if he was *“sleeping around”*, and if he was *“on drugs”* because she found *“lollies”<sup>19</sup> in his working jacket*. She had confronted him after going to Groote Schuur during her pregnancy and finding out she had an STI. Her husband refused to let her return for a follow up visit after this. Nadine had tried to leave the marriage, but he had refused to call the Imam. She had also sought police help, with no use as he hid from them and they continued their relationship later. Nadine found out he was still *“telling lies”*, she in time confronted him again and she described the scene of severe violence which resulted:

*“I asked him something and he hit me till the blood, yoooh the whole room was full of blood. He hit me till he see blood, he said he is going to kill me... kill me, and the baby is so small...”*

Nadia, in a haunting description of her scared child, explained her experience of domestic abuse in one outburst the daughter was on her arm:

*“she don’t know she must cry... he don’t care whether she on my arm, he did hit her on the head \*gestures a hand swiping past a head\*. She is frightened because she want to cry but then she look at him \*opens her eyes wide and blinks\* and stop, and then she just shake a little”.*

Nadine wanted to leave her marriage, but could not seek refuge with her mother as her mother was already taking care of her son and she did not want to “burden” her further. Another area of isolation felt by a few of the married women were if they grew up Christian and converted to Muslim faith upon marriage. For Nadine, the conversion was not so much a spiritual problem as it was a social one. Her husband not only controlled her mobility, and social communications, he also prevented her from going to her church. This prevented her from getting familiar support from her church group network, and additionally her mother. Institutions such as the church and the clinic appeared to further offer spaces of support networks for Nadine and other women, in pregnancy and everyday life.

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<sup>19</sup> ‘Lollies’ is slang for a tik pipe

Nadine, and other participants, one of whom wanted to remain anonymous, had reflected on the changes felt after marrying their male partners – changes that involved infidelity, drug use, and domestic violence. They felt that they should never have gotten married, and that the marriage revealed their partners' characters' as violent, "*when he got me his true colours came out*" said Nadine; something which they had been warned about but did not believe would happen after marriage. Male partners and their family were often spoken about in an othered way, for example, "his people", "they are not my people", and an emotional 'getting ready' to join his family through marriage.

Similarly to Nadine, some women emphasised the maternal kin network of support that was not the same once married to a man, as the women felt they could not access it and place strain on their mothers for support in the form of housing them if they were having domestic problems. Others explained, as Merldy did, that she could not access her mother's household for help as it would "*burden her*", but maintained access to support from her sister as Libby had done. Anna Versfeld in her work with women in Manenberg, alongside Elaine Salo's (2004) work (as outlined in Chapter one), described a breakdown of previous "systems of reciprocity that allowed for the flow of resources between households in ways that did not" shame a mother's "momentary inability to provide for her family" (2012:7). Versfeld encapsulates generational changes, social changes, and reciprocal relations with the concept of "zones of influence" (2012:7) that helps her to examine the power dynamics in communities of women, and generational relations and changes (2012:7). Similar to my findings, these maternal support networks once available to women in situations of poverty, childcare concerns, domestic abuse, or illness, were no longer in reach in the same ways once "married".

The extent of Merldy's abuse was not intimate partner related, but directly encountered from her in-laws. Marriage, moving-in, and relations with in-laws ('his people' as Candice put it) were often spoken of as precarious and uncomfortable spaces for women. The extent of this emerges as women are emotional abused, neglected, refused food, and in Merldy's case, these experiences become obstacles and constant stresses that prevent clinic booking and access. Merldy who stayed in the backyard "Wendy house" with her "boyfriend and 2 year old", spoke of the turmoil she experienced with her mother in-law and sister in-law who lived in the main house of the property. Merldy was pregnant with her fourth child when we met. Merldy's children were from different men whose families were a part of the dispersed household child care. Merldy's 10 year old son lived with her mother, who was up the road on 12th Avenue in Retreat. Merldy's mother

lived in the Wendy<sup>20</sup> house in the backyard of her own mother's house with her two daughters and Merldy's son. Her 7 year old lived with his father's family. Merldy was 7 months pregnant when she sought antenatal care, she explained that she was experiencing problems with her mother in-law who was trying to kick her off of the property. Her main concern in retelling the experiences with her mother in-law was that the "stress" was "getting" to her and she was trying to "keep calm for the baby". Merldy's concerns illustrate how pregnant women come to view the relationship between maternal affective states and assumed influence on the foetus, a view expressed in the clinic space during the ANC talks. She explained that the in-laws were spiteful and locked the main house, which was Merldy's only access into her Wendy house. In locking the only avenue to the Wendy house, Merldy, 7 months pregnant, had to go over the fence between her neighbour's yard and the backyard where her Wendy house was. She described that there was a "big rock there" for her to "climb over, but the in-laws have moved it". Merldy could not go to her mother's house because it is too full, despite experiencing stress in that environment and great concerns about finances. She was concerned because she and her partner were unemployed and they relied on her partner's sporadic work and state childcare grants (R330 per child). Merldy spoke about how she receives care from her sister who lived a street up from her. There she could have company and receive a meal for the day, as she said she often could not afford to eat (nor did the in-laws help them when they could not get food). Merldy received small pockets of care from her sister where she could.

A change in social position to motherhood and wife for these women created material changes to their networks of support and care, and for some it shaped their engagements with the clinic, and when and why they sort health care. It shaped engagements with the clinic as some women re-entered the antenatal clinic when they were not pregnant in order to seek help and advice from trusted nurses or the NGO counselling staff on matters such as intimate partner violence or domestic disputes, drug use problems and concerns about effects on children. The clinic and the NGO space become enmeshed in the strategies against violence and poverty for some women who cannot access kinship networks as they previously had (Versfeld, 2012).

The experiences added to the complexity of household relations and household formations as women and children move between households, backyards and Wendy houses, navigating social relations and relying on maternal kin for support, safety, childcare, and food security at times - what my participants called "making a plan". These movements, strategies against violence, and

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<sup>20</sup> Wendy houses are commonly used structures made from wood or corrugated iron and other material that are placed in the backyards of houses. See 'backyard living', 'domestic fluidity' and 'dispersed dependents' Southern African Anthropology (Spiegel, Watson & Wilkinson, 1996)

pockets of care and support, illuminated the dexterity my participants had in attempting to meet emotional, material, and social needs - all the while juggling their developing pregnancies and obstacles in the access to antenatal care.

## **Conclusion**

In describing the chronic, everyday and forms of violence endured by participants, I have brought attention to the “quasi-events” that are shaping factors in participants’ lives – yet go uncounted and unacknowledged in the ways that the state understands “lateness”. With a focus on ‘quasi-events’ (Povinelli, 2011) I sought answers “in scenes of the ordinary that showed how forms of life are fashioned and assembled as gatherings of going-on” (McCormack, 2013: 228; Povinelli, 2011). Following from Povinelli, I have sought to show the events that take place for my participants that do not cross the threshold of eventfulness in state theories of lateness (Povinelli, 2011). I further draw from Veena Das’s (1997; 2007) of *duration* as it focuses attention on how violence is absorbed in the everyday. I find her idea useful to consider how suffering in certain instance moves beyond linear chronology. Povinelli (2011) suggests that *endurance* might be one way to conceptualise the experience of such duratives. In taking my participants’ experiences of time and subjectivity as enclosed in a durative present, because of violence, the pernicious effects of the illegal drug trade, and poverty, the actual (present) and eventual (future) included forms of life where the potential of violence was constantly anticipated. Drawing on Povinelli’s ideas of ‘endurance’ and ‘eventfulness’ (2011), as modes through which to think about the layering of violence in everyday lives, I explored the conditions that made for particular kinds of bodily experiences and possibilities. With this framework, I troubled public health and social science studies that attribute ‘lateness’ to “cultural barriers” or lack of responsibility (Adamu and Salihu, 2002; Zanconato, et al., 2006:15-19). In such studies, “culture” is presented as the obstacle to access, and the reason for “poor results” in satisfactory implementation of antenatal programmes (Adamu and Salihu, 2002; Zanconato, et al., 2006:15-19).

By contrast to these accounts, to call attention to the everyday, especially in spaces of violence and inequality, is to call attention to the “quasi-events” that shape life and responses to care, and here antenatal care. The everyday experiences and quasi-events, that are seen as the attenuated background conditions of life that do not do not enter typical accounts of casualty and life-making, can be brought forward by focusing on the present durative (Povinelli, 2011: 153; Das, 1997; 2007). In calling attention to quasi-events underpinning women’s everyday lives one can see that what public health officials excoriate as ‘lateness’ is rather a combination of various

experiences that are all underpinned by political economy. In looking at space and geographies of violence (including historical and structural) I have argued that health seeking and temporalities are interrupted by eruptions of violence, the episodic presence of gangs (and potential robbers) on route to the clinic, and by constant fears of gangs. Underpinning the moralistic evaluation of women's 'late' attendance at antenatal care is, as I have shown, a complex set of relations, both geopolitical, social and personal, that shape how, when, and with what effects bodily changes are recognised and attended to. The clinic, unable to withstand the penetrating violence, is shaped by it too. I further argue, in considering quasi-events, that domestic violence, and abuse be counted as shaping reasons for "lateness" as well as influencing how, when, and why women seek antenatal care. Additionally, changes in generational support systems once women marry, add to the precarity of living and the violence, abuse, and neglect women (with child), and children, encounter – that are further shaping factors in lateness.

The cleavages of Cape Town segregated by race and class due to apartheid segregation and Group Areas Act produce "the enclaving of exposure to violence, and the reproduction of the forms of segregation that allow for the city to be experienced in such differential ways" (Gillespie, 2014: 204). Gillespie's argument to read the city and violence as a whole and not a condition of a fragmented part, is necessary to understand the layering I have orientated towards when analysing the multiple forms of violence in the Southern Peninsula, especially isolated housing conditions and gang violence as products of apartheid's political-economy. In using this lens, I aim to move toward understanding counting of violence in these areas and the effects on antenatal care seeking practices as part of "the general distribution of quality of life and the quality of death" (Gillespie, 2014: 210).

I see the value of "eventfulness, and quasi-event" in relation to understandings of subject formation (biomedicalisation) in antenatal care, and contesting governing institutions and the tenets that comprise the rationalist discourse of antenatal care (Povinelli, 2011). I have shown the role of the state and public health discourse in framing biomedicalisation and the production of subjectivity, which influence how antenatal health care and responses get managed. In analysing production of space, violence, and the everyday I have argued that 'quasi-events' in the lives of my participants shape their engagements with antenatal care - the embodied dimensions of subject formation. The discursive formations shape the political and ethical responses to antenatal care and maternal health that do not count differing process through which forms of life are produced, and the everyday 'quasi-events' - and in this chapter what is to be counted are the geographies of everyday violence in a political economy where endurance shapes forms of life, and in turn how, when and why antenatal care is sought.

## Chapter Three

### Knowing and counting

*In attending waiting room talks, history booking information, examinations, and ultrasounds pregnant women were repeatedly asked “when was your last period?”. The absence of menses is the “sign” taken as the first indicator of pregnancy. The question was, in many instances, not answerable with a specific day and month. Many women paused to think before they answered, some counted on their hands, others looked to the calendar on the wall, and some counted back with the nurses while looking at the calendar. Often, the “last period” was rounded off to the middle of a month as no date was known. In this repeated interaction, I observed the complex contestations and tensions in the process of biomedicalisation and the assumptions of a ‘knowing’ body. As I show, pregnancy acknowledgement, and experiences of menstrual cycles was not only matter of counting and knowing one’s body in a way that did not sit in the neat category of self-surveillance necessary for regulating ones sexual and reproductive life, it was also a case where many women did not menstruate “regularly” (each month) or did not stop bleeding while pregnant – complicating the “body proper” (Farquhar and Lock, 2007).*

Biomedicalisation of pregnancy and reproductive healthcare in South Africa is constructed across a variety of local and global policy strategies, public health concerns, and clinic procedure that highlight the need for engaged “responsible” citizens who practice safe sex [dual contraceptive methods], utilise family planning services, and when pregnant arrive for early antenatal care booking and continual monitoring throughout the pregnancy. As women’s bodies and lives are interpreted through a biomedical lens, one which focuses on public health goals for “better health for all” and “better futures” as denoted by the state, biomedicine “as a regime of truth” captures the sociocultural and political dimensions of antenatal care regulation (Clarke, et al., 2003: 163). Increased biomedicalisation of women’s bodies and the routinization of medical technology pathologises “normal” bodily processes which leads to medical management (Inhorn, 2007:13). This biomedicalisation, emphasising surveillance, regulation and responsibility of bodies by women themselves, can be understood through the Foucauldian notions of biopower and governmentality. Through this lens, power operates by focusing on the social body, where the population is addressed and the social risks formerly understood as responsibilities of the state are re-cast as individual problems of self-care; forms of power seek to “monitor, observe, measure and normalise individual and populations” through modes of self-surveillance and self-regulation (Foucault, 1977, 1976, Clarke, et al. 2003: 165). I examine these governing rationalities

as they took form in state and biomedical discourse that assumes a universal female body and experience. I show how conceptions of time are not only implicated in forms of power, knowledge and regulation, but also conceptualised subjectively for pregnant women. I show that women's experiences of menstruation, contraception and their interpretations of the 'signs' of pregnancy are experienced in a variety of ways that complicate biomedical ways of knowing and regulating the reproductive body. I argue that women's interpretations are shaped as much by local understandings of life cycles ('the right time to be pregnant', the symbolically weighted age of 21, generational cycles and menopause) as by medical models. These experiences are layered in the social worlds positioned within a neoliberal political economy, thus I argue for "local biologies" (Lock, 1993). Drawing on Elizabeth Povinelli's ideas about *corporeality* and *carnality*, I show how it is not only discourses that produce and shape socialities and bodies, but also the bodily experience of pregnancy and care from a specific structural position (Povinelli, 2011; Lock, 2013). I show that women's knowledge of their pregnancy is shaped phenomenologically and relationally – through the experience of pregnancy and through engagements with partners, kin, peers, clinic staff, technology and bureaucracy. As I demonstrate, knowing one's state is less about the forms of surveillance and self-knowledge anticipated in medical models than it is about coming to know through experiential and relational engagements. Within these arguments I will show the complex contestations and tensions in the process of biomedicalisation and its assumptions of a "knowing" body – of a body proper (Farquhar and Lock, 2007).

As I've shown in chapter one, during antenatal and HIV talks in the waiting room, "knowing" one's reproductive body - from the start of first menstrual cycle, menarche, to pregnancy, to menopause - was a site where forms of knowledge and regulation were enacted during observations. This discourse of 'rights' and regulation of women of reproductive age emerged within the clinic space, and discourse of responsibility took shape both during the public talks and in the private examinations. Here, "knowing" was implicated in a discourse on women's "empowerment", and "responsible" citizenship that could be attained through disciplined "safe sex" practises, and health conscious behaviour during pregnancy (Nguyen, 2010). Gender empowerment discourse, replete with tropes such as "choice" and "rights" (Denwar, 2006; Ferreira 2014), was frequently used by the clinic staff when talking to women about their relationships to male partners and their own futures. Pregnant women were told they should focus on "*themselves and their education*". Often staff imagined women's futures as absent of male partners or as precarious. Women were told to "take responsibility" for their lives through 'empowering' themselves by knowing their bodies, using contraception, and focusing on education rather than "*disappointing*" families by becoming pregnant *too early* or too often.

Biomedical subjection of pregnant women saw pregnancy as a site for surveillance and regulation both of the pregnancy and of women’s sexualities under the dual rhetoric of preventing and managing pregnancies and spread of HIV while navigating intimate social relationships. Underpinning the uses of the terms of “empowerment”, “responsibility”, and “knowing”, there was an underlying categorisation of the “good woman”. Thus I argue, this shows a gendered subject position of women in relation to the state, to the clinic, to the community, as *good woman* then *good mother*.

### Bodies, signs, symptoms: women’s bodies and the knowing subject

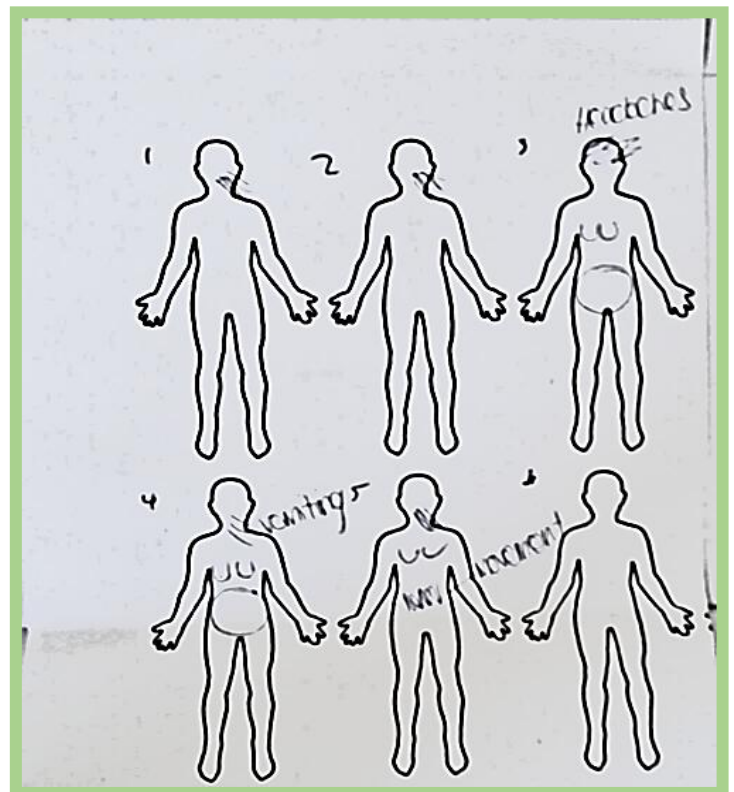
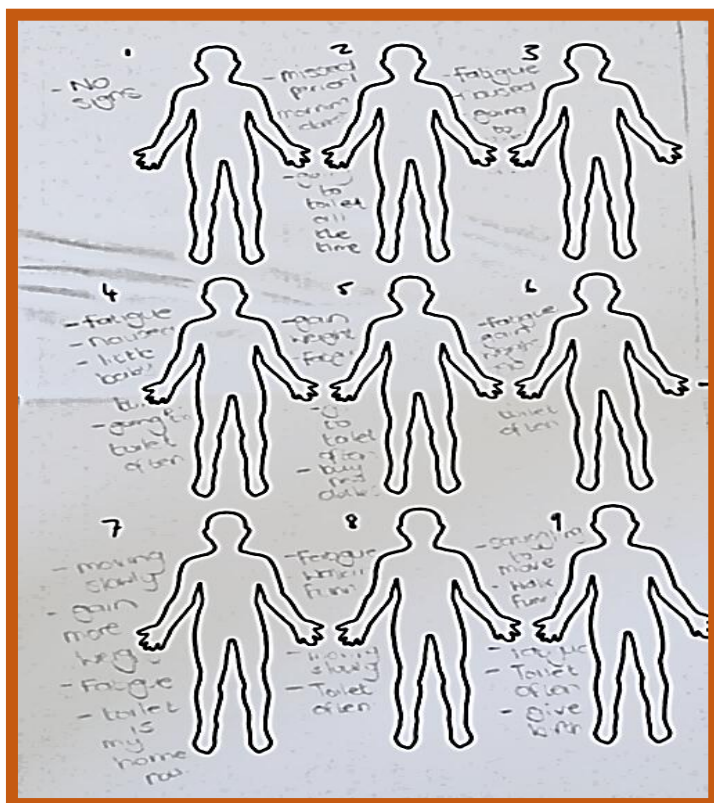


Image 19: Stacey-Lee and Danielle’s body mapping of pregnancy experiences

Grosz (1993: 199) argues that biomedicalisation “has been characterised as the making of a *body pliant to power*” – the expectations placed on women to know their bodies and menstrual cycles, can be understood as Grosz states, as well as within a Foucauldian self-surveillance sense of governance and subjection (Earle and Letherby, 2007:235). I show the tensions in this process of “knowing” and the reality of how women come to know and experience menstruation, pregnancy, contraception, and menopause.

80% of my research participants were technically “late” for their first booking; all had arrived after the recommended “early”<sup>21</sup> time of 12 weeks. The policy strategies mark the pregnant women who arrived after 12 weeks and certainly after 20 weeks as the “other” 40.2% who do not “arrive on time” (Day and Gray, 2012/2013: 241; Masuku, et al., 2012). “Not knowing” that one is pregnant becomes a contested site that challenges state, medical and epistemological authority over women’s bodies, universalistic pregnancy indicators, and the recommendations to “arrive and book early in pregnancy”.

### Menstrual cycles and mixed symptoms

*“Are you pregnant? Maybe your period’s just a day overdue. Or maybe it’s going on three weeks late. Maybe your only symptom so far is that missed period” (Eisenberg, Murkoff and Hathaway, 2002: 2)*

*“You can have all of the signs and symptoms of early pregnancy and not be pregnant. Or you can have only a few of them and be very definitely pregnant” (Eisenberg, Murkoff and Hathaway, 2002:5),*

A widely available guide to pregnancy, *What to Expect When You’re Expecting*, notes that the absence of menstruation is commonly taken to be the first indicator of pregnancy, although it is known that “periodic staining or bleeding during the first months of pregnancy” can occur (Eisenberg, Murkoff and Hathaway, 2002:5). And yet, as no one symptom of pregnancy can be taken as “absolute confirmation” (Eisenberg, Murkoff and Hathaway, 2002:5)(see image 20) of pregnancy, knowing one is pregnant is a complex engagement with one’s body and counting menstrual cycles, regulating contraception and sexual practices, and reading the numerous ‘signs’ to be taken as markers of pregnancy. These “signs” not acknowledged or experienced by some women who did not know they were pregnant till as far along in the pregnancy as 20+ weeks when their stomachs started growing and hardening. The reasons for not knowing they were pregnant were because they had “irregular” menstrual cycles which either “did not occur monthly regardless of pregnancy, or they continued to bleed during the first months of pregnancy. Some women explained that they did not have *pregnancy symptoms*. “Knowing” and accepting markers and “symptoms” of pregnancy are further complicated when considering the psychological factors of

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<sup>21</sup> **Maternal Care Guidelines 2015** “early booking visit (preferably <12 weeks)”.

**Basic Antenatal Care Handbook (2007:7)** “The aim of the Department of Health is for pregnant women to attend antenatal care four times, starting before 20 weeks gestation... Most women will confirm their pregnancy within the first three months of missing a menstrual period”

**Basic Antenatal Care Handbook (2007:21)** “In South Africa, antenatal care has tended to start late, after 20 weeks gestation. This must be dealt with in order to reach the goal of having healthy women and babies. Antenatal care should start in the first trimester, that is, in the first three months of pregnancy. To accommodate this goal and the wishes of pregnant women, the ideal timings of ANC visits in South Africa would be at pregnancy confirmation (usually within the first 12 weeks), and thereafter at 20, 26, 32 and 38 weeks gestation.

“unwanted” pregnancies where women may be repressing information or ignoring what they know.

POSSIBLE SIGNS OF PREGNANCY		
You can have all of the signs and symptoms of early pregnancy and not be pregnant. Or you can have only a few of them and be very definitely pregnant. The various signs		and symptoms of pregnancy are only clues—it's important to pay attention to them, but you can't rely on them for absolute confirmation.
SIGN	WHEN IT APPEARS	OTHER POSSIBLE CAUSES
Amenorrhea (absence of menstruation)*	Following conception	Travel, fatigue, stress, fear of pregnancy, hormonal problems, illness, extreme weight gain or loss, going off the Pill, breastfeeding
Morning sickness (nausea, with or without vomiting, any time of day)†	2–8 weeks after conception	Food poisoning, emotional stress, infection, a variety of illnesses
Frequent urination	As early as 2–3 weeks after conception	Urinary tract infection, diuretics, stress, diabetes
Tingling, tender, swollen breasts	As early as a few days after conception	Birth control pills, impending menstruation
Darkening of areola (area around nipple) and elevation of tiny glands around nipple	First trimester	Hormonal imbalance or effect of prior pregnancy
Blue and pink lines under skin on breasts and later on abdomen	First trimester	Hormonal imbalance or effect of prior pregnancy
Food cravings	First trimester	Poor diet, stress, impending menstruation
Darkening of line from navel to pubis ( <i>linea nigra</i> )	4th or 5th month	Hormonal imbalance or effect of prior pregnancy

\*Some women have periodic staining or bleeding during the first months of pregnancy; others may have some bleeding during implantation of the embryo in the uterus.  
†More than half of all women experience morning sickness.

Image 20: table of possible signs of pregnancy (Eisenberg, Murkoff and Hathaway, 2002: 5,6)

“There were no real symptoms”

Many of my participants stated the reason that they did not come in to the clinic earlier was because they did not know they were pregnant. The markers of pregnancy, or as Nondumiso put it, “*the real symptoms*” were mentioned by participants as: menstrual cycle stopping; painful and growing breasts; vomiting (morning sickness); changes in appetite; and maybe mood changes. These “usually” occur during the first three months of pregnancy. The next sign is a growing and hardening stomach and movement felt at 20+ weeks. Tania, 27 year old with three children, pregnant with her fourth said that,

*“There are periods you wait for in pregnancy... In the beginning you wait for next period (menstrual cycle) and wait for a sign to know you're pregnant... signs as in being tired, sleeping a lot, eating a lot, and then you miss*

*your period*". Staff assessed her as being 22 weeks pregnant, however, she thought she was around 12 to 16 weeks pregnant because she was still experiencing morning sickness; something she associated with the *"first 3 to 4 months"*.

Many women did not remember the dates of their last period, let alone the specifics that staff requested - *"the last period"* and *"the last day of that last period"*. Knowing when one is pregnant assumes universal experience of menstruation and pregnancy "signs and symptoms". The first assumption is based on stopping one's menstrual cycle, and second that one's menstrual cycle being regular enough to know a missed period means pregnancy, as opposed to signalling illness or "menstrual disorder". The "regularity" of menstruation is assumed and understood around a norm that menstruation occurs periodically, typically every 28 days (Nordqvist, 2016)<sup>22</sup>. The assumption of knowing and counting one's cycle is complicated when marking menstrual cycles does not take place under a "regular" notion - with absence to be taken as a "sign" of pregnancy. As shown below in *table 1*, many of my participants had "irregular" menstrual cycles and did not take the sign of absence to mean pregnancy. On the other hand, there were other women (4.2%) who continued to bleed for the first three months of what they would subsequently know to be their pregnancies. They had experienced themselves as menstruating during that time. In other words, women's bodies are not necessarily easily knowable, at least in the early stages of pregnancy, and interpretation matters.

<b>Women with irregular periods (<i>periods not occurring every month</i>)</b>	<b>Reasons</b>
34% of women	<ul style="list-style-type: none"> <li>• Anaemia</li> <li>• "I don't know"/usually skips</li> <li>• The cold weather</li> <li>• Hormonal contraception</li> <li>• Sick/antibiotics</li> <li>• Menopause</li> <li>• Periods stopping and starting irregularly</li> <li>• Irregular periods due to nutritional deficiency</li> </ul>
<b>Percent of women who continued to menstruate into pregnancy</b>	4.2%

*Table 1. Percentage of participants with 'irregular' menstrual cycles and reasons*

<sup>22</sup> Against this medical norm, difference of monthly cycle is framed as "abnormal" and pathologised under "menstrual disorders": Oligomenorrhea (infrequent periods); hypomenorrhea (short or extremely light periods); polymenorrhea (too-frequent periods, understood as more frequent than 21 days); hypermenorrhea (extremely heavy or long menstrual cycle); dysmenorrhea (painful menstrual cycle); metrorrhagia (breakthrough bleeding between menstrual cycles); amenorrhea (absent periods) (Long, 1990).

The expectation placed on women to know their bodies, mainly to know their menstrual cycle was stated during the ANC talks to the waiting women, as well as in the consultations. Women were expected to know the history of their periods, what date they started and ended their last period, how long they bled for. They were also asked about previous family planning usage and side effects, which could include “irregular” menstruation. Bleeding was read by women as a sign of not being pregnant, even if the bleeding during the last few months was different than their previous menstrual cycles, for example a 3 day cycle as opposed to a 5 day cycle. Counting menstrual periods in order to monitor ones reproductive body is premised on fully knowing your body in relation to Gregorian time calendar, and placing bodily experiences within this framing of time by memory or marking.

Shantay, aged 25 described how confused she had been about her first pregnancy because she had gotten her period for the first three months of her pregnancy and had not had other expected signs such as nausea. Jessica, like Shantay, had continued to “bleed” during the first three months of her pregnancy. She, a 35 year old mother of three children, came to her first booking at 15 weeks for her 4<sup>th</sup> pregnancy. Jessica described how she knew she was pregnant with the other 3 pregnancies based on bodily changes and past experience such as her “*breasts hurting*” and her “*period stopping*”. She stated though, that her periods were generally irregular, and this time she had carried on bleeding for a few weeks longer during her cycle so she thought she was ill, but she did not think that she was pregnant. She did not have sore breasts, or nausea, and her menstrual cycles only stopped three months into her pregnancy. Pregnancy guides describe this kind of bleeding as “spotting” “periodic staining” and “bleeding”; the women experienced them as normal menstrual cycles. How are “signs” to be read then? Are sexually active heterosexual women to assume “pregnancy” each month, like one young woman who, in great fear of pregnancy, was not only using ‘the patch’ as contraception, but also taking a pregnancy test “*every month*” to be sure she was not pregnant (Ferreira, 2014).

Deniell a 23 year old was at Retreat for her 3<sup>rd</sup> pregnancy. She said that she was “late to know” she was pregnant because there were “no pregnancy signs” such as “nausea, vomiting and period stopping”. The nurse thought that her period had carried on for two months into the pregnancy. She said that she came to the clinic because she had “felt movement” and then thought she was pregnant. Contemplating her “*late*” arrival, she described feeling confused as she had had “*pregnancy signs*” for the other two. There was an expectation that you would experience the same pregnancy signs and bodily changes for all your pregnancies. Nuraan emphasised that her period

was regular and if it stopped that meant “*something is up... after your first pregnancy you go through it, you know what happens*”. Other participants reflected on their bodily experiences and how different each of their pregnancies were in retrospect. So even when pregnant women assumed there would be similar “signs” that they were pregnant (i.e. absence of menses, sore breasts) based on their past pregnancy experiences, like Deniell, those same “signs” did not always show.

Some of the participants did not attach not having a period for a month or two as being a sign of pregnancy, rather not having a period was a sign of their anaemia, or the common perception that menstrual cycles do not always arrive each month and they did not know why. Missing periods was seen as a norm for various reasons (*table 1*), especially as Veronica described that “sometimes you miss your period because of the cold in winter” she said that “happened to me already... last year” and added that this was a common perception where she lives. Women reporting at this clinic were structurally located within unequal spaces of living in within post-Apartheid neoliberal South Africa where employment and food security are precarious for many.

The norm of having irregular menstrual cycles was experienced by 34% of my participants. Candice did not know she was pregnant until after 12 weeks gestation because of her irregular menstrual cycle. Candice said that she usually did not menstruate for one or two months, which meant that she did not notice she was pregnant until she missed her third period. Sharnaleigh, too, had had irregular menstrual cycles. Aged 21, she had come to book “on time” at twelve weeks despite the fact that initially when she had missed two menstrual cycles, she had not thought she was pregnant:

*“because I have anaemia so I usually skip my period. So it’s normal to me... I don’t track my periods at all the only way how I know is from my back pain, and then I know I’m having my period. If I don’t have my period for a long time for the month I’m like ‘okay my blood is maybe too low now I need to take my tablets<sup>23</sup> until I get my period. ”*

Throughout my research, many women came to the clinic after 12 weeks who did not know when their last period was, or when exactly in the month it was even when they experienced “regular” monthly cycles. Lying on the examination table one client answered that her last period was “*in June*”. The nurse followed the question up by asking “*when in June?*”, but the woman said that she did not know. Another replied to the same set of questions with “*I’ll be serious with you, April, man, can’t remember the date*”. One woman tried to figure out when her last period would

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<sup>23</sup> Sharnaleigh meant that she had an iron deficiency and that her iron was too low. She attributed her absent menstrual cycles to low iron and took iron tablets until her menstrual cycle resumed.

have been: “*I was saying to myself 2 months ago... I think it was the end of the month May 31<sup>st</sup> the period I didn't get*”, she said as she looked up at the calendar on the wall. The nurse asked again, “*your last period was when?*” and she decided it was in “*April*”, the nurse then doubled checked that she was sure. Figuring out when their last periods were during consults was common, especially looking up and marking with the nurse their last date against the calendar on the wall. Often both the women and the nurses placed the last period in the middle of the month if the month was given but not the date.

How is pregnancy marked when menstruation is experienced as regularly “irregular” in cycles? Women are still to know when they are pregnant, despite that signs of pregnancy may also be indicating “a variety of illnesses”. These experiences alongside biomedical and popular menstrual knowledge and pregnancy discourse illuminate tensions in knowing and not knowing, “normal” and “irregular”. Yet in the effort to “arrive on time” lives are subjugated to biomedicalised critique, where women are to know their bodies where any sign and symptom may mean pregnancy. Women are expected to fulfil expectations of the “responsible good woman” and biomedical subject by heightened self-surveillance of their bodily signs and sexual lives. I observed this heightened sense of self-surveillance among women in the examinations, as exemplified below. During an observation of one of the examinations the sister asked a woman when her last period was to which the woman answered “*14 July*”; the sister responded by asking if she knew and if she had a pregnancy test. The woman did not have a pregnancy test with her, but she said that she had “*had unprotected sex on the 24 of July*” so she knew she was pregnant. If the “normal symptoms of pregnancy” were not present, how were women to “know” and arrive “on time” unless they had a heightened surveillance of their bodies and sexual intercourse as this woman had, or undertook monthly (paranoid) home testing as with Kanyi.

Danielle who was 18 and at the clinic for the first time thought to be 14 weeks pregnant, based on the measurements from the physical examination early that day, although she thought she was still within the first trimester. Danielle had known she might be pregnant when she had missed an expected period. She knew to expect it because she said, “*I have this app on my phone that I type in [menstrual dates] and know [when the next menstrual cycle is]. That night when it happened [unprotected sexual intercourse] I knew when I was supposed to get my period from that time... but I didn't get it...*” Her boyfriend also knew she had not gotten her period, because he too knows what information and time marking she does on her phone around her period. By marking time through the use of her

phone within a linear calendar time, Danielle was able to monitor her monthly cycle with technological precision, and with the involvement of her partner - *yet* still became pregnant.

### **Contraception, medication, and the shaping of a reproductive body**

Some women missed their periods because they were on hormonal contraception, changing between hormonal contraception options, or on antibiotics and had an infection.

A 19 year old woman having her history taken for her second pregnancy, on 29 September, replied to the nurse's question of her last period with her confusion about being pregnant because of her family planning usage. She explained that she had been on the injection from January till April and had carried on bleeding throughout that time. She said that she had gotten pregnant on the 2 month injection, and now she was 6 months pregnant. She thought her last period was in April. She explained that she had not gone on the 3 month injection because every time she went to the clinic for it "*they didn't have it and people had told me that you get pregnant on the 2 month one*". The nurse asked about her last period and injection use. She asked if she was sure she was only 6 months pregnant then. The young woman responded that she had been on the pill from "December, January, and February" because she bled heavily, so she had overlapped on both pill and injection during January and February. The nurse then said it could have been that combination and switch over that she got pregnant. The nurse then decided to put her on the implant after birth, after convincing her that it was not *cancerous*<sup>24</sup>.

The questions of knowing one's reproductive body in relation to monthly counting and marking, is further complicated when as in the above case, there are other intersections of complex issues at hand. The ways people juggle birth control; the different varieties available; the health scares and common fears and assumptions about illness or infertility when using contraception – the ways that all of these shape what it is to have a (re)productive body. As with the experiences above of different menstrual cycles, different pregnancy signs, and absence of a presence, experiencing and having a reproductive body is shaped in many ways. These many experiences of having a reproductive body complicate the relationship to a rationalist discourse of "family planning" contraception that instantiates a linear temporality to the reproductive cycle.

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<sup>24</sup> Participants thought that hormonal birth control implant could cause cancer. There was fear of 'side effects' of hormonal birth control.

Renesia, a small, glasses wearing woman, with her hair tied back, cheerfully sat in the comfort of the NGO's room with her hoodie tightly snug around her belly. She was 26 years old, reporting with her 2<sup>nd</sup> pregnancy. She was at 28 weeks gestation when we met. She claimed not to have known she was pregnant because she had had an infection and had been vomiting. The Grassy Park day clinic had treated her with “5 white tablets” (antibiotics) and “*afterwards I show the signs of pregnancy*” which was her stomach growing. She had thought the vomiting had been a symptom of her infection, not a sign of pregnancy<sup>25</sup>.

As with Renesia above, Stacey, a 20 year old 17 weeks pregnant with her first pregnancy at her first booking appointment in October, had also been sick and on antibiotics. She exclaimed that “*I was on antibiotics for 3 months so I googled it, because I missed my period in July, I thought it was the antibiotics that made me miss my period. Then I went to the doctor and I found out I was 2 months pregnant*”. There was the underlying question about the extent to which women blame antibiotics, and medical treatments, whose side effects were “not well explained” or not understood, might be a more “socially acceptable” reason for pregnancy at a young age. A reason that could prevent “skelling” from nurses.

Another woman had thought that her period had stopped because of bodily changes that happen from switching contraception. She had been on the injection for four years and recently switched to using the pill, and had been on the pill for six months. She further mentioned that she had also been on antibiotics recently. This experience echoes the opening case where there are multiple complexities that shape what it is to have a reproductive body, again here the juggling of birth control intersecting with ill health and antibiotic usage.

Missing periods was not an immediate “sign” of being pregnant for a lot of women, which lead many women to only think about being pregnant only after 3 missed periods, or not know at all. Nondumiso – came in at 6 months for her first booking because she did not know she was pregnant until she was 5 months. Like Denielle, she did not have ‘*symptoms of pregnancy*’. She said that her *periods were irregular*, and had been irregular before the pregnancy *because* she went on the *pill*. Irregular periods on the pill was a contested subject that came up twice during observations with women claiming it made menses ‘irregular’. It was contested because the nurses and doctors said that the pill should make you “very regular”, and blamed women for forgetting to take the pill at the same time every day. Nondumiso had started her first job in a year during this time, realising only after she had begun that she had already been 2 months pregnant when she took it.

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<sup>25</sup> Family planning clinics are required to explain that antibiotics interfere with hormonal contraception (Ferreira, 2014).

She learned the fact of her pregnancy when she went to the day clinic thinking she had flu, and the routine pregnancy test came back positive. Theresa had also thought herself sick as opposed to pregnant. A 26 year old Zimbabwean who had a 2 and a half year old son, news of her pregnancy was a surprise: “*I thought maybe I was having arthritis because I was having pain on my joints so I went to Victoria [hospital] and that’s when they said ‘you are pregnant’*”. Theresa was identified as being 7 weeks pregnant at that time. Symptoms women associated with flu and other illnesses revealed their pregnancies.

Nondumiso’s experience raises the consideration of both authoritative knowledge in biomedicine, assumed universal reactions and consistency when taking the contraceptive pill, as well as the consideration of new biologies forged in relation to contraception. Discourse on women’s reproductive bodies assumes a universal norm of menstruation and pregnancy symptoms; experiences lying outside this norm are read as “deviations” from the norm and may be pathologised. Side effects and changes in menstrual cycle are known and expected to occur when using hormonal contraception, yet women are still expected to pay attention to all bodily signs that differ from month to month cycles and to consider whether they may be pregnant even while taking contraceptives. Changing or differing menstrual cycles, as well as side effects from hormonal contraception conflict with the “normal” pregnancy signs. The self-surveillance discourse requires a disciplining of the body by means of acquiring bodily knowledge and paying continual attention. Knowing and the female body is situated within a temporal understanding of a reproductive life spanning from puberty to menopause, with knowing being marked in relation to calendric time: monthly marking from the onset of puberty, to specific attention to bodily signs for pregnancy, and an end of a reproductive life timeline marked as menopause.

### **Reproductive life-cycles**

Women’s reproductive bodies become intertwined with specific discourses of time. Elizabeth Grosz (1999) argues that “time has been understood as a priori category, taken for granted, yet there is a plurality of times and temporalities” (cited in Earle and Letherby, 2007: 236). Temporal expectations of the reproductive body are challenged not only through medical interventions such as contraception, but also through social constructions of time, age, and aging (Earle and Letherby, 2007: 245). Time is a process related to unfolding experiences of bodily and social rhythms. For my participants, time and regulation of reproduction was monitored on the basis of calendrical time and temporal experiences of reproductive bodies was viewed in relation to

imagined futures and social expectations of age roles and aging. This raises the issue of what Elizabeth Povinelli (2011) calls “social tense”. Social tense frames and bounds a temporality of reproduction. I turn now to the social framing of age and aging, shaping how bodily signs are read, as it related to participants who thought they were going through menopause, despite their ages being between 37 and 44, which in biomedical framing they were not yet at the end of their reproductive life. These perceptions and experiences of aging and “wearing out” not only show the cultural constructions of age and aging in relation to reproduction and care giving, but also point to the structural processes that work on bodies.

Some women experienced their bodily changes as indicating menopause when they were actually pregnant. Douglas’ (1973: 93) argument that, “the social body constrains the way the physical body is perceived” aids in considering the differing social constructions of aging and bodily “signs” women interpret (cited in Earle and Letherby, 2007:235). The women I worked with understood menopause and an ending of a reproductive stage as beginning between their late 30s and early 40 years (as opposed to biomedical understanding of menopause occurring in the late 40s and early 50s). Some women viewed their reproductive processes within social notions of aging where ‘40’ was understood to be old; “too old” to be having children. They described themselves as being “worn out” from having children already and from the exhaustion of trying to make ends meet and make a plan for existing children (make a plan). Women were likely to be grandmothers by 40 having had their first child in their late teen years (or earlier for some) (Mkwahanazi, 2004; Ross, 2010: 215, 228), an experience that shaped understandings of pregnancy and birth in relation to generational cycles as opposed to biological reproductive life cycles.

I spoke to Shamila, a 42 year old mother of 8, attending the clinic for her 9<sup>th</sup> pregnancy. She was tired and the nurse noted that Shamila “looked down” (sad, depressed). Her expressionless look was read as “disengaged”. The nurse noted this for follow up or referral to the NGO councillor (an informal protocol established through 17 years presence of NGO counselling services located in the hospital)<sup>26</sup>. The nurse was also concerned about the number of pregnancies Shamila had had, and that she was already 20 weeks pregnant at aged 42, missing the opportunity for a referral to Groote Schuur for a 12 weeks scan. Shamila, spoke to me in the curtained

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<sup>26</sup> Honikman, et al. 2012 “Despite high levels of antenatal and postnatal depression, there is no routine screening or treatment of maternal mental disorders in primary care settings in South Africa”. The Edinburgh postnatal depression scale was not observed to be used; nurses made assessments based on their own medical, cultural and social knowledges

examination room while the nurses were having a tea break. She sat on the one available chair, and I, legs swinging, sat on the examination bed. Her slender face was marked with dark rings under her eyes, and scatterings of wrinkles – her blue head scarf added a vibrancy to her despite her tired look. Her oldest son was 24 years old, she had been in and out of Retreat MOU since 1991 for her 8 pregnancies, all of which she tried to book at 12 weeks gestation. In asking how far along she was for this 9<sup>th</sup> pregnancy, Shamila told me that she was late to book at the clinic because she thought she had “menopause” because she had “missed 3 periods”, bringing her to 20 weeks gestation at her first booking. Shamila had consulted her husband about her missed menstrual cycles. He too had thought it was menopause. Neither imagined it was another pregnancy; despite not using contraception, her last pregnancy had been 5 years previous. She repeatedly described herself as “tired”, not just from the day’s events of early rising and waiting at the clinic, but a “deeper tired”. “After 4 [children]”, she said, “you learn to live with it”. She, like many of the other Muslim and Christian women I spoke to, emphasised that despite her feelings of disbelief about the pregnancy, the child was “still a gift from god”. Shamila accepted her pregnancy, after a confusion of (mis)reading her bodily signs of fatigue and the absence of menstruation as signs of menopause. The greater the time period between the last pregnancy and the current ‘surprise’, for women in their late 30s and 40s, added to the complexity of knowing their reproductive bodies and their potential for another pregnancy as opposed to the onset of menopause.

Ingrid, 41, just needed to talk. She was crying during the interview and took some tissues. She was upset about being pregnant again and not “satisfied with the pregnancy”. Her circumstances were not “good” for another child she said. She had had 4 children already. Her first 2, boys ages 23 and 15 live with their father who had taken them away from her because he said she was unstable due to her depression. They seldom see her. She was distraught about these facts. Her eldest son uses drugs and has been in and out of Pollsmoor Prison. The youth’s father cannot assist. Ingrid had left him because he was abusive. She has a new partner and two children aged 5 and 2. She had thought after the 5 year old girl was born she would not have any more children. She thought she was going through menopause – not least because her eldest son was old enough to have fathered children himself - but she was actually pregnant. As she explained:

*“my period just got away and I was moody like quite moody and very sweaty \*laughs\* and my husband, no sex at all, (no sex drive). Ja, it was very low, my husband said “Are you sleeping around or what, what’s going on here?”, then I just said, ‘hey it’s my age man’ maybe I’m at that stage now. My friend went to the clinic in Klip Road and I went with her because she said ‘go for pregnancy test’. So I just went for a test and it showed*

*positive. I was crying while my friends... as the days go on, I'm learning to accept it. I'm really learning. It's just tough for me due to the circumstances that we live in."*

### Age perception

While Ingrid and Shamila had thought they were experiencing menopause, some women older than 35 thought they were too old to be pregnant again. Libby, for example, was concerned about the nausea she was experiencing. She, like Shamila, had not been pregnant for many years – her only child was already 18 years old. She visited the day clinic thinking the nausea could be a thyroid problem. The day clinic staff had also told her to book at the MOU because of her age and announced that she was 15 weeks pregnant.

Lelani who was 38 and experiencing her 6<sup>th</sup> pregnancy, although only 3 of her children survived, spoke about feeling old in relation to having to experience a pregnancy again. She said that after all those pregnancies and the last two children:

*"I feel old and to sit with another pregnancy \*shakes head\*... am I going to do this again!? I thought I was finished no more babies..."*

It was not only women who felt they were too old to reproduce; others around them expressed similar ideas. For example, one woman (aged 40) said she was not happy about the pregnancy "because I'm old". She added that her husband's brother chastised her: "you're old, why you still have babies?". Her husband is 38, but her husband's brother did not say he was too old to be having children. The nurse then told her that even at 46 she can still be pregnant. Their perception of age and ability to carry on having children, differed from the biological model expressed by the nurse. One model views the reproductive life cycle as ending at around 40 years old, mostly in accord with a social model in which many women are already grandmothers by that age, while that described by the nurse understands the reproductive life cycle in terms of a biologically reproductive life that extends into the mid to late 40s and early 50s, ending with menopause. The biomedical markers of menopause are not taken to be the same as symptoms of pregnancy, the former being absence of menses, hot flashes, sweating, mood changes; the latter being absence of menses, sore breasts, nausea, bodily swelling. As Lock has shown, these markers differ cross-culturally (1993). Ingrid and Shamila's symptoms - the fatigue, absence of menstruation, "moodiness" and sweating – were taken to be the onset of menopause, when they were actually pregnant. The slight overlap of "symptoms" of absent menses, fatigue, mood swings, and sweating was complicated perceptions of ageing.

Young argues that “the exclusion of femininity from Western metaphysics has severe consequences for its conceptualization of embodiment and subjectivity. The notion of the autonomous, self-enclosed subject is profoundly questioned if we take female experience into account” (2005, 46, 57; Särnstedt, 2011). Särnstedt, illuminating Young (2005), further argues that bodily experiences such as “menstruation and pregnancy, shared by many women, contest the idea that normal embodiment is stable, and that rational reasoning should or can remain unaffected by bodily changes.” (Särnstedt, 2011: 9). Ginsburg and Rapp argue that “most biomedical research is premised on scientific representations of the human body as a universal constant, not accounting for the biological impact of cultural differences and social inequalities” (1995:7). They further explain that “reproduction, in its biological and social senses, is inextricably bound up with the production of culture” (1995:2). They argue that reproduction “provides a terrain for imagining new cultural futures and transformations, through personal struggle, generational mobility, social movements, and the contested claims of powerful religious and political ideologies” (Ginsburg and Rapp, 1995:2). These critiques trouble the “body proper”, troubling too the ontological and epistemological truth-claims of biomedicine (Lock, 2013: 296; Lock and Farquhar, 2007). Lock, in a thoughtful critique of biomedical truth-claims about the “universal” body, does not seek to “demonize biomedicine”, but rather, to “contextualize and embed bodies in time and space, thus destabilizing that which is assumed to be essentially universal, “natural”, and readily standardisable” by foregrounding entanglements of history, social, political, and material (2013:296).

The social inequalities marked on the bodily experiences of women with whom I interacted was highlighted in the previous section especially in relation to missing periods due to “the cold weather” and irregular eating. Lock argues that the “representation of life course is undergoing reconceptualization” and the terms of aging and an “inflexible age-based chronology” are being considered more malleable (2007:201). She argued (1993) that Japanese women’s experiences of menopause highlighted that there was not a universal menopause symptomatology. In analysing a “local biology” relating to subjective and cultural experiences of aging and menopause, as opposed to menopause pathologised as a deficiency disease with universal symptoms (as in the biomedical model), she illuminated how Japanese women’s encounters with aging took different social, cultural and somatic forms (Lock, 1993) (Inhorn, 2007:11). The idea of “local biology” situates the material body in the specific historical, social, political, and environmental realities of lived experience. Lock argues that “this recognition should not be reduced to racialized or stigmatized difference, but rather entanglements over time” (Lock, 2013: 292, 302). While my participants were not experiencing menopause, although they took their bodily changes to be

menopause related, and where their perceptions of menopausal symptoms did not differ from biomedical markers, it was their age range and reproductive timeline that differed. Their cultural perceptions of aging, being “worn out” from previous pregnancies, parenting, financial and housing strains, and being classified as “too old”, “old enough to be a grandmother”, led them to interpret their bodily symptoms as being makers of menopause rather than pregnancy.

### **Knowing: coming to know and relational ontologies in pregnancy**

Knowledge and meaning making that shape understandings and actions provide contestations to the control and distribution of knowledge and practices of sexuality and reproduction. The knowledge contestations and tensions were observed during my research at points where the biological, social, medical, political economic, bureaucratic, and technological intersected. Knowing was an intersubjective experience linked to aspects of pregnancy that were implicated in various social, political, economic, cultural, and biomedical levels. Knowing becomes layered within these different interactions – one comes to know.

#### Knowing as relational

Nawaal’s case offers a significant story of how one comes to know about a pregnancy as a relational process. Nawaal, a 20 year old first time mother, had found out she was pregnant when she did not menstruate for the month of August. Her loss of a period was her only indicator. Nawaal had not even realised she had missed her period until her sister, with whom she was very close, had asked Nawaal why she had not started her period yet for the month as she had.<sup>27</sup>

*Nawaal thinking about how she knew she was pregnant retold it as it unfolded between her and her sister: “my sister, the one close to me, we tell each other everything... we do too much together, like when she gets her period, I also get my period, ...she asked ‘when are you getting your period? I already got my period’... I didn’t take note of her till afterwards I’m skeeming ‘what now, when did I last get my period, I said no wait, maybe I’m going to skip this month get it now last month – but I didn’t get it...”*

Upon realising she might be pregnant, because her sister pointed her to her missed cycle based on her own menstrual cycle, she took a pregnancy test and told her sister it was positive.

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<sup>27</sup> Strong bonds between sisters was theme throughout the research and not only indicating of relation ways one comes to know about bodily changes and pregnancy signs, but also bonds of supports that kept isolation, poverty, and domestic violence at bay (chapter two).

Sharnaleigh, who had missed her periods but thought it was her anaemia, had decided to take a pregnancy test because her boyfriend had asked her too because he thought she was pregnant even though she did not think so and was not experiencing any other signs during those weeks.

*“He wanted me to take the test... I wasn’t going to take the test because I thought I’m not... but he says no, just take it. And I took it and I was SURPRISED! I asked her why he had asked her to take a pregnancy test and she said that “he told me that like he can feel... it’s just something he can feel differently...”*

The boyfriend had also encouraged her to come into the clinic early for the booking, as did her mother. Throughout the first trimester Sharnaleigh had explained with a laugh that her boyfriend was also experiencing morning sickness (couvade syndrome). His involvement in and almost literal experience of aspects of her pregnancy shows the layers of how social and relational pregnancy can be.

Coming to know one is pregnant was also found out abruptly for some women, such as Libby.

Sitting with Libby sipping tea after her 20 week ultrasound, she spoke of the experiences of her pregnancy and coming to know about it. We talked for over two hours. Her thoughts revolved around reflecting back on her first pregnancy, of the son (now aged 18) whom she had borne when she was 17 years old. He was now “old enough” and she was giving him guidance on using condoms in his intimate relationship. Their bond was emphasised by her in their shared favourite colour red, her gentle tending to him with Vicks Vapour Rub when he has a cold, and her admiration of his tidiness of dress. A boy whose life was not expected, abruptly brought to her attention while she sat at her school desk as a male peer pointed out that she was “leaking” from her breast. Embarrassed and angry she remembered how she had felt:

*“I was sitting in class, my Home Economics class and that boy (actually most of my friends are boys) and the one told me ‘see there your milk’, and I actually swear at him in the class... and I told my friend in the road, because I am in grade 11 and I have big plans for myself; I wanted to finish matric, I wanted to have my 21<sup>st</sup>, I wanted to go study for a lawyer or social worker... and the next thing, I wasn’t in matric, I dropped out of school in April, and the 1<sup>st</sup> of July Darren was born...”*

When my participants could not hide their pregnancies or remain “unknowing” once their stomachs started growing, their pregnant bodies became visible sites for others to read, comment on and give opinion or advice about healthcare seeking. It was usually male partners, and mothers that influenced women’s healthcare timing. I have thus far shown that coming to know is a relational experience linked to aspects of pregnancy that are connected in various social, political, economic and biomedical levels. I now turn to the 20 week ultrasound as a site that

showed the complexities of knowing, where tensions in coming to know emerged between women's bodies and visual technology. I argue that the ultrasound is a technique of knowing.

### The ultrasound as a technique of knowing

Knowing when a last period was, gestational age and due date unfolded throughout sets of questions in the history taking, during the body examinations and stomach measurements, or during the ultrasound. One comes to know through a set of engagements with the people around them as well as with the clinic staff. Finding out the gestational age depended on the dates the women gave of their last menstrual cycles, which was placed into the wheel the nurses have that calculates gestation age. They also measured fundal height and that too was set against the last menstrual date. The final space of being able to know gestational age was during the 20 week ultrasound. The 20 week ultrasound as a technique of knowing, rests on complex sets of interactions that presume prior knowledge (if the last menstrual cycle had been properly remembered). Or the scan was used as a way of making sense of prior experience (to recount menstrual and conception dates).

The ultrasound was scheduled on a Thursday each week from about 08:30– 11:30 and were performed by a visiting doctor. The doctor was seeing about 15 – 20 women for their 20 week scan. The limited availability of time given to the ultrasounds meant that a lot of women were booked for the ultrasound after they were 20 weeks gestational age, this was partly due to there not being enough space for more bookings per week. During one set of ultrasounds the doctor was seeing women who were 22 weeks and further because they had been booked too late for the scan, highlighting bureaucratic and administrative processes affect aspects of knowing and timing of appointments. The doctor acknowledged that women who were over 22 weeks gestational age were 'late' for the scan, partly because of the staff booking women over 20 weeks gestation, and partly because women do not know when they became pregnant and their last menstrual cycle. This was reiterated when the doctor was talking to medical students who were observing and asked if the gestational age given during the ultrasound was accurate, to which the doctor said "*sure, if dates of the period is given accurately from the pregnant women and [there are] early scans, but no one in our set up can give these because most are unplanned*". The doctor said that the sisters are usually good at "palpitating" how "far along" women are, but during observations of examinations there were times when they did not know, nor did the women. The nurses told the women that the ultrasound would tell them their gestational age. The emphasis from the women was also on the ultrasound appointment being the space that would tell them the gestational age. This was stated when I spoke to a woman waiting and asked her how far along she was, she

laughed and said *“that’s what the scan is for”*. Her 20 week scan was to be scheduled the following week but she still did not know how far she was.

During one examination the woman answered the nurse and said that her last menstrual cycle was the “2<sup>nd</sup> week of June”. The nurse then asked the woman to show the last menstrual date on the calendar and give a precise date to be worked worth to palpitate gestational age. The nurse further asked if the woman had felt any foetal movement (felt in the second trimester around 20 weeks gestation); the woman had not felt movement. The stomach was measured and assessed against the roughly given period dates, as well as with the knowledge that there was no movement yet. The nurse said that she was 10 weeks along and the measurements matched her dates, she further said that the scan would work with her given dates. Movement and size are measurements of time and growth that are set against biomedical calculations of gestational age. These measurements of time and growth become a part of clinic interaction across different bookings, and add to the complexity of coming to know and counting.

These measurements got set against each other by the women during the 20 week ultrasound, when the due date given during the scan did not match the one given in earlier appointments by the nurses. Numerous conversations I witnessed demonstrated the complexity of ‘knowing’ with any accuracy. One interaction makes clear this complexity and is an example of the many similar conversations I witnessed:

*The pregnant woman was lying on the table, wiping off the gel from her belly while the doctor wrote the ultrasound numbers into her file. She had asked the doctor if the ultrasound would show her the due date. The doctor replied with a straight forward answer that the due date given from the scan was the 2<sup>nd</sup> of March. The woman looked confused and said “but the sister’s gave me 16 April”. The doctor replied telling her that “maybe your dates were a bit out”.*

This example showed there to be six weeks difference between estimated due dates given by the nurse, and dates given during the ultrasound. Women were often confused when they were given a due date during the ultrasound that was earlier or later than the due date given to women by the nurses. They relied on the ultrasound as a final point in knowing the gestational age, and being able to calculate when their last menstrual cycle was accurately.

There were times when the doctor during the ultrasound could not tell how far along the woman was either. While the nurses might be good at ‘palpitating’ to ascertain how far along women are, the onus of knowing was placed on the pregnant women in relation to a discourse of ‘planning’ and knowing their body and dates. For example, a woman had come in with her boyfriend in late

August. This was her 4<sup>th</sup> pregnancy and she thought that she was only 20 weeks now, especially as she was booked for the 20 week scan. However, when the doctor looked at her she said she looked “*very far!*” and asked her how far she thought she was. The woman said that she had “counted from my last period which was March”, the doctor proceeded to then say that the “scan is now not accurate” and explained to me that “the head, abdomen and bone length all measure differently at 39, 27, 22...there are lots of discrepancies at this stage past 20 weeks”. The doctor was happy to be able to see the sex and give them that information, but she said that November may be the due date “*but you are far for the scan so your guess is as good as mine*”.

## **Conclusion**

The normalising discourse of women’s health that universalises reproductive experiences and menstrual experiences serve as the benchmark for how women are to count, know, and survey their bodies, their cycles, their intimate relationships, and pregnancies within a given temporality. In the making of a biomedical subject, the urging of strict ‘early’ arrivals, and timed visits, warrants a subject with heightened self-surveillance of their sexual lives and reproductive cycles, however “irregular” the latter. This generates a self-surveillance discursively framed around ideas about “responsible” citizenship, and “good women”; ideas that have concrete form in women’s disappointments about ‘not making it to 21’; their confusion in being asked for specific dates of menstrual cycles; and in medical staff’s informal interactions with their clients that frequently include ‘skelling’ (harsh scolding). As described in earlier chapters, much of the everyday lives of work, access, child care, bureaucratic booking complications, and geographies of Cape Town emerge as a stifling constraint on access to the clinics. Here, I have critically evaluated biomedicine’s “body proper”, arguing that what it is to have a reproductive body emerges in temporal and material complexities of contestations and tensions around what it is to “know” and count menstrual cycles (assumed a universal regular), monitor sexual intercourse with birth control, and pay attention to commonly assumed “signs” of pregnancy and life-cycle. Lastly, knowing, premised on a rational individualist model, neglects the relational ways women come to know, and how knowing unfolds within a set of engagements with different clinic staff at history taking, physical examination, and technologies such as the ultrasounds.

## **The social phenomenology of trust and uncertainty: unsettling the parameters of biomedical “lateness”**

The biomedicalisation model of pregnancy and antenatal care assumes that women come to the clinic as though they had no prior experience of distress or history of the medical system. In this chapter I will show that the history of experience is a shaping factor for women when seeking antenatal care at differing times. People’s perceptions of medical institutions and the services they offer are shaped by previous histories, not only of their pregnancies or ill-health, but also of other people’s suffering. Histories and experiences play an important part in whether people trust medical systems or not. ‘Lateness,’ I argue, is placed within the life-cycle as opposed to the biomedical chronological experience of one pregnancy. Candice’s experience described below opens a critique of biomedical models of time, including ‘lateness’, a model that individuates experience and assumes decisions are made *ab initio* for each pregnancy. The experiential and social come to bear on relations of trust in medical systems, which in turn influence when and why women seek antenatal care at differing points in their pregnancy, or why some do not seek care until labour.

### Candice: trust, belief, and failings

Candice was lying in the recovery ward with her Newborn tucked under her breast. The baby, eyes shut, lightly wrapped, was alternating between being quietly curled under Candice’s bare breast and suckling. I met Candice, a 28 year old mother, in the clinic, a few hours after she had given birth to her 5<sup>th</sup> child at 6:20am at home. She was categorised by clinic staff as a “BBA” (birth before arrival). She cuddled her Newborn and shifted her breast to help her suckle while talking to me. I rested against the empty bed next to her as we spoke, getting up to get her a glass of water or move around for the ward sisters. Candice explained that she had felt cramps at around 8pm, but she did not come into the clinic at that time because, as she calmly explained that when you cramp, *“it’s not your time yet, you need to walk up and down, sit, do what you want, and come when the contractions and pain are close together”*. Her labour progressed in the early morning and she had not been able to make it to the clinic ‘on time’ to give birth there, so her aunt and her boyfriend’s cousin had helped her give birth at home, and brought her to the hospital straight afterwards. We shared a laugh when she said her boyfriend was not there *‘because he just makes me unnecessarily nervous during labour’*.

Candice had a deep distrust of medical professionals based on her experience of the deaths of her mother and grandmother during her first pregnancy while she was a teenager. She had only sought antenatal care when she was about 24 weeks pregnant because she was scared and did not know how to tell anyone she was pregnant. A month after telling her family and visiting the antenatal clinic, both her mother and grandmother died. The doctors told her that her mother had died of TB, but her scepticism was around knowing that *“people don’t just die of TB”* - a heavy statement spoken with a low voice as she gazed past me. Candice looked down, and squeezed her breast back into position for the baby to feed before continuing. She was sceptical because she thought that something else was going on that the doctors were not telling her, and that they were hiding information because of how soon the mother died after her clinic visit. Her mother had not reached her 50<sup>th</sup> birthday. This death had struck only a week after her grandmother had died. Candice was upset by the memory:

*“She died when I needed her most... I don’t trust hospitals, doctors, needles...”* She explained that her experience with the MOU clinic was *“okay”*, but that, *“I just don’t believe in doctors and hospitals... maybe they say one thing... but I just don’t believe in them so much, not since my mother. They didn’t tell the truth. They are meant to be the experts and help us. It is their fault, they could have done something.”*

Candice’s trust in medical authority was unsettled by the experience of double loss in a short time. Despite her distrust of hospitals and not attending clinics for antenatal care for any of her four children after the first pregnancy, she had planned to come in to deliver her fifth child in the clinic, because she was *“nervous and scared”* of giving birth at home as something could go wrong. In other words, she was prepared to trust the medical system with her labour.

The hospital and medical technology are sites that confirm life or death, and during pregnancy and labour they are sites that help keep mother and baby alive. For the state, and for those women who followed its routines, the threshold of “keeping alive” was antenatal care from 12-20 weeks gestation onwards for continual monitoring. For others, coming in to the clinic happened if a ‘danger sign’ (pain, bleeding, no movement) was present. For a few women, like Candice, coming into the clinic in order to keep mother and child alive was at the point of labour. For Candice, it had not been trust that the medical service would ‘keep alive’, but a memory of how she felt it had ‘let die’ that shaped her engagement with medical institutions. Her loss was all the heavier when considering the importance of maternal kinship networks for support. Trust and putting your trust in the clinic and medical staff differed for women at different stages in their pregnancies. For Candice it was at the last moment of exit into the world,

the clinic overlapped with her body and birth as the threshold for keeping alive as opposed to at any other point during the pregnancy. The state's emphasis on beginning antenatal care at 12 weeks gestation is its threshold; Candice's was much later. She recognised that she was taking a "risk" in not coming in until birth, but for her, irrespective of antenatal care, "*you can never know if everything is fine... I know I'm taking a risk but if God wants it to be here it will be okay*". Biomedical staff might be able to help "keep alive" during birth, but until then risk and health, and life itself for Candice, was determined by 'God'. The perceptions of the failings of the state medical care during her mother's illness diagnosis and swift death had shaped her relationship to biomedical antenatal care and were woven with notions of risk, chance and faith. The unpredictability of life and death, and the histories of (negative or positive) experiences with state medical care shaped belief and trust, and came to bear on when and why women sort antenatal care.

### **Medical authority, trust and distrust**

This chapter elucidates and contests biomedical margins of temporality through an analysis of the social phenomenology of trust over the course of the life cycle and at different thresholds in pregnancy. Within biomedical framings, particular thresholds are critical markers. One such is the recommendation that women report to clinics for antenatal care between 12 and 20 weeks of gestation. This then sets the parameters for arrival time, and follow ups, instantiating a particular kind of temporality and with it, a particular subject – the good mother. Here, I explore ideas about 'lateness' that are enmeshed with social phenomenology of trust. The time at which people enter the clinic are shaped by social relations and questions of trust. Trust itself is shaped by medical knowledge and authority, and biomedical technology – all of which are imbued with power relations (Jordan, 1997[1978]; Davis-Floyd and Sargent, 1997; Good and Good, 1993). These add continual sites of negotiating trust and distrust.

Among those with whom I interacted in the clinics and outside of them, medical authority and trust were set up against notions of risk and chance, as well as experiences of failings (failing of state care, failing of contraception, failing of pregnancy tests, and ultrasound tests). The tensions of these experiences shaped thresholds of practices of health-care seeking. These thresholds I argue were based on perceptions throughout pregnancy of the points at which 'keeping alive' became live matters. They contrast with the antenatal care threshold of 'early 12 week arrival' for *continual monitoring* to prevent risks and keep foetus and mother alive. The nurses take the biomedical threshold seriously. Several volunteer to go into the surrounding communities to find

pregnant women and “get them booked” so that they do not arrive to give birth without any records, so that they receive appropriate care based on individual histories, and so that they do not get referred to the second tier hospitals unnecessarily. Their actions raise questions about the state – what it is, and where it ends, and what kinds of labour it draws on. Questioning the boundaries of the state and state labour, volunteer efforts in this context speak to areas of questions of legitimate and illegitimate use of power and regulation. The state, as contextualised in the introductory chapter, had called for intervention in pregnancy to occur in the first trimester, wanting to lower the “40.2%” of “late” arrivals, and in so doing, to decrease the alarmingly high maternal and infant mortality and morbidity rates. While the clinic staff also advocate for “early” first trimester arrivals, their volunteer efforts had a triage approach to making sure women, ‘no matter how far along’ they are, get booked before arriving in labour. For the women I spoke to, arriving to the clinic and engaging with antenatal tests and biomedical reproductive technologies such as contraception, pregnancy tests, and ultrasounds, were layered with tensions around trust, risk and chance, thus shaping different thresholds of when women came to the clinic and how they engaged with biomedical technologies.

I use the concept of “threshold” in two ways. First, as a way to understand state health care framings of antenatal care in terms of ‘early’ arrival by using Weir’s (2006:27) framework of the ‘threshold of the living subject’. Weir uses this concept to show where prenatal testing reshaped understandings of risk, separating the unborn foetus and the pregnant woman and treating them as different, in this way accomplishing a maternal-foetal distinction for clinical practices of differentiated risk assessment. The threshold of the ‘living subject’, initially located at birth, was relocated as “prior to birth” in order to monitor foetal health throughout pregnancy, with concomitant implications for the surveillance governance of the body during pregnancy. The second way I use “threshold” relates to the different temporal and experiential stages in pregnancy when pregnant women decided to go into the antenatal clinic. I understand these ‘thresholds’ through a “social phenomenology of trust” that links the life-cycle histories of experiences and attitudes of trust as “they are formed in, and of, the social sphere of human life” (Carolan and Bell, 2003; Liisberg and Pedersen cited in Liisberg, et al., 2015: 10). According to Pedersen and Meinert, attitudes of trust and distrust depend on past experiences and social environments (cited in and Liisberg, et al., 2015: 11). I argue that the nuances of experiences, beliefs, understandings of risk, and ideas of chance shape scepticism or acceptance of medical knowledge and medical authority, and impact on when antenatal care is sought.

Women’s scepticism around regulatory claims on the reproductive body, and the authority of biomedical knowledge was based on claims of uncertainty. The social phenomenology of trust

offers a framework through which to highlight histories of experience and view factors bearing on 'lateness' as situated within an individual's life-cycle rather than within individuated, singular pregnancies. The experiential comes to bear on present relations and decision-making about timing of antenatal care and engagements with reproductive technologies and staff. I show the importance of the experiential in relation to trust and its effect on antenatal attendance; the interrelations between experience, trust, knowledge, and power; and I use these further to question constructions of trust in relation to knowledge and power in biomedicine, its practitioners and institutions.

### **Stories of scepticism, experiences of failings**

In situating a social phenomenology of trust and distrust, I begin where my participants began; with stories of contraception and its failures. This allows me to trace where trust and distrust surfaced during reproductive experiences. Many of my participants blamed their distrust of biomedicine and its actors on their experiences of contraceptive failure, or their experiences of false negatives in pregnancy tests. These become examples of how trust is unsettled through experience over time.

Medical authority is built up alongside the perceptions of the efficacy and authority of technology and biomedical technologies. Women's stories and experiences of failings and shortcomings of contraceptive technologies, tests or pregnancy assessments (such as the ultrasounds) added to the dynamics of trust. Trust, scepticism and uncertainty were thus enmeshed in actual histories and experiences of usage among women. Women took seriously the stories told to them by other women as well as their own past experiences of failings, side effects and infertility. Shantay, for example, described the value of hearing stories as part of women's experiences of reproduction: *"it happens with a lot of females... you listen to other people's stories and you go from there"*. Hormonal contraception also brought forward the concern about side effects (such as hair loss and weight gain), as well as concerns about cancer. These concerns were usually articulated in conversations with other women, or in rare examples of younger women researching on the internet. These stories framed how some women understood risk and interactions with reproductive technologies.

Several of my participants claimed to have become pregnant while using hormonal contraception. This in turn led women to blame those inconsistencies and failings on

biomedicine. Two of the 37 women with whom I worked most closely were on the Triphasal pill and took it every day as required, did not take other medication such as antibiotics, and yet still became pregnant. Other women blamed the medical technologies for not working, when they had in fact been using the contraception irregularly or had been taking medications (such as antibiotics) which interfere with the efficacy of hormonal contraception. After experiences of negative side effects of hormonal contraception (*“makes you over-weight, your cycles change, and your mood”*), and contraceptive failure (becoming pregnant), women were not entirely trusting of medical institutions or reproductive contraception technologies. In particular, women were highly sceptical of the “two month injection”, as Danielle had said, her sister had become pregnant twice while on the two month injection.<sup>28</sup>

As explained in the previous chapter, local conceptions of the body (Lock, 1993) influence different experiences of bodily processes and engagements with medicine. Among the concern about side effects and failures, women believed that hormonal contraception caused infertility, and that it *“wears out the body”*, a concern raised particularly by Candice and Qudsiyya. The belief that contraception causes infertility was often related to me, usually framed around stories of women in the participants’ neighbourhoods who had not been able to conceive and who had been on contraception previously. There was no thought that it could be the men that were infertile, nor that the women were infertile before using contraception. *‘Why would the nurses have put a woman on contraception if she was infertile?’* asked one woman. Sharnaleigh’s comments typified the concerns of many women:

*“My father’s new wife can’t have kids, and she was on family planning for all those years before trying for a baby. That’s why I am afraid of family planning because I don’t know what to expect... never mind if I have four pregnancies... before I fall pregnant I don’t want there to be any complications with becoming pregnant... so I don’t bother [using contraception]”.*

For the women, it became a matter of weighing up the risks of using contraception (side effects, possible infertility) against the risk of not using contraception (pregnancy).<sup>29</sup> Risk was thought to be “50/50” as Kylie succinctly put it. For Kylie there was a 50% chance of becoming pregnant when using contraception, and there was also a 50% chance of becoming pregnant when not on contraception. Like her, other women leant toward taking the chance of not using contraception

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<sup>28</sup> Injectable contraception is one of the main forms of contraception offered to working class women who use state facilities.

<sup>29</sup> Condoms were used sporadically by my participants (non-use was for pleasure, other times for convenience, and many times because women did not have condoms and their male partner did not want to use them).

because they did not have to fear side effects of contraception only the 50% chance of becoming pregnant.

Hearing *stories* was not just limited to contraception and adverse side effects, but also to pregnancy test. There was a widespread perception that they often ‘failed’. I was told by a few women like Shantay, that the home pregnancy tests they had done did not show that they were pregnant, when in fact they were. Shantay spoke about how “*tests can be wrong*” especially with the pregnancy test where it was not only her experience of her personal test failing, but also hearing of a friend having missed menstrual periods and haven then taken three pregnancy tests that all read negative until a doctor confirmed the pregnant. Thresholds of life are enmeshed with the sociality of stories women listen to from other women. Scepticism accumulates through these stories. The effects of speech, stories, and experiences create distrust by placing kernels of doubt in the effectiveness of reproductive technologies and the institutions that offer them. These experiences also come to bear on the relationships between women and the clinic staff as contraception usage is a part of the history-taking during care, as are questions about future ‘family planning’.

### **The clinic process**

Differing notions of risk and chance influenced temporal decisions for arriving for antenatal testing. Women often stressed that birth was the only threshold of ultimate certainty of knowing. They usually argued that ‘God’ was the ultimate determiner of life.

Participants held that antenatal examinations and testing did not need to occur at a specific time in the pregnancy, despite biomedical and public health recommendations for first trimester check-up and booking tests. For many women, having the tests such as blood pressure, sugar, HIV, STI’s, and growth examinations were understood as necessary, but they felt the tests could be done at any point in the pregnancy. Nadia, a 35 year old mother in her second pregnancy, explained that she had only made it to the clinic 35 weeks into her pregnancy because she had to work and could not come in. She thought that the antenatal tests and screenings were important to knowing the foetus was healthy, however she was “comfortable” with only coming in 35 weeks pregnant as she stated, “*I did the tests now, I did all the tests*”. When asking about what tests were meant to happen in the first trimester 12 week booking she did not know but said with a annoyed tone and confused expression: “*I did a test now and they told me everything is fine, the baby is fine*”. Rehana, too, echoed Nadia’s perception of tests being necessary but not at a specific time.

She understood coming in to the clinic at 20 weeks to be acceptable. The risk of “something being wrong”, particularly in relation to HIV infection was contrasted to her thought that *“the baby is already developing everything...they can only see when the child is born, take tests after... they can’t tell you if the baby got it when you come in pregnant”*. In other words, because the baby’s HIV status could not be ascertained before birth, women felt it unnecessary to report “early” for tests that included their own HIV status. Most women I spoke to trusted everything was going “well” in the pregnancy and that antenatal tests could be done at any point throughout the pregnancy revealing the same information as they would have done if they had come “earlier” (first trimester tests for the health of the foetus)<sup>30</sup>.

For the women, as for the medical staff, clinic testing was there to confirm health and life, but women read the cues of their bodies to know if anything was going wrong, trusting their own ability to read “danger signs”. Bodily signs of “danger in pregnancy” – pain, bleeding and lack of movement - partly intuitive knowledge, partly by clinic discourse, prompted women to go to the antenatal clinic. These bodily signs were points of entanglements of technologies of self-surveillance urging women to pay attention to their sexual and reproductive bodies, women’s own intuition in trusting they would “feel if something was wrong”, and medical staff’s ability to work with the cues and confirm health, life, or death. In other words, antenatal care is sought by some at thresholds of ‘keeping alive’ - rather than for its capacity to “continually monitor” mother and foetus.

Notions of risk undergird biomedical temporal framings of antenatal care. Women’s framing of risk in terms of particular danger signs and their understandings of timing of tests are not in contrast to biomedicine, but rather enter these biomedical framings at an angle, as Povinelli (2011) would frame it. From these examples, women’s experiences and understandings, influenced by notions of trust and risk, sit askance the biomedical model that identifies their attendance as “late arrival” at the antenatal care clinic.

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<sup>30</sup> Decisions about abortion were decided by many during visits to the Day clinics where they went to confirm pregnancies. If there was a decision to abort, the women were referred from the Day clinic to Retreat MOU and then referred for termination of pregnancy to Victoria Hospital.

## Risk, chance, belief

Trust was set up against pregnant women's "stories" they hear, beliefs and scepticism about contraception, and state care. There was an expectation that the doctors 'should know', and that women 'should' and 'have to trust' the clinic staff because "*they know what is best*". As I have described, women's experiences of contraception, pregnancy tests, and medical tests failing, and information being wrong shaped their trust. Across these moments, religion was highlighted as a guiding point on knowing the outcomes of anything, where the most trust women had did not rest with clinic staff, doctors or biomedicine, but with god, and his/her "plan". Many women described a trust that "*God wouldn't give me anything I couldn't handle*" in relation to having another child and the outcomes of pregnancy. The decisions around trust I observed were morally charged within a religious framing in a given political economy, and in relation to the re-occurring discourse that "*one never really know till it comes out*". The discursive placement of this general 'uncertainty' of outcomes came to bear on the ways differing notions of trust were woven into thresholds of life.

Rehana, for example, strongly stated that even though she had come into the clinic 20-24 weeks into her all 4 pregnancies she was not concerned that there would be anything wrong. As she put it, "*I trust everything is fine and I believe in God and he wouldn't do that to me*".<sup>31</sup> She also trusted her ability to read if there was no movement or bleeding as a sign of a need for medical attention. Rehana likened being pregnant again to chances of lottery winning:

*"Jirra another child... not planned, I didn't want more children... I'm here pregnant... like the lottery... like someone who wins the lotto just get babies all the time... I've had enough... and things are expensive... It wasn't planned but it's there and God won't give you stuff that you can't handle... but jirra you must think sometimes... don't just having children, children, children"*.

Risk and a religious rhetoric of God as the knower and decider offered both comfort in unpredictable situations (bodily and financial) and a structure to ease future concerns. Leslyn, 35 year old and reporting at the clinic with her 3<sup>rd</sup> pregnancy, was very upset at becoming pregnant again because she had not "planned" for another child. She said she "didn't want another child" because "*you have to think about their futures. The other 2 are so far apart that they are manageable to plan for ... you have to think into their future... but this is my gift from God; it was not my plan, it was His*".

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<sup>31</sup> i.e., God would not let anything go wrong in her pregnancy.

Taking “chances”<sup>32</sup> with not using contraception or not coming into the clinic often were layered with perceptions of *respectability* that did not match the reality of being able to come in on time or the reality of engaging intimately with partners without contraception. Merldy, who was 29 and at the clinic 24 weeks into her 4<sup>th</sup> pregnancy when we met, had internalised the discourse of “responsibility,” “planning” and “the right time”. She explained that she felt “*irresponsible for only coming in now*”, but it was because of the household family and financial dynamics. She said it was the “right thing to do to come in to the clinic”, explaining that “you need to know your baby is safe and healthy... You don’t want to put their lives in danger in any way... *I’ll blame myself*”. Concerned about financial stability, she had no income other than two social grants for the two children that live with her. Her third child’s grant went to her mother who takes care of that child. Merldy strongly believed that she would *make a plan* to take care of the new child. She described herself as “*irresponsible for not using condoms*” but that she had “*no reason to use them*” because her boyfriend was her only partner and she said they were “*faithful*”. She *knew there was a possibility of pregnancy, “but I accept as it is”*. Risk, chance and respectability here conflicted with experiences of intimacy with her partner.

Ideas of risk were complex. Women with long-term partners did not fear risk of HIV infection because they believed they could trust their partners, despite many expressing concern about the faithfulness of their partners. Women were generally more concerned about the risk of pregnancy, but within a marriage or long-term relationship where contraception (including condoms) were not used, the risk of pregnancy was accepted. Here, risk and chance are layered with lived experiences, intimacy, notions of respectability, and religious framings. However, even the women who had not come in for any antenatal care and arrived having given birth before arrival still wanted to give birth in the clinic. The clinic was still envisaged as a safe birthing space, suggesting a trust in the institutional operations of birthing, if not of care.

### **Trust and power dynamics**

At differing points throughout the clinic processes, medical authority and the power dynamics in the engagements with clinic staff became a part of how trust and distrust were experienced. Throughout the other antenatal examinations and processes over the course of the pregnancies, trust in the clinic staff and medical examinations was framed around a set of power dynamics of how women should engage with the staff in order to be treated “nicely”. The explanation given

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<sup>32</sup> A term used both by staff and pregnant women.

at the beginning of the day to the waiting room during the antenatal talk was that ultimately if “*you are nice to them, they will be nice to you*”. Veronica reiterated this point when she explained that her previous birth there was “*fine*”, adding “*I didn’t have any problems... some people think there’s a problem... some people want to skel (scold) with their mouths, and don’t know here the nurses are there to help you*”. Women frequently commented that the “nurses were there to help you”; an important finding in view of research that demonstrates routine verbal abuse (‘skelling’) and sometimes physical abuse in state medical institutions (see Masuku, et al., 2012; Abrahams and Jewkes, 1998; Villar et al, 2001). One mother accompanied her pregnant daughter to the clinic specifically to make sure she would not be scolded for arriving after 12 weeks for her first booking. The nurse in that interaction laughed and said it would not happen if “you are nice to us, we are nice to you”.

Trusting the staff, and “listening to them” was implicated in histories of the power dynamics of medical knowledge, the hierarchies of respect in place for medical staff, and the “stories” and past experiences of scolding from nurses, especially when one arrives “late”. As experience unfolds, trust intersects with the clinic staff and histories of experience with medical institutions. Trust becomes hinged on past and present experiences with medical power dynamics, not necessarily on the actual belief that women trust the clinic and staff.

### **Expectations vs experiences: the ultrasounds and the ground of uncertainty**

Medical authority, framed in terms of respectability and respect, is hinged on racial and class power dynamics. (White) medical doctors are perceived to be at the pinnacle and women have strong expectations that they ‘speak truth’. Despite this expectation, I learned that during interactions with medical practitioners, uncertainty emerges. Medical doctors are more flexible and contingent in their statements than women expect – or desire. This became particularly clear during scheduled ultrasound scans.

One of the important ways that trust is created is through the ultrasound scan, but medical staff and patients have different ideas about the purpose of the scan. Women initially imagine that the scan will identify foetal abnormalities and the foetus’s sex, whereas doctors use it to assess growth (although as I have shown in the previous chapter, assessment itself is complicated by the ways that numbers count in determining foetal development). Within these interactions there is a complex negotiation between doctors and pregnant women and those who accompany them, with doctors cautioning and emphasising “you can’t know 100%” and patients demanding

certainty from doctors. Knowing and trusting was constructed from past experiences with institutions, and were relationally fashioned within interactions with doctors and nurses.

The doctor who did the ultrasounds on Thursdays began the mornings by speaking to the group of women waiting along the line of chairs on the wall. She, like the other clinic staff, explained the process for the day as it related to the ultrasound. She made clear what would happen during the ultrasound: she would be looking at the ‘heartbeat, measuring the top of the head circumference, the abdomen, and the bone in the upper leg’. She would check the ‘fluid’ and the ‘placenta’, but the scan was to see the growth of the baby and not abnormalities. The women would also be told how “far along” they were and given a “due date”. The point most anticipated for and asked about was the sex of the baby. The ultrasound machine was not as new as the one at Mowbray maternity hospital, so nuances of the foetal features such as facial features and fingers could not be as clearly seen. Often the image was “too fuzzy” to “tell the sex”. Visually finding and seeing the foetal sex often took the longest, especially when women were “overweight”, “making the image fuzzy” or if the foetus was in a position that blocked the area, such as having its legs crossed. The doctor would take her time, often squinting at the screen to see, and scrolling the ultrasound computer’s mouse around while moving the ultrasound probe along the women’s bellies. If the doctor still could not make a judgement about the sex, she would roll and shake the pregnant women back and forth in an attempt to get the foetus to move. Then, and throughout the check-ups, the doctor reiterated that she may not be able to see the sex, and even if she does, it is “*never 100%*”. The point of “*never 100%*”, and other remarks such as “*you can never really know*” was reiterated in the morning’s opening explanation, during the ultrasounds, in the antenatal talks, and in relation to family planning methods. This uncertainty of ‘knowing’ was repeatedly announced to the waiting room, met with head agreeing head nods, or eye rolling and head shakes.

One morning, a woman with a rounded stomach came into the ultrasound room after her number was called. She timidly asked if her husband, who was holding their 1 year old, could come in with her. Ordinarily, the rules do not allow more than one person accompanying the pregnant women to come in. The doctor gave permission, and, upon entering the room, the woman immediately said “*thank you for this opportunity*”. After settling her on the table and applying gel to her stomach, the doctor began the examination by finding the heart and pointing at the heart beating on the screen. Usually once the doctor spoke, the women or their partners asked questions or commented. It was rare for the women or partners to speak before the doctor did. After seeing the heart beat the woman asked whether “*it’s fine?*”. The doctor told her the

foetus looked fine and she carried on looking at the abdomen on the screen. Abruptly once hierarchies of speech had been broken in that space, the question of the foetus' sex was: "*Doctor, can we see the sex?*" to which the doctor replied: "*I'm getting there...*" while continuing to look at the screen before saying that "*the placenta is low, you will need a scan at 32 weeks*". The process the doctor followed was to find the heartbeat first before "seeing" anything else. She explained to me that this was because of one previous experience where she went through all the other checks before, only to devastatingly find no heartbeat – a point where visual technology was used to confirm death. Thereafter she checked for signs of life first. The doctor had to move the woman from side to side in an effort to get the foetus to move so she could try to tell the sex. This bodily shaking was a point of humour for the women and their partners, and was framed around the personification of the foetus and the attempt to "wake it up", even saying while moving the woman "wakey wakey". In the case I am describing here, unlike in many others, the doctor was able to give her opinion of the sex: "*I think I saw the sex, but I want to show you... maybe it's a boy... may be a scrotum*". The husband was excited and wanted to know from the doctor if he could "*celebrate with the boys at work who are holding thumbs for him!*" because he had two girls already. Instead of confirming the sex for him, the doctor rather reiterated that this was not a certain account. "*I trust your judgement!*", exclaimed the man. The doctor replied that he should rather "*wait till it comes out*". The father was still confused but decided to tell the people in the waiting room that he was having a boy when they asked as he left.

The women waiting in the ultrasound line would often talk to one another about what they were 'expecting to see'. The 20 week ultrasound, a visual site of the threshold of 'the living subject', was a space where trust and distrust were woven with expectations "to see", dynamics about medical authority of doctors and the ability of new technology to reveal. The 20 week ultrasound was an important marker for the pregnant women to confirm life and health, not just foetal sex. The excitement of knowing and sharing news of the foetal sex is taken up in chapter six, where I show the importance of the scan for repairing social relations and in considering what technology can offer the social.

In the previous chapter, the 20 week ultrasound was introduced as a technique of knowing, where pregnant women and clinic staff had an opportunity to confirm and "know" their gestational age and due date. The ultrasound technology is used as an "instant visualization to measure, date, position, and intervene in pregnancies, while "reassuring" their patient that their foetuses are developing in a normal manner" (Rapp, 2007: 608). However, although women thought that the scan would reveal the gestational age, due date, health, and sex of the foetus, this was not always the case. The first lowering of expectations of medical authority was when

the doctor explained that the scan assessed growth not abnormalities, lowering expectations that the scan might reveal the foetus's sex accurately if at all. Trust and authority in relation to the doctor and the technology was built up and contested in those small moments. Here, the internal of the woman's body and the foetus remains partially a mystery until birth, when the complete exit into the external world is affected.

The expectation that the doctor should know, and the reality that often the sex could not be told, or the due dates might not be the exact day, often created confusion or even tension with authority. This tension was observed when a woman having her second child was having the ultrasound and had been accompanied with her boyfriend. He had been unable to come to the ultrasound for their first child because he was working. The point of tension arose when the doctor told them *"I don't think I can see sex because it's fuzzy... but it might be a boy"*. The boyfriend responded by rolling his eyes and shaking his head abruptly at that statement, unimpressed with the lack of clarity in the assessment.

The doctor did not necessarily always refute other ways of knowing or the pregnant women's intuition about her pregnancy and foetal sex. For instance, some women thought they might be having boys based on how their stomachs were sitting higher in an "egg-like" shape. In one instance a woman had said that she was hoping for a boy but had had a dream it was going to be a girl, as did her brother. The doctor engaged in her intuitive dream by asking about morning sickness to which the woman had experienced morning sickness for this pregnancy. The doctor then told them that she can tell or "predict" the sex based on how morning sick women were. She said if the women were sicker, it was likely to be a girl based on the scientific explanation of "the pregnancy hormone being higher when it's a girl". The doctor was not explaining this to convince them of the sex, but rather having a casual conversation about different ways of reading the body and being open to 'women's intuition', because, as she repeatedly reminded people, "you can never really know".

Rayna Rapp has argued that sonography "bypasses women's multifaceted embodiment and consciousness, providing independent medical knowledge of the foetus" (Rapp, 2007: 615). However, as I've shown, in these moments where medical authority is contested and interactions with pregnant women are open to engaging with intuitive knowledge, multiple experiences of reading are able to exist. These are encapsulated in the oft-repeated phrase that any way of knowing is not "100% sure". Medical authority was produced in the control of the space and how women and partners moved in and out of it, the time of interactions, and how the questions were answered. It was also re-enacted through the explanation of behaviours that were seen as

medically detrimental to foetal health, such as smoking and drinking. The clinic became a space to “educate” at times. This did not happen regularly and it mainly revolved around issues of cigarette smoking. The doctor either asked them if they smoked if she smelt smoke on women, or if she read the amniotic fluid was low or perceived the size of the foetus to be small (a point not as clearly definable during 20 week scans as it would be at a 12 week scan). The doctor explained that by visually showing the women, she was “able to get the message across that they must stop smoking”. The visual technology as a space to open up an “education” about social behaviours such as smoking reproduces hierarchical social interactions.

The site of the visual technology intersecting with biomedical knowledge and authority becomes a point at which power and its relation to knowledge and trust in knowledge are brought forth in the interaction between the doctor and patients (Ransom, 1997; Foucault, 1977). The doctor’s uncertainty or refusal to “know” foetal sex, coupled with women’s experiences of failings throughout their reproductive experiences come to bear on how trust and distrust are woven together at thresholds of life. The uncertainty of “knowing” attests to Foucauldian notions that “knowledge can never be absolute or final” (Ransom, 1997: 19; Foucault, 1977). Pregnant women here are faced with the tensions between experiences of failings and modes of uncertainty that underpin both reproductive experiences and the expressions of biomedical knowledge in the clinic.

What unfolds in relations of power when the importance of knowledge within modern constructions of power is underpinned by a mode of uncertainty? The passage from the internal to the external becomes enmeshed in multiple ways of reading, testing, and here “seeing”, but ultimately privilege is returned to birth as the site at which there is complete externalisation of the internal as it related to foetus sex and health.

### **Conclusion: the social phenomenology of trust and scepticism**

Macdonald (2012) notes that in the sphere of public health scepticism is usually understood as ‘non-compliance’ (see also Pigg 1996; Needham 1972; Lambek 1993). As previous studies show (Abrahams and Jewkes, 1998), pregnant women who do not arrive within the recommended time to antenatal care are framed as “ignorant” of care during pregnancy and blamed for their “lack of knowledge” and “failure to care”. Here, I have shown how in engaging with histories of experience and with reproductive technologies and antenatal care, the webs of medical authority, technology, and knowledge, trust and distrust are woven together at thresholds of life. In setting up biomedical temporal framings of antenatal care as the regime of truth, a dichotomy is set up

between “truth” and “ignorance” that bear the markers of temporal idioms of modernity (progress/backwardness) (Pigg, 1996). As we saw in the vignette about Candice’s experience of suffering and loss that she attributed to medical institutions, histories of experience shape trust and distrust and complicate relations to medical authority, which in turn affect timing to antenatal care. Similarly Liisberg and Pedersen argue that trust and distrust are “formed in, and of, the social sphere of human life” (cited in Liisberg, et al., 2015:10). I argue that timing is enmeshed with a social phenomenology of trust - where the temporal is not bounded to state recognition of 'lateness' that individuates experience to each chronological pregnancy. Rather, the temporal enters the complexity of the social where histories of experiences and beliefs of trust come to bear on attendance. The social phenomenology of trust takes into consideration the life-cycle of experience with medical institutions, distressing situations, unpredictable outcomes of contraception, and present flexible practitioner authority. Interactions with antenatal care and ‘early’ attendance are influenced by experiences of life’s ambiguities and histories and experience of trust, risk, and belief.

## Chapter Five

### Navigating pregnancy's social life: 'sitting with', speaking, punishment, and repair

In ethnographically detailing the complexity of social belonging and bearing life, I revolve this chapter around moments in the stages of pregnancy that were poignant for the women I spoke to. I place these moments within a framework that highlights the social claims to pregnancy and complicates linear experience of pregnancy and antenatal care.

Rayna Rapp's (1999) analysis of amniocentesis, specifically her approach that highlighted the moral dilemmas of women undergoing amniocentesis testing, centred women as "moral pioneers" and "private philosophers", who were confronted with the existential, moral, emotional, religious, and financial concerns and decisions surrounding their pregnancies and selective abortion. The decisions were deeply entangled in social relations as the diagnostic "fact" of amniocentesis test for patients was understood through constructions of beliefs about being a good "mother" a good "parent", commitments and obligations to family members, financial concerns, beliefs about risk, disability and morality. Rapp (1999:3) argues that as moral pioneers women "are forced to judge the quality of their own foetuses, making concrete and embodied decisions about the standard of entry into the human community". While my participants were not engaged in the philosophical dilemmas of selective abortion through amniocentesis, I use Rapp's concept of moral pioneers to show how the social rhythms of pregnancy and knowledge circulation become enmeshed in "complex relational ground", especially when faced with "unintended" or "unwanted" pregnancies (Rapp, 2011:14). The decisions women were faced with during pregnancy were shaped by constructions of morality, gender and sexuality. Poignant moments included confronting their ideals of "reaching 21", dealing with the weight of "disappointment", "responsibility", and the responses of others to the pregnancy. I show that those moments resulted in particular effects, of which waiting (what I call "sitting with") knowledge), dealing with rejection and punishment, and engaging in the slow repair to their social fabric and family support are central. I argue that in sitting with decisions around life, futures, social relations and care, the pregnant woman as "moral pioneer" experiences pregnancy events as unfolding within a matrix of relations "which are at once social and biological" (Rapp, 1999: ii,3). In speaking to women about their arrival to the clinic after the 12 week recommended "early" first visit, it became clear that once a marker of truth was taken that they were pregnant, what to do first involved deciding whether to keep the pregnancy or not. That decision often involved remaining silent for a time before revealing their pregnancy to family member. The

“coming out” and “speaking of” pregnancy revealed the negotiations within family relations that highlighted layers of gendered moral expectations about “good” women, and at times the dire material consequences and forms of punishment for not meeting such expectations. In navigating these social relations throughout pregnancy, I demonstrate that the ultrasound undertaken as part of the 20 week antenatal appointment at the clinic was an event that allowed the social work of “repair” between families to begin. The visual technology not only materialised the foetus in a gendered way, but also materialised new family formations as the foetus was given placement in the world. Through the focus of women as “moral pioneers” I seek to highlight patterns of relations in the biosocial that complicate the linear “cause-and-effect” framework of pregnancy that underpins biomedical models. Pregnancy status does not just become a matter of “*arriving on time*” to the clinic - a recommendation that not only ignores the complexities of bodies, the question of how one knows one’s body, the social phenomenology of trust, but also the ways the pregnancy has a claim on the social where existing networks of obligation, responsibility and exchange constitute persons and relations that influence when and how women seek antenatal care.

### **Babalwa and the spilt milk: the social life of coming to know a pregnancy**

In the small room in the antenatal care unit, sitting in on a history taking session with Babalwa, the nurse ticked the box “unplanned”. Babalwa was still coming to terms with being pregnant. Babalwa and the nurses thought she was 15 weeks pregnant based on her last menstrual dates and information from the day clinic from which she had been referred. Her solemn tone and downward gaze in explaining her “unplanned” pregnancy to the nurse led me to further the conversation. We talked in the empty room during a tea break, she crunching a fresh yellow apple I had brought while explaining that she was still in shock that she was pregnant. She thought after 16 years of not becoming pregnant after her last child was born, she would not get pregnant again. She was 37 with two children (22 and 16 years old). Babalwa was finishing her first year at nursing school in Cape Town with the support of her mother, who was living in the Eastern Cape. She expressed grave concern about her mother’s finances and her high blood pressure, which added to Babalwa’s desire to finish the nursing school. Babalwa was in a relationship with a 39 year old policeman who lived in Khayelitsha. This would be his first child. She was not fully trusting of him as his attention had waned and she took it to mean he could be seeing another woman. Her concerns about her mother and the stability of her relationship with her boyfriend cycled in and out of the conversation for the hour – she did not know what would

happen to her relationships because of the pregnancy and feared revealing it to her mother. She was anxious about how to continue studying and support another child.

Babalwa thought she was pregnant when she was in the house with her friend and milk spilt on the floor. As she put it, this was a sign: *“In Xhosa we believe that spilt milk means someone is pregnant”*. The two women with milk on the floor between them had both thought the other was pregnant, and so both took pregnancy tests. Babalwa’s was positive. *“I screamed in shock,”* she recalled. Still in a state of disbelief, she went to the day clinic to see if she had an ulcer because of the nausea and vomiting - but it was confirmed that these were symptoms of pregnancy. Her concerns about finishing nursing school, being supported by her mother who had high blood pressure, and being in a relationship with a man who she did not know if she could fully trust was weighing on her thoughts about the pregnancy. Besides the friend who knew she was pregnant from the pregnancy test, she did not tell anyone and decided she would not keep the pregnancy. Babalwa described how she *“tried to get an abortion at three clinics”*, the one *“in Khayelitsha”* she *“went on the wrong day”* and they *“wouldn’t take her”*; the other one she could not *“remember the name”*, and said that it was *“full and only seeing young women 25 and under”*; and the third visit was to Victoria Hospital where she had an appointment and a scan that she explained *“they couldn’t see anything... so they couldn’t give me a pill to take”*<sup>33</sup>. After these three experiences of navigating obstacles in her access to a termination of pregnancy, she decided *“I should just keep the baby because of all those signs”*. When I spoke to her she had by then told her boyfriend who said he would support the child, and the nursing college had told her she could take time off when the baby was born. Babalwa was still too scared to tell her mother, both because of the latter’s potential disappointment and because she feared that her mother would, in anger, cut her funding off (see Mkhwanazi 2004; 2010; 2014 teenage pregnancy and generational dynamics in South Africa).

Babalwa’s story indicated a few of the concerns and decisions women were faced once they knew they were pregnant. Babalwa like many other participants was worried about maintaining relationships with her family members, not “disappointing” them, not burdening them with financial concerns, not meeting social expectations around when the right time to become pregnant was, not meeting expectations about education and employment before pregnancy, and the concerns and tensions around relationships with male partners and emotional and material support. She had not come in sooner to Retreat antenatal clinic, because she was navigating her

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<sup>33</sup> *“Medical Process abortion*, sometimes referred to as the abortion pill, uses pills/tablets to terminate a pregnancy. The first set of tablets is taken orally in the clinic and the second set is taken later at home. Before 4 weeks a pregnancy can be difficult to detect. Sometimes even at 4 or 5 weeks a pregnancy can be too small to detect on a scan and you may be asked to rebook and visit the centre in another week. This is for your safety” (Mariestopes, 2016)

concerns about the pregnancy, and actively moving from clinic to clinic navigating access to an abortion and the difficulties of thinking about this. This ‘sitting with’ knowledge and keeping information to oneself illuminates the private life of information, and demonstrates the unfolding process of revealing information about being pregnant. I use the term “sitting with” as a way to capture the weight of decisions and strained social relations. “Sitting with” was a phrase many women when describing their experiences “unplanned” or “unwanted” pregnancies. Their phrasing was often accompanied by a head shake or a sigh. They used phrases such as, “you sit with another pregnancy”, “you sit with a child”, “I’m sitting with another baby”, “if you sit and think alone”. Drawing from their usage, I use “sitting with” to express the weightiness of bearing life and navigating reproductive choices, not as a literal description of “remaining still” or “sitting”. “Sitting with” is a social experience of pregnancy, and one that weighs on women as they keep social knowledge of a pregnancy at a distance.

This process of negotiating knowledge circulation, I argue, adds another dynamic to the temporality of pregnancy and shapes when women book for their first antenatal check-up. The public health necessity to “book early” neglects the social processes of negotiating knowledge circulation. The processes involved the complexity of sitting with knowing one is pregnant and decisions to keep the pregnancy or not; the act of revealing that one is pregnant to partners and family, and dealing with the consequences of them knowing. As Nguyen argues in the context of HIV, disclosure and ideologies of “patient empowerment” gained from the disclosure of status and “coming out”, relied on “the idea of that people form social relations by revealing a hidden truth to the self” to one another, and “ignored existing networks of obligation, responsibility, and exchange that both constituted persons and bound them together” (Nguyen, 2010: 83). I argue that the social life of a pregnancy *unfolds* around key social moments that involve the circulation of knowledge and the social relations in which they are enmeshed. It is not solely a physiological experience, framed by a biomedical temporality, but is also a social one in which networks of support and social relations are navigated and, for some, as I learned, come to settle and find repair through the 20 week ultrasound.

## Sitting with, speaking

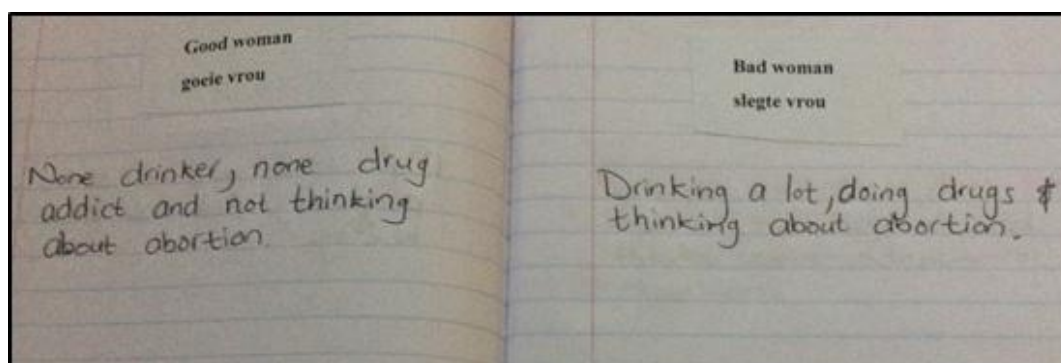


Image 20: Sharnaleigh's journal showing the moral discourse that surrounds decisions about abortion.

Babalwa's move from clinic to clinic seeking an abortion, yet deciding against it showed a common theme of deciding about the life of their pregnancies. Abortion and adoption were two critical issues to be thought through once a woman knew she was pregnant. Religion, sociality and ideas of being able to 'make a plan' for the child amongst family members influenced these decisions. For some like Babalwa 'signs' changed their minds. Abortion was a heavy decision that was negotiated and paused on, especially once pregnancy was revealed to family, and influenced timing to the clinic as well as relations with family.<sup>34</sup>

Sitting in the silence of history taking room with the nurse, Alvina took out a crinkled, folded piece of paper – a letter of confirmation to terminate her pregnancy. She showed the nurse and explained that she had changed her mind and would keep the pregnancy. The nurse checked with her about her previous decision about the abortion; Alvina had gotten the letter after contemplating her relationship with her boyfriend who, she said, had begun abusing her. Alvina was not only concerned about this intimate partner abuse and bearing another child (her daughter was 2 years old), but also the practical financial strains of another child in the household. Her mother was the primary earner in the household, home to Alvina and her daughter, Alvina's sister, and her two brothers. Alvina's concerned words rang in her description of the meaning of living with financial strain: "*my mommy cleans houses. She is working, some days on, some days off – the income is not right... there is sometimes that we don't have food, sometimes don't have money*". After much thinking, and, like Babalwa, moving toward accessing a termination of pregnancy, Alvina changed her mind about the abortion after ultimately facing the tensions that

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<sup>34</sup> Staff said that on an average week there about three pregnant women who were referred to Victoria Hospital for abortion procedures.

the decision for an abortion would have on her religious and moral beliefs: “*Abortion is not right because the baby didn’t ask for life... it’s a blessing of God*”. As we have seen, this was a common sentiment when referring to ‘unplanned’ or ‘unwanted’ pregnancy - the rhetoric of the gift imbued with religious tones of a blessing from God. Alvina had decided to keep the pregnancy and maintain a relationship with her boyfriend in an effort to “give him another chance” and get support with the child. She then booked her first antenatal visit. From finding out she was pregnant, sitting with the information and decision making, and negotiating material and social consequences of a new life, Alvina did not book at the antenatal clinic “on time” at 12 weeks gestation but at an estimated 20 weeks gestation.

Moral decision making and revealing pregnancy information was not only about heaviness of deciding life or death, but also the burden of thinking about the child’s care and futures once born. Revealing pregnancy to families complicated decisions for some women about abortion or putting babies up for adoption, because family members tried to convince women otherwise. Families attempted persuading them they would support their new family member materially, financially and emotionally. This was emphasised in religious rhetoric of the *‘child as a gift from God’*. These complications with decisions about life enmeshed in kinship dynamics and religious rhetoric was brought out strongly by Ameera and her mother in a discussion one day. Ameera was an 18 year old Muslim woman who had come to the first clinic visit 24 weeks into her pregnancy accompanied by her mother and was firm about wanting to put the baby up for adoption, a decision causing great tension with her family. I spoke to both of them in the NGO’s small interview room. I was concerned about the dynamics of Ameera’s mother being in the room and what that would do to Ameera speaking, but Ameera was calm and assertive in her speaking as she described her journey. She spoke about having missed her periods and had been confused about it. She sought counsel with her Life Orientation (L.O) teacher, who told her “stress” was likely the cause of the menstrual absence. Taking this information, Ameera repressed the thought that she was pregnant until her stomach grew and hardened at what she later learned was five months gestation. With a growing belly as her stark sign of pregnancy, Ameera decided to go the clinic to book for an abortion, but was told she was too far along. She eventually had to tell her mother because she was “showing” and could not have the abortion; up until then she had been deliberately lying to her mother about not having sex let alone being pregnant. Unable to terminate the pregnancy, Ameera had to speak to her family, navigating the tense resultant relationships. The tensions unravelled in the little room as Ameera and her mother spoke their views about Ameera’s decision to put the baby up for adoption once she had given birth.

Ameera was adamant that she did not “want” the baby - she had just finished matric and was planning on studying engineering next year.

The circulation of information during pregnancy cannot be concealed indefinitely in most cases, like Ameera whose body gave her information away to public view and knowledge - a rounded belly showing life was on the way irreversibly at 20 weeks, and thus prompted a verbal revelation. Often other people (partners, friends, parents) read the young women’s bodies as pregnant, a point which might become a public secret until revealed by the pregnant woman through the act of speaking (Mkhwanazi, 2010: 353). Once her pregnancy was revealed, the tensions between Ameera and her family grew, especially as these concerned her decision to put the child up for adoption. The family said that she had enough support from them and so she *should keep* the pregnancy. Ameera’s mother explained that you can, as a Muslim, put a child up for adoption if you cannot provide and support it, but that it was “*a sin to put baby up for adoption to a non-Muslim family*”. The mother’s concerns lay in grappling with religious guidelines for life and giving kin up to non-Muslim families. Ameera’s concern was focused on her future education plans. Despite the tensions with her family, Ameera was still certain she was going to put the baby up for adoption. This was not the case for other women whose social networks influenced their decisions around abortion and adoption as well as their religious beliefs.

“It lies at everyone’s door” – sitting with concerns, contemplating consequences.

Moments of ‘private thinking’ and the weight of these concerns were felt strongly in the tone of Meshe’s statements. Meshe, a small woman barely 5ft3” in jeans and a hoodie, was a 19 year old at the clinic for the first time at “5 months” with her first pregnancy. She had been accompanied by her mother for support. Meshe was happy to talk to me as she was last in the queue of 20 people and did not like the waiting space. While speaking to Meshe in an empty kitchen room in the maternity wing, I had to pause at moments when our conversation was interrupted by screaming coming from the labour ward. A wide-eyed Meshe, thanks to the screams of labour in the background, begun her story with her day’s start to the clinic. She had walked to Retreat with her mother that day, thankful there was no rain. It was her mother not her that had booked her into Retreat after they had gone to Montague Clinic to confirm her pregnancy when she was about 3 months pregnant. Meshe had not wanted or planned this pregnancy, she was not using hormonal contraception and had not used a condom because her boyfriend “did not have one on him”. I asked her to explain the difference between a pregnancy being unplanned and

unwanted to which she replied that pregnancy is “unwanted” till the mother is 22 years old; it is unwanted if the mother has not yet reached her 21<sup>st</sup> birthday.

*“When I’m done with my 21<sup>st</sup>, have a job, reach a high level to have a child. Now look I’m 19 - it takes you very far in life if you sit alone and think. It’s a LOT, yob”.*

In dragging out her “yoh” at the end of a sigh, she looked upwards and elaborated on the thoughts burdening her mind when she sat alone with the weight of being pregnant at 19, anticipating a different future from that recently envisaged:

*“when you are done with high school then you can put your life after each other... But now, the road is going that side \*curves her arm sideways\*, and you planned it straight, and now it’s skew”.*

Meshe’s tone brought attention to the great many things women think about once they find out they are pregnant. As Weidman writes, “attending to voice in its multiple registers gives particular insight into the intimate, affective, and material/embodied dimensions of cultural life and socio-political identity” (2014: 37). Meshe’s tone, and the heaviness with which she let her thoughts out about being pregnant and her future gave insight into the intimate, affective and material dimensions of life. My participants often described how their families were disappointed with them, how they themselves had planned for a different future, one where they would have “made it to 21”, been a glowing example to teenage girls, and were now embarrassed and scared. Many young women’s hopes hinged on finishing high school and finding stable employment after further studying. The journal excerpts throughout the chapters further bring attention to these insights, especially when considering the expectations placed on young women to be “good” and virtuous. The ethical dilemmas faced by the women, the burden of finding out one was pregnant, and the shattering of “planned” futures were framed within a discourse of gendered morality and social mobility.

Sitting with the knowledge of pregnancy compounds time when those moments are weighted with future thinking and the fading of previously “straight” planned futures. Meshe continued her account by describing how she had been “terrified” to tell her mother after her pregnancy test was positive, for the fear of being kicked out of her home. However, unlike many other women to whom I spoke (and see also Mkhwanazi, 2004; 2010; 2014 on generational expectations), her mother told her there is *“no shame, it lies at everyone’s door, nothing to be ashamed of”*. Meshe lived with her mother, her two siblings, and her grandmother. Despite the support from her mother, Meshe’s grandmother after knowing she was pregnant was not talking to her, she said *“my grandmother is still cross with me. She doesn’t give me food, nothing, she doesn’t want to talk to me”*.

Withholding care and support materially and emotionally was something that frequently came up as women discussed the consequences of telling family they were pregnant. For Meshe neglect and withholding of care was in the form of food, and speaking. Similarly, Danielle, and Sharnaleigh's fathers did not talk to them for some time after telling them they were pregnant. As their pregnancies unfolded, they began opening conversation again in small gestures of greetings and small talk. Danielle explained that after her father walked out of the room aggressively telling her she should have an abortion, and then refused to talk to her for several months, he started greeting her slowly and started speaking to her when she went for the ultrasound. As pregnancies unfolded toward the 20 week ultrasound, small gestures of speech and silence, care and neglect materialised between pregnant women and their families. These material and social consequences call forth attention to the punishments young women face when revealing their pregnancies to their families (see Mkhwanazi, 2004; 2010; 2014).

## **Punishment**

“Human strivings for belonging, I contend, are articulated in particularly poignant ways in the realm of pregnancy and childbearing, where new individuals are brought into being... and the fundamental sociality of human existence is made manifest... the dependencies and vulnerabilities that characterise human existence as such often stand out with particular clarity” (Gammeloft: 2014, 10).

### On “not making it to 21”

Social tense frames and bounds a temporality of reproduction. The “right time” both to become pregnant and to come in to the clinic are socially constructed around expectations of knowledge and morality. Women are expected to know and control their sexual and reproductive bodies in the matter that fashions a “good woman” and a “good mother”. The socially accepted time to become pregnant was after their 21<sup>st</sup> birthday, an occasion marked by elaborate celebrations with friends, family and the community, at which the woman wears a white dress. 21 is the age women are expected to “make it to” without becoming pregnant. The event is premised on certain ideas about purity, and virginity, as well as influenced by neoliberal notions of planning one's life and future around goals, and aspiring to social and economic mobility and grounded in ideals about decency and respectability (*ordentlikeid*). Respondents described the linear path to “a better life and future” as entailing finishing school, getting a job, getting married, and not being pregnant before 21. This was acutely felt by those who “did not make it to 21”.

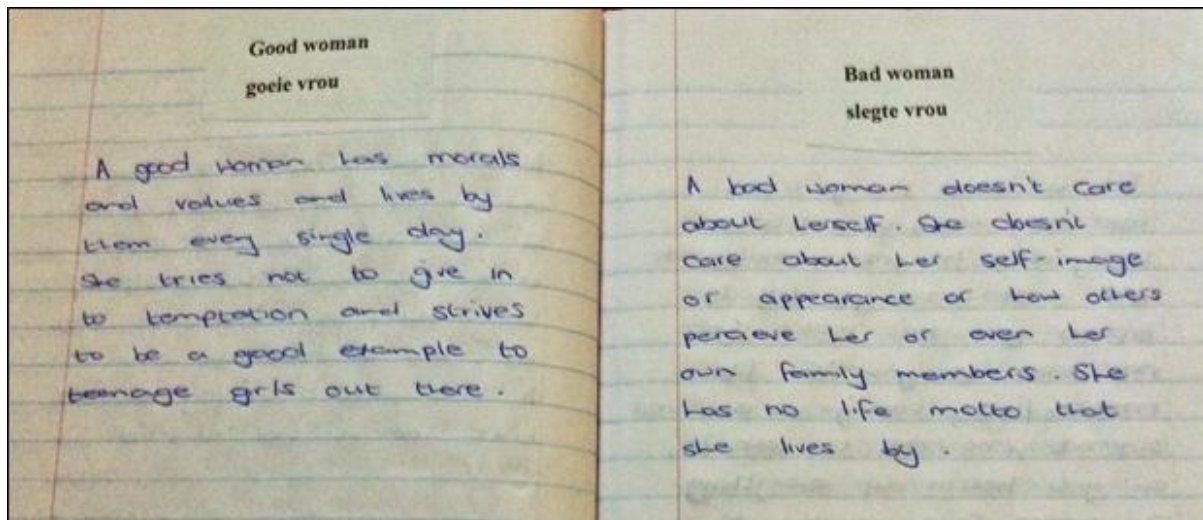


Image 21. Stacey's Journal describing "good" and "bad" woman attributes

*I met Stacey during her first booking at the clinic. She was speaking to the nurse during history taking. The nurse, new to history taking and antenatal care, had enquired about where she was living. Stacey, a gentle faced, calm young woman with her hair tied back tight and her hands in her lap, told the nurse that her grandparents had "kicked her out". The nurse sternly questioned if she had returned to their house to "apologise". Stacey, with a slight frown replied that she was "not ready". The nurse replied with a sharp: "you're not ready?! They have a right to be angry... they are disappointed... they looked after you and had dreams and aspirations!". Stacey looked down and remained silent. Later, when speaking to me alone, I enquired how she felt about the nurse comment. She responded by describing how unfair it was and how angry she was with the nurse and her grandmother.*

Stacey was 20 years old, and 17 weeks pregnant during that first visit. In recalling when she knew she was pregnant, Stacey spoke of how she had found out when she was 2 months along. Stacey had known about her pregnancy at 8 weeks, but had booked at the clinic at 17 weeks because she was navigating the social relations and consequences of telling her family she was pregnant. Shocked and upset at finding out she was pregnant, she went to her boyfriend to tell him, "I was really surprised. I was so scared, I took the taxi immediately to my boyfriend and was crying because I didn't know what to do". She explained more about finding out she was pregnant, with a recall that was wrapped in her browbeaten tone as she continued: "I was surprised, because I'm being very cautious, because next year is my 21<sup>st</sup> and I wanted my grandparents to be proud of me". Stacey lived with her grandparents because her mother had passed away and her dad did not "have anything to do with" her. Her grandparents as well as her boyfriend's parents had said that they were "disappointed" in her and them.

Stacey was shamed by her grandmother, had her emotional and material support taken from her as she was *kicked out* of her grandparents' house and her phone was taken away. She had no other choice but to stay with her boyfriend in his parents' house. Stacey said that her grandmother who had already begun "*planning*" her 21<sup>st</sup> was "*disappointed*" and "*embarrassed*" that Stacey had become pregnant (see Mkhwanazi 2004; 2010; 2014). Her boyfriend was 21 and still studying engineering and living with his parents in Sea Winds. Sea Winds was less volatile than her Lotus River home, which was wracked by gang violence, yet Stacey could not consider it "home" for her even though she was to live there with her boyfriend. It was not only her boyfriend who had taken up further education, Stacey had completed matric and tried to get into UCT but was not accepted which "broke her heart".

Stacey explained that 21<sup>st</sup> birthdays are attached to notions of virginity for young women:

*"We already started planning my 21<sup>st</sup>. They wanted me to wear a white dress and do the whole ball thing. I didn't want one... I'm not a virgin ... I think it is also to do with embarrassment because you see younger girls around you or your friends who don't make it to their 21<sup>st</sup>, and you don't want that for yourself, you want to be able to brag and say "no, I made it to my 21<sup>st</sup>,"; it's something like that, it's like really huge. So when you don't make it to 21, it's embarrassing"*

The word "disappointment" cropped up throughout clinic consultations with women 21 and under, and throughout the young women's explanations of family relations and networks being disrupted after making their pregnancy public. Naming sets in motion a set of consequences and social relations as the naming constellates people, concerns, emotions, debates and outcomes. As participants described it during interviews, informal conversations, and in the journal method, "disappointment" arises from failures of "responsibility". These were core terms in describing the social expectations placed on young women.

For Stacey, the meaning of the word "responsibility" within the contexts of her home and clinic were illuminated in her journal:

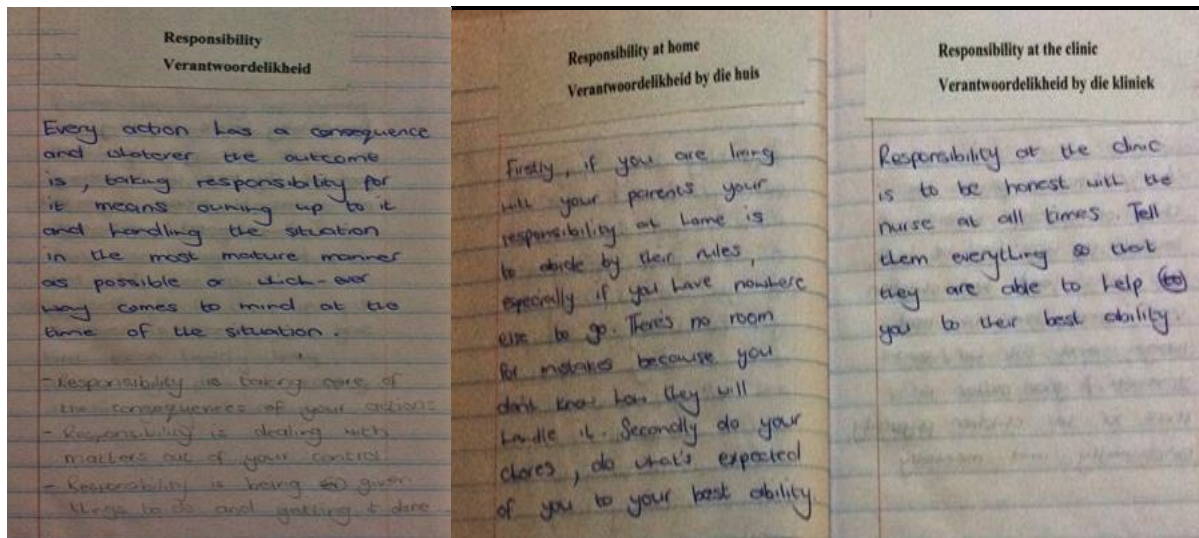


Image 22: Failure of responsibility as seen from Stacey's journal exert emphasis how precarious relations are and living situations where "there's no room for mistake".

The next time I met Stacey to catch-up was when she had returned to the clinic at 23 weeks for a check-up. She had come into the labour recovery ward to find me while I spoke to women waiting alone in the quiet room pre- or post- labour. She was showing slightly with a bump on her slender body, she had also dyed her hair almost platinum blonde. Smiling, she explained that she was feeling a little calmer about the situation with her grandparents and that she would attempt to go and speak to her grandmother soon and "apologise", even though she maintained that her grandmother had been wrong for evicting her. She was going to try and make amends before the birth to "lift that weight" off her shoulders" (see Mkhwanazi, 2004; 2010; 2014). As she was there at 23 weeks and had expressed excitement about feeling the baby kicking, I had asked if she had gotten the 20 week ultrasound scan offered by the clinic and she told me that she had not because they could not book anymore.

Past anthropological research in the area of pregnancy has focus on the public and private secret of pregnancy and the hiding of pregnancies by teenage girls (Mkhwanazi, 2010: 353). As Mkhwanazi observed in her study on teenage pregnancy, most teenage women kept their pregnancy a secret until they could no longer hide it and it became public knowledge, after which the genitor was named and "damages" collected (2010, 353). While my participants' ages ranged from 18-42 (none were minors), there was a pattern of keeping pregnancies to oneself for some women whose pregnancies were labelled as "unplanned" and "unwanted" while they made weighty decisions about abortion, adoption, or the right time to speak to their families and

partners. For my participants this period was more to do with “coming to know” rather than “keeping secret”, and the moral weighting of “sitting with” pregnancies and “speaking” to parents and family members. This sharing of information was a key stage in accepting pregnancies and seeking antenatal care. Some women explained they needed support from their family (emotional support and guidance on what to do during pregnancy) before going to the clinic, as Meshe put it, she needed her mother so she knows what to do. Once information about the pregnancy was public, most women did not go for an abortion. Making information public, and I argue “speaking about” pregnancy opens up social tensions and dilemmas for pregnant women as their pregnancies are no longer private. There are social consequences of revealing being pregnant. As Strathern writes in relation to negotiations of knowledge circulation, “explicitness has a displacement effect” (in Ginsburg and Rapp, 1995: 354). While Strathern is referring to the circulation of knowledge and knowledge creation in reproductive and scientific knowledge, I apply her ideas about explicitness to understanding how speaking and explicit disclosure of information can have negative social consequences. As moral expectations are placed on women, displacement occurs when they did not reach those planned expectations in reality. Previously held assumptions are displaced, women face stigma, especially if they are young, not in a steady relationship. For some, this was accompanied by physical displacement as they were removed from spaces of emotional, familial, and material support.

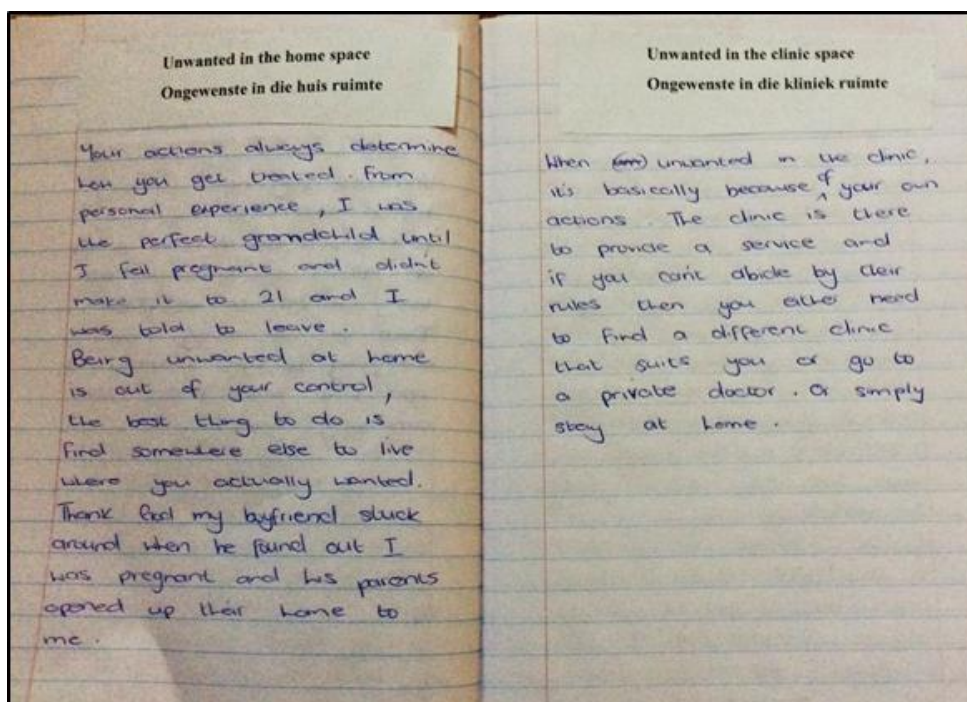


Image 23. Stacey's journal excerpt on the how the label “unwanted” settles in different spaces for her. “

Stacey's comment in the journal above, "Your actions always determine how you get treated" resonates with the moral expectations placed on women to make it to 21. If not, there will be consequences that can involve forms of neglect and punishment. The small actions that make up forms of punishment faced by young pregnant women, was brought forth by Lecal, a lively 20 year old I met during her first clinic visit. She thought she might be about 3 months pregnant but did not know. Lecal was living with her aunt (her father's sister) and had been since she was 3 years old because her father took her away from her mother. She said she had "never met" her mother "properly" due to "alcoholism". She commented that her mother had been in her life for the *"first 2 years and in that space I was neglected due to my mother's drinking"*. This left an effect on the way she now thinks what "environment" she will create for her own child. She ended up living with her aunt because her father *"became an alcoholic because it was too stressful to care for a child"*. Lecal had finished grade 10 and was working at a crèche. She paid half of her salary to her father "because he doesn't have anything". She was concerned about working next year as the crèche owner might not continue running the crèche. Lecal was even more worried with that news because she was now pregnant and concerned that women do not get hired when they are pregnant (a reoccurring concern amongst my participants), *"but that's life"* she sighed. Lecal found out she was pregnant, after waking up with a headache from a previous night of "drinking and smoking". She said that she usually did not get headaches after a "little amount of alcohol". She decided to take a pregnancy test - two of them, and explained how she, *"watched them turn purple and then it faded and then 2 lines... then another and shit!"*. She was in such shock and in tears that she thought she could not be pregnant because she did not have any "symptoms" and the *"tests were playing games"* with her. She repeatedly stated that common religious phrasing of keeping the pregnancy although indicating a weight to her thoughts on 'responsibility' because *"the child didn't ask to be here... so it's a huge responsibility. It's God's gift"*. Lecal had first told her boyfriend, who was 21 and was going to support her with the baby with his sporadic work as a welder with his father. Relieved at her boyfriend's support, Lecal told her aunt with whom she lived. Her aunt was "disappointed" in her, and had told her she should seek an abortion. A Catholic, Lecal was opposed to abortion, a view shared by others in my research like Danielle who had stated that abortion was *"not normal"*. Lecal further described her anxiety that this might be her only pregnancy. In so doing she alerted me to women's fears about their future fertility. She explained that to her aunt. The aunt then demanded that Lecal move out of her house. Lecal upset but strong willed, stayed in the house, and maintained her "rights" as she put it, to remain until she could find other accommodation. The only option was for her and her boyfriend to find an affordable place and move in together. In feeling the great failing of meeting generational

expectations, and the pressing concerns about finances and housing, Lecal wondered if it would have been better to have “*kept the pregnancy a secret*” from her aunt until after her 21<sup>st</sup> birthday which was in three weeks’ time – “*the woman who raised me and now kicked me out*”. Her aunt had been planning her 21<sup>st</sup> and had arranged a “tiara” and for her to “wear a white dress”, but she continued to think that if she had waited till after her 21<sup>st</sup> party “*she would have wasted more on me*”.

The situation at home with the aunt had become unbearable as the aunt’s disappointment manifested in cruel way towards Lecal. “*It’s not nice aunty vermaak [making fun of] you*”, Lecal spoke of the verbal scathing she endured in the punishing words that ‘the child would be born disabled’ if she kept it and telling the boyfriend ‘the child was not his’. It was not only the verbal abuse that Lecal endured, but also small punishing acts as she described how she got on with her household chores of “washing, cleaning and getting food”, but that her aunt had begun making things hard for her. For instance, she described how her aunt had made her take her clothes out of the washing machine and wash them herself by hand, and had taken the washing power away from her. The washing machine as a household item was not to be taken-for-granted, as it greatly eased daily work of maintaining a household. Lecal had to come home every day after “working 13 hours a day” because she has picked up extra shifts to get as much money in as possible, and then had to do extra chores. To add to her loss of support from her aunt, Lecal’s “best friend” had stopped talking to her after she told her she was pregnant. In speaking and “coming out” with her pregnancy, Lecal experienced the social consequences of being kicked out, treated “badly”, and communications and relations cut off - the cruel responses of stigma in operation. While navigating social relations, working 13 hours a day, tending to the burdening household chores, sending money to her father, and figuring out where she would live and get the money for a new place to stay when her aunt kicks her out, she had additionally to think of the pregnancy and booking “early” (something she understood as happening at 20 weeks not the recommended 12 weeks).

In speaking to me Lecal emphasised the experiences of facing stigma, rejection and punishment as intergenerational expectations and tensions around pregnancy arose. There are high expectations placed on these young women to not become pregnant, especially given generational reproductive histories in South Africa, and exemplified in Meshe’s mother’s understanding statement that “*it lies at everyone’s door*”. Amoateng et al. (2007: 99) show that some forty-four per cent of South African women bear a first child before marriage... approximately thirty per cent of women bore their first child before the age of twenty (Statistics SA, 2005: 76; Ross, 2010: 215) (see **appendix 3**). Nevertheless, harsh scolding, and punishment surround

unexpected pregnancies, as families' "disappointment" materialised in forms of punishment and neglect.

My participants' punishing experiences show stigma in operation. Work on stigma within medical anthropology, specifically disability, HIV, mental health, and tuberculosis studies reveal the social implications for stigmatization (Ablon, 2002; Goffman, 1963; Henderson, 2011; Shuttleworth, 2004; Abney, 2001). Goffman (1963) defines stigma as a "discrediting attribute, an undesired differentness from social expectations" – a 'differentness' experienced when not 'making it to 21' (in Shuttleworth, 2004: 146). Stigma produces social marginality and alienation as it carries negative connotations, where language and labels are central to how stigma is constructed and perpetuated (Abney, 2011) The sociocultural construction of pregnancy, and gendered expectations of timing for my participants were foregrounded when expectations were not met, followed with the associated labels of "bad woman". Among my participants, Stacey and Lacial felt the harshest punishments for being pregnant at the "wrong age", their experiences resonate with the process of stigmatization as argued by Link and Phelan that "stigma is present when elements of labelling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them" (2001: 377 cited in Heijnders and Van Der Meij 2006:1; Abney, 2011).

In navigating the tense and punishing relations during the first few months, many participants had accepted their pregnancies and sought care outside of strained relations by the time they went for their 20 week ultrasound. The ultrasound was a site where women were also able to repair relations as the photographs and gendering of the foetus made repair and social formation possible.

### **Slow repair**

*In speaking to Stacey a few months after I had seen her when she 23 weeks pregnant, she told me she had gotten a private ultrasound scan from a doctor in town near the train station as she could not get one at Retreat. Her "aunt" had paid for the scan, which cost R550. Unlike the scan from Retreat where patients take their own photos from their phones, Stacey received a photograph of her son that her boyfriend's grandma put on her fridge. The image stayed there proudly pressed against the fridge, so she took a picture of it from her cell phone, an image which she later showed her own grandmother after she returned to "apologise" and make amends as she had spoken about doing. The grandmother had accepted her apology and they had reconciled. Stacey had gone to make*

*amends with or without the image, in having the image her pregnancy was made real for her grandmother as she commented on how “he’s going to have his daddy’s head”.*



*Image 24: Right: The examining rooms and ultrasound room. Left: The women along the left hand wall are waiting for the ultrasound.*

### The 20 week ultrasound

*The ultrasounds were conducted in a small examination room about 2 to 3 metres by 2 metres, with a door leading to the waiting room area which women were called from, and a curtain closing the room off from the other side which formed the back section divided into 4 examining rooms. The curtain was too light a material and let the light in from the window which affected the visibility of the screen. The doctor would come in with her own dark material, usually shawls or tie-dyed sarong material which she would clip onto the curtain with her wooden washing line pegs. Two feet away against the wall was the bed, with the ultrasound monitor placed in line with the pillow and woman’s head, and tilted toward the bed. The doctor would sit on the bed next to the women, and look at the screen. The accompanying partners would stand behind the doctor, or sit behind her at the foot of the bed. The doctor called women in for roughly 5 minutes at a time, and as described earlier, the clients were told to wait until she told them to take a picture of the screen with their cell phones, and emphasised she could not always see the sex nor was it 100% certain when she did see it. Despite this explanation to everyone waiting, partners and*

*women still asked about the sex of the foetus immediately when in the examining room with the ultrasound underway.*

The 20 week ultrasound was a poignant stage in pregnancy for my participants. It was observed as a ritual for most women who booked for it as it was a space where the pregnancy was fully acknowledged and news of it shared, time was marked, a due date set, and gendering the foetus occurred. I argue that participants used the ultrasound imagery and cell phone picture technology to extend to the foetus into their social worlds and form connections, as they showed and spoke of the sex of the baby to other people through pictures taken from cell phones of the ultrasound. The sex of the baby was the main focus for the women, their partners and family in the 20 week ultrasound, and the point where excitement was expressed most vividly. The foetus was not only personified, but also assigned a place in the world, a material gendered imagining.

I argue at this stage that the body of the foetus and reductive notions of biological sex conflated with gender were bounded and reproduced under heteronormative discourses of belonging, and material imaginings. Women (and their families) could start to “*prepare*” by buying gendered colour “clothes”, and a “chest of drawers”, as well as “prepare” for labour, and for some couples, to “prepare” to move in together. I claim this visual technological site to be a site of primary interpellation into gendered subject making, where life is confirmed visibly in a gendered way (Butler and Athanasiou, 2013; Foucault, 1976). A site where visual technology allowed women and partners to assign gender and material place for the foetus in the world, and form connections to other family members. For Danielle, Stacey, Sharnaleigh, and the other women dealing with sitting with their pregnancies, or forms of punishment and family rifts, the 20 week scan was a marker in their pregnancy which was deeply significant in imagining a material placement of their child in the world, and a material relationship to family and friends. The visual technology and the evidence of the scan (photographs on cell phones), of the sex (now assigned a gender), of the belly size – of the presence – was used to reimagine relationships with the rift family.

During observations on the 20 week ultrasound, most women and their accompanying partner could not wait to know what the sex was, as seen in a previous chapter. The anticipation to know the foetus’s sex was often built up in conversation with partners and family members as they engaged in telling the women what sex they thought, felt (size of stomach and shape), sensed, or dreamt it was. These experiences and embodied and relational engagements with sex-ing the foetus aligns with what Loblay explains, “bodily senses are implicated in the build-up of

expectation about sex determination” (2009: 190). The reactions to knowing the sex were often the only physical and verbal extroverted reactions in the scan results, often big smiles, laughs, loud praising religious statements, and gestures such as air fist pumps and claps. Participants could not wait to tell their family what the foetus’s sex was, and was the main point of conversation in the waiting room after the ultrasound as people wanted to know *“what it was”* as they spoke to one another. Qudsiyya reflecting back to her ultrasound and laughing at the thought that she was *“more excited about the sex than anything else... I actually forgot to think that ‘is my baby healthy!’”*. This moment of seeing the foetus was poignant for Qudsiyya because after *“meeting”* her baby in the ultrasound she explained, *“I look at things differently now...I will look at certain clothes, look at certain things that was for that sex, instead of ... neutral clothes”*. She also spoke about how excited her family was, especially her mother in-law who was *“waiting to buy clothes”*. Often women would tell me how excited their parents and in-laws were to start buying clothes after the scan results.

The excitement to tell the family was often formed in capturing the ultrasound image on the accompanying partner’s cell phone. In one case with Sharnaleigh who explained before her scan that she was excited to have the ultrasound because I *“just want to know what the baby is”* so she can *“tell people because they want to buy stuff too”*. Sharnaleigh was at the scan with her boyfriend at Mowbray, as I waited outside the room for them to finish the scan, he came sprinting out and asked for my cell phone as his battery had died (the always ill-fated timing of batteries dying!). He ran back to the room and took many pictures which I later sent to his cell phone via WhatsApp so they could show the family.



*Image 25: Sharnaleigh’s ultrasound.*

Medically, the 20 week scan is to check the growth of the foetus and determine if the foetus is biologically well through growth measurements and finding the heartbeat - sex determination is incidental. Participants using the ultrasound technology were creating social relations while doctors were checking the visual image for biological well-being. Moments where medical students observed the ultrasounds shed light on the medicalised use of the ultrasound and what the doctor was “seeing” as opposed to what was told to patients and what they wanted to “see”:

During observations of the ultrasounds one morning, three 3<sup>rd</sup> year medical students came into the ultrasound room to watch the doctor and learn how to read the ultrasound machine. The doctor gave them a more medicalised explanation as she used biomedical terminology for what she was looking for when she said “*heartbeat, head, abdomen, and leg*” and checking the placenta to the clients:

*“This scan is for foetal growth not abnormalities. I check: bpd, head circumference, abdominal circumference, and leg length”. The doctor went on with the scan and spoke to the medical students at each phase: “BPD<sup>35</sup>, outer skull to inner skull... you have to see that to know you’re in the right place. Head circumference, move from outer skull to outer skull \*she rolled the machine mouse so the cursor clicked on the outer skull, a circular shaped object on the screen, and moved the cursor through the inner skull centre and to the opposite side of the outer skull\*... this is working with a moving target. The heart... what you want to get is the 4 chamber view of the heart. It is hard to see sometimes... the stomach, ribs vertebrae, portal vein you can’t always see.” In the 3<sup>rd</sup> trimester check fluid, amniotic fluid test, at these 20 week scans it is just an estimate, you eyeball it, and it should be pockets of fluid to see. The placental position is important to see, not easy test even for guys who know what they’re doing”. She then showed them on the screen the placenta and cervix and said “the placenta can’t be over the cervix otherwise head can’t come out. If it is low then you redo scan at 32 weeks”.*

Sex was given by the doctor through the reading of the ultrasound for anatomical markers:

*In moving onto determining the sex, the doctor moved the cursor around and explained what she saw between the foetus’ legs: “a hamburger... 1,2,3, stripes therefore it’s a girl. But not always 100%. So you check from one side to the other and also be sure there are no twins and check for fluid and movements”. For a male foetus she said they could see “the scrotum and penis”.*

In speaking to the clients, the doctor did not explain the medical/technological/visual markers of “three stripes” she saw when the foetus was sexed as female, she would say “it’s a girl” “a baby girl”, and if asked how she knew, she would say, “there’s no penis”. When it was determined as being sexed a boy, she would often point to the bump between the foetus’ legs and say “it’s the scrotum” or “a penis”. In translating the visual sexed image to the pregnant women, the foetus was personified and the marker of sex determination was constructed by the presence or absence of a penis. For the pregnant women, gender materialised through acts of buying colour coded clothes

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<sup>35</sup> Biparietal Diameter (BPD) is the widest transverse diameter of the fetal head

and imagining moments with the future “baby girl/boy” as someone to “*play soccer with his dad*”, “*a sister for my daughter to dress up with*”.

In research on new reproductive technologies, and visual imaging such as ultrasounds, Denbow claims that, “fetal imagery has been used to promote bonding between the foetus and the public” (2015:108). The excitement about sex determination and taking pictures and news to family and friends materialises the foetus and technology is used to extend the foetus’ still forming body into the social. In explaining the use of technology Georges (1996) writes about “how the apparatus embodies and helps construct specific kinds of social, cognitive, and expressive order in the world” (Georges, 1996: 158; Pfaffenberger 1992; Winner 1985). Georges is offering a perspective that views technology as charged with a “valence” (1996: 158; Bush, 1983:155). This “valence” draws “actors toward specific patterns of use”, that in turn “reinforce broader cultural values and political agendas” (Georges, 1996: 158). The ultrasound technology is used by participants as a ritual that has the effect of personifying and extending the foetus into the social and forming connections that reinforce heteronormative material binaries through gendered colour coding; while the doctors use the technology to check biological health, measure growth, and check the placenta is not covering the cervix. Danielle explained the social use of the scan during her second visit to the clinic saying that she “*will be more excited*” about the pregnancy when she sees the “*scan*”, because she wanted to know the sex of the baby so she could “*buy clothes*”. Danielle had her 20 week scan at Mowbray, she was elated with seeing the image on screen and in finding out it was a boy, later mentioning it was also interesting to see the rest of the features of the healthy foetus. On hearing it was a boy she and her boyfriend went and bought a “*dresser, crib, and blue clothes*”. Often remarks such as “*I can go buy blue/pink now*”; “*now I’ll buy blue*” were spoken by many participants upon finding of the sex, showed the colour coded ways gender materialised from a sexed foetal image, and how drawers were aids in a placement of the child to be in their house and worlds.



*Image 26: Danielle chest of drawers for her son Cairo.*

Chest of drawers were a significant symbol of home-making for couples moving in together after the birth. Quite literally gendering clothing with colour and materially placing it within a dresser in the home. When foetal sex could not be determined, the women and their partners were, as we saw earlier in the thesis, explicit in their disappointment at not being able to buy gendered clothes and tell family. One woman expecting a girl sighed as she was disappointed to not find out: *“I can’t go buy pink now”* she lamented. The male partners at times were the ones to want to know for certain as they had planned celebrations with male friends if it was a boy, and friends and family were explained to have been waiting the news.

While buying clothes had a utilitarian purpose primary for some women who described themselves as *“liking to be prepared”*, it was mostly a point of connecting to family members and friends, generating material resources for the baby, and symbolically attaching gender through material colour. The gendered colours were specific: girls were to be dressed in pink and boys in blue. White was *“too plain”*, and people generally did not like green and yellow. One woman described them as *“ugly colours”*, and another being *“I don’t want to buy vomit colours, yellow, and green”*. Judith Butler (1990:10), asking ‘how and where does the construction of gender take place?’ answers that: *“on some accounts, the notion that gender is constructed suggests a certain determinism of gender meanings inscribed on anatomically differentiated bodies”*. From my observations, ultrasounds served this inscription process. Butler suggests that *“if the body is a situation, there is no recourse to a body that has not always already been interpreted by cultural meanings; hence sex, could not qualify as a prediscursive anatomical facticity... sex, by definition, will be shown to have been gender all along”* (1990:10). From my research it seems

that the foetal body and particularly its sex was constructed in three ways: through the skilled medical practice of reading visual lines and bulges; in the absence of a penis or scrotum (women are the sex which is not); and in the making of sex synonymous with gender for and by patients. In considering the social use of the visual images, gendering of the foetus can be seen as “gender is a relation”/ “a relation to another” (Butler, 1990: 13).

In analysing the social processes that come to bear on how pregnancy was imagined and produced, colour was significant to my participants as they materialised the pregnancy as a social fact that implicated others besides the pregnant woman and foetus. I suggest that the symbolic work of the colour shows the social ways life gets produced. Colour and consumption do the symbolic work of the political economy of gender. In so-doing, the child is socially constituted (Taylor, Layne and Wozniack, 2004; Clarke, 2000; Layne, 1999; Taylor, 2000). The ultrasound was a space to confirm life in a gendered way, through a material placement and connection to family members. A ritual activity to solidify the unborn child’s place in the social and material world, the ultrasound was part of a meaning making processes that involved symbolic colour associations, social connections, and placement (Taylor, Layne and Wozniack, 2004; Clarke, 2000; Layne, 1999; Taylor, 2000).

What was more intricately unfolding in the sexing, gendering and materialising was a visual bridge to connect to the social and family formations. Visualising the foetus has a health-related objective for biomedicine, but it also achieves a social objective of connecting to family members and friends, promoting sharing and enabling bonding. The foetus was gendered and personified, and through a visual image of this, the relatives are introduced to the new social formation in which they are now a part of as grandmothers, grandfathers, uncles, aunts, cousins and so on. The relations to new social formations that the visual technology enabled through a series of materialisations was important for some of the young women who were previously being punished or were suffering through family tensions, as they were able to reconnect, repair, and re-form bonds with rift family. For example, Stacey took the image back to her grandmother with an apology and was able to reinstate her relationship with her grandmother. Danielle and Sharnaleigh’s fathers begun speaking to them again after 4 months once they had seen the scans; Sharnaleigh’s father accepted her relationship to the ‘older’ boyfriend; clothes and chest of drawers were bought, or handed down from family members and placed in bedrooms. As relationships were repaired, the technology and imagery also allowed for pregnant women to legitimate their new status as ‘mother’ and legitimate a couple living together. This highlights how the visual materialises gender and placement of the foetus as a cell phone image of the

ultrasound moves through the world forming gendered boundaries of material colour, new social formations and connections, and material and social belonging.

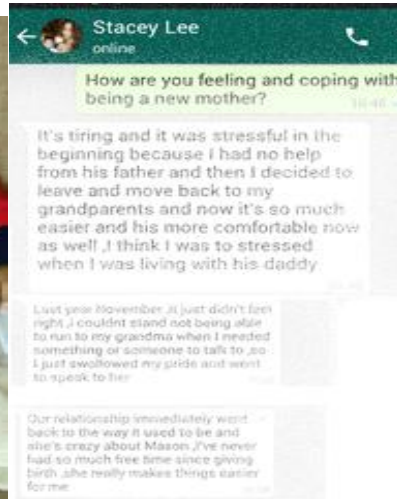
### **Conclusion: technology and the social work of repair**

I have drawn on Rapp's idea of women as 'moral pioneers' navigating the biological, social and moral terrain of life as it unfolds around key social moments. The linear approach to pregnancy and antenatal care assumed in the chronological ordering of foetal development, and the policies and practices put in place as a result, neglects the social processes that surround pregnancies. The biomedical temporal structure that functions as the norm of antenatal care and the call for "early" booking, neglects the enmeshment of the biosocial, where coming to the clinic involves an unfolding process of negotiating and navigating social worlds. In assessing this, I have shown how women bear the burden of 'sitting with' decisions about life, speaking and endure speech's consequences in the forms of harsh punishments and stigma, and finally engage in a slow repair with the use of visual technology produced through the twenty week scan. As pregnancy unfolds around these key social moments, families are re-engaged, new relations imagined, and futures crafted.

Writing on art and the naked body, Elizabeth Grosz (in Hooke and Fuchs, 2013: 124) states that "a body reproduces itself not only biologically but through the rigors of its practice" she then refers to art as re-presenting the body. Grosz uses Nietzsche's view on art and science as the very exploration and use of the body, to challenge and rethink assumptions about the body (in art and science). Drawing on her ideas, I suggest that technology and ultrasounds re-present the body, biology, and reproduction, as assumptions about 'normal' are produced according to diagnostic criteria, medical authority and gendering the foetus. For the participants the excitement was in the presentation of biological sex and the assigning of a gender that allowed an unfolding of the social process of 'connecting' people, and 'preparation' for a gendered 'placement' in the world. The representation of the sexed foetus not only makes visible the product of biological reproduction, but the product of discourse and 'cultural' reproduction. Normalisation was premised on the visual of the sexed foetus in the ultrasound. I argue the visualisation process allows the foetus' body to be presented in the social world as gendered bodily boundaries emerge through technological imagery and enter the social in a process of becoming. In these instances and excitement over assigning gender and placement in the world – the body is re-bounded and re-produced under heteronormative discourse of belonging. It was a stage that not only visually materialised the foetus and its place within the women's bodies, but

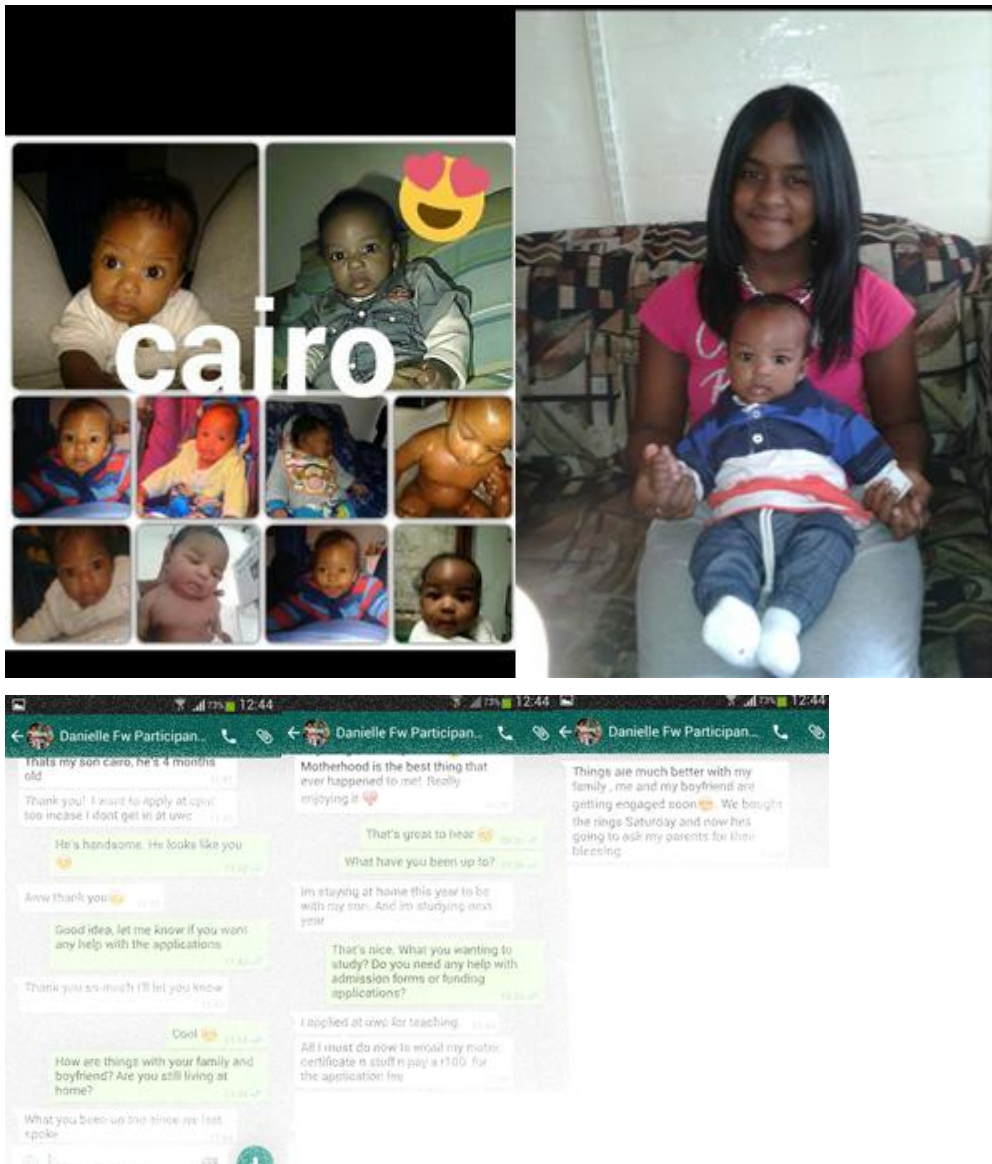
also was a site of primary gender interpellation as life was confirmed in a gendered way, and formed social connections through gendered materiality and 'family' place-making with gifts of colour coded clothes, and specific desires for 'chest of drawers' for the child to be. The life of the foetus was by this stage assured as there was acceptance of the pregnancy, and talk of abortion and adoption had resolved as families repaired relations. The 20 week ultrasound became a site through which women could start to rematerialize relationships as relations are solidified or repaired.

After birth: Stacey, Danielle, and Sharnaleigh:



*Image 27*

Stacey and Mason May 2016. Stacey gave birth on the 14 March 2016. She said the birth went fast, but she struggled with the contractions. She called her son Mason. Stacey, after her 20 week mark and ultrasound time had decided to mend relation with her grandmother and she explained over whatsapp messages that after apologising their relationship went back to how it was before she was pregnant. Stacey's first few weeks with her newborn had been "tiring" and "stressful" because she was not getting any help from her boyfriend despite living with him and his family. Stacey decided to move back in with her grandparents and is much happier and comfortable, and her gran was helping with Mason. Stacey will be reapplying to different universities with my help to try get accepted for a psychology or business management degree in 2017, or find employment.



*Image 28*

Danielle and Cairo May 2016. C-section in January, she was due to deliver on the 24<sup>th</sup> of December 2015. When I messaged at the end of December she explained that she was still “heavily pregnant” in the middle of the December heat wave with temperatures up to 38 degrees Celsius. By the end of May Danielle expressed the joy of new motherhood, and how relations with her family and boyfriend were “much better”. She was about to get engaged and had applied to UWC to study a degree in teaching in 2017.



*Image 29*

Sharnaleigh and Jake May 2016. She had moved in with her boyfriend Dylan and they were both enjoying parenting. He was trying to spend as much time with them both before and after work every day.

## Chapter Six

### Conclusion

A rationalist model that underpins state health policy anticipates that women operate as autonomous agents who will ‘take responsibility’ for the care of their bodies and fetuses. This model anticipates that women will firstly, know when they are pregnant, and secondly book at the antenatal clinic “early” (12-20 weeks gestation) in line with policy. While the state’s effort to secure maternal and foetal well-being is laudable, women are blamed if they do not report ‘on time’ for ante-natal care. In each chapter I aimed to describe a temporality that is deeply social. I did so by moving from the biomedical to the social, from a technical mode that frames antenatal care to the relational and experiential modes of my participants. I moved from the political economic, historic and environmental, the person and bodily, the life-cycle and history of experience, to the ways technology works to social repair. In resting on the experiential, social and relational in each chapter, I have shown how pregnancies are materialised as social entities. The individual is enmeshed in complex relations over time. In each chapter, the biomedical framing is juxtaposed with the experiential – and shows how pregnant women’s relationships with the clinic and biomedicine sit askance to the biomedical framing of pregnancy.

Access to ante-natal care and indeed even to the space of the clinic is implicated in the wider political economy and the historical production of a geography of violence. As policy, strategy, biomedical and clinical protocols and clinic interactions shape the making of a biomedical subject (Clarke et al., 2003; Davis-Floyd and Sargent, 1997; Jordan, 1997; Inhorn, 2007), what goes uncaptured in the statistical capturing of “lateness” in spaces of violence are the ways that local worlds are shaped, including by violence. For pregnant women, arriving “on time” and maintaining clinic schedules are implicated in subjective experiences of layers of ‘violence’, in the production of space and in the relation between violence and sociality. As shown in chapter one, factors of late arrival are perceived in public health studies as “cultural” factors that create barriers for successful implementation of antenatal care programmes that require “early” booking. In so far as economic factors are considered, they are encapsulated in the descriptors “lack of transport” and “lack of access”. I argue that lateness is not “cultural” and should not be individuated through laying the blame on transport; rather, it is a combination of factors that are underpinned by political economy. I contextualised lateness within a temporality of the everyday,

where gang and other violence, structural inequality, and financial precarity shape local worlds. Povinelli offers the frames of ‘endurance’ and ‘eventfulness’ (2011), as modes through which to think about the layering of violence in everyday lives. She suggests that everyday ‘quasi-events’, by which she means events that “never quite achieve the status of having occurred or taken place”, do not rise to the surface of what can be seen and accounted for in political evaluations of Aboriginal life. Quasi-events are not aggregated, and thus apprehended, and evaluated - they do not reach a status of eventfulness that is to be grasped as an ethical and political demand in the same way that crises and catastrophes receive response (Povinelli, 2011: 13). I use her ideas to think about how the statistical capturing of “lateness” – those 40.2% of pregnant women who arrive late for antenatal care – misrecognises the composition of the subject who reports for care. The everyday experiences and quasi-events, that are seen as the attenuated background conditions of life that do not enter typical accounts of causality and life-making, can be brought forward by focusing on the present durative (Povinelli, 2011: 153; Das, 1997; 2007). The benefit of critically viewing these events and affects as everyday, enclosed around the durative, allows one to ask as Das (1997:68) asks, what this does to the self, community, and nation.

Biomedical models assume women “know” their bodies and count reproductive time in terms of menstrual cycles. The normalising discourse universalises reproductive experiences where menstrual experiences serve as the benchmark for how women are to count, know and survey their bodies, their intimate relationships, and their pregnancies. This way of thinking about temporality and counting were in tension with women’s actual experiences of their bodies. I have shown how women have differing experiences of menstrual cycles, and often report “not knowing” they were pregnant. This ‘not knowing’ was partly because of differing experiences menstrual cycles, differing experiences with contraception, and differing experiences with the assumed universal “signs” of pregnancy. I critically evaluated biomedicine’s “body proper”, arguing that what it is to have a reproductive body emerges in temporal and material complexities of contestations and tensions around what it is to “know” and count menstrual cycles (assumed a universal regular), and pay attention to commonly assumed “signs” of pregnancy and life-cycle.

In taking the social phenomenology of trust as a framework, I have shown how women’s prior experiences with medical institutions and with medical technologies, such as contraception, come to bear on lateness and shape when and why women seek antenatal care. In taking women’s

experiences of trust, distrust and scepticism seriously, I have shown that “lateness” is placed within the life-cycle, where trust in medical institutions and processes is unsettled through individual experience over time, as opposed to the biomedical model that individuates experience and assumes decisions are made *tabula rasa* for each pregnancy. The experiential enters the biomedical at an angle.

The linear approach to pregnancy and antenatal care assumed in the chronological ordering of foetal development, and the policies and practices put in place as a result, neglects the social processes that surround pregnancies. Pregnancy status does not just become a matter of “*arriving on time*” to the clinic - a recommendation that not only ignores the complexities of bodies, the question of how one knows one’s body, the social phenomenology of trust, but also the ways the pregnancy has a claim on the social, in which existing networks of obligation, responsibility and exchange constitute persons and relations that influence when and how women seek antenatal care. In ethnographically detailing the complexity of social belonging and bearing life, I have shown the poignancy of different stages in pregnancy for the women I spoke to. These are placed within a framework that highlights social claims to pregnancy and complicates linear experience of pregnancy and antenatal care. Timing to the clinic involves an unfolding process of negotiating and navigating social worlds. In assessing this, I have shown how women bear the burden of ‘sitting with’ decisions about life, speaking and enduring speech’s consequences in the forms of harsh punishments and stigma. I have also shown that the 20 week ultrasound is critical for women as they use the visual imagery to repair social relations, specifically with mothers and grandmothers. The scan, which comes too late to schedule abortions for unwanted pregnancies, offers opportunities to reconceptualise “unwanted” pregnancies as ‘gifts from God’. Here, foetal sex becomes a way to reopen ruptured conversations and relations, and repair an older generation’s disappointment with pregnancies that are ‘too early’ (i.e. before a woman turns 21). The 20 week scan (where gender and material placement occurs) seems to be the point at which antenatal care becomes important for pregnant women and families. Here, technology offers the potential to enable social repair. As pregnancy unfolds around these key social moments, families are re-engaged, new relations imagined, and futures crafted.

The individual is enmeshed in complex relations over time. The biomedical model individuates pregnancies and brackets recognition as “early” or “late”. I have offered a theory of ‘lateness’ that takes account of the everyday, in all its complexity and punctuated-ness. Antenatal care that is crafted through modes of surveillance and responsibilisation draws attention away from the local words, the everyday. By drawing on the experiential, I have offered an alternative view of lateness: a temporality of events and their placement that is relational and experiential. The

analysis offers a different way of assessing what is happening, and what is counted. Instead of thinking about pregnancy and response as an event that is set apart from the everyday, I considered how deeply social the experience of pregnancy is, noting how and where care and response are enmeshed in the everyday. I have shown the textures of everyday life from the political economy of the South Peninsula, to the relational experiences between partners, kin, and clinic staff. I have shown how pregnant bodies materialise within these contexts where precarity and violence are experienced daily. By focusing on pregnancy, the making of life, I have further been able to assess everyday life and the production of various subjectivities (biomedicalised and those embedded in everyday social worlds). The state's representation of 'lateness' misrecognises the composition of the subject who reports for care. The individual is the site of complex relations (to history, state, space, violence, institutions, intimate partnerships, kinship relations) and these shape how the experiential and relational come to bear on antenatal care attendance and access. In analysing how pregnant women enter antenatal care, one can view 'lateness' from an alternative perspective of a life-cycle, rather than the linear cause-and-effect biomedical model. Even though biomedicine and pregnant women have the best interests of subjects at heart, the biomedical model and the explanatory models and worlds inhabited by pregnant women with whom I worked seem to be askance to one another.

Differing experiences of and relationships to space, body, institution, history, kin, technology shape timing and access to antenatal care. In assessing time, I have taken Povinelli and Das's theorisation of quasi-events, endurance, and duration as key ideas. Doing so enabled me to look below the threshold of state awareness and moralistic evaluations of women's "late" attendance, and to examine the flow of everyday life in the present durative. Pregnancy and care seeking is experienced in relation to state, community, and self. The approach of event/quasi-event/endurance/and durative has enabled me to show the complex set of relations, both geopolitical, social and personal, that shape how, when, and with what effects bodily changes are recognised and attended to. Using this theoretical approach, and contesting governing institutions and the tenets that comprise the rationalist discourse of antenatal care, allows for a critical engagement with the embodied dimensions of subject formation.

## Reference List

- Ablon, J. 2002. The nature of stigma and medical conditions. *Epilepsy and Behaviour*, 3 (6).
- Abney, K. 2011. Whoever said a little 'dirt' doesn't hurt? Exploring Tuberculosis (TB)-related stigma in Khayelitsha, Cape Town. Unpublished Masters Thesis, Social Anthropology, UCT.
- Abrahams, N and Jewkes, R. 1998. "Study Of Health Care Seeking Practices Of Pregnant Women In Cape Town Report Three: Women's Use and Perceptions of Retreat Midwife Obstetric Unit and T. C. Newman (Paarl) Hospital". *CERSA-Women's Health Medical Research Council*.
- Abrahams, A, Jewkes, R and Mvo, Z. 1998. "Study Of Health Care Seeking Practices Of Pregnant Women In Cape Town Report Four: Summary Of Findings, Conclusions And Policy Action". *CERSA-Women's Health Medical Research Council*.
- Abrahams, N, Jewkes, R and Mvo, Z. 2001. "Health Care-Seeking Practices of Pregnant Women and the Role of the Midwife in Cape Town, South Africa". *Journal of Midwifery and Women's Health* 46 (4)240-247
- Abrahams N, Jewkes R, Laubscher, Hoffman M. 2006. Intimate partner violence: prevalence and risk factors for men in Cape Town, South Africa. *Violence Vict* 21 (2): 247–264.
- Abuja Declaration. Special Summit on HIV/AIDS, Tuberculosis, and Malaria in Abuja, Nigeria, from 2-4 May 2006, adopted the Abuja Call on "Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by A United Africa by 2010".
- Adamu, M and Salihu, H.M. 2002. "Barriers to the use of antenatal and obstetric care services in rural Kano, Nigeria". *Journal of Obstetrics and Gynaecology* 22(6) 600-603.
- African Health Strategy 2007-2015. Third Session of the African Union Conference of Ministers of Health 2007. South Africa: AU.
- African Union Commission. Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007-2010.
- Amoateng, A., Heaton, T. and Kalule-Sabiti, I. 2007. "Living arrangements in South Africa". In: Amoateng, A. Y. and Heaton, T. B. (eds). *Families and households in postapartheid South Africa*. Cape Town: HSRC Press.
- Ardner, S. 1981. "Ground Rules and Social Maps for Women: An Introduction". In Ardener, S (ed.) *Women and Space: Ground Rules and Social Maps*. Oxford: Oxford University Women's Studies Committee.
- Atkinson, S.J. 1993. "Anthropology in Research on the Quality of Health Services". *Cad. Saúde Públ., Rio de Janeiro*, 9 (3): 283-299.
- Bhaga, T. 2010. The impact of working conditions on the productivity of nursing staff in the midwife obstetric unit of Pretoria West Hospital. Masters in Social Work. Unpublished. University of Pretoria.
- Bledsoe, C and Banja, F. 2002. *Contingent Lives Fertility, Time, and Aging in West Africa*. Chicago: University of Chicago Press
- Brodwin, P. 2011. "Futility in the Practice of Community Psychiatry" *Medical Anthropology Quarterly* Vol.25 Issue 2 189-208.
- Butler, J. 1990. *Gender Trouble: Feminism and the Subversion of Identity*. New York and London: Routledge
- Butler, J and Athanasiou, A. 2013. *Dispossession: The Performative and the Political*. USA: Polity Press.
- Carolan, M and Bell, M. 2003. In Truth we Trust: Discourse, Phenomenology, and the Social Relations of Knowledge in an Environmental Dispute. *Environmental Values* 12 225-45.
- Cavell, S. 1979. *The Claim of Reason: Wittgenstein, Skepticism, Morality, and Tragedy*. New York: Oxford University Press.
- Cavell S. 1989. Declining decline: Wittgenstein as a philosopher of culture. In *This New Yet Unapproachable America: Lectures After Emerson After Wittgenstein*. Chicago: University of Chicago Press

- Clarke, A. 2000. Mother swapping: The trafficking of nearly new children's wear. In *Commercial Cultures: economics, practices, spaces*. Jackson, P. Lowe, M. Miller, D. Mort, F. Oxford: Berg.
- Clarke, A, Fisherman, J, Fosket, J, Mamo, L, and Shim, J. 2003. Biomedicalization: Technoscientific Transformations of Health, Illness, and U.S. Biomedicine. *American Sociological Review*, 68(2)
- Clifford, J and Marcus, G. 1986. *Writing Culture: The Poetics and Politics of Ethnography*. California: University of California Press.
- Collie, N. 2013. Walking in the city: urban space, stories, and gender. *Gender Forum* 42.
- Comaroff, J and Comaroff, J. 1991. Revelation and Revolution Volume One: Christianity, Colonialism, and Consciousness in South Africa. Chicago: University of Chicago Press
- Comaroff, J and Comaroff, J. 1997. Revelation and Revolution Volume Two: The Dialectics of Modernity on a South African Frontier. Chicago: University of Chicago Press
- Das 1997. "Language and Body: Transactions in the Construction of Pain". In Kleinman, A, Das, V and Lock, M (eds) *Social Suffering*. Berkeley: University of California Press. 67-89
- Das, V. 1998. "Wittgenstein and Anthropology". *Annual Review of Anthropology* 27 171-95.
- Das, V. 1999. "Violence and the work of time" in Cohen, A (Ed) *Signifying identities: Anthropological perspectives on boundaries and contested values*. New York: Routledge.
- Das, V. 2007. *Life and Words: Violence and the Descent into the Ordinary*. Berkeley: University of California Press.
- Das, V. 2008. Violence, Gender, and Subjectivity. *Annual Review of Anthropology, Vol. 27. Pp. 283-299*
- Das, V. 2015. *Affliction: Health, Disease, Poverty*. New York: Fordham University Press
- Davis-Floyd, R and Sargent, C (Eds). 1997. *Child Birth and Authoritative Knowledge: Cross-Cultural Perspectives*. California: University of California Press.
- Day, C and Gray, A. 2012/2013 "Health and Related Indicators Chapter 17". *South African Health Report*
- De Certeau, M. 1984: The Practice of Everyday Life. Berkeley: University of California Press.
- Dippenaar, J.M. 2009. "Sustainability of Midwifery Practice within the South African Healthcare System". *Doctor Curatoris in Nursing Science Thesis*. Faculty of Health Science, University of Johannesburg.
- Denbow, J. 2015. *Governed Through Choice: Autonomy, Technology, and the Politics of Reproduction*. New York: New York University Press.
- Dewar, F. 2006. "Empowering Women? Family Planning and Development in Post-Colonial Fiji". Master of Arts Thesis: University of Canterbury. [O] at: [http://ir.canterbury.ac.nz/bitstream/10092/943/1/thesis\\_fulltext.pdf](http://ir.canterbury.ac.nz/bitstream/10092/943/1/thesis_fulltext.pdf). Access: March 2014.
- Dlakavu, W.F, 2012. "Self-referral of women in labour at Chris Hani Baragwanath Hospital after the introduction of a triage down-referral system". *Research Report MMed Obstetrics and Gynaecology. University of Witwatersrand*.
- Douglas, M. (1973) [1970] *Natural Symbols*. Harmondsworth: Pelican Books
- Dunkle KL, Jewkes RK, Brown HC, Gray GE, McIntyre JA, Harlow SD. Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *Lancet*. 2004; 363(9419):1415–1421.
- Earle, S and Letherby, G. 2007. Conceiving Time? Women who do or do not conceive. *Sociology of Health and Illness* 29(2).
- Eisenberg, Murkoff, Hathaway.2002. *What to expect when you're expecting third edition. Simon and Schuster Inc: Australia*.
- Fabian, J. 1983. *Time and the Other: How Anthropology Makes Its Object*. Columbia University Press: New York
- Feldman-Savelsberg, P 1999. *Plundered kitchens, empty wombs*. USA: University of Michigan Press.
- Ferreira, Nicole. 2014. *Rationalising Sexual Relations and Reproductive Negotiations: Young Women's Experiences of Family Planning in Cape Town*. Unpublished Honours thesis, Social Anthropology, UCT

- Fordyce, L. 2013. "Accounting for fetal death: Vital statistics and the medicalization of pregnancy in the United States". *Social Science & Medicine* 92 124-131
- Foucault, M. 1975. *Discipline and Punish: The Birth of the Prison*. New York: Vintage Press
- Foucault, M. 1990[1976]. *The history of sexuality: An introduction, Volume I*. New York: Vintage Press.
- Gammeloft, T. 2014. *Haunting Images: A Cultural Account of Selective Reproduction in Vietnam*. Berkeley: University of California Press.
- Gastaldo, D, Magalhaes, L, Carrasco, C, and Davy, C. 2012. Body-Map Storytelling as Research: Methodological considerations for telling the stories of undocumented workers through body mapping. [O] available at: <http://www.migrationhealth.ca/undocumented-workers-ontario/body-mapping>. Accessed: 09/06/15.
- Georges, E. 1996. Fetal Ultrasound Imagining and the Production of Authoritative Knowledge in Greece. *Medical Anthropology Quarterly* 10(2): 157-175.
- Gillespie, K. 2014. Murder and the whole city. *Anthropology Southern Africa* 37 (3&4) 203.
- Ginsburg, F and Rapp, R. 1995. *Conceiving the New World Order: The Global Politics of Reproduction*. Berkeley: University of California Press
- Goffman, E. (1963). *Stigma. Notes on the management of spoiled identity*. New York: Simon and Schuster, Inc.
- Good, B. and Del Vecchio Good, MJ. 1993. "Learning medicine": The construction of medical knowledge at Harvard Medical School. In Lindenbaum, S. and Lock, M. (eds). *Knowledge, Power and Practice: the anthropology of medicine and the everyday life*. USA: University of California Press.
- Grosz, E. (1993) Bodies and knowledge: feminism and the crisis of reason. In Alcoff, L. and Potter, E. (eds) *Feminist Epistemologies*. New York: Routledge.
- Grosz, E. (1999) Space, time, and bodies. In Wolmark, J. (Ed.), *Cybersexualities: a Reader on Feminist Theory, Cyborgs and Cyberspace*. Edinburgh: Edinburgh University Press
- Grosz, E. 2013. "Naked". In (eds.) Hooke, A and Fuchs, W *Encounters with Alphonso Lingis*. USA: Lexington Books
- Gupta J, Silverman JG, Hemenway D, Acevedo-Garcia D, Stein DJ, Williams DR. Physical violence among intimate partners and related exposures to violence among South African men. *CMAJ* 2008; 179 (6): 535-541.
- Hames-Garcia, M. 2009. "Three Dilemmas of a Queer Activist Scholar of Colour". In *Activist Scholarship: Antiracism, Feminism, and Social Change* (Eds.) Julia Sudbury and Margo Okazawa-Rey. Paradigm publishers
- Hatton, J. 2011. "How and why did MARS facilitate migration control? Understanding the implication of migration and refugee studies (MARS) with the restriction of human mobility by UK state agencies". Doctoral Thesis, St Antony's College Institute of Social and Cultural Anthropology.  
[O][http://aa.ecn.cz/img\\_upload/224c0704b7b7746e8a07df9a8b20c098/hatton-thesis.pdf](http://aa.ecn.cz/img_upload/224c0704b7b7746e8a07df9a8b20c098/hatton-thesis.pdf). Accessed: 09/10/13.
- Heijnders and Van Der Meij 2006:1 Heijnders M. and Van Der Meij, S. (2006) 'The fight against stigma: An overview of stigma-reduction strategies and interventions' *Psychology, Health & Medicine*, 11(3): 353- 363.
- Henderson, P. 2011. *A Kinship of Bones: AIDS, Intimacy and Care in Rural KwaZulu-Natal*. KwaZulu-Natal: University of KwaZulu-Natal Press.
- Hofmeyr, G and Hodnette, E. 2013. "Antenatal care packages with reduced visits and perinatal mortality: a secondary analysis of the WHO antenatal care trail – Commentary: routine antenatal visits for healthy pregnant women do make a difference". *Reproductive Health* 10(20)
- Honikman S, van Heyningen T, Field S, Baron E, Tomlinson M (2012) Stepped Care for Maternal Mental Health: A Case Study of the Perinatal Mental Health Project in South Africa. *PLoS Med* 9(5): e1001222. doi:10.1371/journal.pmed.1001222

- Inhorn, Marcia C. 2007. *Reproductive Disruptions: Gender, Technology, and Biopolitics in the New Millennium (Fertility, Reproduction and Sexuality)*. New York: Berghahn Books.
- IOL. 2003. "Who's who in Cape Town's gangland". IOL [O] at: <http://www.iol.co.za/news/south-africa/whos-who-in-cape-towns-gangland-110751>. Accessed June 2016.
- Isaacs, L. 2015. "Lotus River, Ottery remain volatile following sporadic shooting". EWN [O] at: <http://ewn.co.za/2015/11/15/Lotus-River-Ottery-remain-volatile-following-sporadic-shootings>. Accessed June 2016.
- Jain, L and Kaufman, S.R. 2011. "Introduction to Special Issue After Progress: Time and Improbable Futures in Clinic Spaces". *Medical Anthropology Quarterly Vol.25 Issue 2 183-188*.
- Jewkes R, Levin J, Penn-Kekana L. 2002. Risk factors for domestic violence: findings from a South African cross-sectional study. *Soc Sci Med* 55 (9):1603-1617.
- Jordan, B. 1997(1978). *Birth in Four Cultures*; "Authoritative Knowledge and its construction". In Davis-Floyd and Sargent (eds) *Child Birth and Authoritative Knowledge: Cross-Cultural Perspectives*. University of California Press: California.
- Kaufman, C. 1997. "Reproductive Control in South Africa" No.97. [O] available at: <http://www.popcouncil.org/uploads/pdfs/wp/97.pdf>. Accessed 19/03/14.
- Kristeva, J. 1982. *Powers of Horror: An Essay on Abjection*. New York: Columbia University Press.
- Lambek M (1993) Knowledge and practice in Mayotte: Local discourses of Islam, sorcery, and spirit possession. Toronto: University of Toronto Press
- Layne, L. 1999. "I remember the day I stopped for your layette": goods fetuses and feminism in the context of pregnancy loss. In Foetal subjects, feminist positions. Morgan, L. Michaels, M. (Eds.) Philadelphia: University of Pennsylvania Press.
- Lefebvre, H. 1991. *The Production of Space*. Trans D, Nicholson-Smith. UK: Blackwell Publishing.
- Levinas, E. 2001. *Is it Righteous to Be? Interviews with Emmanuel Levinas*. Robbins, J (ed.). Stanford: Stanford University Press.
- Levine, S. 2014. "The miracle workers: obstacles and opportunities for restoring sight to children in KwaZulu-Natal". *Anthropology Southern Africa* 37 (1&2) 81-93.
- Lewis, A. 2014. "Cape Clinics under siege". IOL [O] at: <http://www.iol.co.za/news/crime-courts/cape-clinics-under-siege-1735471>. Access June 2016
- Lüsberg, S, Pedersen, E. 2015. "Introduction. Trust and Hope". In Lüsberg, S, Pedersen, E and Dalsgård, A (eds) *Anthropology and Philosophy: Dialogues on Hope and Trust*. New York: Berghahn Books.
- Lindmark, G., 1992. Assessing the scientific basis of antenatal care: the case of Sweden. *International Journal of Technology Assessment in Health Care* 8, 2-7.
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363 – 85.
- Loblay, V. 2009. Everyday ethics: sex determination and ultrasound in Australia. *Indian Journal of Medical Ethics Vol VI (4)*.
- Lock, M. 1993. *Encounters with aging: Mythologies of menopause in Japan and North America*. Berkeley: University of California Press.
- Lock, M and Farquar, J. 2007. *Beyond the Body Proper: Reading the Anthropology of Material Life*. Durham: Duke University Press.
- Lock, M. 2013. The Epigenome and Nature/Nurture Reunification: A Challenge for Anthropology. *Medical Anthropology*, 32:4, 291-308, DOI:10.1080/01459740.2012.746973
- Long, W. 1990. Abnormal Vaginal Bleeding. In Walker HK, Hall WD, Hurst JW (Eds). *Clinical Methods: The History, Physical, and Laboratory Examinations. 3<sup>rd</sup> Edition*. Boston: Butterworths
- Lorber, J. 1994. *Paradoxes of Gender*. . USA: Yale University Press.
- Lovell, A. 2011. "Debating life After Disaster: Charity Hospital Babies and Bioscientific Futures in Post-Katrina New Orleans". *Medical Anthropology Quarterly Vol.25 Issue 2 254-277*.

- Macdonald, H. 2012. Believing sceptically: Rethinking health-seeking behaviours in central India. In Susan Levine's (ed.) *Medicine and Ways of Knowing*. HSRC: South Africa.
- Mafeje, A. 2001. *African Social Scientist Reflections Part I: Anthropology in Post-Independence Africa: End Of An Era And The Problem Of Self-Redefinition*. Heinrich Böll Foundation: Kenya
- Malgas, N. 2015. "Gang violence fears for Ottery residents". EWN [O] at: <http://ewn.co.za/2015/04/30/Ottery-residents-live-in-fear-of-gang-violence>. Accessed June 2016.
- Mametja, S. 2009. Factors associated with late antenatal care attendance. Unpublished Masters in Medicine Public Health Thesis, Faculty of Health Science, University of Cape Town.
- Masuku, M, Mampe, T, Matse, M and Jassat, W. 2012. "Community Dialogues: North West Province". *Health Systems Trust, KZN*.
- Mathole, T, Lindmark, G, Majoko, F and Ahlberg, B.M. 2004. "A qualitative study of women's perspectives of antenatal care in a rural area of Zimbabwe". *Midwifery* 20, 122–132.
- Mathole, T, Lindmark, G and Ahlberg, B.M. 2005. "Dilemmas and paradoxes in providing and changing antenatal care: a study of nurses and midwives in rural Zimbabwe". *Health Policy Plan.* 20 (6): 385-393.
- Mbembe, A. 2000. At the edge of the world: boundaries, territoriality and sovereignty in Africa. *Public Cult.* 12(1): 259-84
- Mbembe, A. 2001. *On the Postcolony*. Berkeley: University of California Press.
- McCormack, D. 2013. Scenes of persistence. Book Review. *Dialogues in Human Geography* July 2013 3: 228-230, doi:10.1177/2043820613495786
- Michalow, J, et al. 2015. "Triple return on investment: the cost and impact of 13 interventions that could prevent stillbirths and save the lives of mothers and babies in South Africa". *Pregnancy and Childbirth* 15 (39)1-13.
- Mkhwanazi, N. 2004. "Teenage pregnancy and the making of gender identities in a post-apartheid township". Unpublished Doctoral dissertation, University of Cambridge.
- Mkhwanazi, N. 2010. Understanding teenage pregnancy in a post-apartheid South African township. *Culture, Health & Sexuality Vol 12(4)*.
- Mkhwanazi, N. 2014. "An African way of doing things" : reproducing gender and generation, *Anthropology Southern Africa*, 37:1-2, 107-118.
- Moodley, J, Pattinson, RC, Fawcus, S, Schoon, MG, Moran, N, and Shweni, PM. 2014. "The confidential enquiry into maternal deaths in South Africa: a case study". *BJOG: An International Journal of Obstetrics and Gynaecology* 121(4) 53-60.
- Mukhopahyay, C and Higgins PJ. 1988. "Anthropological studies of women's status revisited: 1977-88". *Annual Reviews in Anthropology* 17 461-495
- Muller, L. 2004. The geography of the clinic: spatial strategies at the Western Cape Community Health Centre. *Anthropology Southern Africa* 12 (1-2) 54-63
- Myer, L and Harrison, A. 2003. "Why Do Women Seek Antenatal Care Late? Perspectives from Rural South Africa". *Journal of Midwifery and Women's Health* 48 (4) 268-272
- National Department of Health. 2007. Guidelines for Maternity Care in South Africa: A Manual for clinics, community health centres and district hospitals.
- National Department of health's report of the health data coordination committee 2011
- National Department of Health. Strategic Plan for Maternal Newborn Child and Women's Health and Nutrition in South Africa 2012-2016. Pretoria: DoH.
- National Department of Health. South Africa's National Strategic Plan for a Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa 2012. Pretoria: DoH.
- National Department of Labour. 2014. Basic Maternity Leave. [O] at <http://www.labour.gov.za/DOL/legislation/acts/basic-guides/basic-guide-to-maternity-leave>. Accessed: June 2016.
- National Department of Health. 2014. Annual Health Report 2013-2014. Pretoria:DoH.

- Needham R (1972) *Belief, language, and experience*. Oxford: Basil Blackwell
- Ngomane S, and Mulaudzi, F.M. 2012. "Indigenous beliefs and practices that influence the delayed attendance of antenatal clinics by women in the Bohlabele district in Limpopo, South Africa". *Midwifery* (28) 30-38
- Nguyen, V-K. 2010. *The Republic of Therapy: Triage and Sovereignty in West Africa's Time of AIDS*. Durham: Duke University Press.
- Nordqvist, C. 2016. Menstruation, Periods and the Menstrual Cycle. [O] at Medical News Today <http://www.medicalnewstoday.com/articles/154699.php>. Accessed June, 2016.
- Oakley, A. 1982. "The origins and development of antenatal care". In Enkin, M and Chalmers, E (eds.) *Effectiveness and satisfaction in antenatal care*. Clinics in Developmental Medicine Nos. 81/82.
- Pattinson, R. 2005. "Basic Antenatal Care Handbook". MRC Maternal and Infant Health Care Strategies Research Unit Obstetrics and Gynaecology Department, University of Pretoria.
- Pedersen, E and Meinert, L. 2015 Dialogue Three. Intentional Trust in Uganda. In Liisberg, S, Pedersen, E and Dalsgård, A (eds) *Anthropology and Philosophy: Dialogues on Hope and Trust*. New York: Berghahn Books.
- Petchesky, R and Judd, K. 1998. *Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures*. London: Zed Press.
- Petersen, C. 2015. "Gang fighting turns Ottery in to war zone". IOL [O] at <http://www.iol.co.za/news/crime-courts/gang-fighting-turns-ottery-in-war-zone-1854769>. Accessed June 2016
- Pfaffenberger, B. 1992. Social Anthropology of Technology. *Annual Review of Anthropology* 21: 491-516.
- Pigg, S. L. 1996. The Credible and the Credulous: The Question of "Villagers' Beliefs" in Nepal. *Cultural Anthropology* 11(2) 160-201.
- Pinnock, D. 1984. *The Brotherhoods: Street Gangs and State Control in Cape Town*. Cape Town: David Philip.
- Pinnock, D. 1989. "Ideology and urban planning: Blueprints of a garrison city". In W G Jame and M Simons (eds). *The Angry Divide: Social and Economic History of the Western Cape*. Cape Town: David Philip.
- Pinnock, D. 1997. *Gangs, Rituals and Rites of Passage*. South Africa: African Sun Press with the Institute of Criminology, University of Cape Town.
- Pinnock, D. 2016. *Gang Town*. South Africa: Tafelberg Publishers Ltd.
- Povinelli, E. 2011. *Economies of Abandonment: Social Belonging and Endurance in Late Liberalism*. Durham: Duke University Press.
- Pulerwitz, J, Amara, H, De Jong, W, Gortmaker, S, and Rudd, R. 2002. Relationship power, condom use and HIV risk among women in the USA. *AIDS CARE Vol 14 (6) 789-800*.
- Ransom, J. 1997. *Foucault's Discipline: The Politics of Subjectivity*. Durham: Duke University Press.
- Rapp, R. 1999. *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America*. New York: Routledge
- Rapp, R. 2007. "Real-Time Fetus: The Role of the Sonogram in the Age of Monitored Reproduction". In (eds.) Lock, M and Farquhar, J. *Beyond the Body Proper: Reading the Anthropology of Material Life*. Durham: Duke University Press.
- Rapp, R. 2011. Reproductive Entanglements: Body, State, and Culture in the Dys/Regulation of Child-Bearing. *Social Research Vol. 78: No. 3*.
- Rogerson, J.J.M. Unpublished Doctoral Thesis, Social Anthropology, UCT. 2016
- Ross, F. 1995. *Houses without Doors*. Pretoria: HSRC.
- Ross, F. 1996. "'Vat Jou Goede en Trek'": The effects of domestic violence in Die Bos' in L Glanz and A D Spiegel (eds). *Violence and Family Life in South Africa: Research and Policy Issues*. Pretoria: HSRC.
- Ross, F. 2010. *Raw Life, New Hope. Decency, housing and everyday life in a post-apartheid community*. Cape Town: UCT Press.

- Salo, E. 2003. Negotiating gender and personhood in the new South Africa. *European Journal of Cultural Studies* 6(3) 345-365.
- Salo, E. 2004. Respectable mother, tough men and good daughters: Producing persons in Manenberg Township, South Africa. Unpublished Doctoral dissertation, Department of Anthropology, Emory University
- Sanders J, Somerset M, Jewel D, Sharp D. 1999. "To see or not to see? Midwives' perceptions of reduced antenatal attendances for 'low risk' women". *Midwifery* 15: 257-63.
- Santelli, J, et al. 2003. "The Measurement and Meaning of Unintended Pregnancy". *Perspectives on Sexual and Reproductive Health*. 35(2) 94-101
- Särnstedt, E. 2011. Knowing Bodies: Emotive Embodiment in Feminist Epistemology. Masters thesis: Centre for Gender Studies Uppsala Universitet.
- Schaay, N and Sanders, D. 2008. "International Perspectives on Primary Health Care over the Past 30 Years". In South African Health Review. South Africa: Health Systems Trust.
- Setty-Venugopal V, Upadhyay UD. 2002. Birth spacing: three to five saves lives (Population Reports, Series L, Number 13). Baltimore, MD, Johns Hopkins Bloomberg School of Public Health, Population Information Program.
- Shuttleworth, R., & Kasnitz, D. (2004). Stigma, community, ethnography: Joan Ablon's contribution to the anthropology of impairment/disability. *Medical Anthropology*, 18(2), 139-159.
- Solarin, I and Black, V. 2012. "“They Told Me to Come Back”: Women's Antenatal Care Booking Experience in Inner-City Johannesburg". *Maternal Health Journal* 2013 17:359-367
- Spiegel, A. 1987. "Dispersing Dependents: a response to the exigencies of labour migration in Rural Transkei". In Eades, J (ed.) *Migrants, Workers and the Social Order*. ASSS: London.
- Spiegel, A, Watson, V and Wilkinson, P. 1996. "Domestic diversity and fluidity among some African households in Greater Cape Town". *Social Dynamics* 22(1).
- Standing, A. 2006. Organised crime: A study from the Cape Flats. Pretoria: Institute of Security Studies.
- Statistics South Africa. 2005. 'Stages in the Life Cycle of South Africa's'. Report no. 03-02-46(2001). Pretoria: Statistics South Africa
- Statistics South Africa. 2013. Millennium Development Goals, Country Report 2013. Pretoria: Statistics SA
- Statistics South Africa. 2016. Demographic Indicators. Johannesburg: Institute of Race Relations.
- Strathern, M. 1995. Displacing Knowledge: Technology and the Consequences for Kinship. In Ginsburg, F and Rapp, R *Conceiving the New World Order: The Global Politics of Reproduction*. Berkley: University of California Press
- Supanich, C. 2009. "“You're too late!": Prenatal Health Seeking Behaviours of Guatemalan Mayan Women in Palm Beach County". Masters of Arts Thesis. Florida Atlantic University.
- Swingler, S. 2015. "The Cape's youth gang: Bigger, deeper, more dangerous" Daily Maverick [O] at: <http://www.dailymaverick.co.za/article/2014-05-26-the-cape-youth-gangs-bigger-deeper-more-dangerous/> accessed June 2016.
- Taylor, J. 2000. An all consuming experience: Obstetrical ultrasound and the commodification of pregnancy. In *Biotechnology and culture: Bodies, anxieties, ethics*. Brodwin, P. (Ed.). Bloomington: Indiana University Press.
- Taylor, Layne and Wozniack, (Eds.) 2004. Consuming motherhood. USA: Rutgers University Press.
- Thompson, K. 2007. 2007. *No room at the inn: Cape Town's midwife obstetrics units, 1973-1999*. Unpublished Honours Thesis. University of Cape Town
- Tlebere, P., Jackson, D., Loveday, M., Matizirofa, L., Mbombo, N., Doherty, T., et al. 2007. Community-based situation analysis of maternal and neonatal care in South Africa to explore factors that impact utilization of maternal health services. *J Midwifery Womens Health* 52(4) 342-350
- Versfeld, A. 2012. Generational change in Manenberg: the erosion of possibilities for positive personhood. *Agenda* 26 (4).

- Villar, J et al, 2001. "WHO antenatal care randomised trial for the evaluation of a new model of routine antenatal care". *The Lancet* 357 (9268) 1551-1564
- Wage Indicator. 2016. *Maternity Leave*. [O] at <http://www.mywage.co.za/main/decent-work/maternity-and-work/maternity-leave>. Accessed: 01/06/2016
- Wedin, K, Molin, J, and Crang Svalenius, E.L. 2010. "Group antenatal care: a new pedagogic method for antenatal care – a pilot study". *Midwifery* (26) 389-393
- Weidman, A. 2014. Anthropology and Voice. *Annual Review of Anthropology* 43: 37-51
- Weir, L. 2006. *Pregnancy, Risk and Biopolitics: On the threshold of the living subject*. New York: Routledge.
- WHO. 1978. Risk Approach for Maternal and Child Health Care. *WHO Offset Publication No. 39*. WHO Press: Geneva.
- WHO. 2005. *The World Health Report 2005 – make every mother and child count*. WHO Press: Geneva
- WHO. 2015. *Family planning/ Contraception Fact sheet*. WHO [O] <http://who.int/mediacentre/factsheets/fs351/en/> Accessed 01/06/2016
- WHO. 2015. Trends in Maternal Mortality 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. WHO [O] [http://data.unicef.org/corecode/uploads/document6/uploaded\\_pdfs/corecode/Trends-in-MMR-1990-2015\\_Full-report\\_243.pdf](http://data.unicef.org/corecode/uploads/document6/uploaded_pdfs/corecode/Trends-in-MMR-1990-2015_Full-report_243.pdf).
- Winner, L. 1985. Do Artifacts Have Politics? In D MacKenzie and J. Wajcman (eds). *The Social Shaping of Technology: How the Refrigerator Got Its Hum*. Philadelphia: Open University Press
- Wittgenstein L. 1953. *Philosophical Investigations*. New York: Macmillan
- Young, Iris Marion (2005) "Pregnant Embodiment". On Female Body Experience. "Throwing Like a Girl" and Other Essays. Oxford University Press.
- Zanconato, G, Msolomba, R, Guarenti, L, and Franchi, M. 2006. 2006. "Antenatal care in developing countries: The need for a tailored model". *Seminars in Fetal & Neonatal Medicine* 11, 15-20.
- Zola, I.K. 1972. Medicine as an institution of social control: the medicalising of society. *The Sociological Review*, 20, 4, 487–504.

## Appendix 1

### Maternal and antenatal guidelines

*(Maternal care guidelines 2015: 34-47)*

#### THE IMPORTANCE OF THE FIRST ANTENATAL VISIT

Complete assessment of gestational age and risk factors can be made at the first ante-natal visit. It is not necessary to wait until the second visit before such assessments are finalised. After one visit, a pregnant woman can be regarded as 'booked'.

At the first visit, find out what health care the woman has received so far in the pregnancy, especially from private practitioners. If she has had previous antenatal care obtain information (records) from the provider, if possible and regard that as the first visit.

#### History Taking:

Take a full and relevant history including:

- Current pregnancy
- Previous pregnancies, any complications and outcomes
- Medical conditions, including psychiatric problems, and previous operations
- Familial and genetic disorders
- Allergies
- Use of medications
- Use of alcohol, tobacco and other substances
- Family and social circumstances

#### Physical Examination:

- Do a general examination including weight, height, heart rate, colour of mucous membranes, blood pressure, a check for oedema, and palpation for lymph nodes
- Do a systemic examination including teeth and gums, breasts, thyroid, and heart and lung examination. When no staff member in the antenatal clinic has been trained to perform heart and lung examination, this may be omitted provided the pregnant woman has no history or symptoms of heart or lung disease. Refer women with dental problems to a dentist or dental therapist.
- Examine the pregnancy including inspection and palpation of the pregnant uterus; with measurement of the symphysis-fundal height (SFH) in cm”.

Schedule for return visits: “a basic antenatal care schedule of four follow-up visits is provided for women without any risk factors. Following the early booking visit (preferably <12 weeks), return visits should be scheduled for 20, 26-28, 32-34, and 38 weeks and 41 weeks if still pregnant by then. This is not applicable for women with risk factors, whose return visits schedules will depend on their specific problems”

#### ESSENTIAL SCREENING INVESTIGATIONS

- Syphilis serology. Rapid tests are preferable, as results are immediately available. Take care to follow the instructions from the manufacturer carefully to avoid false negative results.
- Rhesus (D) blood group, using a rapid test.
- Haemoglobin (Hb) level, using a portable haemoglobinometer or copper sulphate screening method.
- Human immunodeficiency virus (HIV) serology, using rapid test kit. This must follow the National guidelines on routine counselling and voluntary testing
- Urine dipstick testing for protein and glucose

## MEDICATIONS AND VACCINES

The following are given to all pregnant women (tick the appropriate block on the antenatal card when dispensed):

- Ferrous sulphate tablets 200 mg daily, to prevent anaemia.
- Calcium tablets 1000 mg daily, to prevent complications of pre-eclampsia (e.g. calcium carbonate (168mg) 2 tablets orally, 3 times daily with food. This is best taken 4 hours before or after iron supplements.
- Folic acid tablets 5 mg daily.
- Tetanus toxoid (TT) immunization, to prevent neonatal tetanus:  
First pregnancy: TT1 at first antenatal visit, TT2 4 weeks later and TT3 6 months later.  
Later pregnancies: Two TT boosters, one in each pregnancy at the first visit, for the next two subsequent pregnancies, at least one year apart.  
A total of five properly spaced doses of TT provide life-long protection against tetanus.
- If in a subsequent pregnancy, there is no record of previous immunization, treat as for a first pregnancy”

## ESTIMATION OF GESTATIONAL AGE

Indicate on the antenatal card (page 2 of the MCR) how the gestational age was estimated. The first estimation of gestational age, with the expected date of delivery, should be used for the remainder of the pregnancy and must not be changed unless important new information becomes available.

Last menstrual period. This is valid if the woman is sure of her dates, and where palpation of the uterus and SFH measurement are compatible with the given dates. Gestation age must be calculated from the first day of the last menstrual period.

### Symphysis-fundal height (SFH) measurement

This is used for estimation of gestational age after 24 weeks if the dates from the last menstrual period are unknown or wrong, in the presence of a normal singleton pregnancy. The measured SFH is plotted onto the 50th centile line on the SFH graph, allowing the corresponding gestational age to be read from the graph.

### Palpation

The SFH measurement is of little value for estimation of gestational age at <20 cm and  $\geq 35$  cm (corresponding to <20 weeks and term respectively). In early pregnancy, bimanual and abdominal palpation can be used, and at term, palpation of the fetal head is of some value. Gestational age assessment by palpation requires care, skill and experience.

### Ultrasound

An ultrasound scan for gestational age estimation should be requested for women who are unsure of dates with SFH measurement less than 24 cm. Foetal measurements by ultrasound give reasonably accurate gestational age estimates before 24 weeks of gestation. Ultrasound after 24 weeks is less reliable, but in obese patients, it can still be used up to 28 weeks”

## Appendix 2

### Table of Participants

Participant	Age 18-42	Gestational age at 1 <sup>st</sup> booking	Number of pregnancies
Meshe	18	20 weeks	1 <sup>st</sup> pregnancy
Danielle	18	14 weeks	1 <sup>st</sup> pregnancy
Ameera	18	24 weeks	1 <sup>st</sup> pregnancy
Stacey-Lee	20	17 weeks	1 <sup>st</sup> pregnancy
Kyle-Lee	20	34 weeks	1 <sup>st</sup> pregnancy
Lacal	20	12 weeks	1 <sup>st</sup> pregnancy
Nawaal	20	12 weeks	1 <sup>st</sup> pregnancy
Sharnaleigh	21	12 weeks	1 <sup>st</sup> pregnancy
Neliswa	21	32 weeks (gave birth a week later)	2 <sup>nd</sup> pregnancy
Alvina	21	14-20 weeks	2 <sup>nd</sup> pregnancy
Qudsiyya	22	13 weeks	1 <sup>st</sup> pregnancy
Deniell	23	27 weeks	3 <sup>rd</sup> pregnancy
Chantey	25	18 weeks	2 <sup>nd</sup> pregnancy
Theresa	26	16 weeks	2 <sup>nd</sup> pregnancy
Reneshia	26	28 weeks	2 <sup>nd</sup> pregnancy
Tania	27	22 weeks	4 <sup>th</sup> pregnancy
Nuraan	27	13 weeks	2 <sup>nd</sup> pregnancy
Candice	28	*BBA	5 <sup>th</sup> pregnancy
S*	28	20 weeks	2 <sup>nd</sup> pregnancy
M*	28	20 weeks+	2 <sup>nd</sup> pregnancy
Mariam*	29	20 weeks	2 <sup>nd</sup> pregnancy
Merldy	29	28 weeks	4 <sup>th</sup> pregnancy
Mersell	29	24 weeks	4 <sup>th</sup> pregnancy
Jemima	29	22 weeks	3 <sup>rd</sup> pregnancy
Lee-Ann	32	*BBA	5 <sup>th</sup> pregnancy
Rehana	34	25 weeks	4 <sup>th</sup> pregnancy
Nondumiso*	35	20 weeks	5 <sup>th</sup> pregnancy
Jessica	35	15 weeks	4 <sup>th</sup> pregnancy

<b>Nadia</b>	35	32 weeks	2 <sup>nd</sup> pregnancy
<b>Veronica</b>	35	20 weeks	5 <sup>th</sup> pregnancy
<b>Libby</b>	36	12 weeks	2 <sup>nd</sup> pregnancy
<b>Babalwa</b>	38	15 weeks	3 <sup>rd</sup> pregnancy
<b>Lelani*</b>	38	12 weeks	6 <sup>th</sup> pregnancy
<b>Ingrid</b>	41	24 weeks	2 <sup>nd</sup> pregnancy
<b>Shamila</b>	42	16 weeks	9 <sup>th</sup> pregnancy
<b>*Nadine</b>	30	Not pregnant. At the clinic seeking advice after a domestic violence incident.	Not pregnant (3 children, 4 pregnancies)
<b>*J</b>	40+	Was at the clinic attempting to adopt from a 33 year old from her area who was using drugs.	Not pregnant

9 out of 37 women where at the clinic with their first pregnancy; 11 women where at the clinic with their second pregnancy; 3 women where at the clinic with their third pregnancy; 5 women where at the clinic with their fourth pregnancy, 4 women where at the clinic with their fifth pregnancy; 1 woman was at the clinic with her sixth pregnancy; 1 woman was at the clinic with her ninth pregnancy.

**\*BBA:** Birth before Arrival - Women who had given birth before arriving at the clinic. The two BBA's interviewed had not come in to the clinic at all during their pregnancies

## Appendix 3

### Birth rates and ages

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#### DEMOGRAPHICS

##### Births by age of mother (proportions)<sup>a</sup>, 2000-13

Year	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	Other <sup>b</sup>	Total <sup>c</sup>
2000	12.4%	23.1%	23.6%	19.7%	11.9%	4.9%	1.0%	0.4%	2.9%	100.0%
2001	13.1%	23.6%	24.1%	19.4%	12.1%	4.8%	1.0%	0.3%	1.6%	100.0%
2002	13.1%	24.8%	23.6%	20.3%	11.3%	5.0%	0.9%	0.3%	0.8%	100.0%
2003	13.8%	26.4%	23.1%	19.3%	10.5%	5.4%	0.7%	0.3%	0.6%	100.0%
2004	14.3%	27.0%	23.2%	18.8%	10.4%	5.1%	0.6%	0.2%	0.5%	100.0%
2005	14.5%	27.7%	23.3%	18.0%	10.9%	4.3%	0.8%	0.1%	0.5%	100.0%
2006	14.2%	28.5%	23.6%	18.3%	10.4%	3.7%	0.7%	0.1%	0.4%	100.0%
2007	14.1%	28.2%	24.3%	18.1%	10.8%	3.4%	0.6%	0.1%	0.4%	100.0%
2008	14.2%	27.9%	25.0%	17.9%	10.6%	3.4%	0.6%	0.1%	0.4%	100.0%
2009	14.4%	28.0%	25.1%	17.7%	10.4%	3.4%	0.5%	0.0%	0.4%	100.0%
2010	14.1%	27.6%	25.7%	18.0%	10.5%	3.4%	0.4%	0.0%	0.3%	100.0%
2011	14.0%	27.4%	25.9%	18.0%	10.7%	3.3%	0.3%	0.0%	0.3%	100.0%
2012	13.6%	27.3%	25.6%	18.7%	10.7%	3.4%	0.3%	0.0%	0.4%	100.0%
2013	13.7%	27.1%	25.8%	19.0%	10.2%	3.0%	0.2%	0.0%	1.0%	100.0%

Source: Stats SA, interactive data, accessed 25 June 2013, *Recorded live births 2013*, Statistical release P0305, 26 March 2015, Appendix D, p27

a IRR calculations.

b Births by mothers aged below 15 or over 54, including unknown/unspecified.

c Figures should add up horizontally but may not, owing to rounding.

##### Births by numbers and rate, 2010-25

Year	Numbers	Rate <sup>a</sup>
2010	1 061 317	21
2011	1 059 462	21
2012	1 058 115	21
2013	1 056 848	20
2014	1 055 471	20
2015	1 053 886	20
2016	1 052 089	20
2017	1 050 133	20
2018	1 047 986	19
2019	1 045 552	19
2020	1 042 763	19
2021	1 039 632	19
2022	1 036 238	19
2023	1 032 666	19
2024	1 028 961	18
2025	1 025 086	18

Source: ASSA, *ASSA 2008 AIDS and Demographic Model*, March 2011

a Per 1 000 people.

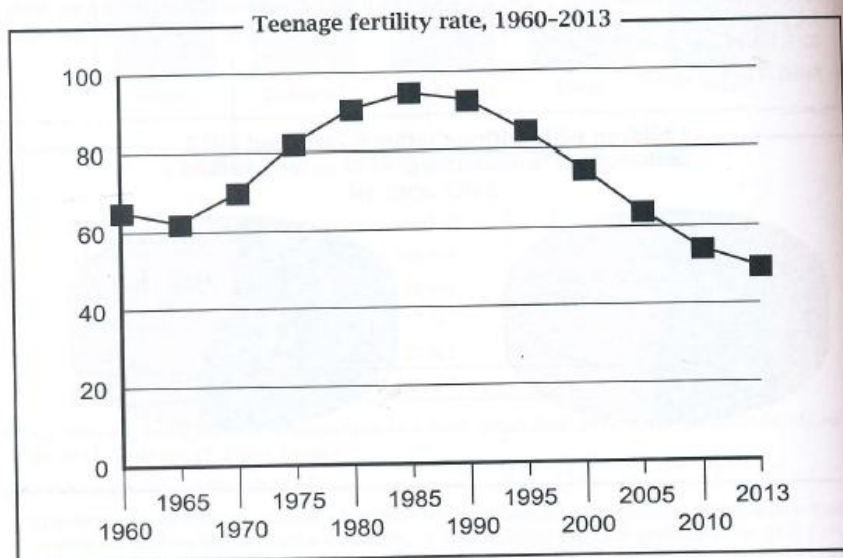
*These forecasts have not been updated by the source and do not take into account other newer population figures in this chapter.*

Teenage fertility rate<sup>a</sup>, 1960–2013

Year	Births per 1 000 women aged 15–19
1960	65.08
1965	62.12
1970	69.85
1975	82.12
1980	90.59
1985	94.65
1990	92.62
1995	84.67
2000	74.67
2005	63.78
2010	54.18
2013	49.41
<b>1960–2013</b>	<b>-24.1%</b>

Source: World Bank, *World Development Indicators 2015*, databank.worldbank.org, accessed 13 May 2015

a The number of births per 1 000 women aged 15–19.



**Pupils who got pregnant in ordinary schools  
by province and grade, 2009–13**

Please refer to the Education chapter.

## Appendix 4

### Information sheet and consent forms

#### Information sheet (English version)

Hello! My name is Nicole Ferreira, and I am a Master's student in Social Anthropology at the University of Cape Town. I am currently conducting research on antenatal care and late attendance to antenatal care clinics. This information sheet will explain more about this project and what it means to participate.

#### **The research project**

I am researching the reasons why pregnant women report late, after 12 weeks of pregnancy, to antenatal clinics. I aim to understand the thoughts and experiences of pregnancy, especially thoughts relating to how pregnant women understand the first three months of pregnancy, their fears, beliefs, and thoughts on planned/wanted/unplanned/unwanted aspects. I also aim to gain an understanding of the engagements pregnant women have with family members, community members, antenatal clinics and screenings, and their experiences with transport to the clinic.

#### **Methods**

My research will consist of observations within the clinic space as well as during visits with the midwives into the communities of Capricorn Park and Phillipi. Informal conversations with pregnant women and staff within the Retreat MOU space while pregnant women wait for their appointments and after their appointments. Semi-structured interviews with pregnant women and staff. Life history information, of which you will have time to speak about your family; where you live; if you used to live anywhere else; the experiences you have within your community and with your family; partner; friends and neighbours.

#### **Participation**

If you agree to participate in this research, it means that you will be sharing some of your time and your experiences with me. Interviews may take 30 minutes to 1 hours and will be recorded if you agree. The interview will involve questions such as:

When did you think you were pregnant? (Sexual activity, contraception use, signs, pregnancy test)

How did you feel when you thought you were pregnant? Why?

Did you tell anyone? Who and why them? What did they say? What did they say about what you should do?

What did you do next? How did you know what to do? What do you think you should do when you became pregnant?

What care do you think you should receive when you are pregnant?

What medical practitioner do you seek?

When did you go to the clinic? Why did you decide to go then? How did you get there? Did anyone go with you? Other children? Work? Why did you go 'late'?

How did you know you should go to the clinic?

What was your clinic experience like? Paper work? Queues? Treatment?

What did you understand needed to be done on your first visit? Do you think these are important screenings, why/not? What do you think you should do when you are pregnant? Does the clinic understand the other things you think you should do during pregnancy?

Why do they think you came late? Do you think you went to the clinic late? Why/why not?

When do you think the right time to go is?

Why is going to the clinic important?

Have you been pregnant before? How many children have you delivered? When did you go to the clinic then?

Unwanted.

What do you mean by this term?

When did you think that your pregnancy was unwanted?

Did you tell anyone? Who and why? What did they say? (Mother, father, partner, grandparents, friends).

What happened after you had this feeling?

Do you want children in the future?

Do you still feel it is unwanted now? Why/why not?

Your participation is voluntary and you can choose to remove yourself from the study at any point. There will be no remuneration in the study, but you will be given tea and snacks and made to feel comfortable throughout the process. If you choose to participate, you will be asked to sign a consent form. There are no risks involved in the research, and you will be given counselling information and support should you want it. Your participation in the research will be beneficial to public health interventions in South Africa that aim to achieve quality healthcare and antenatal care to all women.

### **Queries**

If you have any questions or concerns about this research, you can contact me, or my supervisor. I would be happy to explain my research in person to you and answer any questions you may have.

#### **Nicole Ferreira**

Researcher

Cell: 071 4369 142

[nicole.ferreira@rocketmail.com](mailto:nicole.ferreira@rocketmail.com)

#### **Professor Fiona Ross**

Supervisor

Tel: 021 6503 718

[Fiona.Ross@uct.ac.za](mailto:Fiona.Ross@uct.ac.za)

## Consent form for pregnant women (English version)

### **Title of research project:**

Enduring lateness: the political economy of public antenatal care attendance, and the conceptualisation and organisation of time and conduct during pregnancy.

### **Name of principal researcher:**

Nicole Ferreira

### **Department/research group address:**

School of African and Gender Studies, Anthropology and Linguistics, Anthropology Section, Upper Campus, University of Cape Town, Rondebosch 7700

### **Telephone and email:**

071 4369 142 [nicole.ferreira@rocketmail.com](mailto:nicole.ferreira@rocketmail.com).

My supervisor is Professor Fiona Ross. Email [Fiona.ross@uct.ac.za](mailto:Fiona.ross@uct.ac.za)

### **Nature of the research:**

I am researching the reasons why pregnant women only attend antenatal clinics after 12 weeks of pregnancy.

### **Participant's involvement:**

We will have conversations after you have booked at the clinic or seen the midwives after their community visit, while you wait for your consultations, and after your consultations (if you have time) in order to understand your experience of antenatal care and your engagements with staff and screening procedures. Interviews will be conducted in the privacy of the Zoe Project room or a safe space that is convenient for you. The interviews and life history information will be based on your experiences with your pregnancy, contraception, relationships, transportation, house-hold information and engagements with the clinic staff, protocols and screening procedures. The interviews will be audio recorded (if you agree).

### **Benefits and Risks of the study:**

There are no risks to this study as data will be collected through observations and interviews. Protection from psychological and emotional harm have been ethically considered and will be responded to through the aid of counselling services and support if necessary. The benefits to the research will be in its contribution of qualitative data to existing quantitative data on "late and unbooked" pregnant women. Retreat MOU will further benefit from the research into the staff's voluntary efforts to mobilise unbooked pregnant women in Capricorn Park and Phillipi, which will aid in applications for community interventions. There will be no remuneration in this study, but tea and snacks will be provided during conversations and interviews.

### **The purpose of the research is to:**

- Understand the factors influencing why first attendance to antenatal clinics only occurs after 12 weeks.

- Gain an understanding of the thoughts and experiences of pregnancy, especially thoughts relating to how they understand the first three months of pregnancy, their fears, beliefs, and thoughts on planned/wanted/unplanned/unwanted aspects.
- Gain an understanding of the engagements pregnant women have with family members, community members, antenatal clinics and screenings.

I \_\_\_\_\_,

Resident at \_\_\_\_\_

Agree to participate in this research on antenatal care and late attendance run by Nicole Ferreira (Masters Social Anthropology, University of Cape Town), under the supervision of Prof. Fiona Ross (Social Anthropology, University of Cape Town).

I understand the objectives of the research.

I have read the information sheet, understand its contents and have had the opportunity to ask questions about it or have it explained further to me.

I agree to audio-recordings of interviews conducted  (Please tick if you agree to this).

I understand that my participation is voluntary.

I understand that I can withdraw from the research at any time without penalty.

I understand that the information is confidential and that I can select a pseudonym if I wish.

I agree to information obtained being used in a MA thesis and journal articles. In the case of dissertation research, the document will be available to readers in a university library in printed form, and possibly in electronic form as well.

I understand that if the researcher becomes aware of harm to a child they are legally obliged to report to a Social Worker or Community Organisation, in this case the Zoe Project counsellor.

If you would like to contact the HREC at any point to discuss and clarify your rights and welfare as a research participant, their details are as follows:

Faculty of Health Sciences, University of Cape Town, Human Research Ethics Committee (HREC):

Room E52-24 Old Main Building  
Groote Schuur Hospital  
Observatory, 7925  
Tel: 021 406 6338

Signed by \_\_\_\_\_

On (date): \_\_\_\_\_

Researcher's signature: \_\_\_\_\_

## Consent form for Midwives (English version)

### **Title of research project:**

Enduring lateness: the political economy of public antenatal care attendance, and the conceptualisation and organisation of time and conduct during pregnancy.

### **Name of principal researcher:**

Nicole Ferreira

### **Department/research group address:**

School of African and Gender Studies, Anthropology and Linguistics, Anthropology Section, Upper Campus, University of Cape Town, Rondebosch 7700

### **Telephone and email:**

071 4369 142 [nicole.ferreira@rocketmail.com](mailto:nicole.ferreira@rocketmail.com).

My supervisor is Professor Fiona Ross. Email [Fiona.ross@uct.ac.za](mailto:Fiona.ross@uct.ac.za)

### **The Nature of the research:**

I am doing research on antenatal care attendance and why pregnant women only seek care after 12 weeks of pregnancy. I aim to understand the thoughts and experiences of pregnant women, as they relate to how they understand the first 12 weeks of their pregnancies and what influences antenatal care attendance. The clinic space and the engagements with midwives and staff are important factors to examine for the purpose of understanding what influences the pregnant women's experience of attendance and care, as well as how the clinic staff understand and experience antenatal care and interactions with patients, clinic structures and protocols, attendance and booking.

### **Midwives and Retreat MOU's involvement:**

Conversations with the researcher and informal interviews. Allowing the researcher to accompany you on your voluntary visits into Capricorn Park and Phillipi to speak to pregnant women who have not booked at the clinic. You will be asked to sign a consent form, allowing the MOU to be used in the study. The MOU will be used as a space to conduct interviews (within the privacy of the Zoe Project room), observe interactions between staff and pregnant women as the book and while they wait for their appointments, and to recruit pregnant women who wish to participate.

### **What is involved:**

We will have conversations before, during (if appropriate and where it does not interfere with your professional activities) and after pregnant women have been booked, and consulted with. I will observe the interactions between you and the pregnant women as they relate to how antenatal care is structured, and experienced. If you agree to be part of the study, you will be engaged in the project for a maximum of 6 months. The researcher will ensure the research does not interfere with your professional activities. Interviews will be conducted in the Zoe Projects room, or within a safe space that is convenient to you. They will last 30 minutes to an hour. There will be no remuneration in this study, but tea and snacks will be provided during conversations and interviews.

### **Benefits and Risks of the study:**

There are no risks to this study as data will be collected through observations and interviews. Protection from psychological and emotional harm have been ethically considered and will be responded to through the aid of counselling services. The benefits to the research will be in its contribution of qualitative data to existing quantitative data on “late and unbooked” pregnant women. Retreat MOU will further benefit from the research into the staff’s voluntary efforts to mobilise unbooked pregnant women in Capricorn Park and Phillipi, which will aid in applications for community interventions.

**The purpose of the research is to:**

- Understand the factors influencing why first attendance to antenatal clinics only occurs after 12 weeks.
- Gain an understanding of the thoughts and experiences of pregnancy, especially thoughts relating to how they understand the first three months of pregnancy, their fears, beliefs, and thoughts on planned/wanted/unplanned/unwanted aspects.
- Gain an understanding of the engagements pregnant women have with family members, community members, antenatal clinics and screenings.

I \_\_\_\_\_,  
Resident at \_\_\_\_\_

Agree to participate in this research on antenatal care and late attendance run by Nicole Ferreira (Masters Social Anthropology, University of Cape Town), under the supervision of Prof. Fiona Ross (Social Anthropology, University of Cape Town).

I agree to the Retreat MOU being used in this study and understand I can withdraw the practice form the study at any stage, should I wish to do so.

I understand the objectives of the research.

I have read the information sheet, understand its contents and have had the opportunity to ask questions about it or have it explained further to me.

I agree to audio-recordings of interviews conducted  (Please tick if you agree to this).

I understand that my participation is voluntary.

I understand that I can withdraw from the research at any time without penalty.

I understand that the information is confidential and that I can select a pseudonym if I wish.

I agree to information obtained being used in a MA thesis and journal articles. In the case of dissertation research, the document will be available to readers in a university library in printed form, and possibly in electronic form as well.

I understand that if the researcher becomes aware of harm to a child they are legally obliged to report to a Social Worker or Community Organisation, in this case the Zoe Project counsellor.

If you would like to contact the HREC at any point to discuss and clarify your rights and welfare as a research participant, their details are as follows:

Faculty of Health Sciences, University of Cape Town, Human Research Ethics Committee (HREC):

Room E52-24 Old Main Building  
Groote Schuur Hospital  
Observatory, 7925  
Tel: 021 406 6338

Signed by \_\_\_\_\_

On (date): \_\_\_\_\_

Researcher's signature: \_\_\_\_\_

## Appendix 5

### Contacts sheet

#### ***SA Depression and Anxiety Group***

Suicide crisis line: 0800 567 567 or SMS 31393 (8am - 8pm, seven days a week)

Help line: (011) 262-6396 (8am - 8pm, seven days a week)

E-mail: Zane Wilson (founder) for counselling queries; [www.sadac.org](http://www.sadac.org)

021 465 7373 (Office line)

#### **Counselling (in addition to the services offered by the Zoe Project)**

Trauma Counselling is available for those affected by:

Self-inflicted injuries

Domestic violence (mental, physical, emotional and sexual abuse)

Sexual offences (e.g. rape, forcible fondling, pornography)

Social crime (e.g. armed robbery, hi jacking, assault, murder)

Gang violence

Hate crime (e.g. Xenophobia, homophobia, racism)

Vicarious trauma

Secondary traumatic stress

082 444 4191 (Emergency Line) [info@trauma.org.za](mailto:info@trauma.org.za)

#### **Child Protection Services**

Childline - Cape Town - (021) 461 1114 / 0800 055 555

#### **Shelters for Abused Women and Children**

Beautiful Gate - Phillipi - (021) 370 2500

Carehaven - Athlone - (021) 638 5511

Saartjie Baartman Shelter - Athlone - (021) 633 5287

Sisters Incorporated - Clareinch - (021) 797 4190

St Anne's Homes - Woodstock - (021) 448 6792

#### **Drug and Addiction Services**

Cape Town Drug Counselling Centre - (021) 447 8026

City of Cape Town Alcohol & Drug 24/7 Helpline - Cape Town - 080 043 5748

#### **Marie Stopes Clinics**

A government-approved health facility with clinics throughout South Africa. Offers safe abortions, family planning services including birth control, pregnancy tests, male and female sterilisation, HIV testing and ante-natal services. Fees charged according to client's income bracket.

Toll free call centre: 0800 11 77 85

#### **Retreat MOU offers TOPs.**

The **Zoe Project** offers counselling for all pregnant women on all matters, and is experienced in counselling on violence, unwanted pregnancies, adoption or abortion.

Call: 073 174 1992