

MOTHERS MATTER:
A CRITICAL EXPLORATION OF MOTHERHOOD AND DEVELOPMENT
THROUGH A VIDEO CARD INTERVENTION IN A LOCAL CLINIC

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Declaration

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.

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Abstract

New discourses of foetal and infant development, individual well-being and population futures, argue that mothers matter during the first thousand days of a baby's life, which commences from conception to the age of two. Women, particularly (black, working class) pregnant women and mothers, have consequently become the target of several international and local interventions related to maternal and child health (MCH) and early childhood development (ECD). The *Together from the Beginning* video card is one such intervention that emphasises the value of MCH and ECD, as supported by the latest scientific research, and that presents diverse childcare knowledge and practices to parents and caregivers. The video card intervention was piloted and evaluated over a two-month period in the waiting areas of the antenatal clinic and Midwife's Obstetrics Unit (MOU) at a Community Health Clinic (CHC) situated outside of Cape Town. A total of eighty participants, including sixty pregnant women, eight partners or fathers of their babies, ten nurses and two counsellors, were interviewed and observed during this time. Based on ethnographic research conducted in the clinic, this thesis argues that while mothers do matter in the physical development of babies, mothers are 'developmentally constructed' and thus 'made to matter' through MCH and ECD development discourses and interventions that reinforce and normalise dominant discourses of motherhood. More specifically, it will be shown how three different maternal figures – 'the waiting mother', 'the educated mother', and 'the ideal mother' – were produced, developed and 'made to matter' within public healthcare spaces for the sake of development, which in turn reframed and undermined the time, knowledge, and experiences of these women.

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List of Abbreviations

CHC	Community Health Clinic
ECD	Early Childhood Development
MAMA	Mobile Alliance for Maternal Action
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MOU	Midwife Obstetric Unit
NGO	Non-Governmental Organisation
NPO	Non-Profit Organisation
SDG	Sustainable Development Goals
SHRH	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNICEF	United Nations Children’s Emergency Fund
WHO	World Health Organization

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Chapter One

Motherhood and Development

Introduction

“To ‘mother’ a child implies a continuing presence, lasting at least nine months, more often for years. Motherhood is earned, first through an intense physical and psychic rite of passage — pregnancy and childbirth — then through learning to nurture, which does not come by instinct” (Rich, 1986: 12).

Mothers matter in significant ways — from conception, during pregnancy, and beyond. Within new and increasingly popular discourses of foetal and infant development, individual well-being and population futures, mothers have been understood to matter particularly during the first thousand days of a baby’s life, which commences from conception to the age of two. “The one thousand day span has become the critical window for intervention for both improved nutritional outcomes as well as cognitive development” (Pentecost, 2016).¹ While the first thousand days revolves around the development of the foetus and infant – with caregivers, family members, health professionals, and the state, contributing to the child’s development – the mother is said to play a particularly vital role during this timeframe. Not only does she carry the baby in her womb for the first nine months (roughly two-hundred and eighty days), but thereafter, policy dictates that the baby should be exclusively breastfed for a minimum of six months, despite several barriers that may render this process challenging (see Waltz, 2014; Majombozi, 2015). Moreover, mothers, along with other caregivers, are expected to provide cognitive stimulation, love, nutrition and safety for the infant, as advised and guided by developmental institutions, organisations and agencies (Black et al., 2016). This is the current depiction of mothers in contemporary development discourse, yet “builds on a long history of intervention in the lives of (black) women that is predicated on a model of mothers as deficient, ignorant and in need of education” (see Pentecost and Ross, 2017). In other words, despite the fact that mothering is not practiced solely by biological mothers, nor is it limited to women, in development discourses, motherhood is normalised, with mothers being *made* to matter for various reasons and in a variety of ways. Why do mothers matter in development and public health discourses? How and by whom are mothers influenced during the first thousand days? How and to what extent are mothers ‘developed’? How and why are mothers *made* to matter?

¹ In addition, “the thousand days between conception and a child’s second birthday is presented in contemporary epidemiology and public media, shaped by new knowledge in neuroscience, epigenetics and Developmental Origins of Health and Disease (DoHaD) research, as a critical period that determines future health and potential” (Pentecost, 2016).

Women, particularly pregnant women and mothers, and especially those from low socioeconomic backgrounds and developing countries, have recently become the target of myriad development interventions aimed at promoting early childhood development (ECD) and maternal and child health (MCH). This can be attributed to two of the eight Millennium Development Goals (MDGs) that set the stage for many interventions aimed at reducing child mortality (MDG4) and improving maternal health (MDG5).² Moreover, with the growing realisation and acknowledgement that the first thousand days are crucial for child development, numerous organisations, agencies, and policies are beginning to spread awareness about, while also taking advantage of, the potential benefits of this developmental period. This is generally done by placing the mother at the centre of the development narrative. At an international level, the leading NPO, *1,000 days*, works in the United States and around the globe to improve nutrition, ensuring that women and children are healthy during their first thousand days. Other organisations, such as *US Aid* and *Save the Children*, focus their work on nutrition, but also suggest ‘maternal education’ as a solution to achieving optimal infant development, and also limiting infant morbidity and mortality. *UNICEF* has also played a major role – by promoting the rights and needs of women – in ensuring early childhood survival and development through the ‘development’ of mothers. As stated in a report that explores the influence of Roma women’s status and social situations on the survival, growth, and development of children:

The care a child receives is directly dependent on the knowledge, perceptions, abilities, skills and motivation of the primary caregiver or mother, the support she receives and the social services to which she has access. All of these can be significantly compromised by poverty, illiteracy, gender bias and ethnic discrimination. Since mothers, rather than “parents” or “families,” are the primary mediators of efforts to improve the growth and development of young children, it is critical that their needs and rights as women and as members of poor and excluded communities are addressed if improved child development outcomes are to be reached (UNICEF, 2011: 7).

At a local level, the *First 1000 Days* initiative, with the slogan “Right Start, Bright Future”, was recently established by the Western Cape Government, as led by the Department of Health, to raise awareness about ‘the vital developmental period’. In particular, “the initiative is a holistic programme promoting the well-being of mothers and their babies, as well as the healthy development of infants in communities across the province” (Western Cape Government, 2016). The initiative is built on three key pillars:

² MDG4: reduce child mortality — target 4.A. Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate. MDG5: improve maternal health — target 5.A. Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio; target 5.B. Achieve, by 2015, universal access to reproductive health.

- 1) ensuring the health and nutrition of mother and baby;
- 2) providing mother and baby with support — from fathers, families and communities;
- 3) providing stimulation for the baby to learn, while also providing them with safe environments to promote overall well-being.

Once again, the mother is highlighted as the primary carer and is placed at the centre of not only her baby's development, but also at the centre of the political and development discourse. While the intention behind these interventions are to provide 'appropriate' care to children to ensure optimal development, mothers, rather than other role-players, are regarded as the main actors responsible for providing childcare. These representations and perceptions of mothers aligns with what Adrienne Rich (1986) termed "the patriarchal institution of motherhood". From an ideological perspective, as explained by Rich, motherhood and mothering practices are influenced by patriarchy, specifically in the ways that the bodies and social lives of women are experienced. In *Of Woman Born*, Rich (1986: 13) differentiates between motherhood as a *potential relationship* of women to their powers of reproduction and to children, and motherhood as an *institution* that ensures this potential relationship remains under male control. As an institution, motherhood is regarded by Rich as constrained, dominated, and regulated by structures and systems setup through patriarchal control. Rich further identifies two features of patriarchal motherhood that she argues are harmful to mothers. The first is based on "the assumption that mothering is natural to women and that child rearing is the sole responsibility of the biological mother," while the second relates to "the practice that assigns mothers the sole responsibility for motherwork, but gives them no power to determine the conditions under which they mother" (O'Reilly, 2004: 5). In both cases, patriarchy positions women as primary caregivers, but limits their ability to define mothering. This, despite the fact that mothering and motherhood have been constructed historically, culturally and socially (see Silva, 1996). Based on this dominant ideology of motherhood, along with the understanding that the future of the nation is at stake when children do not reach their developmental potential, mothers become sites 'necessary' to be 'developed'. As such, while the dominant discourse of motherhood holds that women are naturally maternal, if we consider that mothering and motherhood have been constructed over time, then women are subsequently rendered as categories of development. This in turn increases the tension between mothering as 'natural' and mothering that needs to be 'developed'. The 'development of mothers' is not only evident in the way that "the state, its rhetoric and the policies it implements arguably maintain and enhance the power of the motherhood discourse" (Garwood, 2014: 22), but also through the countless development interventions created and implemented, especially in public healthcare

facilities that use motherhood as the starting point with which to ensure ‘appropriate’ caregiving. As a result, the mother’s childcare knowledge, beliefs, behaviours, and actions are judged and devalued by those with power, thus rendering ‘necessary’ and legitimising certain interventions to ‘educate’ her in her childrearing practices. At the same time, and as with most interventions, MCH and ECD development interventions aimed at foetal and infant well-being are anticipated to produce a range of consequences. The *Together from the Beginning* video card intervention, piloted in a state antenatal care unit and MOU, was no exception to the rule.

Together from the Beginning

The *Together from the Beginning* video card intervention was created by child and adolescent psychiatrist, Professor Astrid Berg in conjunction with the Department of Health, in particular the Facilities Board of the Red Cross War Memorial Children's Hospital. The video is housed in a video card: an interactive handheld device, the size of an A5 book, that automatically plays the video once the card is opened (see figure 1). The video is approximately thirteen minutes long and is available in English, Afrikaans and isiXhosa. It emphasises the value of early childhood development and maternal and child health during the first thousand days period, as supported by the latest research in neuroscience,³ and also highlights a variety of childcare practices for parents, but specifically mothers. The aim of the video is “to increase awareness in parents regarding their infants’ development and needs and thereby enabling them to adapt their handling of their young children” (Berg, 2006). As confirmed by Berg, the video has already been shown to a wide range of audiences, including parents, professionals and students, who commended the non-judgmental attitude that is apparent in the video. Because it was created from the perspective of a clinician with extensive working experience in the Khayelitsha community,⁴ particular care was taken to state facts in a way that would be acceptable to even the most vulnerable mothers. The video displays childcare scenarios in various socioeconomic backgrounds, representing racially diverse families and caregiving in the Western Cape and South Africa at large. Three infants, at different developmental stages, are introduced throughout the video; each infant encounters his or her own set of potentially harmful social experiences, which are told as narratives from the three infants’ perspectives.

³ Scientific research has revealed that the brain of an infant is at its most receptive during the first eighteen months of life (Schore, 2001) and that trauma and stress can alter the architecture of the brain (Lou, 1994; Pollak, et al., 2010). Moreover, the sensory systems of infants are acute, allowing them to make immediate connections (Stern, 1985; Farroni et al., 2002).

⁴ Prof. Berg worked at the Kuyasa Clinic in Khayelitsha, where the original video for the video card was filmed. Khayelitsha is a high density suburb in Cape Town, with a population of 391 749 – reported in the 2011 census.

Somi, boy, ante-natally and after birth, then at 13 months

While in the womb, Somi is aware of both his internal and external environments. When his mother smokes and drinks during pregnancy, the infant is negatively affected by it. Somi's mother also suffers from depression, but she seeks emotional support from the Kuyasa Clinic in Khayelitsha once her son is born. By doing so, Somi's mother's overall health and well-being improves and she is able to take better care of Somi.

Josh, boy, 4 months

Josh's mother lets him cry for too long because she is busy cooking. His parents also fight in his presence, which causes him great distress. Only once the mother, or both the mother and the father, begin to pay attention to Josh and begin to talk and play with him, does his mood improve. He smiles back at his parents when they engage gently and lovingly with him.

Radheefa, girl, 9 months

Radheefa's mother leaves her with a stranger (caretaker) before she goes to work. Being left with a stranger causes the infant to cry after her mother. Only once Radheefa's mother spends time with her and the new caretaker and reassures Radheefa that she is safe, does the infant begin to feel comfortable being taken care of by a stranger.

Overall, the video emphasises:

- 1) that the foetus and infants are aware of what is going on in their environments;
- 2) the need for parental cohesion and calm behaviour; and
- 3) the need for love, play and stimulation.



Figure 1: The prototype of the physical video card device.

In addition, as outlined by Berg (2006) in the original research proposal for the creation of the video, the *Together from the Beginning* video content highlights the following:

- The importance of maternal health during pregnancy, such as the deleterious effects that smoking and drinking have on the baby
- The importance of the feeding relationship between mother and baby, i.e. breastfeeding
- Showing developmental milestones, such as smiling, babbling, and motor development
- The normal curiosity and activity of toddler-hood (which is often misinterpreted as ‘naughtiness’ and hence punished)
- The importance of sibling and peer relationships
- Considering caregiving arrangements from the baby’s point of view – to prevent disrupted attachment experiences

The video further advocates that mothers visit local clinics (here demonstrated by reference to Kuyasa Clinic in Khayelitsha) and hospitals (here, the Red Cross Children’s Hospital) regularly to seek emotional support and medical assistance where and when needed.⁵

Method

Research Background and Purpose

This research project was proposed by Professor Astrid Berg and established in conjunction with the UCT Knowledge Co-op (project #270).⁶ The pilot project was funded by The Innovation Edge (DG Murray Trust), and was supported by both the Anthropology of the First Thousand Days of Life, chaired by Professor Fiona Ross, and by the Western Cape Government Department of Health. As a requirement for the Master’s Degree in Practical Anthropology, I presented a formal research report to all parties involved on 31 July 2016. The research report was intended to assist the Department of Health in determining whether and, if so, how best to implement the video card in all major public healthcare facilities throughout the Western Cape. Practical anthropology – also referred to as *development anthropology*,

⁵ The video has the potential to form part of the proposed service development of the Parent-Infant Mental Health programme and could also be linked to the Early Childhood Development Provincial Strategy of the Western Cape Government, which aims “to facilitate, measure and monitor the provision of a range of ECD services and programmes that include a developmentally appropriate curriculum, knowledgeable and trained staff and educators, and support the health, nutrition, physical and social wellbeing of children” (Western Cape Government, 2011).

⁶ “The UCT Knowledge Co-op builds on [the] tradition of social responsiveness – and aims to make it easier for community partners to access UCT’s skills, resources and professional expertise. The Knowledge Co-op helps initiate joint projects that benefit both the community and the university. It links community groups with appropriately qualified staff and students at UCT, and it supports both partners throughout the project – from initial planning to final product”. For more information, visit: <http://www.knowledgeco-op.uct.ac.za>

action anthropology, applied anthropology, and advocacy anthropology – is characterised by problem-oriented research that applies “anthropological data, concepts, and strategies to the solution of social, economic, and technological problems, both at home and abroad” (Ferraro and Andreatta, 2008: 50). On a practical level, the aim of the research was therefore to pilot and evaluate both the content and the overall usage of the video card: to implement the video card in the clinic, to determine whether pregnant women and nurses were supportive of the intervention, to obtain suggestions to improve the video, and also to determine whether the video card was a sustainable intervention in the clinic. The participation and support of pregnant women, mothers and clinic nurses was vital because the intervention was intended to assist the nurses in disseminating information to pregnant women about their childcare behaviours, habits, and practices. While the video could have been shown to all patients in the clinic, pregnant women and their partners (when present) were targeted as the primary participants, as requested by the Department of Health. All pregnant women, regardless of their stage of pregnancy, were allowed to view the video and then to participate in the study, if they chose to do so.

On a more theoretical level, a critical development anthropological perspective was employed to explore ideas related to motherhood in development discourses and development interventions. While my original set of research questions (see Appendix A) were useful in the initial preparation for ethnographic fieldwork, the following research questions guide the overall structure and purpose of this thesis: How and by whom are mothers influenced during pregnancy and early childhood? How and to what extent are mothers ‘developed’ within the public healthcare facility? What are the consequences of ‘developing’ mothers? What are the implications of placing the mother at the center of the particular development discourses? How and why are mothers *made* to matter within the public clinic? I demonstrate that while mothers do matter in the physical development of babies, mothers are *made* to matter through development discourses and interventions related to maternal and child health (MCH) and early childhood development (ECD). This, in turn, reinforces and normalises the dominant discourse of motherhood, while also undermining the time, knowledge, and experiences of these women. At the request of the Department of Health, research was focused on the waiting areas of a public healthcare facility where I engaged with women and observed interactions between pregnant women, those accompanying them, mothers and nursing staff. I examine also the creation, implementation and analysis of the *Together from the Beginning* video card (both the physical device and the video content), along with other development interventions that were

present in the public healthcare facility. Pertinent questions and assumptions related to development, motherhood, maternal knowledge and care, power relations, and the current state of the public healthcare system in South Africa are revealed. I present these through three broader themes – ‘waiting’, ‘educating’, and ‘interrupting’ – that materialised in the research and that lead to deeper discussions regarding the intricate link between development discourses and interventions and contemporary notions of motherhood.

Community Health Clinic and Pregnant Participants

The Community Health Clinic (hereafter the CHC) was chosen as the primary research site to pilot the video card because the facility manager expressed an interest in the project when approached by the Department of Health. The clinic was conveniently located in close proximity to my home and its catchment area drew from several working class populations in densely settled areas outside of Cape Town. The CHC is a public clinic, which operates in the Metro Region, Cape Town. As a primary healthcare facility, the CHC provides HIV, AIDS and TB-related treatment, care, support and triage services to a large working class and unemployed population. I interviewed eighty participants, consisting of sixty pregnant women, eight partners or fathers of their babies, ten nurses and two counsellors. Of the sixty pregnant women who completed the demographic survey, 85% were South African nationals, while the remaining 15% were from various African countries, including Congo, DRC, Rwanda and Zimbabwe. Fifty per cent of the pregnant participants indicated on the survey that they identified as ‘black’, 43% ‘coloured’, 5% ‘white’, and 2% ‘Indian’. Their ages ranged from 17 to 38 years (median: 26). Most pregnant women lived in surrounding areas of the CHC. While twenty-one pregnant women had obtained their Matric certificate, with five women having obtained a higher education diploma or certificate, more than half ($n = 34$) of the women had not completed high school. Ten per cent of the pregnant women reported themselves as single and 3% as engaged to be married; the majority of the women were either married (42%) or ‘in a relationship’ (45%).⁷ Twenty per cent of the pregnant women were expecting their first child, 25% their second, and 13% their third. Most (63%) of the women were in the third trimester of their pregnancy, while 30% were in their second trimester, and only 7% were in their first trimester.

⁷ By ‘in a relationship’, women reported that they were ‘dating’ men, but were not engaged/married to them.

Interviews and Observations

I approached pregnant women while they were sitting on the benches in the waiting area of the antenatal clinic and MOU. They were informed individually, in pairs, or in groups of four about the purpose of the research study. A convenience sample of pregnant women and mothers was selected, depending on the interest or willingness of the women to participate in the study. Those who showed interest, after having read the information sheet, were invited to participate (see Appendix B). Informed consent was obtained from the pregnant women in writing, and thereafter each woman completed a demographic survey (see Appendix C and D).⁸ Once the survey was complete, pregnant women were interviewed using a structured questionnaire that was divided into two sections: *pre-intervention* and *post-intervention* interview questions (see Appendix E and F). These questions were made available in both English and Afrikaans, which were two of the main languages spoken by the participants with whom I interacted. Pre-intervention interview questions were asked before the pregnant women watched the video. They examined expectations and experiences of pregnancy, ideas about foetal care, support structures (including who takes care of them and their children), access to healthcare resources, and questions about the partner's or father's involvement in the pregnancy. Video cards were then distributed and participants could either watch the video alone or with other pregnant women seated alongside them. I observed how viewers interacted with the video cards and one another while they watched the video, so as to examine the efficacy of the video card device in the clinic. Other observations included pregnant women's experiences of waiting in the designated waiting areas; the relationship between women and nurses, women and partners, women and children, as well as the overall clinic environment. I also observed the rhythms and routines of the clinic, noting the extent to which the video card interrupted or was interrupted by the clinic flow throughout the research project. I took notes in the moment and then wrote them up at the end of every day. Collecting field notes in the clinic formed a fundamental part of understanding the process of waiting in the clinic, as well as how the video card featured in and altered women's experiences of waiting. As such, I draw on fieldnotes throughout the chapters to provide first-hand observations of the clinic waiting spaces, and situate the analyses of the women's experiences of waiting and of watching the video cards.

⁸ The demographic survey collected data about the pregnant women's age, relationship status, stage in pregnancy, and number of previous children. Since the demographic survey consisted of standardised, closed-ended questions, the data was statistically and analytically comparable.

After watching the video, pregnant participants were asked the second set of structured (post-intervention) interview questions. These related to the video content, the process of watching the video and handling the video card, information sharing, as well as suggestions for future interventions. Interviews ranged between six to twenty minutes per participant. Nurses were also interviewed after having watched the video, and again after administering the video cards on their own for a period of two weeks. All interviews with the participants were recorded and transcribed verbatim. The transcribed interviews were initially analysed using NVivo and were sorted into themes as guided by the interview questions: experiences and symptoms, paternal involvement, foetal and infant care, healthcare and information, previous knowledge, support and care, as well as based on responses to video card — positive, negative, emotions, regret and guilt, stress, suggestions. Thereafter, further analysis, using thematic coding, was completed using similar themes to gain a deeper understanding of the women's experiences. Given the scope of the research project, a pilot assessment, it was not possible to conduct additional research outside of the clinic space. Findings were limited to what I heard and saw in the one clinic. While this is a limitation in the project, it is not likely that the findings here would not be replicated in other studies.

Ethical Considerations

The study, which took place over a two-month period (7 March – 6 May 2016), was approved by the University of Cape Town's Anthropology Section (EARC2015-20b), the Human Research Ethics Committee from the Faculty of Health Science, University of Cape Town (HREC REF: 810/2015), and the Western Cape Government Department of Health (REF: WC_2015RP52_37). The research adhered to the Anthropology Southern Africa's code of ethical conduct, as well as the Helsinki Declaration of 2013 and the National Health Act of 2003, as required by the Faculty of Health Sciences, University of Cape Town. During interview sessions, all information shared with me was regarded as sensitive. Pregnant participants who required emotional or physical support after watching the video had direct access to the peer counsellors, health promoters, and the facility manager at the CHC. Individual participants were given pseudonyms, and their identities were further protected by replacing the names of places or by omitting the names altogether. Research participants were volunteers and were not remunerated for their participation in the research project; they had the right to withdraw from the study at any point. Pregnant women and those accompanying them were also free to watch the video without participating in the interviews and discussions. The name and location of the Community Health Clinic, as well as the names of all surrounding

areas have been omitted from the thesis, as per request of the Western Cape Government Department of Health in terms of its ethics procedures.

Chapter Outline and Thesis Argument

The thesis critically explores how motherhood is represented and constructed in development interventions, as it was revealed to me during my ethnographic research at the clinic. It examines core assumptions that underpinned the creation and implementation of the *Together from the Beginning* video card development intervention in the CHC: that (1) time spent waiting is time wasted; (2) women have the time and resources available to implement the interventions in their lives; (3) working class women lack childcare knowledge and practice; (4) scientific research related to ECD and MCH is regarded as knowledge that women ‘need’; (5) women do not receive ECD and MCH-related information from others; as well as (6) women will be positively influenced by ECD and MCH development interventions. As mentioned, three dominant themes emerged from the ethnographic fieldwork and data analysis, namely: waiting, educating, and interrupting. Using these themes, I will demonstrate how three different maternal figures were produced and developed within the CHC: the waiting mother, the educated mother, and the ideal mother.

Chapter two, *The Waiting Mother*, contextualises the creation and implementation of the *Together from the Beginning* video card intervention and situates the research within the waiting areas of the CHC antenatal clinic. I will argue that (waiting) mothers were made to matter within the clinic space via interventions by the state and development agencies for the sake of development. This was done by reframing the waiting time of women to become an ‘opportunity’ during which to educate specifically pregnant women and mothers about ECD and MCH developmental issues. I show how women’s time spent waiting is imagined and (de)valued by outsiders, to the extent that it normalised waiting, while also legitimising the ‘need’ for interventions.

In chapter three, *The Educated Mother*, I will explore the assumptions that underpinned the perceived ‘need’ for the *Together from the Beginning* video card and other development interventions implemented at the CHC – that maternal education ‘needs’ to improve and that mothers ‘need’ to learn how to care for babies adequately and appropriately in order for them to reach their full development potential. I will argue that (educated) mothers were made to

matter within the clinic through development interventions and nursing staff who emphasised, reinforced and normalised the ‘need’ for maternal education, often in biased and racist ways.

Chapter four, *The Ideal Mother*, explores the unintended consequences caused by the *Together from the Beginning* video card. In particular, this chapter outlines the spatial and emotional interruptions that occurred throughout the research project, as facilitated by the physical video card and video content. I argue that (ideal) mothers were made to matter through the video card development intervention by (unintentionally) emphasising the principles of ‘intensive mothering’ in the video content. This, however, resulted in some women reflecting on their pregnancy and mothering experiences with anxiety, thus producing feelings of guilt and stress about their self- and childcare practices. Women’s experiences and everyday lived realities outside the clinic were consequently disregarded and undermined.

By the end of this thesis, I will have shown that, while mothers do matter in the physical development of babies (during pregnancy), mothers are ‘developmentally constructed’ and thus ‘made to matter’ through development discourses and interventions related to maternal and child health (MCH) and early childhood development (ECD), which reinforces and normalises dominant discourses of motherhood. More specifically, I will also have shown how the (waiting, educated, and ideal) mothers were produced, developed, and made to matter within public healthcare spaces for the sake of development, which in turn reframed, undermined and disregarded the time, knowledge, and experiences of these women.

Chapter Two

The Waiting Mother

Dear patient,

When you arrive at the entrance gates of the Community Health Clinic (CHC), you will pass two informal traders. Their wooden trestle tables, perched up against the high wire fencing that surrounds the clinic, will be covered in piles of *NikNaks*, *Flyers*, *Cornachos*, *Wilson's Toffees*, alongside bananas, apples, and oranges.⁹ These food items are primarily intended to be sold to the patients entering the public clinic, some of whom will spend minutes to hours waiting to be assisted. If you have not packed in a snack, it is highly recommended that you buy something from these traders before entering the clinic, as you will most likely become hungry at some point during the day. Thereafter, walk past the security guard, enter a small building to your right, and then walk through the metal detector. The metal detector will beep every time you (and every other patient) walk through it; however, the security guards will never check your (or anyone else's) backpack or pockets for potentially harmful items. Proceed to walk along the concrete sidewalk. Once you reach the end of the sidewalk, you will pass a building surrounded by large glass windows. This is where patients sit on wooden benches and plastic chairs, waiting for the clinic to open and to be assisted by clinic staff. Some patients arrive long before the clinic opens at 07:00, just to ensure that they receive a seat in the glass 'pre-waiting' area. You may also want to arrive before 07:00 in order to be assisted quickly, but this is *not* guaranteed. Once the clinic opens, you, along with all the other waiting patients, will be called into the clinic and told to line-up and collect your clinic folders from the reception desks before being directed to the relevant section within the clinic. Your waiting will then continue in designated waiting areas.¹⁰

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⁹ *NikNaks*, *Flyers*, *Cornachos* refer to the names of crisps or chips; *Wilson's Toffees* refer to a type of toffee candy. These products are all produced in South Africa.

¹⁰ This is an imaginary letter based on my experiences and observations at the CHC; it is intended to situate the ethnographic research and this particular chapter.

Introduction

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

Waiting is an inevitable part of human existence. Whether we are waiting for the bus, waiting to heal, waiting to give birth, or waiting for the day to begin or end, waiting manifests for a variety of reasons, durations, and may be accompanied by a range of emotions. For Giovanni Gasparini (1995), waiting is a basic aspect of human experience, and contains a wealth of meaning. In *On Waiting*, Gasparini demonstrates how different kinds of waiting are interrelated in everyday life. He proposes that waiting can be analysed in three ways: as blockage of action, as an experience filled with substitute meanings, and as a meaningful experience. Furthermore, waiting can be regarded as subjective or objective (Fujita, 1985); modal, relational, or active (Auyero, 2011); or as political, social, or cultural (Hage, 2009). Waiting can also be perceived as a fruitful process, providing one with time to think. For Harold Schweizer (2008), “waiting can be a rewarding experience, eliciting reflection on time and human existence”, and proposes that “waiting is an essential condition for aesthetic and ethical values” (2008: 126). On the contrary, for Javier Auyero (2011), waiting implies ideas of powerlessness and helplessness, and does not affect everyone in the same way (see also O’Brien, 1995; Schwartz, 1974 and 1975). For Auyero, waiting can be interpreted as stripping the waiting person from his or her agency. However, while it is easy to assume that “waiting is a passive modality of being where people lack agency” (Hage, 2009: 2), waiting can also be agentive in nature. Waiting, for instance, can entail “passive activity” (Crapanzano, 1985) or “active passivity” (Hage, 2009). Both versions imply waiting as a form of activity, action, or something we do. Waiting therefore offers many lenses through which to understand and make sense of the complexities of everyday life. As an analytical tool, the concept of waiting proved useful in understanding my research process, and also how time affected pregnant women and mothers in the clinic. A core theme in my research, waiting emerged as the activity that took the most time in the clinic. As such, since waiting affected all pregnant women and mothers in the CHC, this chapter not only situates the research within the waiting areas of the CHC antenatal clinic, but also shows how the time that women spent waiting in clinic was normalised for the sake of development. Who waits? Why do pregnant women wait? What do pregnant women wait for? How do pregnant women wait? What emotions are attributed to waiting? What do pregnant women do while they wait? By whom and how is waiting perceived? In what follows, I will seek to answer these questions, and will demonstrate how waiting was perceived by different stakeholders; describe the physical waiting space of the CHC antenatal

clinic; and outline what women in the antenatal clinic waited for. In doing so, I will argue that (waiting) mothers were made to matter within the clinic space via development interventions supplied by the state and development agencies. This was done by reframing the waiting time of women as ‘wasted time’ and as an ‘opportunity’ during which to educate specifically pregnant women and mothers about ECD and MCH developmental issues. I therefore demonstrate how women’s time spent waiting is imagined and (de)valued by outsiders, to the extent that it legitimises the ‘need’ for interventions.

Waiting as Wasted Time

“When we wait in the doctor’s clinic, for example, we surrender our time to another. This is willingly done, except when it takes *too long*, when we start to feel out of synchronicity with the time that we think it should take. Waiting, then, becomes a waste of time...” (Tan, 2009: 73; italics in original text). When waiting is perceived as wasted time, it can evoke subjectively negative emotions within the person who is expected to wait; as Crapanzano states, “waiting produces in us feelings of powerlessness, helplessness, and vulnerability — infantile feelings — and all the rage that these feelings evoke” (1985: 45). That waiting was perceived as ‘wasted time’ was a dominant belief held by me, the state, and the developmental agency that supported both the development of the video card intervention and this research project.

The researcher

Waiting formed a major part of my own experience of this research project. Firstly, as the primary researcher, I found myself constantly waiting for documents granting permissions, appointments with professionals, and so forth. Perhaps the most important “object of waiting” (Crapanzano, 1985: 45) was the ethics clearance process that would allow me to conduct the ethnographic research. After having obtained clearance at the level of my home department, I applied to the Human Research Ethics Committee (HREC) at the University of Cape Town’s Faculty of Health Science, as dictated by national health policy. Clearance there took two months to obtain, and was formally received on Monday, 14 December 2015. I then waited to obtain permission from the Western Cape Government Department of Health in order to conduct the research at the CHC. This process took another two months; I formally received the document on Friday, 19 February 2016. Once I had obtained both clearance and permission documents, I was officially able to start my fieldwork; however, I was faced with more delays. One was because the video cards were not ready for collection at the beginning of the research.

I was thus forced to work with the sole video card that I had in my possession. I then waited several more weeks for the new edited versions of the video cards to be delivered to me; however, delays from the editors meant that I only had the original video content to analyse. I also needed to wait days to weeks for email responses from the CHC facility manager and staff. In essence, waiting was rendered through delayed bureaucratic processes and technologies. Once I was in the antenatal clinic, I faced a new type of waiting: waiting for an opportunity to interview the first pregnant woman. As such, waiting not only manifested as a result of my own insecurities, but was also, to a greater degree, externally imposed upon me. What I found most problematic from my own experience was that waiting appeared to be a passive, normalised and an unavoidable process that *felt* as though my agency had been stripped from me, as Auyero has noted, even though objectively speaking, it was not. The long periods of waiting felt like it was beyond my control and was instead controlled by bureaucratic powers “above”. I could not predict when or if my research proposal would be approved by the HREC, nor did I know whether I would receive the video cards before the start of my research. I was in a constant state of uncertainty and frequently felt powerless. Throughout the various stages of research, I was merely expected to wait, despite the personal urgency I felt in wanting to start my research as soon as possible in order to graduate “on time”. This latter phrase is suggestive of temporality, whereby time is rendered as something to be managed. Waiting subsequently tested my patience through every step of the research project, and often left me feeling helpless, demotivated and exhausted. At the same time, having to endure waiting myself gave me a sense of how the women at the CHC may have felt while they waited for the names to be called and for their antenatal appointments to begin and end – or so I imagined.

The state and development agencies

Analysing waiting in a welfare office in Buenos Aires, Javier Auyero’s (2011) research represents the subjective mode of waiting (see Fujita, 1985) and demonstrates how the waiting experiences of poor people in the welfare office were grounded in (subjective) feelings of confusion, uncertainty and arbitrariness. Auyero argues that “these waiting experiences persuade the destitute of the need to be patient, thus conveying the implicit state request to be compliant clients” (Auyero, 2011: 6).¹¹ He does so through an analysis of the sociocultural

¹¹ Etymologically, the word *patient* (noun) means “suffering or sick person under medical treatment”; whereas *patient* (adjective) means “enduring without complaint”; however, both words stem from the Latin word *patientem* (Etymonline, 2016). The shared Latin root could imply that to be a *patient* one also needs to be *patient*, and should endure the lengthy waiting periods and the poor public healthcare without any complaint.

dynamics of waiting experienced by primarily, but not exclusively, women and their children in the welfare office. As found by Auyero, the welfare clients often compared their waiting time at the welfare office to the waiting time in public hospitals: “in both places they have to (silently) endure; they have to act not as citizens with rightful claims but as patients of the state” (Auyero, 2011: 23). This belief that waiting was to be ‘(silently) endured’ by patients was also held by the development agency that supported the implementation of the video card in the CHC. Their support was further based on the fact that only those who paid for (private) healthcare do not have to wait long, while those who accessed free (public) healthcare waited for long periods of time. The lengthy periods of waiting experienced in South African public spaces – especially in the waiting areas of public services spaces, such as “home affairs for birth registration, SASSA offices for grant applications and collections, primary healthcare clinics for antenatal visits and immunisations” (NGO Pulse, 2014) – were thus normalised and perceived by those with power, such as the state and development agency, as time that was ‘wasted’ and as time that patients should make available in order to access state resources. In other words, they viewed waiting as time that must be ‘endured’ and simultaneously as time that must be used ‘productively’. The latter interpretation of waiting can be understood as the “political economy of waiting”, which, according to Hage (2009: 3), regards waiting as an economic factor (i.e. time equals money). When this occurs, waiting can be seen as an ‘opportunity’ during which to achieve certain goals. This was the case for this particular research project which was closely aligned with and supported by the “Waiting Room Project” as launched by The Innovation Edge in November 2014 (NGO Pulse, 2014), which called for creative and innovative ideas to transform various ‘waiting places’ into ‘engaging spaces’. As I will show, however, the assumption that ‘waiting places’ are not necessarily ‘engaging places’ is somewhat erroneous since a great deal of activity happens in waiting spaces. The *Together from the Beginning* video card was thus supported by The Innovation Edge because it was imagined and anticipated that the intervention would be able to ‘transform’ the CHC antenatal clinic and MOU waiting places into engaging spaces. In particular, it was expected that the video card would enable (working class) pregnant women and parents to learn about foetal and infant care behaviours via the video as they waited in the CHC waiting areas. Three assumptions consequently rendered this project possible: the assumption that waiting in public healthcare facilities was inevitable and normal; the assumption that waiting places were not necessarily engaging spaces; and the assumption that waiting time and waiting spaces were wasted opportunities. It was therefore as a result of these assumptions about waiting that the ‘waiting mother’ was produced, developed and made to matter within the CHC waiting rooms.

The Waiting Room

“The waiting room is a peculiar sort of place, a space of liminality, suspended time, even containment. It is a space defined as temporary, only intended as a lead-in to another place. The goal is to get into or out of the doctor’s office” (Ticktin, 2013). In Miriam Ticktin’s analysis, waiting rooms are liminal: spaces on the way to other spaces and the events they contain. Although the physical spaces of waiting in the CHC were more waiting ‘areas’ than confined and contained waiting ‘rooms’, they were imperative sites where the complex worlds of women were revealed through personal narratives and daily experiences of waiting. It was in these supposedly liminal areas of waiting where I interacted with clinic staff, pregnant patients and some of their partners (when present), and also observed the prolonged waiting periods that many of the pregnant patients encountered and endured. While my interactions with the women were limited to these waiting clinic spaces – which were often noisy, cramped, lacking privacy, and replete with interruptions – it was hard to ignore the fact that the public healthcare waiting areas were embedded in rich social, economic, cultural, and political histories: that is, that they were indeed places and not merely spaces. The wooden benches and plastic chairs in the waiting areas became my primary sites for data collection, as it was thus both *on* and *because of* these waiting benches and chairs that I was able to introduce the video card intervention, as well as the purpose for my research to the nursing staff, pregnant women and mothers. It was also on these waiting benches that I received a glimpse into the everyday lives of women as they attempted to navigate their time, knowledge, and experiences as mothers and mothers-to-be.

Monday, 7 March 2016. My first day of research at the CHC; I arrived early, at 06:25. After making my way through the metal detector, down the sidewalk and past the “pre-waiting” area, as described in the opening letter to this chapter, I was directed by a male security guard to the Midwife Obstetrics Unit (MOU), where the head nurse was stationed. Before entering the MOU, a female security guard seated outside the entrance requested that I sign into a visitor’s book, and then punched in a code to open the door. Entering the MOU, I introduced myself to the nurses on duty, who commented on how early I was, noting that the head nurse would only arrive at the clinic at 08:00. I took a seat on one of the fifteen black, plastic chairs, strategically selecting one that would allow me to see the MOU entrance door, the reception desk, and into one of the nurse’s rooms. I then sat quietly in the small 3m x 5m MOU waiting area from 06:30 to 08:00, using this time to observe the setting and interactions occurring around me. Shortly after I took my seat, a young pregnant woman arrived, clinic file in hand.

Within an hour, three more pregnant women, three mothers with infants, and two men accompanying them, took their seats on the cold plastic chairs, patiently awaiting their names to be called by the nurses. By the time the head nurse arrived at the MOU at 07:45, I had read over each poster stuck to the pin boards on the walls (see figure 2) where health and citizenship directives were mixed together: *MOU Infant Feeding Policy*; *Pregnant? Join MomConnect*; *Did You Know? Birth Registration (must be filed within 30 days from birth)*; *Latching for Comfort (how to breastfeed successfully)*; *ATTENTION ALL NEW MOTHERS: please be advised that you are not to clean your new born babies (sic) navel with a Disprin. You should ONLY use Surgical spirits. Your co-operation will be highly appreciated.*



Figure 2: A pin board, covered in posters, hangs on the wall in the waiting area of the Midwife Obstetrics Unit (MOU) at the CHC.

During this time, I witnessed multiple male and female nurses enter and leave the MOU, a mother breastfeed her infant, a man accompany a pregnant woman to her appointment, a pram take up half of the waiting area, a nurse discuss ‘private’ matters with a woman in a small room adjacent to the waiting area (with the door wide open and the conversation audible to all), a white nurse struggle to understand a black pregnant woman who was complaining about having stomach cramps.¹² “What’s wrong with you? Is it gastro? Diarrhoea? Pain? Where is the pain?”

¹² The terms “African or black, coloured, white, and Indian” are used to refer to racial classifications previously established and enforced in South Africa under apartheid law. The structuring effects of apartheid’s race categories remain visible in the social, economic, and political landscape in the country today, and while the terms are no longer legally enforced, people readily make recourse to them in everyday interactions.

asked the nurse of the pregnant woman in a curt tone. The pregnant woman, who was clutching her belly and bent over in agony, struggled to articulate her symptoms in English to the nurse. In the ninety minutes that I had been waiting in the MOU for the head nurse to arrive, I had already witnessed and experienced plenty: the way that time appeared to move slowly in the crowded waiting area; the physical discomfort of waiting on a hard, plastic chair; how long durations of waiting in the waiting areas appeared to be perceived as inevitable and normal; the multiple attempts to inform and educate specifically pregnant women and mothers (rather than parents and caregivers) about “appropriate” childcare practices through visual media; the relationships between pregnant women and their partners (at least for those who were present); as well as the asymmetrical power dynamics between nurses and patients (particularly pregnant women and mothers) that were revealed through language barriers and racialised tension. These experiences, as I would come to discover, repeated themselves in the waiting areas of both the antenatal clinic and the MOU at the CHC over the following two months.



Figure 3: Corridor of the CHC antenatal clinic at 06:45 in the morning before the clinic was opened to patients; four wooden benches strictly designated for the pregnant women attending the antenatal clinic.

I followed the head nurse down the antenatal clinic corridor (see figure 3), and began to take in my surroundings, each footstep sparking my senses and stirring questions within me. With the first few footsteps, I noticed the peach walls covered in posters intended for pregnant women. *Do the women read these posters? Are they able to learn anything from the posters?*

With the next few footsteps, I noticed that there were no clocks on the walls in the corridor, nor were there any windows. *Why were there no windows or clocks? Was this intentional?* The more steps I took down the corridor, the noisier the clinic grew. I heard women chatting to each other, on their phones, and to those accompanying them; nurses calling patients' names; doors banging as patients entered the nurses' rooms; toilets flushing and doors creaking as women entered and exited the bathrooms. *How will the women hear me when I interview them? How will they hear the video?* A few more steps and the pungent smell of urine that seeped through the bathroom doors and from the containers that each pregnant woman held in her hand permeated the air.¹³ When the head nurse and I reached the end of the corridor, what I had thought was the end of the queue of waiting women, was not. Around the corner was a larger waiting area, connected to, but separate from, the waiting benches in the corridor. It held another four wooden benches that each seated five to six pregnant women (see figure 4). *How long had these women been waiting for? Were they interested in watching the video and participating in the research project?* These questions, along with others, filled my mind and prepared me for the next eight weeks of research at the CHC.



Figure 4: Separate larger waiting area; four longer wooden benches strictly designated for the pregnant women attending the antenatal clinic. Photo taken at 06:45 in the morning before patients arrived.

¹³ After collecting their clinic files from reception and dropping them off in room 10, all pregnant women were expected to fill their small medicine containers with a urine sample to be tested. These containers were given to the pregnant women during their initial antenatal check-up.

Waiting for Something

“Waiting is always waiting for something. It is an anticipation of something to come — something that is not on hand but will, perhaps, be on hand in the future” (Crapanzano, 1985: 45). I entered the clinic with a narrow idea of what, and how long, pregnant women waited for: to give birth (spanning over several months) and to be assisted by nurses (ranging from minutes to hours); however, my observations revealed that the “object of waiting” (Crapanzano, 1985: 45) for those pregnant women, with whom I worked in the antenatal clinic, extended far beyond these two simplified forms of waiting, as did the duration that they spent waiting in the clinic. Below are field notes from Tuesday, 29 March, that document the appointment and waiting times of four pregnant women (see table 1). As the table demonstrates, the waiting time and appointment lengths varied for each woman, ranging from twenty minutes to three hours.¹⁴ As I demonstrate below, however, some women spent a great deal more time than this waiting in the CHC.

Table 1: Total time spent in the CHC antenatal clinic

	“Petersen”	Margaret	Rachel	Yasmina
Arrived at CHC	10:50 [15mins]	9:30 [10mins]	09:00	9:45
Pre-intervention interview	N/A	9:40 [3mins]	10:40 [3mins]	10:31 [2.5mins]
Post-intervention interview	N/A	10:00 [1min] (interrupted)	10:55 [3mins]	10:47 [3mins] (interrupted)
Check-up in room 20	11:40-11:50 [10mins]	10:00-10:10 [10mins]	11:00-11:10 [10mins]	10:50-11:00 [10mins]
Post-intervention interview (continued)	N/A	10:10 [6mins]	N/A	11:35 [1.5mins]
Additional	Room 10 and counselling [30mins]	Unknown	Waiting for counsellor [50mins]	HIV counsellor [10mins]
Left clinic	11:50	11:15	12:00	11:45
Total time spent in clinic	1 hour	1 hour and 45mins	3 hours	2 hours
Waiting time	20mins	1 hour and 30mins +	2 hours +	1 hour and 40mins

¹⁴ Tracking the waiting times was challenging because: waiting time differed depending on the day and what time of the day it was; pregnant women did not always return to the same benches in the waiting areas; some women arrived hours before their appointments (I did not know the time of their appointments); and pregnant women left while I was busy interviewing other women and I often did not see them leave.

During the minutes to hours that pregnant women spent waiting in the CHC antenatal clinic, it can be argued that the women were “always waiting for something” (Crapanzano, 1985: 45). To elaborate, the waiting process (for all patients and those accompanying them) started in a separate building located beside the CHC main entrance. At 07:15, the pregnant women entered the clinic building and proceeded to the antenatal clinic, where they sat on benches in the corridor and waited for their clinic cards to be checked by nurses.¹⁵ “Is your appointment for today?” asked the nurses to the waiting women. If the pregnant woman answered “yes”, the nurse stamped the pregnant patient’s hand, and the woman moved to sit in the adjacent benches in the larger waiting area. If she answered “no”, the pregnant woman remained seated on the corridor benches and waited to be assisted by a nurse in room 20, where she was then issued a (first-time visit) appointment date and left the clinic only to return on her new appointment date. After ten minutes of sorting through the two groups of women, pregnant women seated in the larger waiting area were called and given clinic cards. One by one, the women were sent to the clinic reception windows, where they then waited in a queue to collect their clinic files. Once they received their files, the pregnant women delivered their files to a nurse in room 10 and then returned to the benches in the larger waiting area, where they waited for the HIV counsellor. During this period, a nurse addressed the group of waiting women. She explained the importance of HIV counselling session; informed them about pap smear procedures; discussed sonography rules and follow-up appointments, and emphasised the need to bring their ‘pregnant books’ along to their appointments.¹⁶ By 08:15, once the counsellor had addressed the women and had drawn their blood for mandatory HIV testing (done in a private room), the pregnant women returned to the benches in the antenatal clinic waiting area where they then waited to be seen by a nurse in room 10. During this time, pregnant women filled empty tablet containers with urine. In room 10, nurses weighed the women and updated the obstetrics data in the women’s ‘pregnant book’. Thereafter, the women returned to the benches where they then waited to be examined by another nurse. If the women were in weeks nineteen to twenty-two (five months) of their pregnancy, they then needed to wait again to be

¹⁵ This description was based on observations made during a “first-time visit” day, which took place on Friday, 15 April 2016. The antenatal clinic procedures for first-time visits (Tuesdays and Fridays) differed from follow-up visits (Mondays and Wednesdays). After their initial first-time visit to the clinic, pregnant women were given specific dates and times for their follow-up clinic visits. Upon their arrival to their follow-up clinic visit, they would first collect their blue clinic files before waiting in the antenatal clinic.

¹⁶ The “pregnant book”, as referred to by the nurses, is provided by the Western Cape Government Department of Health, and is used to document maternity case records. Sections within the book include *antenatal records*, *labour assessments*, and *assessment of newborn*. As stated on the cover of the book: “this document must always accompany the client when she is transferred to another health facility”.

seen by the sonographer. Some pregnant women also needed to wait to confirm the sex of their babies and other test results (such as blood tests and HIV/Aids tests).¹⁷ Whether pregnant women waited for the clinic to open, for their clinic cards to be checked, for their names to be called, for their appointment dates to be issued and to arrive, for their appointments to begin or end, or for their test results, the process of waiting for and in between these standardised procedures, was always presented as ‘inevitable’ and ‘normal’ in the public healthcare facility.

The notion that waiting is ‘inevitable’ and also ‘beyond our control’ is explored by Ghassan Hage (2009). Within its (albeit ambivalent) capacity to be agentic, waiting can also be political, as there is a politics around *who* has to wait, *what* waiting entails, *how* to wait, and also how waiting is *organised into a social system* (Hage, 2009: 2). In this regard, waiting is linked to power, an idea supported by Pierre Bourdieu who states, “the all-powerful is he who does not wait but who makes others wait” (2000: 228). Waiting is thus not only shaped by the person who is waiting, but is also determined and shaped by those providing whatever it is that people are waiting for (Hage, 2009: 3). This is particularly the case for public healthcare facilities, where the lack of efficiency, poor services and the scarcity of specialised medical professionals is measured by the duration of waiting time. Nursing staff at the CHC therefore experienced waiting differently to pregnant women. Some nurses, for instance, could not wait for their workdays to end because their schedules were generally overloaded. Within the CHC antenatal clinic, only five to six nurses were on duty at a time. These nurses were responsible for checking psychosocial, medical and obstetrics history records; examining women’s bodies for possible problems (blood pressure, obstetrical exam); screening and testing blood; treating possible STIs; offering preventative measures; and offering health education, advice, and/or counselling for all pregnant women present. While it was possible for the nurses to fulfil these duties on ‘first-time visit’ days, when only thirty women were allowed to make appointments (which equated to four-five patients per hour), on ‘follow-up visits’, nurses were expected to assist fifteen patients per hour. In other words, for the nurses, ‘there was no time to waste’. Their experience stands in direct contrast to that of their patients, who were assumed to both ‘have’ the time and to be ‘wasting’ it by waiting. The follow-up antenatal visit days were thus significantly busier than the first-time visit days, yet the same number of nurses were expected to work three times as fast as they would on other days. As a result, the number of nurses

¹⁷ According to the head nurse, given the high volume of pregnant women who attend the antenatal clinic every day, sonograms were strictly used to check on the babies’ development, and *not* to determine the sex of babies.

available and their level of efficiency, together with the high number of patients present, and the lack of healthcare resources directly influenced the duration of waiting time in the antenatal clinic. The waiting experienced by the pregnant women in the antenatal clinic was thus not necessarily the fault of the nurses. Instead, on a larger scale, they waited because they were situated in a public space that lacked resources, was under-staffed, and over-populated.¹⁸ The clinic was thus also expected to wait: for resources, staff, medications, information and so forth.

Once pregnant women entered the nurses' examination rooms, they experienced a different 'mode' of waiting. In the *Modes of Waiting*, Mikio Fujita (1985) differentiates between objective waiting ("what is waited for") and subjective waiting ("how we wait"). While subjective waiting can be characterised by feelings of patience or impatience, hope and expectation (Fujita, 1985: 110); objective waiting, according to Fujita (1985), consists of the world of instrument-machinery (e.g. waiting for an elevator), where waiting implies doing nothing; the world of nature (e.g. waiting for flowers to bloom), where we feel powerless, but continue to wait because we trust the external flows and rhythms; and the world of becoming (e.g. waiting for the completion of an artwork), where "what is waited for is realised through various trials and modifications, abandonments and new beginnings" (Fujita, 1985: 113). Although these three worlds are analytically different, they are not mutually exclusive and can be linked to make sense of the myriad experiences of waiting. For example, drawing on this model, the experience of (objective) waiting in the CHC antenatal clinic can be analysed in the world of instrument-machinery. In other words, while the pregnant women were initially waiting to hear their names called by nurses (for their appointments to begin), their periods of waiting were predetermined by medical instruments and machines, such as the needles and syringes to draw blood, testing strips for urine, ultrasound machines, blood pressure monitors, and the bureaucratic architecture of medical preparation and consultation. Once in the nurses' rooms, pregnant patients were expected to 'do nothing' while they waited for the machines to produce results. A such, within the world of instrument-machinery, the object of waiting for pregnant women was beyond their control; whereas outside in the waiting area, women had some, but not complete, control of the time they spent waiting.

¹⁸ The budget for healthcare needs to be considered. As reported on by Dr. Nomafrench Mbombo, the Western Cape Department of Health experienced a major budget cut of R600 million in the 2016/2017 financial year. Despite the fact that the Western Cape Department of Health receives the "lion's share of the provincial budget", according to the Minister of Health, "there is a clear tension between our available resources and the demand for quality healthcare" (Mbombo, 2016).

Returning to his analysis of waiting in a Buenos Aires welfare office, Auyero (2011) categorises waiting as modal, relational, and active. Firstly, waiting is a modal experience; patients “have to wait for almost everything (e.g. housing, health services, employment)” (2011: 9). Secondly, waiting is a relational experience; “they create or mobilize a set of relations or networks that allow them to spend long hours there. While there, they often meet with friends and relatives who help them tolerate and make sense of those boring and tiring hours” (Auyero, 2011: 14). Thirdly, Auyero’s ethnographic observations revealed that welfare clients kept themselves active while they waited, by playing with their children, feeding and changing their infants, walking around, leaving the building to buy snacks, playing games on their cellular phones, or occasionally reading the newspaper (Auyero, 2011: 15). Based on my observations, the waiting for the pregnant women in the CHC antenatal clinic can also be categorised as modal, relational and active. While most of the women sat alone and in silence, waiting for their names to be called by the nurses and for their antenatal appointments to begin (i.e. their waiting time was modal); some were accompanied by their partners or fathers of their babies, family members, friends, and younger children (i.e. their waiting time was relational). Moreover, some women browsed through the *Mother, Child Health and Nutrition* booklets and breastfeeding pamphlets that were provided to them by the nurses; some listened to the peer counsellors’ educational talks; some were busy on their cell phones, either playing games, texting, making phone calls, or browsing the Internet; and some waited by eating food or not eating at all (i.e. their waiting time was active). Nevertheless, while many of the women managed to occupy themselves while they waited in the antenatal clinic waiting areas, and thus had ‘some’ control over their waiting time, this was not always an enjoyable experience for all.

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

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

Zara’s period of waiting was the longest I had encountered during my fieldwork. Even though her appointment was for 07:00, she arrived thirty minutes beforehand to ensure that she would be assisted “on time”. When I first started with her interview at 12:15, she had still not been assisted by any of the nurses, and by the time our interview had ended at 13:10, she was still

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

Researcher: Last question: how long have you been waiting?¹⁹

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

Researcher: It’s half past one (13:30).

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

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

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

Researcher: Ok, so this is long?

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

The feelings of boredom, exhaustion, and frustration that accompanied long durations of waiting at the CHC were also revealed to me in other unexpected situations. Shortly after interviewing Robyn, I went outside for a short break, where I was approached by a young man. Making small talk, he said to me: “Gosh! Here, one waits until one dies” (“*Yoh! Hie’ wag ‘n mens tot jy dood is*”). All I could do was sympathise. As I stood outside, Robyn walked past me on her way back from buying crisps at the informal trader; she, too, suddenly commented: “*Yoh!* I must still wait long... Probably until tonight!”. Robyn was eventually done with her antenatal appointment and left the clinic at 14:40. Having arrived around 12:30, she had spent over two hours at the clinic. While some working class pregnant women found waiting to be “boring”, others were content with waiting, provided they received free and adequate antenatal services from the clinic, and that they had something with which to occupy their waiting time.

¹⁹ I had been interviewing Robyn for approximately twenty-two minutes before the first question was asked: the pre-intervention interview questions took seven minutes to complete, and we were already fourteen minutes into the post-intervention interview questions (out of fifteen minutes).

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

Chapter Three

The Educated Mother

Introduction

Mothering is a contingent process that evolves in non-linear ways. Not only does mothering entail learning *how* to mother (gaining maternal knowledge) or *how not* to mother, but it also involves decision-making on different levels, for different reasons, and involving different actors and resources (see Bryant Merrill, 1987; Silva, 1996; Waltz, 2014). Within the health sector, as defined by Adejoke Clara Babalola (2015) in her research on literacy and decision making among married women in Nigeria, “maternal knowledge enables women to know more about their health issues and to take appropriate steps towards enhancing their health status” (2015: 212). Babalola further explains that when women are able to “understand appointment slips, medical forms, medication labels, patients’ educational materials and hospital clinics signs easily” (2015: 212) they will be able to take appropriate care of their own health and their children’s health. As with other interventions, there is an underlying assumption that the more the mother knows (i.e. the greater her maternal knowledge), the better she will be able to care for herself and her children. This notion has been widely supported.²⁰ For example, a study of maternal knowledge of first-time mothers in Australia draws on work by Vincent Smeriglio and Peggy Parks (1983) who “recommended that parenting knowledge should at least consist of an awareness of typical developmental milestones, caregiver strategies and techniques to encourage early learning of skills, and an understanding of the relationships between caregiver practices and future development outcomes” (Williams, Pearce and Devine, 2014: 15). It was argued that when parents possess knowledge about child development milestones, not only will they attempt to construct suitable learning environments for their children to develop in, but they will also interact with their children in ways that are sensitive and responsive (Williams, Pearce and Devine, 2014: 15-16). As their example shows, research on early child development suggests that the beliefs and knowledge that parents possess strongly affect the manner in which they rear their children; “however, little is known about the level of knowledge parents possess about typical child development, and even less is known about the factors that influence such levels of knowledge” (Reich, 2005: 144).

²⁰ Many studies have been conducted to determine ‘maternal knowledge’ and maternal beliefs in a wide range of areas related to childrearing: early communication and development (Williams, Pearce and Devine, 2014); child development (Reich, 2005); diarrhoea and oral rehydration therapy (Datta, John, Singh and Chaturvedi, 2001); childhood acute respiratory infections (Denno, et al, 1994). Anthropological studies also traced childrearing cross-culturally (Whiting, and Whiting, 1975; LeVine, et al. 1996; DeLoache, and Gottlieb, 2000 and 2004).

The *Together from the Beginning* video card was developed in the context of these broad understandings about maternal knowledge. As Berg (2016), its creator, notes:

What parents do with their children is often done without understanding and knowledge of [these] subtle and delicate developmental requirements. However, once they have been alerted to their babies' abilities, parents become more aware of the impact that their actions have on their children and they alter their handling of them accordingly without having to be told specifically what to do or not to do.

Parental knowledge, but more so 'maternal knowledge', regarding foetal and early childcare practices formed a major component of this research project.²¹ Berg (2015) further proposes that "mothers do what they do because of habits and not-knowing" and that the early childcare practices of parents are generally guided by assumptions that babies are too young to feel (emotions), too young to understand (language), and too young to be affected (by actions). She also argues that "all parents have the right to be informed of the latest developments in research so that they can treat their children accordingly", and that the knowledge parents received did not need to be incompatible with traditional childrearing values and practices. Her account thus accords value to both rights and cultural practice, and does not expect that they overlap. In this chapter, I will explore the assumptions that underpinned the perceived 'need' for the video card and other development interventions implemented at the CHC – that maternal education 'needs' to improve and that mothers need to learn how to care for babies in order for them to reach their development potential. Why do pregnant women and mothers *need* to gain information about infants? Why do they need to be educated about ECD based on science? What did pregnant women know about foetal and infant care *before* watching the video? Where else did they receive information from? I reflect on the various sources that pregnant women received maternal and child health (MCH) and early childhood development (ECD) information from; discuss the interactions that occurred between nurses and women; and show how different discourses frame the 'educated mother'. I will show that these constitute the grounds on which mothers can also be perceived as the targets for development interventions. I will argue that (educated) mothers were made to matter in the clinic by development interventions and nursing staff who emphasised, reinforced and normalised the need for maternal education. By doing so, the state-provided interventions, as well as the nurses, not only controlled and regulated the childcare knowledge and practices of pregnant women and mothers, and thus disregarded and undermined the existing childcare knowledge and practices

²¹ "Maternal knowledge" rather than "parental knowledge" is discussed because mothers were the target audience of the video card, the main actors in the video, and the primary caregivers of the infants in this study.

that women possessed, but also reinforced and normalised the idea that mothers, as opposed to other caregivers, required education (via interventions) in order to ‘appropriately’ care for themselves and their babies and themselves.

Maternal Knowledge

Pregnant women and mothers entered the CHC with their own maternal knowledge; however, based on pre-intervention interview responses, their knowledge regarding foetal and infant care, and the sources from which they obtained their information, varied greatly. Most reported their primary sources of information to be mothers and mothers-in-law, families (aunts, sisters, parents, grandparents), friends, work colleagues, “older people with experience” and children of their own, television programmes, parenting classes, and books. The Internet proved to be one of the main sources of information for many of the women in the CHC: twenty-three of the sixty pregnant women in the antenatal clinic reported they ‘Googled’ to find information about their pregnancies, giving birth, and childcare. They saw the Internet as convenient and believed the information they sourced to be trustworthy. Moreover, as the majority of the participants had been pregnant before and had at least one child already, they relied on their own previous experiences to guide their current pregnancies. Three-quarters of participants (forty-five of the sixty pregnant women), however, reported that “the clinic” was their primary source of information, which included conversations with nurses and counsellors, sessions from a peer counsellor, as well as state-provided pamphlets and booklets that were provided free of charge to all pregnant women and mothers at the CHC. Pre-intervention interview responses related to foetal care further revealed that most women knew not to drink and smoke, to eat “healthy” food (defined as fruit and vegetables), to drink plenty of water, to exercise, and also to rest during pregnancy. Five of the participants referred to these key foetal care practices as “the basics”. Others mentioned that taking vitamins and antiretroviral (ARV) tablets and “using protection” or “condomising” when engaging in sexual intercourse while pregnant was vital. Pregnant women also explained that breastfeeding was crucial because, as one woman phrased it, “it is where the baby gets all the nutrients and vitamins from”. The maternal knowledge that the women expressed in their interviews therefore directly mirrored what was presented to them at the clinic and via the *Mother, Child Health and Nutrition* booklets.²²

²² Note, however, the potential research bias: participants’ tendency towards answering that “the clinic” was their primary source of information may have been influenced by the fact that the research took place in a clinic where nurses and other staff were present.

The *Mother, Child Health and Nutrition* booklet (see figure 5), which every pregnant woman received upon her first antenatal appointment, proved to be another key source of information, and contained chapters on the following topics:

1. *Care during pregnancy*: attending antenatal clinics, eating healthy food, taking vitamins
2. *Problems during pregnancy*: “how to” — reduce morning sickness, heartburn, improve digestion and reduce constipation
3. *Prepare for a safe delivery*: practice safe sex, avoiding sexually transmitted infections
4. *Care for mother and baby after delivery*: skin-to-skin contact, spacing the births of children
5. *Feeding your baby*: breastmilk is perfect, development, breastfeeding, solid foods
6. *How to reduce mother to child transmission of HIV before, during pregnancy and during labour and delivery when a mother is HIV positive*
7. *Monitoring and promoting the growth of your child*: take your baby for immunisations

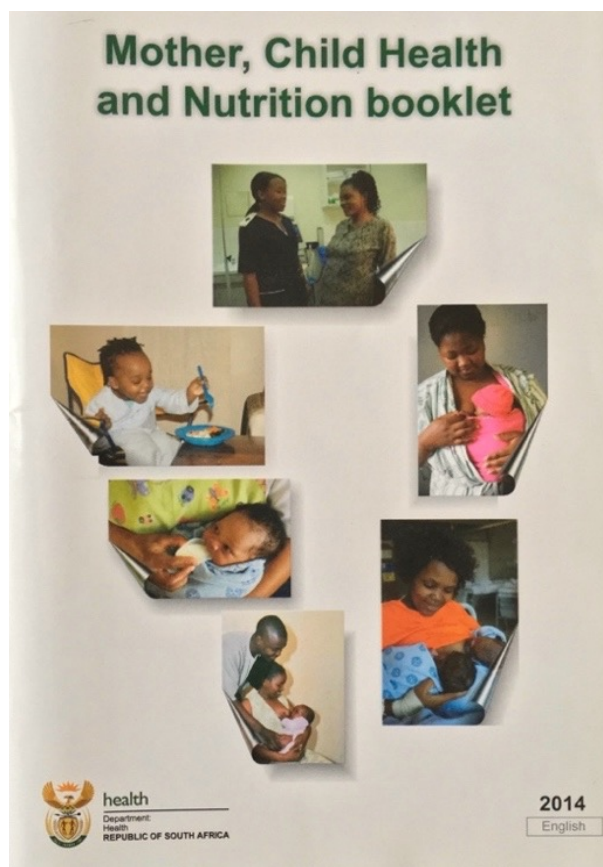


Figure 5: The cover of the *Mother, Child Health and Nutrition* information booklets that are supplied to all pregnant women at their first antenatal clinic. The booklet cover displays six images (clockwise from top): (1) friendly interaction between nurse and pregnant woman; (2) woman performing skin-to-skin contact with baby; (3) mother breastfeeding baby; (4) man (possibly the father) watching as mother breastfeeds baby; (5) baby drinking milk from a cup; and (6) infant eating food on their own.

Pregnant women’s perceptions about foetal and childcare practices and behaviours were thus largely formed and informed by the nurses, the clinic, and on a broader level, by the state. The provision of the *Mother, Child Health and Nutrition* booklets to women in the CHC mirrors

what had occurred in the United States between the nineteenth and twentieth centuries, when a major source for spreading “scientific motherhood”, as referred to by Apple (1995), was through state pamphlets, especially the *Infant Care* pamphlet provided to mothers by the federal government (Apple, 1995: 96).²³ The role of the state in shaping women’s experiences and ideas about their pregnancies can be understood as “governmentality” (Foucault, 1991). Governmentality is concerned with the well-being of populations at large, and seeks to secure “the welfare of the population, the improvement of its condition, the increase of its wealth, longevity, health, etc.” (Foucault, 1991: 100 cited in Li, 2007: 1). The *Mother, Child Health and Nutrition* information booklets, supplied by the Department of Health, were intended to inform or educate pregnant women about the different stages of their pregnancies and early childhood development, thus regulating their foetal and infant care processes, such as their actions of delivering, feeding, and caring for their babies. More specifically, the booklets were aimed at educating black, working class women. This is not only overtly evident in the images displayed on the cover of the *Mother, Child Health and Nutrition* booklets (see figure 5), but also by the fact that free public healthcare facilities were predominantly accessed by black and coloured, working class women, as was also the case at the CHC. As Tania Murray Li (2007) explains, “at the level of population, it is not possible to coerce every individual and regulate their actions in minute detail. Rather, government operates by educating desires and configuring habits, aspirations and beliefs” (Li, 2007: 1). As such, by educating black and coloured, working class pregnant women or mothers, it was imagined and anticipated that the state, through the health sector, would be improving the well-being and development of individual infants, as well as the overall welfare and development of the future population. This forms part of a set of interventions that aimed to reduce infant mortality and morbidity rates, while simultaneously ensuring that children reach their full developmental potential. In other words, maternal knowledge is not only important because of the potential impact it might have on the infant’s development, but by rearing and caring for the infant in particular ways — as prescribed through state development interventions — also promises the end goal of a ‘regulated’ and ‘improved’ population and nation. By regulating maternal knowledge, the state further aims to meet the goals set by local and global initiatives, including the previous MDGs

²³ “Scientific motherhood,” a term coined by Rima Apple (1995), is defined as “the insistence that women require expert scientific and medical advice to raise their children healthfully” (1995: 90). Scientific motherhood sought to displace women’s knowledge about mothering, and redefined what it meant to be a “good mother”. As such, with the rise of medical and scientific expertise, American mothers became the target recipients of interventions related to infant and child care that were guided by scientific discoveries.

and now Sustainable Development Goals (SDGs) that are intended to improve MCH and ECD. Maternal knowledge is thus highly political in nature, as it provides an ‘open’ platform for external intervention. Within the CHC antenatal clinic and MOU, the maternal knowledge of the mainly black pregnant women and mothers was frequently judged, exposed and challenged; not only were women provided with and influenced through physical media (via interventions supplied by the state), but they also influenced verbally (by nurses and counsellors).

Nursing Knowledge

Field note, Wednesday, 9 March 2016: *I arrived at the antenatal clinic at 9:00. Unlike Monday, there were far fewer women waiting in the waiting area. By the time I took a seat on a bench in the corridor, Sr. Pam had nearly completed her information session. I managed to catch a few of her final points on breastfeeding, formula milk, changing lifestyle to care for baby. As I sat on the bench next to a pregnant woman, I again found it difficult to hear what Sr. Pam was saying, mainly because of the high noise levels in the clinic. This meant that most of the patients in the corridor could also not hear Sr. Pam’s educational messages, since she was only addressing the mothers in the main waiting area at the opposite end of the corridor.*

Sr. (sister) Pam was a peer counsellor commissioned from the La Leche League, a voluntary organisation that provides information and support to breastfeeding women. Every day, during my first month at the CHC, Sr. Pam strained her voice to educate the waiting pregnant women. While it was often difficult for me to hear her, given the noisiness in the clinic, I vaguely made out that she was teaching the pregnant women about breastfeeding, using an anatomical chart, a rag doll, and a silicone model of a female breast as props to demonstrate her various points. She informed the women about proper hygiene, HIV care, post-delivery care, and general infant care, including not to use a dummy (pacifier), encouraging skin-to-skin (kangaroo) care, and advised women to use blankets rather than towels to keep their newborn babies warm. This information session lasted more than an hour. During this time, the waiting women were instructed to put their cell phones away and to listen to Sr. Pam, even though the noise in the CHC was such that they could not hear her. I, too, had to wait until the session was done before I could begin conducting interviews. “Breastmilk is the best option for your baby! But baby must suck on the *whole* breast and not just the nipple otherwise you will get blisters. And don’t bath your newborn because the fat layer around baby protects the baby once he or she is born, so do not wash it off immediately,” shouted Sr. Pam over the bustle, buzz, and bangs in the antenatal clinic waiting area. Sr. Pam’s stories were always entertaining and, when the noise levels in the waiting area permitted it, many women listened attentively as Sr. Pam strained her voice to share her important messages with the women.

One morning I arrived at the antenatal clinic and was surprised to see Sr. Pam talking to only four pregnant women sitting on a single bench rather than standing in front of the larger crowd in the waiting area and shouting her information as she usually did. Later, Sr. Pam sat next to me on a bench and explained that, as a result of constantly talking and shouting during her information sessions (she speculated), she “no longer had a voice” and that she had been absent from the clinic for the past week with a sore throat. She explained that she had been for a tuberculosis (TB) test for which she was awaiting the results, and would visit Karl Bremner Hospital the following week for a check-up.²⁴ While it was not clear whether Sr. Pam had disclosed her concern about having possibly contracted TB with the CHC staff or manager (given that she was still permitted to be in close proximity to pregnant women), her willingness to continue her information sessions at the clinic reflected her commitment to educating the pregnant women. Indeed, Sr. Pam further explained that, although she did not plan to renew her work contract with the La Leche League, she was sad to be leaving because she knew that “the mothers *needed* the information” she was sharing. She also did not know whether the La Leche League would send a new peer counsellor to replace her. Sr. Pam did not return to the CHC after our conversation, and for the following month of fieldwork, the pregnant women relied on the resources provided by the clinic, not only for information, but also to pass the time that was spent waiting in the clinic. There was also no television installed in the antenatal clinic and MOU to entertain, educate, or even distract the women from their long periods of waiting. These long periods of waiting subsequently became ideal opportunities during which maternal knowledge and practices were observed, judged, and regulated by the CHC nurses.

Nurses are valuable assets within the healthcare system, and were regarded by the pregnant women and mothers at the CHC as one of their primary sources of information; however, as Mazzoni notes, “knowledge has been and in altered ways continues to be the battleground between midwives and doctors, between caregivers and mothers themselves: for the one who knows more is the one with the decision-making power” (Mazzoni, 2002: 9). This connection between knowledge and power became apparent during my observations within the MOU waiting area, where nurses often openly confronted mothers about their maternal knowledge and infant care practices. In one incident, a nurse scolded a mother because she had swaddled her infant in a towel *before* wrapping a warmer fleece blanket around the towel. “Why are you using the towel to put baby in? Why on earth do you use towel to close baby?”

²⁴ The CHC patients are referred to Karl Bremner Hospital for additional treatment.

No *gogo* (grandmother) can tell me why we still use towel! It's a new generation, 2016!" Addressing the group of mothers and partners waiting in the MOU, the nurse continued to say: "Only black, not coloured, or white mothers use towels. Towels do not keep baby warm!". This one minor example of a nurse-patient interaction at a local clinic reveals some of the complexities surrounding the negotiation of maternal knowledge and practices by black, working class pregnant women and mothers. Firstly, the nurse argued that wrapping a baby in a towel was an unnecessary step as towels do not retain heat the way blankets do. Secondly, the nurse implied that mothers should "know better" than to accept traditional or "outdated" advice from elders, who may not be aware of contemporary childcare knowledge and practices. Thirdly, while not based on 'scientific knowledge' per se, the knowledge about towels was presented to mothers by nurses as 'common sense'. In doing so, the MOU nurse not only undermined the value of the advice and knowledge that mothers received from their mothers, grandmothers, and others, but also implied that the well-being of the baby would not result from inherited knowledge. Essentially, as will be shown below, the example of this nurse-patient interaction reveals a hierarchy of knowledge that was reinforced in three different, yet connected ways: through the biomedical system, through verbal violence, and through systemic racism. All three components are linked to ideas of power and control, which I explain in terms of "authoritative knowledge".

The (knowledge) relationship that existed between the nurse and mother (patient) was asymmetrical; from my perspective, the nurse was seen as being more autonomous and powerful than the mother, who was, in contrast, seen as more dependent (Lazarus, 1994: 30). This was because, from a biomedical perspective, "control is limited by the power held by the medical profession and more and more by medical institutions" (Lazarus, 1994: 30). Control and power were also exercised through the sharing of information. As stated by the head nurse of the CHC antenatal clinic and MOU, 'patient education' was one of the nurses' many responsibilities; however, nurses rarely had the time to educate mothers because they had other 'more important' duties to complete, and, as previously shown, when nurses did try to impart information, it was usually done in the crowded and noisy conditions of the waiting areas. While some of the nurses, as in the example, did find time to interact with the pregnant women and mothers, it was often in a discriminatory fashion, contributing to the ongoing dissatisfactions of patients with state services in working class areas. In this regard, like the information booklets, nurses also held the responsibility of regulating the 'lay' knowledge, behaviours, beliefs, and practices that working class pregnant women and mothers in the CHC

had about childcare. Moreover, nurses, along with doctors and specialists, belonged in the top rank of the biomedical hierarchy within the designated healthcare spaces. Despite their privileged position as ‘medical experts’, however, nurses often behaved with scant regard for patients’ dignity. For instance, one of the key strategies that the MOU nurse chose to impart her knowledge to the mother with was in the form of scolding (or to *skel* in Afrikaans). Scolding — along with sarcasm, shouting, being ridiculed and humiliated — is considered a form of verbal violence (Kruger and Schoombee, 2010: 85). As Lou-Marié Kruger and Christiaan Schoombee (2010) noted, South African nurses attending to pregnant, labouring and post-birth women employed various strategies such as verbal violence, neglect, physical violence as well as sexual violence with which to ‘control’ the patients during the different stages of labour. The authors argue:

Being attended to by the nurses meant becoming the object of the medical gaze. This medical gaze meant surveillance and intervention, but not necessarily being visible as a person (Foucault, 1989)... [N]urses employ disciplinary procedures to demonstrate their alignment with more dominant discursive constructions of nursing work, ensuring bodies that are docile, obedient and useful. The other instruments of control that nurses used during this state of labour were verbal and physical abuse (Kruger and Schoombee, 2010: 92).

Nurses regarded scolding as a ‘necessary measure’ and an effective process adopted to impart specific knowledge to the women before, during and after they went into labour (Kruger and Schoombee, 2010: 93-94). Nurses who *skel*, however, were not limited to maternity wards, but extended to other areas in the public clinics. By scolding, the nurse sought to reinforce a hierarchy of knowledge, itself based on entrenched systemic racism and racist practices (see Jewkes, Abrahams and Mvo, 1998; Fassin, 2008). Furthermore, publically confronting women in the MOU was a humiliating experience, not only for the targeted woman, but also for myself and the other parents in the waiting area. Scolding therefore also served the function of producing humiliation as a mode through which education occurred. When confronted by the nurses, the ‘guilty’ mother merely sat quietly and slowly began to unwrap the towel from her baby’s body, avoiding eye contact with the nurse and those seated around her. The fact that the mother did not argue with or even respond to the nurse reinforced the power dynamic that was constructed between the nurse who ‘knew’ and the mother who ‘needed to learn’.

Understood differently, the hierarchy of knowledge presented by the nurse coincided with a broader hierarchy of race. As outlined by Sean Elias and Joe Feagin (2016), a racial hierarchy forms a central component of systemic racism, which “involves a racialized system of power relations embedded throughout the social fabric of contemporary societies with

intimate historical connections to the social systems of slavery and colonialism” (2016: 7). As was evident in the interaction between the coloured nurse and (predominantly) black mothers in the MOU waiting area, the legacy of the racial hierarchy once enforced under apartheid, remains visible today. As Elias and Feagin note, “constructions of racial meanings and associated structures of racial relations, with their great power and privilege imbalances, continue to shape contemporary societal worlds and human beings’ everyday interactions” (2016: 17). More specifically, in a country where more than 81% black and over 63% coloured South Africans mainly used public sector health facilities in 2011 (Davis, 2013), racial tension continues to exist between coloured and black South Africans. Racism was revealed, not only through the blatant usage of racial signifiers (“Only black, not coloured or white mothers use towels”), but also through the way the coloured nurse spoke to the black mother in simplified English (“Why on earth do you use towel to close baby?”). Through these interactions, the nurse not only contributed towards the outdated portrayal of black women in society as poor, ignorant, and uninvolved in their pregnancies (Abbyad, 2008: 157), but also established a presumed hierarchy, placing coloured and white maternal knowledge and practices above that of black maternal knowledge and practices.

The relationships that exist between nurses and patients are important for two reasons: “firstly, patients’ experience of nursing will affect health-services access, compliance, quality, and effectiveness,” and secondly, “nurses are [also] not simply health care providers, they are also social actors” (Kruger and Schoombee, 2010: 84-85). While it was part of the MOU nurse’s responsibility to educate mothers about infant care, the way the nurse shared her knowledge was riddled with control and power. Anthropologist, Brigitte Jordan (1993) describes this relation as “authoritative knowledge”. As she notes,

For any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both. In many situations, equally legitimate parallel knowledge systems exist and people move easily between them, utilizing them sequentially or in parallel fashion for particular purposes. But frequently, one kind of knowledge gains ascendance and legitimacy. A consequence of the legitimation of one kind of knowing as authoritative is the devaluation, often the dismissal, of all other kinds of knowing. Those who espouse alternative knowledge systems then tend to be seen as backward, ignorant, and naive, or worse, simply as troublemakers. Whatever they might think they have to say about the issues up for negotiation is judged irrelevant, unfounded, and not to the point... The constitution of authoritative knowledge is an ongoing social process that both builds and reflects power relationships within a community of practice (Jordan, 1993: 152).

In their everyday lives, women are frequently expected to listen and adhere to the advice shared with them by their elders or mothers, including mothers-in-law (see Simkhada, Porter and van Teijlingen, 2010), which may be regarded as authoritative knowledge within those specific contexts. However, regardless of the alternative knowledge systems that women adopted and that existed *outside* the CHC, the knowledge shared *within* the clinic — whether from nurses, peer counsellors, booklets, pamphlets or the video card — was always assumed to be of significance to the pregnant women and mothers. Not only was the authoritative knowledge shared by the CHC nurses situated within specific biomedical and racial models, but it also disregarded the diverse social contexts within which infants were reared. Women were thus expected to juggle information they received from ‘lay’ persons *outside* the clinic with the knowledge shared by ‘experts’ *within* the clinic, which complicated the process of navigating knowledge; however, “this is not to say that all women everywhere and at all times slavishly followed the dictates of scientific and medical experts in raising their children” (Apple, 1995: 101). Similarly, while nurses, doctors, the state, and other actors, may think that they are providing ‘important’ information for pregnant women to guide their childrearing practices, they do not know whether, if or how this knowledge will be incorporated into the women’s daily lives and routines outside of the clinic. Despite this, maternal education for pregnant women and mothers was regarded by the nursing staff, the facility manager, the La Leche League peer counsellor, and more generally by the state, as a crucial component of the CHC waiting experience, even prior to the video card implementation. Regardless of the fact that pregnant women and mothers entered the CHC with their own sets of maternal knowledge, and that some were already experienced mothers, all women were expected to be ‘educated’ about foetal and infant care either visually through development interventions, or verbally by counsellors and nurses. In essence, the development interventions implemented in the CHC antenatal clinic and MOU sought to develop black, working class pregnant women and mothers into ‘educated mothers’ by reinforcing maternal education of a particular kind in various ways.

Maternal Education

Maternal education has been reinforced through scientific and development discourses. Firstly, science, particularly neuroscience and epigenetics, has played a substantial role in highlighting the value of maternal and child health (MCH) and early childhood development (ECD), which has in turn normalised the value of mothers. The ECD objectives, as outlined in the most recent journal by *The Lancet*, titled *Advancing Early Childhood Development: from Science to Scale*, have been largely validated by the latest evidence from scientific research.

As cited in the journal, the underlying science of ECD “[enables] children to become healthy and productive citizens with the intellectual skills, creativity, and wellbeing to reduce global inequalities and ensure sustainable global development” (Black et al., 2016: 11).²⁵ Children are described as having *developmental potential*, which consists of interdependent sensory-motor, cognitive, and social-emotional domains (Grantham-McGregor et al., 2007: 60), and it has subsequently been argued that when children fail to reach their developmental potential, “national development is likely to be affected” (Grantham-McGregor et al., 2007: 60). Based on these dominant discourses, a clear correlation is consequently established between the development of the child and the development of the nation. More still, it is said that today, “the burden of children not reaching their developmental potential remains high” (Black et al., 2016: 11), with poverty, poor health and nutrition, and deficient care being some of the main reasons why globally more than two-hundred million children under the age of five are said to be unable to reach their full developmental potential (Grantham-McGregor et al., 2007: 60; see also chapter three, below). A lack of nurturing care,²⁶ especially during the first thousand days, when rapid brain development and learning occurs and caregiver-child attachments are formed, has been identified as an additional concern (Black et al., 2016: 11). Two potential solutions to ensure children reach their full developmental potential have been suggested and promoted: (1) improve maternal (physical and mental) health, and (2) increase maternal education, the latter being linked to “reduced fertility, and improved child survival, health, nutrition, cognition, and education” (Grantham-McGregor et al., 2007: 60). Maternal education is therefore regarded by the state and development organisations as a viable and convenient ‘solution’ to local and global development problems. As such, it becomes apparent that similar evidence is beginning to arise from diverse scientific disciplines and discourses related to psychology, medicine, and nutrition, that seeks to construct the child at a particular point in its development, and that identifies key interventions as imperative to particular outcomes, be it developmental potential, individual development, and/or national development. According to these discourses, the mother is arguably the most significant intervention in the development of the baby and the future of the nation, and is thus made to matter where and whenever possible.

²⁵ These points have been previously examined by *The Lancet* (2007 and 2011), but mainly focused on nutrition.

²⁶ “Nurturing care is characterised by a home environment that is sensitive to children’s health and nutritional needs, responsive, emotionally supportive, and developmentally stimulating and appropriate, with opportunities to play and exploration and protection from adversities” (Black, et al., 2016: 3).

Secondly, within development discourse, maternal education has been deemed a strategic solution to reducing the ‘unacceptably high’ rates of maternal and infant mortality, especially in South Africa and other Sub-Saharan African countries.²⁷ To date, South Africa has been unable to reach the targets proposed under Millennium Development Goals four and five. While infant mortality in South Africa has decreased from 54 deaths per 1,000 live births in 2000 to 33.6 per 1,000 live births in 2015, and maternal mortality has increased from 85 deaths per 100,000 live births in 2000 to 138 deaths per 100,000 live births in 2015, infant mortality remains high and maternal health remains poor in South Africa (WHO, 2015).²⁸ As recommended by the NGO, Amnesty International to the South African Department of Health:

Develop, fund and implement programmes, including through radio, pamphlets and posters, to educate the population about the importance of early and continuous antenatal care and the associated health benefits. These programmes should be developed and implemented in a way that ensures the inclusion of marginalized communities (Amnesty International, 2014: 63).

While the quote mentions the need to educate the ‘population’, mothers remain the target of educational programmes and development interventions, including mHealth interventions. The *Together from the Beginning* video card, for example, can be regarded as an mHealth (mobile health) intervention, which forms part of a larger move towards utilising electronic devices to disseminate healthcare messages.²⁹ As Linda Waldman and Marion Stevens (2015b) note, South Africa has made vast strides in creating and implementing mHealth interventions. These interventions specifically target poor girls and women from rural and peri-urban (informal settlement or townships) communities who may “have inadequate knowledge about SRHR and thus struggle to make informed decisions” (2015b: 94). Sexual and reproductive health and rights (SRHR), as outlined by the World Health Organisation (WHO), comprises of different components: enhancing antenatal, perinatal, postpartum, and new-born health care; delivering high-quality healthcare services; safe abortion; tackling STIs; and endorsing sexual

²⁷ According to a report by WHO, UNICEF, UNFPA, and The World Bank, the reported maternal mortality ratio in South Africa in 2015 was 138 deaths per 100 000 live births. It was further reported that, “the top five causes of maternal death are non-pregnancy related infections (mainly deaths due to HIV infection complicated by tuberculosis and pneumonia); obstetric haemorrhage; pregnancy-related hypertension; pre-existing medical conditions and pregnancy-related sepsis” (South Africa Saving Mothers Report 2008–2010).

²⁸ The target set by South Africa for infant mortality (MDG 4) was 18 deaths per 1,000 live births; the target set for maternal mortality (MDG 5) was 38 deaths per 100,000 live births (WHO, 2014).

²⁹ “M-health, a component of e-health, refers to the use of mobile phones and other technological, mobile devices in health. This includes SMS messaging, using mobile phones to communicate with health providers, or health providers’ use of mobiles to enhance their work, and the use of portable devices for monitoring and improving health” (Waldman and Stevens, 2015a: 7).

health (WHO, 2004 in Waldman and Stevens, 2015a: 9). It is argued that improving just one of these components will have a positive impact on the others. Despite the wide range of benefits that mHealth interventions can offer — easy means of providing health information; enhancing disease prevention; new forms of data accumulation for disease surveillance and research; decision-making aids can support clinical service delivery; and regular reminders can help patients manage their own health conditions (Waldman and Stevens, 2015b: 93) — mHealth interventions in South Africa, as Waldman and Stevens argue, have focused more on MCH and less on other topics related to SRHR.³⁰ Nonetheless, mHealth interventions that do focus on MCH, “show great promise for empowering and enabling health workers to collaborate with pregnant and parenting women to improve [the] delivery of maternal and child health care” (Waldman and Stevens, 2015b: 93). Development interventions therefore played a large role in not only producing educated mothers, but also reinforced the assumption that women, specifically pregnant women and mothers, required education in order to care for babies appropriately and effectively. The educated mother was thus produced, developed, and made to matter through development discourses and interventions to be regarded as a key ‘solution’ to global development problems. How did the *Together from the Beginning* video card development intervention contribute towards this conception of mothers?

In *Development Intervention*, Juhani Koponen (2004) describes “the modern notion of development” as consisting of three dimensions: the *process* of development, the *goal* of development, and the *intervention*. An intervention is defined as “something thought to be necessary to start or trigger off the process that will lead to the goal” (Koponen, 2004: 6). Although its creator did not intend for the video to be an ‘intervention’ (Berg, 2016, personal communication), I suggest that the *Together from the Beginning* video card can be perceived as a development intervention that was intended to educate parents, but specifically pregnant women and mothers, about ECD and MCH. As such, the *process* of its development was to implement the video card in a public antenatal clinic and MOU facility, which would then lead to the *goal* of development, which was “to increase awareness in parents regarding their infants’ development and needs and thereby enabling them to adapt their handling of their

³⁰ This is also the case for interventions such as Mobile Alliance for Maternal Action (MAMA), MomConnect, as well as *Together from the Beginning* video card. The Mobile Alliance for Maternal Action (MAMA) is a global movement that seeks to use mobile technologies to improve the health and lives of mothers in developing nations. MomConnect is a free service that was built on the success of the MAMA project that aims to use mobile health tools, messaging services and other platforms to create awareness among pregnant women about available health services for their infants.

young children” (Berg, 2006). Essentially, the video card intervention was intended to produce ‘educated mothers’ by providing knowledge that would assist women with childrearing. Using Koponen’s definition of an intervention, the mother can also be regarded as someone “thought to be necessary to start or trigger off the process that will lead to the goal”, and can thus also be perceived as a development intervention herself. In this case, the *process* of development for the mother would be to ensure the growth and development of the foetus and infant, while the *goal* of development would be to ensure the child reaches his or her full developmental potential. By being exposed to countless development interventions, the pregnant women and mothers at the CHC were expected to transform into development interventions themselves. For instance, it was not acceptable for women to merely sit and wait. They were constantly expected to learn, to be challenged, to improve themselves for the sake of their children. This is similar to what Ruth de Souza (2013) found in her analysis of the contemporary maternal subject: “pregnant women [were] constantly charged with ever-increasing responsibility over the health of their foetuses, while they themselves [were] reduced to being a container for their foetuses” (2013: 18). As a result, a specific type of mother – the ‘educated mother’ – was being developed in the clinic space I observed. The educated mother was made to become aware of her maternal actions (during pregnancy and thereafter), and was also made to believe that she *needed* to learn about MCH and ECD in order to develop her foetus and infant ‘appropriately’. This was not only aided through the messages displayed in development interventions in the CHC, but was also suggested through the way that maternal knowledge was overtly challenged by clinic nurses. An educated mother was therefore believed to have a positive impact on the development of her children, whereas an uneducated mother would not.³¹ These dominant beliefs were reinforced on a daily basis within the CHC. Maternal education, as opposed to parental/caregiver education, has thus been directly linked to child development within the clinic space and development discourses. This in turn has normalised the role of women as mothers, mothers as primary caregivers, and the overall ‘need’ for maternal education.

³¹ As John Hobcraft (1993) argues in a literature review, maternal education has significant consequences on the physical, social, emotional, developmental and environmental health and well-being of children. While no threshold level of maternal education was specified, it was stated that “even a small amount of education was usually associated with improved chances of child survival, and the gains generally increased with increasing levels of education” (Hobcraft, 1993: 160). Hobcraft also outlined a number of “pathways” through which maternal education influenced children, suggesting an increase of cleanliness amongst children, as well as an increase in utilising health services for children. Another pathway, Hobcraft suggested, that maternal education may enable is a greater emphasis on child “quality”. In other words, when child survival is no longer a concern, as in the case of many developed countries, maternal education ensures that children are healthy, educated, more affluent, and more emotionally developed, thus becoming higher quality citizens (Hobcraft, 1993: 160). Maternal education is also considered to be empowering for mothers and women in general.

To conclude, given the highly political nature of maternal knowledge, mothers have been perceived and rendered as accessible and open platforms for the sake of development. The belief that pregnant women and mothers ‘need’ to be educated about MCH and ECD via development interventions has conveniently been shaped by several assumptions. Firstly, the creation and provision of interventions, such as the *Mother, Child Health and Nutrition* booklets and the *Together from the Beginning* video card, rested on the assumption that parents and caregivers, but particularly black, working class pregnant women and mothers, “do what they do because of habits and not-knowing” and thus lacked the knowledge, skills, and/or capacity to adequately and appropriately care for babies. Secondly, there was the assumption that the information (authoritative knowledge) shared via interventions and nurses was more valuable and accurate than the maternal knowledge women possessed. This leads to the third assumption: that development interventions were valid and imperative because they were supported by scientific and developmental discourses. Lastly, the fourth assumption held that when mothers were educated (via development interventions in the CHC) they would be able to care for themselves and their babies adequately, therefore ensuring that children reach their developmental potential and become productive future citizens. However, in an attempt to produce, develop and make the ‘educated mother’ matter both *within* and *outside* the clinic, the diverse contexts and cultural frameworks that may have guided the childcare knowledge and practices of mothers and caregivers outside the clinic were undermined and/or disregarded. Moreover, these assumptions about maternal education not only ignored the fact that women required resources and time to implement what they ‘learned’, but also contributed towards the normalisation of motherhood as a dominant discourse through development interventions. Worse still, these assumed ideas about women as ‘mothers in need of education’ were exercised within specific racialised structures that then re-established and reinforced old stereotypes that viewed black (working class) women as ignorant or ‘not-knowing’. Despite all of these implications, the educated mother was produced and viewed as an effective and convenient subject through which the state (via interventions and nurses) could intervene in the development of babies that would benefit the nation in the future. As such, while the development interventions implemented in the CHC were motivated by a larger developmental model that took the infant, the parents, but particularly the mother, and the future of society into consideration, the mother herself – including her individual needs, beliefs, emotions, experiences, and circumstances – was not sufficiently supported during the establishment and execution of these developmental objectives.

Chapter Four

The Ideal Mother

Introduction

Development interventions are generally characterised by the outcomes they produce; they are “planned and unplanned, and commonly [have] both intended and unintended effects” (Koponen, 2004: 12). Formerly known as ‘unanticipated consequences’ (Merton, 1936; de Zwart, 2015),³² and also referred to as ‘side effects’ (Scriven, 1972), unintended outcomes “refer to the effects of an intervention other than those it aimed to achieve” (Jabeen, 2016: 144). These effects can be positive (by producing additional benefits), negative (by directly or indirectly causing harm to recipients) or neutral. While some unintended outcomes are unforeseeable, others can be predicted prior to the implementation of the intervention; “unintended outcomes are generally viewed as a consequence of error or ignorance and imply lack of control” (Jabeen, 2016: 144). However, this is not always the case, because:

Interventions are subsystems in a larger system, involving human beings, and operating in socially, economically and politically dynamic environments, where they interact with other subsystems as well as a larger system. These complex interactions produce effects, which are not often part of initial programme intentions or could be entirely unforeseeable. Thus, unintended outcomes can be considered as inherent to any deliberate attempt to bring about change (Meyers, 1981 cited in Jabeen, 2016: 144).

Development policies, programmes, and interventions are mostly well-intended, however, they can also result in negative consequences or worsen the conditions of the beneficiaries (Jabeen, 2016: 144). As such, while the objectives of the *Together from the Beginning* video card were largely met in the trial, the outcomes, consequences or effects of the intervention did not end there. The video card thus revealed itself to be a true development intervention in that it materialised an intervention population, articulated a future horizon, and produced numerous intended and unintended outcomes upon implementation and evaluation. As supported by Jabeen, using evaluation to learn about unintended outcomes can be technical as it “may provide insights into why a programme resulted in extra benefits or caused damage in a certain context” (2016: 145). On the one hand, capitalising on positive unintended outcomes can lead to the planning of more efficient and effective interventions; whereas, on the other

³² The usage of “unintended consequences” began to replace “unanticipated consequences” in the 1960s. This was mainly due to what the different terms implied: “if unintended effects are anticipated, they are a different phenomenon as they follow purposive choice and not, like unanticipated effects, from ignorance, error, or ideological blindness” (de Zwart, 2015: 286).

hand, by avoiding the negative unintended outcomes, the programme strategy for ongoing or future interventions can be altered accordingly. This information can further help to identify and understand the limitations of the interventions and can also offer alternative perspectives with which to deal with social problems. Evaluations that consider unintended outcomes also have “an ethical obligation to ensure that interventions do not cause harm to any segment of population being served” and should safeguard the interests of the most vulnerable (Jabeen, 2016: 145). Jabeen cites the work Suchman (1967), who acknowledges that “it is not possible that a programme lead to a single change but a series of changes result from a single intervention” (2016: 145) and that these changes may affect participants differently and under different circumstances.

The noun ‘intervention’ stems from the verb ‘intervene’, which has its roots in the Latin word *intervenire* meaning “to come between, intervene; interrupt; stand in the way, oppose, hinder” (Etymonline, 2016). Staying true to its etymological roots, the video card intervention produced interruptions, both directly and indirectly, at various stages of the research project. Firstly, as a researcher, I constantly felt like an interruption in the clinic space; I often felt that I was ‘in the way’ or hindering the functioning of the work of nurses in the antenatal clinic. Secondly, multiple interruptions occurred during the interviews with the pregnant women. Even when I tried to minimize my interruptions of the natural flow of their narratives,³³ our interviews and conversations were regularly interrupted when the nurses called the waiting pregnant women into their appointments. While some women returned to the waiting areas after their appointments in order to complete their interviews, nine of the sixty women did not. This fact gives pause to the common perception that the time spent waiting is somehow bland and undifferentiated. A third form of interruption occurred when the viewing of the video was interrupted when the patients were called by the nurses. The presence of the physical video card thus interrupted the everyday flow of work in the clinic. Lastly, while the physical video card interrupted the clinic space and flow, the video content also interrupted the pregnant women by presenting a specific form of mothering known as “intensive mothering”, which, for some, led to self-blame and feelings of guilt, and which may have also resulted in (prenatal) maternal stress. In this chapter, I will explore both these spatial and emotional interruptions. How are pregnant women and mothers’ lives interrupted?

³³ When I did interrupt the women, it was usually done gently in order to redirect the focus of the conversation to the structured questions (Gorden, 1992).

In what ways did the video card ‘interrupt’ pregnant women and mothers at the CHC? I show how the physical video card interrupted the workflow of the clinic, and provide examples of how the women’s everyday lives (outside the CHC) were interrupted by several stressful events. I then demonstrate how the video content displayed ideas of “intensive motherhood”, which not only normalised ideal mothering, but also led to feelings of guilt in some of the women who watched the video. This chapter will therefore show how an attempt to educate women about childcare practices interrupted pregnant women in a variety of ways.

Space and Flow

Interruption implies a prior state of flow. When interruptions happen, the flow — of energy, of the workplace, of a conversation — comes to a temporary halt. Depending on the type of interruption that occurred, the outcome may either be positive or negative. Sarah Pink and Kerstin Mackley (2015) ask how the concept of flow “enables understandings of everyday life, improvisation and notions of intervention” (2015: 164). While their work focuses on understanding energy consumption in homes (heating the home or doing laundry), from an ethnographic perspective the concept of ‘flow in everyday life’ proves useful for exploring how my own presence, as well as the presence of the video cards, interrupted the flow of the antenatal clinic.³⁴ Piloting and evaluating the video card intervention was particularly difficult in the waiting areas of the CHC antenatal clinic because it interfered with the daily flow of the clinic environment.³⁵ As such, I could not simply stop the rhythms, routines, and flow of the clinic in order to conduct the pilot study; I could not yank nurses from their work to answer my questions or to guide me through the public healthcare facility. Neither could I merely enter the private offices of the nurses while they were examining pregnant women’s bodies. On the contrary, I needed to *wait* and work *with* the flow and disruptions, to acknowledge and accept the interruptions that were both imposed upon me as a researcher and that were imposed upon the pregnant women, nurses, and clinic via myself and the video cards. Although my presence felt intrusive in the CHC, interruptions are common occurrences, especially in healthcare facilities that tend to be demanding, time-constrained environments. While many interruptions – such as phone calls, pagers, alarms, patients (Rivera and Karsh, 2010: 304) –

³⁴ The ‘everyday’ is not only complex to understand, but is also difficult to research since it “is in continuous flow, in flux and [that] is being lived in its ongoing-ness rather than as something that can be stopped, captured and put underneath an analytical lens” (Pink and Mackley, 2015: 166).

³⁵ The ‘flow’ of the clinic, as discussed here and as imagined from the view of the state, anticipated and structured the relations between the physical architecture of the clinic and the bureaucratic and technical architecture that the patients and I were situated in.

can occur without any severe hindrance, some interruptions can lead to medical errors and thus “have implications for safe and high-quality healthcare delivery” (Rivera and Karsh, 2010: 304). This is because when individuals are disrupted, their attention is consequently shifted from the primary task to the interrupting task (Rivera and Karsh, 2010: 306). Rivera and Karsh also describe external interruptions or intrusions, which “occur when an agent external to the interruptee, such as another person, an alarm or a phone, disrupts the interruptee’s workflow” (2010: 307). The *Together from the Beginning* video card can be regarded as an external interruption because it disrupted the workflow of the nurses in the CHC antenatal clinic and MOU.

Field notes, Wednesday, 6 April 2016: *At 11:15, two pregnant women were watching the video cards while seated on two separate benches. Each woman either watched the video on her own or with someone next to her. In that moment of observing the two women in the antenatal clinic, I realised that a major problem the video card posed was that it distracted the viewers and, more specifically, prevented the pregnant women from hearing the nurses call their names for their appointments. [The nurses often became irritated/annoyed when patients did not hear their names being called the first time — nurses would skip patients if they did not respond to the first few calls]. When I told Frances to listen carefully for when the nurses called her name, she responded: “my senses are heightened now that I am pregnant, so I will hear the nurse”.*

While no major medical errors were reported to be caused by the physical presence of the video card in the CHC, the flow of the antenatal clinic was interrupted by the video card in two distinct ways. Firstly, the video card interrupted the workflow of the nurses. When nurses were ready to see their next patient, they called the names of the pregnant women in the antenatal clinic waiting area; however, when the pregnant women were watching the video, they were not always paying attention to the nurses. This not only frustrated the nurses, who were forced to repeatedly call the names of the women, but it also interrupted their workflow by delaying appointment times, albeit minimally. This point was clearly illustrated during my visit to the antenatal clinic on Friday, 8 April 2016 when I had returned to the clinic with the sole purpose of completing six uninterrupted interviews in order to bring my total up to fifty ‘complete’ interviews.³⁶ After interviewing Rachel and her partner, Chris, I left the couple alone to watch the video together, while observing their interactions with the video card from a bench situated nearby. A few minutes into the video, a pregnant woman approached Rachel, and urgently asked: “Is jou van ‘Smuts’?” [“Is your surname ‘Smuts’?”]. It turned out that the

³⁶ I had set myself the goal of completing a minimum of fifty complete interviews, and defined ‘complete’ interviews as uninterrupted interviews, including full completion of the demographic data, pre-intervention, as well as post-intervention interview questions.

nurse had been repeatedly calling Rachel's name, but because the couple had been focused on watching the video, Rachel did not hear her name being called. I personally felt guilty about this delay and regarded this to be a major flaw in the video card intervention — was it not proving too much of a hindrance in the daily functioning of the clinic? In turning waiting time into an educational experience, the flow in the waiting area was compromised. To overcome this problem, some mothers only paid partial attention to the video; the last thing they wanted was to miss their antenatal appointments after having waited for long periods of time.³⁷

A second way that the video card interrupted the flow of the clinic was by adding an extra responsibility to the nurses' already busy work schedules. Implementing the video card entailed handing the video cards to the waiting women in both the antenatal clinic and MOU, monitoring the cards while they were circulated in the waiting areas, answering questions or assisting women with operating the cards, collecting the cards and charging their batteries, and storing them for safekeeping. In other words, implementing the intervention in the clinic required time and effort from the nurses, who were already inundated with work. The video cards were subsequently a greater hindrance for the nurses, particularly for the head nurse who would be held responsible in the event that cards were stolen, lost or damaged. While interruptions are generally regarded as negative, and possibly unsafe occurrences, the video cards did not (for the most part) cause nurses to lose focus of their jobs at hand because viewing the video occurred in the waiting areas and not inside the nurses' offices, where the pregnant women underwent medical examinations that required careful attention and precision. Indeed, as Rivera and Karsh (2010: 307) note, interruptions can even be beneficial to both the interrupter and interruptee; "after all, the interrupting agent may be interrupting to accomplish a particular goal, such as providing or gathering information". This was the case for the video card, which acted as an external interruption that sought to achieve a specific goal: to educate women about early childcare behaviour and actions, while also making their periods of waiting in the clinic more 'productive'. This was especially beneficial at the CHC, as nurses did not always have the time to provide patient education, thus rendering the video card a purposeful interruption. The video card, as an outsourced intervention, however, could only provide information, but could not offer two-way interaction and support the way nurses

³⁷ Unlike other couples whom I had interviewed, where partners remained in the waiting areas to continue watching the video during the women's appointments, Chris accompanied Rachel into the nurse's room. Thereafter, the couple returned to the same bench and restarted the video. Chris suggested that they sit facing the nurse's room so that they could both watch and listen carefully for when their names were called again.

could. Interruptions are thus dualistic in nature: they may either produce potentially negative and harmful outcomes for the interruptee whose attention is abruptly stolen by the interrupter, or they may produce positive outcomes that, in healthcare settings, may prove helpful to medical staff, as well as the patients.

Maternal Stress

While the physical video card interrupted the workflow of the antenatal clinic nurses, the content of the *Together from the Beginning* video had an even greater impact on some of the women in the antenatal waiting areas, producing a particular kind of maternal interruption. In *Maternal Encounters*, the maternal subject, according to Lisa Baraitser (2009), is subject to constant interruption; not only is the mother “subjected to relentless interruption”, but she also emerges from the experience of interruption itself (2009: 67). For Baraitser, maternal interruptions are characterised by sudden gaps, breaks, and intervals that children render in the lives of their mothers. Interruptions experienced by mothers, argues to Baraitser, begin with the first cry of the newborn and continues throughout the early stages of the child’s development, with each stage deeply affecting the mother’s mental, emotional, and social functioning. Baraitser offers a nuanced explanation of an interruption:

Inter means among, and *rupt* is from *rumpere*, to break. An interruption is an insertion of a break between or among something that is otherwise continuous, which has ongoing movement or flow. To interrupt is to perform a stop in this flow, to punctuate the flow thereby creating a ‘between’ or ‘among’ in an otherwise undifferentiated continuum (Baraitser, 2009: 68; italics in original text).

By using this definition, I would like to argue that maternal interruptions occur even before the infant is born and manifests throughout a woman’s pregnancy. For instance, if we were to consider ‘maternal health’ as a continuous, ongoing movement or flow, which spans across the pregnancy, childbirth and the postpartum period, then what would a maternal interruption consist of?³⁸ There is surely no single answer, as lack of nutrition, poor mental health, lack of social support networks, and poverty are but some of the many factors that interrupt maternal health, and which consequently impact the developing foetus and infant. Another major interruption that was revealed in the interviews with pregnant women was stress.

³⁸ As outlined on the World Health Organisation (WHO) website: “Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death”.

Prenatal maternal stress (PNMS) is a specific form of stress that can have significant effects on foetal and infant development. Pregnant women are commonly affected by some of the following stressors: “low material resources, unfavourable employment conditions, heavy family and household responsibilities, strain in intimate relationships, and pregnancy complications” (Dunkel Schetter and Tanner, 2012: 142). While maternal stress may produce negative psychological, physical, or emotional effects for pregnant women, research has revealed that PNMS may also have serious effects for foetal development and health: affecting cognitive and motor development, attention regulation, producing fear and negative reactivity to novelty in the first year of life, increasing behavioural and emotional problems, and decreasing gray matter density (see Mennes et al., 2006; Kashan et al., 2008; Davis and Sandman, 2010; Buss et al., 2010). There subsequently appears to be direct physiological, psychological, and social consequences to the child of maternal stress. Maternal stress, as differentiated by Christine Zeindler (2010), can be objective or subjective. On the one hand, *objective stress* refers to the quantifiable amount of hardship that women face during their periods of stress, which can be measured by the number of days that women were exposed to the stressor, the losses incurred, the physical changes to daily routines, possible threats to safety, as well as the length of the stressor event. On the other hand, *subjective stress* refers to women’s reactions to the stressors, which can be measured by assessing their emotions or feelings at the time they were exposed to the stressors. Pregnant women can have a high level of objective stress, but a low level of subjective stress. Moreover, as Zeindler (2010) notes, maternal stress can also be regarded as chronic, linked to ongoing events in women’s lives, or as acute, referring to sudden changes in the daily routines or environments of the women.

One way that stress materialised in the social lives of the pregnant women I worked with was in relation to the lack of support from their partners (fathers of their babies). Paternal involvement was widely discussed by women; while some described their partners as being involved in their pregnancies, others complained about unsupportive partners and loneliness. The involvement of partners in the women’s lives varied greatly, and, using thematic analysis, can be classified as: *physical support*, *emotional support*, *financial support*, and *childcare*. Initially, *pre-intervention* interview responses revealed that partners were ‘very involved’ in women’s pregnancies; however, a number of pregnant women, mentioned that they could not or did not receive any physical, emotional, financial or childcare support from their partners.³⁹

³⁹ This included the ten per cent ($n = 6$) of the pregnant women who reported to be single.

Michelle, four months pregnant at the time of our interview, was one of the pregnant woman who could not receive support from her partner because he had died in a fatal car accident merely one week after she found out she was pregnant.⁴⁰ Objectively, Michelle's stress was experienced through the lack of physical, emotional, and financial support from her partner and her partner's family during the first trimester of her pregnancy; however, subjectively, Michelle explained that she managed her stress by remaining strong despite her loss, and repeatedly stated that she was taking each day "step by step". Michelle also said that she felt worried about having another baby after her "bad experience" of childbirth nine years earlier.⁴¹ In this example, Michelle's stress is both acute and chronic. In other instances, the fathers were not interested in the women's pregnancy; "the father does nothing towards the child, he doesn't want anything to do with it", said one pregnant woman (age 30, eight months pregnant) as she sat next to her new partner whom she said offered her "lots of support, lots of everything whenever I need it, always". Some fathers were also unavailable to assist because they worked long hours or in shifts: "because he's always busy, working all the time, don't have enough time" said one woman, while another explained "actually he works a lot so he is only now and then, he isn't really there [for me]".

Some participants noted that the progenitors "did not support the pregnancy". These were the realities for Maggy and Beryl. Maggy was thirty-two years old and five months pregnant at the time of her interview. She had grown up in Zimbabwe, and now lived in the outskirts of Cape Town with her family, and worked as a domestic worker. Beryl was twenty-nine years old and nine months pregnant at the time of her interview. She was originally from the Democratic Republic of Congo (DRC), but now lived in the Northern Suburbs with her family, and worked part-time as an informal trader. Both women were pregnant with their third child, both were married, and both left high school when they were in grade ten. When asked who supported her, Maggy replied: (my interjections bracketed):

Maybe awkward, maybe unexpected, but obvious, my God takes care of me... I couldn't do it alone (ja) there is a God above who watches, 'cause without him then I'm nothing (mmm) because people can desert you, but you can always turn to God. When it becomes difficult, and he always makes a way out, because my husband is not very supportive (is it) because

⁴⁰ This was Michelle's second pregnancy, but her partner's first child.

⁴¹ Michelle gave birth to her first daughter at the CHC in 2007. Doctors and nurses were striking at the time and as a result, student nurses assisted Michelle to give birth. Unfortunately, the student nurses forgot to remove Michelle's "afterbirth" (placenta) after successfully delivering her daughter, which was only detected days later after Michelle began to feel ill. Since then, Michelle had been worried about having another baby in case that incident repeated itself.

also he didn't want this baby (aaww) so he say to me, you know in my first, when I first found out, then he says, "you know it's not a baby just yet, you can just go to the clinic and have it taken, get, get rid of it" (aaww) and then I say to him, "is that abortion you're talking about?", then he says, "it's not abortion yet, because it's not a baby just yet". I said, "I'm sorry, but no". And then, then what will I be in front of God, and my mom, what will I tell my mom that I got rid of a baby? (mmm) It's wrong...

Given the lack of physical and emotional support from her husband, Maggy relied on her faith during her pregnancy. While her husband did not support her pregnancy, suggesting she get an abortion, Maggy was determined to keep the baby, not only because she wanted to, but because she considered the judgement of her mother and God in making her decision. However, in deciding to keep the baby, Maggy lost the support from her husband, which resulted in her becoming the main caregiver of her unborn child. Similarly, Beryl's experience of pregnancy was also lonely; while her husband supported her decision to keep the baby, he was never available to assist her with their children or to support her during her pregnancy:

If I do need some help, like I was saying, most of the time I'm alone, (ja, ok) I'm always alone, so for me the experience I went through, I would just say it, I mostly take my little baby with me, first, you know how we put the babies on the back, I do that without (without any help?) there's no one to help me for that, you see, and I have to take my baby with me and do everything that I have to, because the baby is crying, you can't just leave the baby crying like that, you have to be with them, there's no one to help you there, and my husband is not there, he has to go and to look for something for us (ja, ja). I have so much experience, actually not that much, I need also to learn more from what I go through. I'm so lonely, I would tell you I'm so lonely, there is no one to support me, like the kids, like when I'm having the baby, or any one to give me a hand, mostly it's just my husband when he's around, when he's not around, I'm struggling.

Beryl's husband's role was to provide her with financial support through informal trading. While her experience is not uncommon in a context where the role of fathers and husbands in marriage is understood as providing material resources, the absence of her partner resulted in Beryl feeling lonely and under-supported in other ways. Maggy and Beryl's experiences of loneliness, however, extended beyond the perceived support of partners. Since both women were immigrants from other African countries, they also lacked the physical, emotional, and childcare support from their maternal kin, who were not living with them in South Africa.⁴²

⁴² Titilayo Babatunde and Carlos Julio Moreno-Leguizamon (2012) write about similar experience of isolation. They showed that, for African women immigrants in South East London, even though most of the participants in the study were married, their husbands did not help them with child care or household chores. This lack of support was regarded by the participants as an "African thing". In addition, "participants indicated that a major source of distress was being unable to share their emotions with their immediate family for fear of being seen as a failure" (Babatunde and Moreno-Leguizamon, 2012: 8). This was especially the case for unmarried pregnant women. While many participants valued the support from their mothers, "a few never had the opportunity for their own mothers to be present due to their immigrant status" (Babatunde and Moreno-Leguizamon, 2012: 9).

Based on the examples by Michelle, Beryl, and Maggy, acute and chronic stress rendered a major interruption in the lives of these pregnant women. Prenatal maternal stress, specifically caused by the lack of support from their partners and kin, interrupted the pregnant women's health by placing immense emotional and mental pressure on the women to cope with physical, emotional, and financial aspects of life on their own. Social support by family, but particularly from partners, has been considered a buffering factor that decreases stress levels and adverse effects of stress placed on the mother and the infant (Shishehgar et al., 2016; also see Lancaster et al., 2010; Lau and Yin, 2011; Dunkel Schetter, 2011; Divney et al., 2012). Pregnant women who engage in social networking have been reported to feel more confident and valued, which enhances their chances of being healthy, and of having healthy babies (Elsenbruch et al., 2007 cited in Shishehgar et al., 2016). On the contrary, when pregnant women lack social support or experience social isolation, the women may experience prenatal and post-natal dyspnea, digestive problems, and depression (Gabbe et al., 2012). In a study by Sara Shishehgar (2016) and her colleagues, more than two-hundred pregnant women who attended prenatal care at the Shahryar Hospital in Iran were asked to complete questionnaires, which included questions about pregnancy stress, social support, and socio-economic status.⁴³ The study supported the assumption that immediate family members, but specifically their partners, moderated stressful events (related to the delivery process and hospital staff's behaviour) and their adverse effects. In particular, "appropriate social support reduces anxiety and stress through blood cortisol reductions (cortisol is a stress hormone that activates a stress response, including elevated heart rate, pulse, perspiration, *etc.*)" (Ditzen et al., 2008 cited in Shishehgar et al., 2016: 48). Prenatal maternal stress, whether acute or chronic, constitutes a major interruption. Not only do the stressors interrupt the pregnant woman and mother's everyday rhythms and routines, but the resultant stress, experienced psychologically and physically by the woman, may negatively impact the growing foetus and infant by interrupting physical and cognitive development. While many of the pregnant participants experienced stress outside the clinic space, some women also experienced feelings of stress within the clinic, including as a result of the video card content.

⁴³ Only pregnant women who met the following criteria were permitted to participate in the study: in their first or second pregnancy (with a single foetus); neither their husband nor child should be disabled; may not have experienced a major life issue during the last six months; non-smoker and non-drug user.

Intensive Mothering

The *Together from the Beginning* video content, I argue, interrupted pregnant women's notions of mothering by displaying good/ideal mother discourse through the ideology of 'intensive mothering'. Throughout the video, the consequences of maternal actions, both good and bad, are highlighted and directly linked to the foetus and infants' well-being. For instance, when, in the video, Somi's mother drinks alcohol and smokes cigarettes, Somi replies from her womb that these substances "stop my body and brain from growing well"; whereas, when his mother eats vegetables, Somi thanks her for already looking after him so well. Similarly, when the mothers hold their babies in their arms, the narrator comments that the babies feel warm and safe, but when the mothers feel depressed or are unresponsive, the narrator explains that the infants consequently feel sad, and, as a result, do not eat properly and may lose weight, become withdrawn, look sad, find it hard to sleep, become scared of people, and become too attached to caregivers. The narrator further adds, "if we help ourselves as mothers, we also help our babies [and] when a mother and her baby feel happy again, the baby's weight improves and the baby's brain can grow well again". The mother – and particularly her mode of self-care – becomes the centre of the narrative of early childhood development in the video. She is not only responsible for her infant's biological, social and mental development, but also needs to ensure that she remains well enough to provide her infant with everything he or she needs to develop. Ultimately, the video shows how the actions of the mothers have a direct consequence on the development of the foetuses and infants, whether positive or negative. The video content clearly encourages mothers to engage in 'intensive mothering'. Coined by Sharon Hays (1996) in *The Cultural Contradictions of Motherhood*, intensive mothering is an ideology premised on the ideas that women should continue to be the central and primary caregiver of infants and children; that mothers should spend large amounts of time and energy caring for their children; and that mothering is separate from professional paid work, whereby mother and children exist in the private sphere with the family, outside of the public sphere (Hallstein, 2006: 96). Moreover, "[Hays argues] intensive mothering continues to position all women in the subject position of the all-caring, self-sacrificing ideal 'Mother,' ... and, importantly, is the *proper* ideology of contemporary mothering for women across race and class lines, even if not all women actually practice it" (Hallstein, 2006: 97; italics in original text). Intensive mothering also emphasises the role of experts to guide childrearing practices, as described in the previous chapter. I explore each of these points with reference to the video.

Firstly, within intensive mothering, “there is an underlying assumption that the child absolutely requires consistent nurturing by a single primary caretaker and that the mother is the best person for the job” (Hays, 1996: 8). This is also the basic premise of much research on infant attachment, which is itself central in ideas related to infant thriving and maternal function. In the video, *mothers* are represented as the main caregivers of infants, not only due to the lack of representation of other caregivers and fathers,⁴⁴ but also through the different maternal practices displayed in the video between the mothers and babies. When Somi’s mother suffers from depression, the responsibility falls on *her* to obtain help from her nearest clinic or hospital to ensure that she will be able to provide her infant with adequate and appropriate care. Similarly, when Radheefa begins to cry, it is her *mother’s* responsibility to ensure that she comforts her daughter before leaving for work. In each scenario in the video, mothers play a central role in ensuring the “preservation, growth and acceptability” (Ruddick, 1980) of their infants’ lives, health, well-being, and overall development.⁴⁵ Secondly, when the fathers of the infants and other caregivers are unavailable to support mothers, regardless of the reason, mothers become the central and primary caretakers of children. These mothers then engage in intensive mothering, which is “construed as *child-centered, expert-guided, emotionally absorbing, labor-intensive, and financially expensive*” (Hays, 1996: 8; italics in original text). Each of these components of intensive mothering is clearly illustrated throughout the video: the *infants* narrate the video and are placed at the *centre* of the mother-infant relationship; the mothers in the video are advised to seek help from *experts* at their nearest clinics or hospitals when they feel depressed or require information about their children; when Somi’s mother feels unwell, she is unable to provide adequate care for her son, making the process of caring *emotionally absorbing*; when Josh’s mother is alone at home with her infant, she is not only expected to prepare food before her husband arrives, but is also expected to clean the house and care of her son, making the process of mothering (alongside housework) *labour-intensive*; and when Radheefa’s mother leaves for work after leaving her daughter with a caregiver, this, albeit indirectly, implies that mothering is *financially expensive*, to the point where the mother, too, has to work in order to provide financially for

⁴⁴ The fathers of the three infants only appeared for a total of two minutes and twelve seconds in short segments scattered throughout the thirteen-minute video content.

⁴⁵ Sara Ruddick (1980) argues that maternal practices are governed by the preservation, growth and acceptability of the child. Preservation is considered to be the fundamental and most consistent aspect of maternal practice: “once born, a child is physically vulnerable for many years. Even when she lives with the father of her child or other female adults, even when she has money to purchase or finds available supportive health and welfare services, a mother typically considers herself and is considered by others to be responsible for the maintenance of the life of her child” (Ruddick, 1980: 348).

her family. This leads to the third point of intensive mothering: the video demonstrates the separation of mothering from paid work, where Somi and Josh's mothers appear to be "stay at home" mothers (tending to the family in the private sphere), and only Josh's father is shown returning from work (the public sphere).

Pregnant women and mothers (those displayed in the video and those who watched it) were expected to adhere to high standards of intensive mothering displayed in the video, and were consequently expected to transform into 'ideal mothers' themselves. Failure to become this mother and to conform to the principles of intensive mothering (that were unintentionally highlighted in the video) instilled fear of being labelled 'bad mothers' in the pregnant women and mothers at the CHC. Some expressed consequent feelings of guilt, anxiety, and stress. This became evident when some participants spoke about how they felt "mixed emotions" towards the video content. While most viewers said that they enjoyed the video and generally felt positive after watching it, at least five women felt "emotional" after watching the video and expressed feelings of guilt about their own self- and child-care practices. A nurse too conveyed concern about this aspect of the intervention. The women's negative emotions raise concern about *when* the best time would be to show the video to women. For instance, showing the video to a pregnant woman in her third trimester may have produced worse feelings of guilt based on the idea that it would 'too late' to change her self-care practices. This is problematic since most pregnant women 'present late' or do not report for their first antenatal appointments until after the recommended first twelve weeks of pregnancy (see Ferreira, 2016). Nevertheless, even though the video content does not explicitly instruct mothers on how they *should* care for their infants (pre- and antenatally), but rather illustrates the lived realities of mother-child care relationships in South Africa, the women I worked with were affected by both the moving images and the model of mothering expressed in the video. In this regard, the video interrupted pregnant women on an emotional level by enabling them to reflect on the care practices and relationships illustrated in the video in relation to their own care experiences with their infants and partners; however, sometimes, as in the case of those who felt guilty, they evaluated themselves harshly against the ideals displayed in the video.

Debra Jackson and Judy Mannix (2004), in a study to determine mothers' experiences of mother-blaming in Australia, note that blame and liability of mothers does not only occur during pregnancy and throughout children's lives, but also occurs from the moment of conception. "Many women carry the burden of societal (and professional) disapproval, either

because they do not fit society's idealized view of motherhood or because they behave in ways that are not considered appropriate for mothers" (Jackson and Mannix, 2004: 151). This was the case for some of the pregnant women and mothers at the CHC. In an emotional interview, Zara (who had been waiting six hours in the clinic before our interview) used the messages from the video to reflect on her own experiences with her baby: "But it makes you realise, because you think that the baby can't hear you while you're pregnant, but they really can, they don't hear the voice, but they recognise your voice". It was at this point in the interview that Zara began to cry, but continued to explain that: "Oh, as parents we do like mistakes we do not realise, but then by watching the video then you realise certain things that you also do, unintentionally to hurt the child but then, you do, in the long run". Even though Zara had not been aware of the effects of her actions on her child, she blamed herself for her "mistakes" and revealed her feelings of guilt through her tears. In another example, Robyn expressed feelings of guilt about drinking alcohol throughout her pregnancy. Initially, during the *pre-intervention* interview, Robyn casually mentioned drinking a glass of sweet red wine "now and then" in order to relax and "sleep nice at night". After watching the video, however, Robyn reported that she felt "bad" about drinking wine, but quickly covered up her actions by commenting on her 'good' maternal practices: "but besides from that, I don't think I've been bad, like you know, I've been eating a lot of vegetables and I do a lot of walking, cleaning". Similar to Jackson and Mannix's findings, women's narratives revealed the negative effects of blame on women, resulting in feelings of guilt, inadequacy, anger, and self-blame.

In conclusion, early intervention is assumed to be efficacious in interrupting projected health outcomes for mothers and infants; not only in the immediate or short term, as measured by mortality and morbidity rates, but in the longer term, as measured by ideas about disease distributions and inheritance through generations. Part of the intention behind MCH and ECD interventions, particularly those framed around the first thousand days, is an attempt to secure well-being for this generation so that the projected burden of ill-health of future generations will be refigured. Early intervention is thus viewed as critical, with the immediate object of intervention being the foetus/infant, while the long term object is the future, both addressed through the medium of the mother. As a result, it can be suggested that developmental interventions are a mode of interrupting anticipated futures. However, when development interventions do not adequately consider and support the needs of their target audience, then the intervention may not reach its intended outcomes, and may instead produce adverse outcomes or 'interruptions'. With this in mind, while the *Together from the Beginning* video

card was intended to contribute to the numerous patient education interventions already present in the CHC, and to contribute towards the goals of early intervention, it resulted in various interruptions. However, not only did the physical video card interrupt the workflow of the nursing staff and add extra responsibilities to their already busy work schedules, but the video content displayed images and messages that interrupted women's perceptions of care by implying idealised forms of motherhood. In this regard, 'ideal mothers' were attempted to be produced, developed, and made to matter via the messages in the video that reinforced dominant motherhood discourses, as demonstrated under intensive mothering (Hays, 1996). These ideal mothers were produced and made to matter in the clinic with the aim of ensuring that the anticipated futures were met. Despite the fact that the video displayed childcare scenarios in various socioeconomic backgrounds, and represented diverse families and caregiving in the Western Cape and South Africa at large, the video content disregarded, devalued, and undermined the alternative contexts within which women (and other caregivers) raised children. The video therefore not only ignored and underrepresented other external stressors that may have affected women beyond the clinic waiting space, but also reinforced and normalised (ideal) motherhood as a dominant discourse. These implications of the video card are important to consider because it highlights the intended and unintended consequences of development interventions, which has a direct impact on the anticipated futures that it was attempting to 'interrupt'. As such, while some interruptions can produce positive outcomes, many interruptions produce negative outcomes. With that said, "interruption must be ironed out as it is what impedes us achieving our goals, stops us from getting wherever we are trying to get to, what keeps interfering with the forward thrust of our lives" (Baraitser, 2009: 73). On the one hand, ironing out the interruptions caused by the physical video card would imply taking into consideration the work schedules of nurses so that the video card intervention does not become a burden for them to administer to waiting patients. On the other hand, ironing out the interruptions caused by the video content would imply considering the diverse mothering practices of pregnant women and mothers (and others), as well as the subjective and objective stressors present in their lives, without confining them to the standards of intensive mothering.

Chapter Five

Mothers Made to Matter

The *Together from the Beginning* video card was positively received by the majority of pregnant women, mothers, nurses, and counsellors at the Community Health Clinic. However, as a physical intervention, the video card was introduced into antenatal and MOU waiting areas that were regarded by insiders and outsiders as public spaces where time was ‘wasted’. More specifically, waiting time was regarded by outsiders as an ‘opportunity’ during which to introduce development interventions to the masses of waiting women, regardless of how they spent or viewed their time. As an additional patient education tool, the video card, along with other state-funded interventions, sought to educate pregnant women and mothers, particularly black, working class women, about early childcare behaviour and practices that was supported by the latest scientific research and motivated by global developmental goals that would ensure children remained healthy and reach their full development potential. As my research revealed, the state drew on evidence produced in specific scientific disciplines (such as epigenetics and neuroscience), and rendered this as authoritative knowledge via interventions, to direct women’s time, knowledge, experiences, and understanding about mothering and motherhood. This was achieved in a number of ways, including the *Mother, Child Health and Nutrition* booklets, the *Together from the Beginning* video card, as well as nurse-patient interactions. Interventions implemented in the waiting areas of public healthcare facility subsequently deflected from greater issues: that waiting had become a normalised experience for working class patients within the clinic; that women (and other patients) were merely expected to wait for healthcare; that (black, working class) women were expected to visit overcrowded and under-resourced public clinics, and to accept poor maternal and infant healthcare services; that women had time to wait/waste; and that patients in the public clinic were essentially expected to become “patients of the state” (Auyero, 2011). It can therefore be argued that had we lived in a more just and equal society where resources were evenly distributed, the health of the population would be vastly improved without having to target certain gendered individuals, such as pregnant women and mothers. Since this was not the case in the public healthcare facility where I conducted my research, mothers were primarily ‘made to matter’ in the CHC, specifically through development interventions and development discourses that both made use of and devalued women’s time and (childcare) knowledge, while simultaneously disregarding the daily stressors that affected them outside the clinic space.

Regardless of the positive intentions of development interventions, finding the time to ensure that their children reach their ‘full developmental potential’ may be one of the greatest challenges, particularly when women do not have the money, resources or support to care for themselves and their children. Pregnant women and mothers, with their perceived ‘potential’ to raise their children according to scientifically-approved interventions, cannot do so in isolation. They require finances; access to resources, including nutritious food and health care; physical and emotional support; and time, in order to ensure their own well-being, as well as that of their children. A major problem therefore lies in the fact that:

Mothers appear to have the ability to transcend structural problems, such as poverty, and their own illnesses, such as depression. Thus, it is easy to concede that the solution to children’s affect problems rests with mothers, even if they are depressed and struggling to provide their family’s basic needs, and that poverty and depression only affect social development when mothers fail to be sensitive enough to overcome them (Wolf, 2016: 633).

The waiting mother, educated mother, and ideal mother, consequently became entities that others could use and abuse. Not only were the CHC waiting areas convenient spaces within which to target pregnant women and mothers, but these women were also regarded as effective subjects through which to achieve developmental goals, even if they did not have the resources to do so, because these goals were supported by scientific and developmental discourses. In essence, motherhood became an experience of “powerless responsibility” (Rich, 1986), with external players attempting to guide the childcare practices of mothers and influence their maternal knowledge through maternal education via development interventions, even *before* their babies are born. Pregnancy and infancy then became time periods during which social pressures were exerted upon women in order to produce conformity. While, on the one hand, the state and development provided pregnant women and mothers with antenatal services to ensure that they remained healthy for the sake of their babies, on the other hand, mothers were simultaneously subjected to scrutiny and manipulation via a range of interventions from these very institutions. Subsequently, the mother became a site to be ‘developed’ and was *made* to matter within the clinic so that she would produce and develop children who would become productive citizens in society and ensure the prosperity of the population, thus meeting state expectations. She was expected to achieve this while also meeting the standards of intensive motherhood, as set out through the video card and other interventions. The mother, through years of practice and patience, but also through interventions that aimed to ‘educate’ her, was thus transformed into a developmental intervention herself, intended to produce a child that reached his/her ‘full developmental potential’. Failure to achieve this resulted in feelings of

guilt because the mother no longer met the high expectations of the idealised, heteronormative ‘good mother’. The mother was consequently rendered to be both the source of the developmental problems and the solution to problems that had not yet been produced by future populations.

Motherhood, however, is not natural. Indeed, “feminist perspectives have asserted that motherhood and mothering are not *natural* for women but that they are historically, culturally and socially constructed” (Silva, 1996: 1; italics in original text). I have thus attempted to add to this perspective, suggesting that motherhood and mothering has also, more recently, been ‘developmentally constructed’ or ‘made to matter’. In other words, this research contributed towards the understanding of motherhood and mothering as it is currently being represented, constructed, normalised, and reinforced within dominant development discourses and interventions related to MCH and ECD. This research has also helped demonstrate how motherhood and maternal practices continue to be normalised by the hands of the state and other stakeholders, through development initiatives, and especially within public healthcare facilities. I have argued in this thesis that while mothers do matter in the physical development of their babies, mothers were materialised as experimental subjects of policy, and thus *made* to matter through MCH and ECD development discourses and interventions. In doing so, I have shown that three mothers – the waiting mother, the educated mother, and the ideal mother – were produced, developed and made to matter in the CHC. This, however, was problematic for a number of reasons. Firstly, for the waiting mother: when the waiting time of women in the clinic was accepted and regarded as an ‘opportunity’ by outsiders, it made it convenient for the state to target women. It also redirected the responsibility from state, who should have instead focused on reducing the long durations of waiting time endured by working class women (and other patients waiting in public clinics), while also providing better healthcare services and additional resources needed by pregnant women, mothers, *and* other caretakers and role-players, in order to adequately care for children during their early development. Secondly, for the educated mother: when maternal education was normalised in the clinic through development interventions, via information sessions, and from nurses who would *skel*, this enabled the childcare knowledge and practices of women, but particularly black working class women to be the regulated and controlled by the state. Furthermore, by perceiving the information supplied by state interventions and nurses as ‘authoritative knowledge’ not only disregarded the diverse contexts within which children were reared, but also undermined the existing childcare attitudes, beliefs, knowledge, and practices that women possess outside the

clinic. Maternal education was also enforced in racialised ways that reinforced outdated stereotypes of black women as ignorant. Thirdly, for the ideal mother: when the ‘good mother’ ideology was presented and enforced through the *Together from the Beginning* video content and other interventions provided by the state, it contributed towards the reinforcement and normalisation of idealised motherhood. Moreover, the video content interrupted the emotions of some women, causing some of them to feel guilty about the own self- and child care practices. This not only contributed to the already stressful lives of pregnant women and mothers, but also disregarded the external stressors that women may have been experiencing in their personal lives.

One possible way to overcome these problems is to shift the focus of MCH and ECD development interventions away from pregnant women and mothers. Currently, development discourse on motherhood holds that if a child’s full developmental potential is not ‘unlocked’, then it is the mother who is held responsible and receives blame for not achieving her goal as a development intervention. Worse still, the mother blames herself when she ‘fails’ to achieve these goals. As shown in chapter four, the form of intensive mothering that was implied by the video content resulted in mother-blaming that not only interrupted some of the pregnant women’s experiences at the antenatal clinic, causing them to feel guilty and stressed, but also interrupted their conceptualisation of mothering. As such, even when the actions of pregnant women and mothers were out of their control, many of them continued to blame themselves, rather than being blamed by others. In *The Scapegoating of Mothers: A call for change*, Paula Caplan and Ian Hall-McCorquodale (1985) discuss “the practice by many clinicians and members of the healing professions of blaming mothers for whatever goes wrong with their children” (1985: 610). As explained, when fathers (or other caregivers) are not appropriately represented in journals or other sources (such as the video or other interventions), mothers continue to be blamed (by others or by themselves) for their children’s health-related problems, and the contributions of fathers and others towards these problems are never considered:

As long as the mothers are held to be primarily responsible for their children’s emotional adjustment, a dangerous source of intense anxiety, self-deprecation, and fear will be brought to the relationships many mothers have with their infants. For many women, the pervasiveness of mother-blaming means that when they give birth to or adopt a baby, they put themselves in the spotlight where, should anything go wrong, they will almost surely be accused. In view of this, it is perhaps remarkable that any mothers can relax at all (Caplan and Hall-McCorquodale, 1985: 612).

Mother-blame can have “devastating effects on the women’s self-esteem, health and well-being” (Jackson and Mannix, 2004: 154), leading to feelings of guilt, which may cause anxiety, depression and stress. This, in turn, may interrupt the development of the foetus and infant, as discussed under (prenatal) maternal stress. One way to avoid these interruptions caused by mother-blaming is by changing the narrative displayed in the video content and related development interventions. A recommendation proposed by Caplan and Hall-McCorquodale involves replacing *mother*-infant relationships and interactions, as was often represented in clinical journals, with *parent*-infant interactions, so as to place less pressure and responsibility on mothers.⁴⁶ Replacing *parent* with *caregiver* may be even more effective as it will take into consideration the alternative care-relationships that exist beyond the mother, father or parent. If these changes do not occur then, “such interpretations by clinicians, researchers, and other mental health professionals strengthen the notion that the problems are the mother’s fault, and the vicious cycle continues” (Caplan and Hall-McCorquodale, 1985: 612). However, if mothers are going to continue being targeted by MCH and ECD interventions, then the processes for creating and implementing interventions need to change.

MCH and ECD development interventions are largely motivated by future outcomes, with benefits including better mental and physical health, improved academic performance during childhood and adolescence, as well as increased economic productivity and social integration during adulthood (Daelmans et al., 2015: 23); however, these outcomes may only be revealed once the child has grown into an adult and become a ‘productive’ citizen of society. The new emphasis on the first thousand days of life extends these temporal horizons; the productive effects of intervention in that period are anticipated to endure through individual bodies into the future, thus reshaping life’s potential (Pentecost and Ross, 2017). Explained differently, MCH and ECD interventions, especially those present in the CHC, were guided by the notion of ‘potential’, including the developmental potential of the infant, the potential social and economic value of infants as future adults, and the potential to intervene in projected population health outcomes. By educating mothers to raise children according to scientifically supported prescriptions via interventions, mothers (and, to a lesser extent, other caregivers) became responsible for future generations and the overall well-being of society. However, as my research revealed, while mothers were made to matter for the sake of development, their

⁴⁶ The Department of Health is aware of this distinction, and has begun altering their programmes to encompass a more familial model.

own needs, beliefs, and experiences were subsequently disregarded or undermined. As such, if women are going to continue being the target of state development interventions, then they cannot continue being reduced to “container[s] for their foetuses” (de Souza, 2013: 18). Furthermore, we cannot continue making assumptions about women’s time, knowledge, and experiences both within and beyond the waiting spaces of public healthcare clinics. Neither can we assume that women even want to become mothers or have chosen to become mothers. On the contrary, if mothers are going to be made to matter for developmental reasons, then the pregnant women, mothers, and other caregivers, need to be taken into consideration throughout the different stages of intervention creation, production, and implementation.

By using the example of the video card, I have shown how one small intervention offered numerous ways to think more broadly about how we think about concepts and practices linked to mothering, development, potential, the future, and well-being in contemporary configurations of knowledge practices. More specifically, I have shown how MCH and ECD development interventions aimed at pregnant women and mothers normalised the long durations of waiting in public antenatal and MOU services; excluded other role-players — fathers, partners, mothers, family members, and other caregivers — that mothers considered central in the rearing of their children, and thus disregarded the diverse childcare arrangements that existed; reinforced the belief that mothers were primary caregivers, and that black, working class mothers lacked childcare knowledge; placed immense pressure and responsibility on women to provide children with appropriate and adequate care; and re-established the notion of intensive mothering. The institution and ideology of motherhood is constantly and subtly being reinforced and normalised through dominant discourses, development interventions, and everyday interactions within and outside public healthcare spaces. While the women with whom I worked valued the information they received from the development interventions, my research reminds us that we need to become aware of how women are being ‘made to matter’ as mothers.

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Appendix A: Research Questions

1. How is “motherhood” defined, understood and represented by the interventions?
2. What is the *problem* that motherhood is a *solution* to?
3. How is the first thousand days framed within these interventions?
4. What messages are being relayed to mothers/caregivers?
5. Which “type” of mothers/caregivers are these interventions targeting? Why?
6. Are fathers targeted? Why/why not?
7. Who else is targeted?
8. Why do interventions fail? What is at stake if these interventions fail?

Appendix B: Information Sheet

We wish to examine how people respond to a video card intervention. The intervention aims to show people how to care for themselves and their unborn babies and infants. We will invite you to watch the video and to respond to it. Prior to that we have a conversation about what you already know and expect about being pregnant and having a baby.

After the video, we will ask you about how it made you feel, whether you thought it was useful, and how you understood the material being presented.

There are not risks to you in participating in this research. We simply want to know whether this is a useful tool and one we should consider implementing in other clinics.

If you do participate, we ask you to sign a form saying that you agree to be interviewed. We will use pseudonyms for you. All information will be safely stored and only the researcher and her supervisor will have access to it.

The research is being conducted by Kylie Marais from the University of Cape Town, and the Department of Health in the Western Cape.

If you have any queries, please feel free to contact Prof. Fiona Ross on 021 650 3679.

Appendix C: Consent Form

I _____, resident at

agree to participate (without remuneration) in a pilot research project that is examining the reception of “Together from the Beginning”, an educational video card intervention, at the Community Health Clinic.

I understand the objectives of the research.

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

Signed _____

At _____

On _____

Appendix D: Demographic Survey

DEMOGRAPHIC DATA			
Identifier (name/pseudonym):			
Age:		Ethnicity:	<ul style="list-style-type: none"> • Black • Coloured • Indian • White • Other
Place of residence:			
Education level:		Source of income:	
Relationship status:	<ul style="list-style-type: none"> • Single • Engaged • Married • Divorced • In a relationship 	Household composition:	
Children under the age of 18:	Yes _____	No	I am currently pregnant
PREGNANCY			
Stage of pregnancy:		Complications to date (if any):	
Number of prior pregnancies (if any):		Prior birthing histories, if appropriate:	

Appendix E: Pre-intervention Questionnaire

<i>Pre-intervention</i>	
What have been some of your expectations and experiences of pregnancy to date?	
What do you know about foetal care?	
Who takes care of you/pregnant women? Who takes care of the children (while you are here)?	
What health care and other resources are available to you?	
What problems (if any) do you have in accessing information and care?	
Who are the significant role players in this pregnancy?	
What is the father's current involvement?	

Appendix F: Post-intervention Questionnaire

<i>Post-intervention</i>	
What did you think of the intervention?	
Have you encountered this kind of information before? If so, where and how?	
What did you learn from the intervention?	
How does it make you feel about the ways you have been caring for themselves and the foetus to date?	
If you anticipate changes as a result of the video, what resources are available to support you in this?	
How did you feel about the process of viewing the video?	
What did you like/dislike/not understand?	
Would you be able to use this information to inform fathers and others central to the pregnancy and infant?	
What barriers might there be to doing so?	
Suggestions for future interventions?	