Discursive constructions of alcohol use and pregnancy among participants in intervention aimed at reducing Foetal Alcohol Spectrum Disorders.

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Abstract

South Africa's socio-cultural and political history has had significant effects on maternal and reproductive health. The hazardous alcohol use patterns in the country have affected alcohol consumption during pregnancy. Antenatal exposure to alcohol may result in Foetal Alcohol Spectrum Disorders (FASD). The levels of FASD in particular areas of the country are the highest recorded in the world. Epidemiological studies have dominated pregnancy and FASD research in South Africa; however, recently critical scholarship seeking to contextualise the issue of drinking alcohol during pregnancy is emerging.

This study forms part of a developmental/formative assessment of an alcohol and pregnancy intervention. Assessment is an important part of pilot interventions, and discourse is a key area of focus due to its constitutive role for the subjectivity of human beings and legitimation of institutional practices. Using a reproductive justice perspective and a Foucauldian approach to analysis, I identified five prominent discursive constructions of alcohol use during pregnancy produced during interviews with community educators. These interviews were conducted following training workshops with the community educators.

Participants constructed their living environments as 'wholly bad' and 'issue-ridden' and positioned alcohol consumption as 'a destroyer!', 'king' and a social lubricant. They interpellated the foetus, the 'FASD child' and pregnant women into this context. They positioned themselves as transformed subjects able to effect change. The foetus was constructed as 'vulnerable and important', as opposed to the 'defiled FASD child'. Pregnant women were constructed as 'ignorant, preoccupied and unreceptive to knowledge'. These constructions hinged on so-called 'scientific knowledge' of biological processes in utero, demonstrating Foucault's conception of the power/knowledge nexus and how its dynamics transforms knowledge of human beings. Whereas this 'knowledge' transformed alcohol consumption and the foetus into powerful and vulnerable subjects respectively, the circulating discourses had objectivising effects on pregnant women. The discourses of responsibilisation, the personification of the foetus, 'the problem' category of FASD, the discourse of difference, and the discourse of alcohol consumption as an entrenched practice were circulating around pregnant women. I suggest alterations to the identified constructions using principles of community psychology, the harm reduction model, a social model of disability and the reproductive justice perspective.

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Acronyms

ANC	African National Congress
BANC	Basic Antenatal Care
BMI	Body Mass Index
CSSR	Critical Studies in Sexualities and Reproduction
FAS	Foetal Alcohol Syndrome
FASD	Foetal Alcohol Spectrum Disorders
MP	Mentoring Programme
NGO	Non-Governmental Organisation
PFAS	Partial Foetal Alcohol Syndrome
RPERC	Rhodes University's Research Projects and Ethics Committee
SES	Socio-Economic Status
TP	Training Programme
WHO	World Health Organisation

Declaration

I declare that this thesis has been composed by myself and that it has not been submitted, in whole or in part, in any previous application for a degree. Except where states otherwise by reference or acknowledgment, the work presented is my own.

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Chapter One: Introduction and Context

1. Introduction

This study forms part of a developmental/formative assessment of an alcohol and pregnancy intervention run by a Non-Governmental Organisation (NGO)[1]. I conducted individual interviews with trainees from the Organisation's pilot Training Programme. I aimed to identify the discourses used by community educators and the Organisation's social worker to construct alcohol-use during pregnancy. I was particularly interested in the constructions of alcohol-consuming pregnant women. I consider how these constructions can be extended to improve the intervention using a reproductive justice perspective.

To contextualise alcohol consumption during pregnancy, I begin the dissertation by considering South Africa's socio-political history, and the ways in which this has affected public health. I consider the patterns of alcohol use in the country, and how these have affected drinking alcohol during pregnancy. Antenatal exposure to alcohol may result in Foetal Alcohol Spectrum Disorders (FASD). These spectrum disorders are briefly discussed. This is followed by a description of the research conducted on pregnancy and FASD in the country. Although epidemiological studies have dominated FASD prevention efforts in South Africa, recently critical scholars have sought to contextualise the issue of drinking alcohol during pregnancy. These scholars have documented the drinking narratives of South African (pregnant) women. These narratives provide insights into the life conditions that render drinking an entrenched practice, and can provide the framework for informing intervention strategies.

Because alcohol consumption is considered a modifiable behaviour (Chersich, Urban, Olivier, Davies, Chetty, & Viljoen, 2012), there have been multiple: research efforts to try to identify so-called risk factors for the incidence of FASD; studies geared at determining the prevalence of FASD; and intervention strategies aimed at decreasing the incidence of FASD and raising awareness. Below I describe approaches to pregnancy and FASD interventions.

I conclude this chapter by describing the broader research project, the objectives of my study and the Organisation's pilot programmes. I also briefly specify how I deploy the key concept

[1] I anonymise the NGO and refer to it as "the Organisation" throughout the dissertation.

of discourse in this study, introduce the meaning of reproductive justice and map out how this thesis will unfold.

2. Context

South Africa's political landscape has had significant effects on the health of South Africans, as well as health policy and services. Coovadia, Jewkes, Barron, Sanders and McIntyre (2009) show how various stages in the country's socio-political history, most noticeably colonialisation, industrialisation and urbanisation, and apartheid, as well as some aspects in the current democracy have affected public health. Centuries of political exclusion, social separation, economic marginalisation and racial injustices are described by these authors as intensified by the state policy of apartheid initiated from 1948, when the National Party came into power. State health policy under apartheid resulted in massive health inequities, where curative and preventative services and facilities were racially segregated. In 1994, there began a shift in health policy and services when the African National Congress (ANC) was democratically elected. The ANC's health plan, guided by the Alma Ata Declaration of 1978, advocating for 'Health for All', promulgated action by governance and health and development workers to redress health inequities.

Coovadia et al. (2009) further describe that the ANC established a public healthcare system functioning to redress historical health inequities and providing essential healthcare to persistently disadvantaged people. This public healthcare system uses the racial classification system[2], a remnant of the apartheid system, to function. The racial classification system categorised South Africans as *White*[3], *Indian*[4], *Coloured*[5] or *Black*[6]. This system continues to constrain socio-cultural practices and shapes ways of knowing within public health in our present-day democracy. As will become apparent, most South African research conducted in public health, including research related to alcohol consumption during pregnancy, has been epidemiological in nature investigating health phenomena using this racialised classification system. Despite their porous nature and suggestion of essential, biological realities, I reference these socially constructed racial categories. I do this to denote particular population

[2] According to the Population Registration Act (Act No. 30 of 1950).
[3] A race classification used under apartheid, referring to people of European ancestry.
[4] A race classification used under apartheid, referring to people of Asian ancestry.
[5] A race classification used under apartheid, referring to people of mixed ancestry.
[6] A race classification used under apartheid, referring to people of African ancestry.

groups and the experience of people categorised by the classification system. In this way, I acknowledge the sustained extent to which race infiltrates many aspects of our lives.

After democracy, South Africa continued to be characterised by interprovincial and urban-rural differences in access to health and related services (Coovadia et al., 2009). To address this, the ANC promulgated the National Health Act 61 of 2003 (NHA, 2003) which legislated the establishment of the district health system. This district health system was devised with the intention of decentralising power and functions away from central government and including various social sectors (including NGOs) in order to achieve greater equity and efficiency in the distribution of healthcare services to persistently marginalised groups. More specific to maternal and reproductive health, the aforementioned health plan envisioned a system based on community healthcare centres, providing free treatment to children under the age of six years and pregnant women. Primary healthcare and the rights of pregnant women to free care could be implemented within the district system. Thus, the reconfiguration of the healthcare system enabled certain institutional practices. Within this system, certain provinces/districts/communities can be targeted, as well as certain population groups, for intervention. This works to legitimise certain institutional practices. For example, the Organisation targets certain regions in various provinces (i.e. in the Western, Northern and now Eastern Cape) and certain population groups (i.e. *Coloured* and *Black* pregnant women) for its intervention programmes. This practice becomes legitimate within certain configurations of power.

2.1. Alcohol Use in South Africa

South Africa has a relatively low level of total alcohol consumption (WHO, 2014). The World Health Organisation's (WHO) 2014 global alcohol and health status report shows a total alcohol consumption of 11 litres per capita for South Africa in 2010. A significant proportion of South Africans abstain from alcohol (Peltzer et al., 2011); the WHO (2014) report indicates a total of 59.4% of South Africans abstain from drinking. However, when looking at those who drink, per capita consumption for drinkers rose to 27.1 litres of pure alcohol, contained in beer, wine, spirits and other alcoholic drinks. The total alcohol consumption measures alone can thus be unhelpful in understanding alcohol use in South Africa. Local research indicates high burdens of alcohol abuse, resulting in alcohol-related mortality, trauma, violence, crime, risky sexual practices, and injuries to the brain of the developing foetus (Peltzer, Davids, & Njuho, 2011). Thus, understanding alcohol

consumption in terms of patterns of use provides a more helpful lens (Peltzer, Davids, & Njuho, 2011). For example, hazardous patterns are described as those that place consumers at risk for adverse health events (Peltzer & Ramlagan, 2009). The pattern of alcohol use by the South African drinker is reported as often characterised by hazardous binge drinking: that is, having at least five or more drinks in one or more days, particularly over the weekend (May et al., 2000; Parry, 2005). In a national household survey across 20 African countries, although most women reported abstinence from alcohol, the survey results indicated that drinking patterns among South African women drinkers occurs at hazardous levels (Martinez, Røislien, Naidoo, & Clausen, 2011). Thus, although South Africa is ranked 30th (of 195 countries) for total alcohol consumption levels (WHO, 2014), those who drink typically employ hazardous patterns of alcohol use.

Scholars and researchers understand these patterns of alcohol use as a remnant of the socio-political history in South Africa. Socio-economic practices, particularly in wine-growing regions, have laid the foundations for elevated alcohol consumption (Parry, 2005). Historically, these practices are traced to the establishment of a refreshment station in Cape Town and the exchange of alcohol for labour and cattle during the years of colonialisation, and the growth of the wine and brewing industry (Parry, 2005). Although the *dop system*[7] was outlawed in the 1960s, there was evidence that the system continued on some farms in wine growing regions of the country (Te Water Naude, London, Pitt, & Mohamed, 1998). The long-term implementation of this system established social norms around alcohol consumption, and patterns of alcohol misuse continue to play a central and contentious role in the country's socio-cultural heritage.

Additionally, legislation under apartheid fuelled patterns of alcohol consumption: *shebeens*[8] in demarcated *townships*[9] provided otherwise limited recreational settings, where inexpensive commercial beer, wine and liquor were available (Parry, 2005), for those discriminated against and disenfranchised by apartheid legislation. Presently, in these settings which continue to be populated by the persistently socio-economically disadvantaged, and where limited recreational activities persist, alcohol-serving venues continue to be popular as social settings (Watt et al., 2014). Harmful consumption patterns include: high levels of drinking at events such as weddings, funerals, traditional ceremonies, and other such community events;

[7] A system in which farmers partially remunerated agricultural workers in the form of allocations of alcohol (Croxford & Viljoen, 1999).
[8] Informal alcohol outlets.
[9] Densely populated locations designated for so-called *Black* people during apartheid.

drinking apart from meals; and community drinking from a common container (Parry, 2005). As noted above, the patterns of alcohol use in South Africa are mostly characterised by binge drinking as a popular recreational activity.

Jernigan (2002), reporting for the WHO, notes that recently more women in developing societies[10] use alcohol. In South Africa, drinkers employ hazardous patterns of use and the resultant 'burdens of alcohol' have been noted, including Foetal Alcohol Spectrum Disorders. The levels of Foetal Alcohol Spectrum Disorders in particular areas of the Western and Northern Cape of South Africa are the highest recorded in the world (May et al., 2000; Parry, 2005).

2.2. Foetal Alcohol Spectrum Disorders (FASD)

Foetal Alcohol Syndrome (FAS) is the most severe form of Foetal Alcohol Spectrum Disorders (FASD). Other levels of the spectrum disorder include Partial FAS (PFAS), alcohol-related birth defects and alcohol-related neurodevelopmental deficits (May et al., 2008). Antenatal alcohol exposure puts children at risk for anomalies such as microcephalys, craniofacial defects, lowered intelligence, and behavioural problems (May et al., 2008), as well as premature delivery, neonatal death, low birth weight and neurodevelopmental disorders (Behnke & Smit, 2013). Some authors report that various levels of antenatal alcohol exposure correlate with the severity of resultant anomalies in children (Crawford-Williams, Fielder, Mikocka-Walus, & Esterman, 2015). However, this is contested and a number of factors, such as genetic background and larger health determinants including nutrition, are said to mitigate or exacerbate the effects of alcohol on the foetus (Drabble, Poole, Tumwesigye & Plant, 2011). Although alcohol is a teratogen, not all exposure to alcohol to the foetus results in FASD. Research has however been unable to establish 'safe levels' of alcohol consumption during pregnancy (Drabble et al., 2011).

FASD is considered a public health priority in the Western and Northern Cape provinces of South Africa (Urban, Chersich, Fourie, Chetty, Olivier & Viljoen, 2008). Table 1 below demonstrates the reported increasing prevalence rates of FAS (Chersich, Urban, Olivier, Davies, Chetty & Viljoen, 2012).

[10] The terms "developed" and "developing" are seen as problematic by critical scholars, denoting a hierarchy (along with similar terms such as "First/Second/Third World"). Other terms include Low Middle Income Countries (LMIC) [vs. high income], global South and global North. None of these terms are without their problems, though. Although I am aware of the complexities surrounding these terms, I deploy a term used by the researchers I reference.

Table 1: *Reported Prevalence Rates of FAS in South Africa.*

Date	Area	Prevalence of FAS (per 1000 children)	Authors
1990s	Wellington, Western Cape	40.5 - 46.6	May et al. (2000)
2000	Wellington, Western Cape	65.2 - 74.2	May et al. (2005)
2002	Wellington, Western Cape	68.0 - 89.2	May et al. (2008)
2001 - 2004	De Aar and Upington, Northern Cape	74.7 - 119.4	Urban et al. (2008)

In the literature, FASD is considered a societal burden due to its negative impacts on mothers and their children. It is reported to have lifelong impacts on children's functioning, and is thus considered a pressing public health issue - particularly in regions across the world where the incidence of FASD is high (Jernigan, 2002).

2.3. FASD and Pregnancy

The identification of risk factors for drinking during pregnancy has been the trend among South African pregnancy and FASD prevention literature (see Chersich et al., 2012; Croxford & Viljoen, 1999; May et al., 2000, 2008, May et al., 2005, 2014; Urban et al., 2008). Authors argue that the identification of individual maternal risk factors allows for future selective interventions that target high-risk groups. However, I argue that it is only in addition to the psychological, social, cultural and historical context within which pregnant women misuse alcohol that individual risk factors are noteworthy. Moreover, within the context of historical categorical disenfranchisement and oppression, the contextual factors are most important. I, in this way, take a reproductive justice perspective to pregnancy and FASD. I discuss the concept of reproductive justice later in this chapter as well as explicate it further in Chapter Three.

2.3.1. FASD Prevalence

The epidemiological studies, argued to aid FASD prevention efforts, have been mostly located in the Western Cape. Following a survey documenting the incidence of FAS amongst births in a hospital in Cape Town, Croxford and Viljoen (1999) report conducting one of the first surveys among low socio-economic communities concerning substance misuse during pregnancy. The authors reported binge drinking, tobacco use and a marked preference for

beer among pregnant women in their sample. They noted under-reporting of substance use and related this to stigmatisation, fear of loss of medical benefits and legal liabilities.

A subsequent series of studies took place in Wellington in the Western Cape, documenting the prevalence of FASD amongst this community (see May et al., 2000, 2008; May et al., 2005). In May et al.'s (2000) initial study, a multidisciplinary team sought to determine the characteristics of FAS among grade 1 pupils in a South African community. The methodology used tools designed for a multidisciplinary study of FAS specifically in developing[11] societies. The team reported a prevalence rate of 40.5 - 46.6 per 1 000 children, the highest prevalence rate documented in the world at the time. The study displayed the gross socio-structural influences on FAS: children categorised as Black, Coloured and White were screened and the cases of FAS were predominantly found amongst Coloured children, followed by Black children. Within the Coloured group of children reported to have FAS, those of lower socio-economic status (SES) were overrepresented.

2.3.2. Maternal Risk Factors

In May et al.'s (2000) study, the mothers of children with FAS drank 12.6 drinks per week, compared to 2.4 drinks by the control participants. More than 50% reported that they drank more during the pregnancy that resulted in FAS. The women characterised pregnancy as a time with more problems which led them to drink more. The prevalence of FAS was more common in rural than urban populations. The authors identified older maternal age, longer length of drinking career, early onset of drinking, and quantity, frequency and timing of maternal drinking as major risk factors. In a third study, May et al. (2008) reported the following as high demographic and behavioural maternal risk factors for FASD: higher gravidity and parity; lower education and income; rural residence; frequency of and binge drinking on weekends, with no reduction during pregnancy; drinking in all trimesters; partner's alcohol consumption during pregnancy; and smoking during pregnancy. The authors reported that drinking by older and smaller (in weight and Body Mass Index [BMI]) pregnant women of lower SES later in their pregnancies is more likely to result in a greater severity of effects within the spectrum. Authors continued to suspect an under-reporting of drinking, as elicited by their quantitative instruments.

Additionally, Urban et al. (2008)'s study of the prevalence, characteristics and maternal risk factors for FAS and PFAS among Grade 1 pupils in a community in the Northern Cape

[11] See previous footnote (#10).

reported that over two-thirds of the pregnancies were unintended. This finding is consistent with pregnant women's narratives elsewhere (Watt et al., 2014).

In the above described studies in the Western Cape, the BMI of mothers of children with FASD was reported as a risk factor. Subsequently, May et al. (2014) examined the dietary intake of mothers of children diagnosed with FASD, in a community in the Western Cape. The authors explained that food intake can protect against some of the teratogenic effects of alcohol consumption, particularly for pregnant women. Poor maternal nutrition during the antenatal period puts the foetus at risk for low birth weight. Additionally, alcohol consumption during breastfeeding inhibits the delivery of adequate nutrients to the new born. Dietary intake among heavy drinkers is generally considered to be poor; however, less is known about the effects of binge drinking. Sustained alcohol use can affect the absorption and availability of micronutrients. Some of these micronutrients have been shown to mitigate some of the teratogenic effects of antenatal alcohol exposure. In their study, mothers of children with FASD consumed less fat, protein and cholesterol and had comparatively less adequate intake of some micronutrients. The authors conclude that a confluence of demographic, socio-economic as well as nutritional variables affect foetal development; and that "the overall nutrient intake of mothers is likely a contributing factor to poor foetal development in the presence of a known teratogen, alcohol" (May et al., 2014, p. 7).

Authors investigating the epidemiology of FASD conclude that the prevalence of the more severe cases of FASD, FAS and PFAS, have increased and prevention programmes are needed in communities of the Western Cape (May et al., 2008). In the section below, I explore the contextualisation of the prevalence of drinking alcohol during pregnancy using the narratives of South African women.

2.4. Disrupting the Trend: Drinking Narratives of South African Women

There have been various ways of intervening in the lives of women, as it relates to pregnancy and alcohol use; ways that have had an objectivising (Foucault, 1982) effect on women, and others that have sought to contextualise women's reproductive lives. In reviewing the literature on pregnancy and substance use, particularly among Aboriginal women, Rutman, Callahan, Lundquist, Jackson and Field (2000, p.1) note that

> ...it quickly became apparent that material written from the perspective of women who have this lived experience is also not readily available. Instead there is a large

body of literature written by professionals, primarily to suggest how to identify and treat this population of women.

Similarly in South Africa, epidemiological studies conducted with Black[12] women have dominated literature since the late 1900s. However, in recent years, South African literature on pregnancy and alcohol use has sought to document the experiences of pregnant women who consume alcohol. This is a helpful additive balance to the epidemiological investigations around pregnancy and FASD. There are a few recent studies documenting the experiences and narratives of South African (pregnant) women who consume alcohol (Choi et al., 2014; Cloete & Ramugondo, 2015; Kelly & Ward, 2017; Watt et al., 2014). Like the epidemiological studies, these studies have also been predominantly located in the Western Cape. Choi et al. (2014) conducted 12 in-depth interviews with women who drink in Delft, a township in the Western Cape. The scholars found that most of their participants drank heavily, and linked their drinking to life stressors. Watt et al. (2014) explored narratives of drinking during pregnancy among Black South African women. The scholars interviewed 12 pregnant and 12 recently post-partum women who consumed alcohol during pregnancy. The women in this study reported drinking heavily during their pregnancy period as well. Kelly and Ward (2017) interviewed 14 women and conducted 2 focus groups with 13 members of the women's communities and these participants described drinking as a means to regulate negative emotions, and to forget about, avoid or escape from domestic problems. Cloete and Ramugondo (2015) conducted a case study and interviewed 3 women who drank during pregnancy. From an occupational sciences perspective, these scholars explored how maternal drinking emerges within context and argued that drinking is an imposed occupation among those persistently marginalised and disenfranchised.

Through this more qualitative type of research, the scholars referenced above sought to contextualise the complex psychosocial and contextual factors that motivate drinking during pregnancy. These scholars seek to establish a framework for understanding alcohol use among South African pregnant women (Choi et al., 2014), which better enables effective intervention. In synthesising the identified themes across this research, I identified the following factors as salient in the drinking narratives of South African women: drinking to cope with life stressors, drinking to manage negative emotions, drinking as an entrenched practice, drinking for social engagement and other factors which I describe below.

[12] In this case, the term "Black" is used in the Black Consciousness conception of the term, denoting the marginalised Black community which includes people designated as 'non-white' during Apartheid, including Black, Coloured and Indian people.

2.4.1. Drinking to Cope with Life Stressors

It is well-established that South Africa presents with a uniquely challenging environment, particularly for the persistently marginalised and disenfranchised Black majority. This is especially pronounced for women, who are disproportionately subjected to high rates of abuse and sex- and gender-based violence (Jewkes & Morrell, 2010).

Subsequently, in an effort to contextualise women's drinking, Choi et al. (2014), explored the drinking narratives of women as a coping strategy. The women from the study described life stressors as: painful childhood experiences; abusive romantic partners; chronic poverty and unemployment; food insecurity; and poor housing. The women cited both past and present stressors as the motivation to drink; they described drinking more heavily when experiencing problems (Choi et al., 2014). The women in Watt et al.'s (2014) study similarly referenced poverty, unemployment and food insecurity as stressors. In addition, they described pregnancy as a stressor, as well as the economic challenges of having a child in their (socio-economic) situation.

2.4.2. Drinking to Manage Negative Emotions

Relational stressors were frequently cited across the studies, particularly in reference to romantic partners. Kelly and Ward's (2017) participants described drinking as a means to regulate negative emotions and evade domestic problems. Women in Choi et al.'s (2014) study also reported drinking as a means to manage their emotions: they drank alcohol for its hedonic properties and a self-medication strategy to numb negative emotions.

In addition to drinking to manage emotions and cope with life stressors, oftentimes a result of their socio-economic and socio-cultural circumstances, the pregnant women in Watt et al.'s (2014) study further described distress regarding managing HIV disclosure, the child's HIV status and the fear of their own death. They spoke about physical abuse, dissolution of romantic relationships caused by pregnancy, the absence of the partner, and family disapproval. Notably, in addition to the overlaps with the drinking narratives of women in Choi et al.'s (2014), the women in Watt et al.'s (2014) research reported additional pregnancy-related stressors, and spoke about depressive symptomology due to these stressors. The relationship between pregnancy and depression has been documented amongst marginalised women in other research in the Western Cape (Akhurst, 2017). Thus, pregnancy presents as unsupportable (Macleod, 2016) and an exacerbating motivation to drink among persistently marginalised Black South African women, particularly in the Western Cape as

documented by literature. This is suspected to be the case among similarly marginalised women from other communities across the country, including the Eastern Cape (where socio-economic development remains relatively low and socio-structural change slow).

2.4.3. Drinking as an Entrenched Practice

Cloete and Ramugondo (2015) argue that drinking is an imposed occupation among those persistently marginalised and disenfranchised. From an occupational sciences perspective, these scholars explore how maternal drinking emerges within context. They conducted a case study and interviewed three women who drank during pregnancy. Their participants came from two farms in the Western Cape. Criteria for purposeful sampling were obtained from the above-described epidemiological studies in the Western Cape. The women spoke of the hardships they experience and of the harsh childhood environments they grew up under, characterised by instability. They relayed memories which included physical violence, sexual violation and alcohol abuse. Their reflections showed that drinking was an entrenched practice. They drank as a means to cope and try to make their lives bearable.

Cloete and Ramugondo (2015) argue that in the context of limited occupational opportunities as well as occupational deprivation, excessive alcohol use can be introduced and maintained as a form of occupational engagement. Moreover, these scholars argue that historical, cultural, economic and socio-political factors perpetuate occupational inequities, possibly accounting for the increased levels of FASD among the predominantly Black community (as suggested by the epidemiological studies). These authors argue that generational poverty and excessive drinking as an entrenched cultural practice, passed on intergenerationally, renders drinking an imposed occupation among South African pregnant women in some communities.

2.4.4. Drinking for Social Engagement

The women in Cloete and Ramugondo's (2015) study noted that if one does not drink, one does not have friends. Drinking as a recreational and social engagement opportunity to facilitate interpersonal connection was another predominate theme, cited across the literature. The women in Watt et al.'s (2014) study spoke of drinking as a social norm. They explained that drinking is what pregnant women do in their community and that pregnant women do not hide their drinking behaviour from others. They also explained that their friends encouraged them to drink during pregnancy. They reported increased drinking and drinking either at

someone's house or at a drinking establishment. The women in Cloete and Ramugondo's (2015) study too described drinking as an everyday norm.

The women in Choi et al.'s (2014) study described drinking to cope and for social engagement. They described drinking as an escape from their homes, contrasting *shebeens* and *taverns* to their homes; they described drinking for social interaction and a means to access support. The significance of alcohol serving establishments as a venue for social interaction and connection was emphasised in Watt et al.'s (2014) study. Watt et al. (2014) note that most studies on pregnancy and substance use have been situated in antenatal clinics. Both Watt et al.(2014) and Choi et al.'s (2014) data suggest that alcohol serving establishments are important sites to identify and target women at risk of alcohol misuse during pregnancy. These studies were part of a mixed method study investigating pregnancy and alcohol use in Delft, a township outside of Cape Town.

Kelly and Ward (2017) too identified the social nature of alcohol use as a theme from their data. Alcohol was constructed as a collective activity for pleasure, rather than an individual activity. Friendship and drinking were intertwined and friends were found to play a pivotal role in the women's drinking narratives. Kelly and Ward (2017) thus noted that the collective subject positions constructed by the participants could serve to normalise and legitimise pregnant women's alcohol use, as others in the social setting display the same (drinking) behaviour. The scholars note that, in fact, the decision to abstain from drinking could serve to isolate a pregnant woman.

2.4.5. Other Factors

Watt et al. (2014) found that most of the women in her study expressed a lack of attachment to their pregnancies. Some of the women spoke of drinking large amounts of alcohol in the early stages of pregnancy in an effort to terminate the pregnancy (although others expressed reducing and ceasing drinking in the pregnancy period for the child's sake). The lack of attachment is a finding different to the literature cited in other studies (cf. Rutman et al., 2000) and counteracts the 'window of opportunity' idea in pregnancy and alcohol use intervention. This 'window of opportunity' idea is that it may be most effective to target women for intervention to encourage them to reduce or stop drinking alcohol during the pregnancy period because they may, like some of the women in Watt et al.'s (2014) reduce or stop drinking because of the growing foetus. However, the responses of some of the women in Watt et al.'s study refute this idea. The women also expressed signs of addiction, albeit not

recognised as such. They reported drinking instead of eating, hangovers, drinking first thing in the morning, begging in order to attain money for alcohol, guilt about drinking, and going into labour intoxicated. In this way, the assumed significance of pregnancy as a catalyst for change in (drinking) behaviour is undermined.

The women in Choi et al.'s (2014) study spoke of drinking as providing a sense of empowerment: its effects were perceived as increasing their assertiveness and ability to take action for self-protection, as well as the ability to challenge unequal interpersonal dynamics. However, the women noted the limitations of drinking as a coping strategy too. They acknowledged that the relief was temporary and that drinking could exacerbate stressors. The women in Cloete and Ramugondo's (2015) study reflected on the value of lost occupations, as a consequence of an entrenched drinking culture. One of the women reflected on the life she would like to lead, tending to a garden and keeping a neat home.

Most of the women in Watt et al.'s (2014) study reported that their pregnancies were unintended. The scholars' data suggested that pregnancy itself presented as a stressor for women. Pregnancy may exacerbate existing psychosocial and contextual factors, as discussed. Choi et al. (2014) found that South African women in a township in Cape Town with traumatic experiences were more likely to exhibit risky alcohol consumption patterns upon pregnancy recognition. Thus, traumatic experiences, which included childhood abuse and recent interpersonal violence in their study, negatively moderated drinking levels.

Therefore, from the drinking narratives of South African (pregnant) women in the Western Cape, it is evident that, in addition to life stressors facing women of low SES, as presented by the overlaps of drinking to manage emotions and as a means to socialise, pregnancy seems to present as an exacerbating life stressor. Scholars argue that their research, including perspectives from occupational sciences, enhances understandings of the limited occupational repertoires available for pregnant South African women, and that socio-structural factors impinge upon the reproductive lives of Black women.

2.5. Approaches to Intervention

Treatment of alcohol use disorders has previously dominated intervention strategies towards alcohol-consuming pregnant women (Room, Babor, & Rehm, 2005). However, there has been a shift away from alcohol treatment programmes towards a greater emphasis on prevention strategies (Jernigan, 2002). With the increasing recognition of the consequences

of alcohol use, described as 'burdens of alcohol abuse' (Chersich et al. 2012), harm reduction strategies have predominated in alcohol intervention styles (Du Plessis, Young & Macleod, 2017). Harm reduction strategies focus on the reduction of the potential adverse consequences of hazardous and harmful patterns of alcohol misuse. These efforts attempt to halt the potential development of alcohol dependency and reduce the 'burdens' of alcohol abuse. Pregnant women are a population group targeted by preventative interventions because of the potential risks of alcohol exposure to the growing foetus (Du Plessis et al., 2017).

Because alcohol consumption during pregnancy is considered a modifiable behaviour (Chersich et al., 2012), FASD is considered to be preventable through modification of drinking behaviour during pregnancy. Interventions in the alcohol consumption during pregnancy field are typically targeted at reducing alcohol consumption during pregnancy and/or increasing knowledge of the harmful effects of alcohol to the developing foetus (Crawford-Williams et al., 2015). The concern has centred on foetal health and the prevention of the development of FASD. Crawford-Williams et al. (2015) identify two broad approaches to intervention in relation to drinking and pregnancy: clinical and public health approaches.

2.5.1. Clinical Approaches

Clinical interventions are guided by an individualised framework, focussing on diagnosis and treatment. These interventions are recommended for so-called high risk, alcohol dependent and/or depressed women (Chersich et al., 2012). While some studies refer to the pregnancy event as a 'window of opportunity' for change in drinking behaviour (Rutman et al.,2000), others show that the pregnancy event acts as a stressor during which women drink to cope (Watt et al., 2014). Within this framework, intervention strategies targeted at alcohol-consuming pregnant women include: counselling or motivational interviewing; therapy based approaches, such as Cognitive Behavioural Therapy; and one-on-one treatment plans (Chersich et al., 2012). Brief educational and motivational interventions are generally considered to be effective in reducing risky drinking across settings (Chersich et al., 2012).

Critical scholars such as Rutman et al. (2000) argue against this individualised framework and the separation of women as a distinct category for alcohol intervention. These authors highlight the patriarchal undertones of such intervention, arguing that the interest in women as a separate category is rooted in males' concern with human reproduction and parenting. Furthermore, Benoit et al. (2014) highlight that the use of substances is constructed as substance abuse when in relation to women; whereas, when in relation to men, this is

neutralised and referred to as substance use. In this way, women are constructed as more deviant than men (Rutman et al., 2000).

South African women continue to be evidenced as experiencing barriers to treatment services (Myers & Harrison, 2003) despite the rise in treatment services since the country's democratisation (Parry, 2005). With an increasingly multi-facetted understanding of the progression of alcohol dependence, moving from the term 'alcoholism' to 'alcohol dependence syndrome', there has been a so-called 'paradigm shift' from treatment to prevention (Du Plessis et al., 2017). This has in turn influenced and broadened the manner of intervention.

2.5.2. Public Health Approaches

Public health-related strategies focus on what has been described as the 'burdens of alcohol abuse', including adverse physical events, psychological harm, health effects (Parry, 2005; Peltzer & Ramlagan, 2009), adverse impacts on family and community functioning (Jernigan, 2002), as well as economic consequences on a population level. Public health interventions focus on prevention of the adverse effects of alcohol misuse at a community level and include educational interventions, media campaigns and government regulations (Crawford-Williams et al., 2015).

These interventions are typically implemented via community-based programmes aimed at minimising the risk of health and social problems, focusing on non-dependent alcohol users. These interventions focus on the general public, educating them about the harms of alcohol misuse during pregnancy. It is considered beneficial to improve the knowledge of women and their surrounding communities in order to change drinking behaviour during pregnancy and reduce the incidence of FASD (Crawford-Williams et al., 2015). As well as being advocated by the World Health Organisation (WHO) (Jernigan, 2002), harm reduction strategies predominate in the literature on alcohol misuse interventions (Du Plessis et al., 2017), including those during pregnancy (Crawford-Williams et al., 2015). These interventions have been preoccupied with reducing the harms to the developing foetus, rather than the harm to the reproductive health of women.

Although public health-related strategies target FASD prevention on a population level, and thus seem to arguably work beyond the individualised framework, such approaches to intervention are based on the belief that people are individually responsible for their health behaviour. This assumed agency is particularly pronounced in relation to (pregnant) women

referred to as ‘People of Colour’ in the global North and Black in the global South, of low SES (Bailey, 2011; Benoit et al., 2014; Lupton, 2012; Rutman et al., 2000; Salmon, 2011).

Any approach to, and manner of, FASD intervention is important because, as Rutman et al. (2000) importantly note, treatment, therapeutic and intervention programmes often become sites of the exercise of power of modern society (Foucault, 1982). Techniques of power (Foucault, 1982) have constraining or liberating effects for targeted population groups. In this case, approaches to intervention targeted at alcohol-consuming pregnant women can have constraining or liberatory implications for their reproductive lives. The constructions of pregnant women during interviews following the intervention described in section three below are considered from a Foucauldian perspective in this study. This is expounded upon in the theory chapter.

Following my description of the context around alcohol-use during pregnancy in South Africa, I situate my study and describe the intervention we assessed in the sections that follow. My study is part of a mixed method project, as is further explained below. The Organisation uses elements of both a clinical and public health approach to intervention. I focus on one of their programmes based on a public health approach.

3. The Broader Study

This study is part of a three-part research project in the field of pregnancy and alcohol consumption at the Critical Studies in Sexuality and Reproduction (CSSR) Research Unit at Rhodes University. Three studies form part of this broader research project, exploring alcohol consumption during pregnancy in the East London region of the Eastern Cape. Study 1 was a quantitative study seeking to establish a baseline and end-term measure of the incidence of alcohol consumption by pregnant women in the region. Study 1 sought to assess the impact of the awareness building and training efforts of the Organisation’s intervention. Study 2 was a qualitative study seeking to document the narratives of pregnant women, and their surrounding communities, of drinking during pregnancy. Study 2 sought to contextualise as well as to highlight the psychosocial factors surrounding the incidence of alcohol consumption during pregnancy. Study 3 was a formative/development study of two programmes of the Organisation’s intervention. Study 3 sought to suggest ways in which the intervention could be developed and improved. My study is located within Study 3 and focuses on the discourses deployed during training.

In 2017, research members from Study 1 began gathering data to ascertain a baseline measure of the drinking habits of pregnant women at various antenatal clinics in the East London region. The study sought to establish a baseline measure of drinking habits before the Organisation's intervention programmes were rolled out. The baseline data from this study was used to determine which regions in East London have a relatively high incidence of alcohol consumption by pregnant women. Two regions were identified and the Training Programme and Mentoring Programme were rolled out in these regions. We, the researchers from Study 3, collected data from these training programmes. We gathered data from one of the Training Programmes and one of the Mentoring Programmes. I analysed data from the Training Programme for this mini-dissertation.

The Organisation has previously worked in areas of the Western Cape, as well as some areas of the Northern Cape. It was piloting some of its Training and Mentoring programmes in a region of the Eastern Cape. Assessment is important for this pilot intervention and will help to improve the design and delivery of the programmes. The particular objective of this study was to evaluate the discourses circulating during interviews with participants following the Training Programme. Via the Training Programme, the Organisation sought to raise awareness at a community level - they aimed to reach hundreds of people in the community. For the purposes of a mini-dissertation, the Training Programme in particular was chosen as a site for data collection. This Programme was also chosen due to the projected impact: the training was billed at impacting at a community-level whereas the mentoring was meant to reach 60 pregnant women. I chose to focus on discourse in particular due to its, albeit oftentimes veiled and taken for granted yet, constitutive nature (Willig, 2003). The discourses deployed by participants have implications for the subjectivity of those spoken of and the legitimation of particular social processes (Willig, 2003) in this case in relation to the reproductive lives of women (Bailey, 2011; Lupton, 2012; Salmon, 2011). I expound on this further in the theory chapter.

3.1. My study

Using data from the Training Programme, I aimed to (a) identify the discursive constructs of, and surrounding, pregnant women; (b) identify the discourses circulating during training and deployed by participants during interviews; (c) discuss the possible implications for pregnant women's subjectivity; and (d) suggest ways in which such discourses can be extended to promote a reproductive justice agenda. In contrasts to the epidemiological studies that

dominate the pregnancy and FASD literature, I take a reproductive justice perspective in order to highlight the techniques of power which subvert women's health needs. In this way, I seek to add to the literature which contextualises alcohol consumption during pregnancy and work towards liberatory intervention strategies. In considering the discourses surrounding alcohol use during pregnancy, particularly from a Foucauldian perspective, the structural, social and historical processes that give rise to women's health and social inequities are foregrounded (Lupton, 2012; Salmon, 2011), ensuring that the discourses deployed do not unintentionally reinscribe social and reproductive injustice.

4. The Intervention

The Organisation is a non-profit, non-governmental organisation that works to educate the public about the effects of alcohol consumption during pregnancy, at both a community- and individual-level. Their reported primary objective is to decrease alcohol consumption during pregnancy in order to decrease the incidence rate of FAS. The Organisation has worked in areas of the Western and Northern Cape. High prevalences of FAS have been documented in areas in these provinces (Chersich et al., 2012; Croxford & Viljoen, 1999; May et al., 2008). The Organisation has worked in schools, raising awareness and teaching life-skills to youth of a childbearing age. They have also worked with *shebeen* owners, and farmworkers in these areas. Their prevention campaign comprises of three packages: community awareness around alcohol and drug abuses; a pregnant women mentoring programme; and a programme targeting school children. Two mixed-methods summative evaluations of the Organisation have been carried out to date. These evaluations suggest that the interventions have increased knowledge about FASD.

Between 2017 and 2018, the Organisation piloted the former two intervention packages: the community awareness programme and the pregnant women mentoring programme. These were piloted in a township in the Buffalo City Metropolitan Municipality in the Eastern Cape. This study was part of a developmental/formative assessment of this pilot intervention in the Eastern Cape and investigated particularly the discourses used by members of the Organisation's training workshops, referred to in this study as the Training Programme.

4.2. The Training Programme

The Training Programme (TP) workshop implemented in particular East London regions of the Eastern Cape trained community members about FASD. Here, the Organisation's

community awareness package was delivered. The trainees, hereafter called community educators, underwent a three-day FASD awareness course.

In total, four three-day courses were presented over a four month period in different regions of East London. A targeted 50 community educators were trained on the topic of FASD and in basic presentation skills. These community educators were then tasked with educating 500 other community members about FASD in order to raise awareness around the community. Utilising the public health approach, this programme aimed to be far-reaching. Because of the scope of this mini-thesis, as well as the far-reaching impact of this programme, I focused on the discourses circulating in interviews following this particular training.

4.3. The Mentoring Programme

The Mentoring Programme (MP) workshop implemented in the same East London regions trained community educators to be mentors. These trainees, hereafter referred to as mentors, were educated about FASD and trained in basic mentoring skills. They were then tasked with identifying three pregnant women who were consuming alcohol in their communities and educating them about alcohol consumption during pregnancy. They were also tasked to provide support to these pregnant women. This mentoring relationship was aimed at helping pregnant women to reduce their alcohol consumption or abstain from alcohol.

Similarly to the TP, the MP trained 20 mentors over the four month period. This programme aimed to reach 60 pregnant women. Mentors received further training on identified topics every two months. Child abuse, domestic and sexual violence, anger management, etc. were reported as some of the topics to be covered. Although I conducted the interviews following this training, due to the scope of the dissertation, these data are not included.

The training for both programmes was conducted by the Organisation's trained social worker. This social worker oversaw and facilitated the programmes as well as provided an early intervention service to identified risky substance users, offering support. Both the TP and MP were simultaneously implemented within a 12 month period. The social worker was interviewed following the TP training and data from this interview are included in the findings of this dissertation.

5. Key Theoretical Concepts

Below I introduce two key theoretical concepts which shape the thesis: Foucault's conception of discourse and a perspective employed by Foucauldian scholars in the pregnancy and FASD literature, reproductive justice. Both concepts complement one another by highlighting relations of power in shaping subjectivities and institutional and social practices. Each of these concepts is introduced here and further explicated in Chapter Two and Three respectively.

5.1. Discourse

Aspects of Foucauldian thought are used as a lens to identify: the various ways members of the TP discursively construct pregnant women; the context in which these constructions are made; and the possible implications for pregnant women. A key vehicle by which to reveal and explore these is via the identification of discourse(s). Discourse(s) in the social sciences has tended to be a 'fuzzy' concept, defined within either a formalist or structuralist paradigm (Mayr, 2008). It is thus necessary to specify how I deploy the term in this study. I use the Foucauldian conception of discourse which refers to the ways of constituting knowledge and the accompanying "practices that systemically form the objects of which they speak". It is the embodiment of power/knowledge - a concept explicated in the theoretical chapter (Foucault, 1972, p. 49). In summation, the way I conceive of discourse is the means by which power reproduces itself; it is the site of power relations (Foucault, 1978). I seek to highlight these relations and reproductions as they apply to pregnant women.

5.2. A Reproductive Justice Perspective

A reproductive justice perspective on alcohol consumption during pregnancy conceives of this issue as a lifestyle related public health concern. Rather than focusing on individual behaviour change to FASD prevention efforts, the goal of the reproductive justice agenda is to identify techniques of discipline and gradually alter these in order to achieve greater agency for all women. In this way, a Foucauldian approach is complementary to this agenda.

A reproductive justice perspective focuses on structural change and cultivating life conditions that enable all (pregnant) women, despite race, SES, age and other such demographic markers, to make health decisions. This agenda recognises and is responsive to the intersections of health with social, historical and structural processes. It shifts away from

individualising and essentialising notions of FASD as individual women's failure, towards recognising the processes on women's and children's health which result in persistent marginalisation.

Critical scholars argue for the inclusion of partners, families as well as community members in addressing this public health issue. In addition, they advocate for the incorporation of the decolonisation agenda into FASD prevention and call for the review of state policy which perpetuates health disparities (Salmon, 2011). Ultimately, a move towards a reproductive justice perspective to pregnancy and FASD can affect the manner in which we intervene. In this study, I identify various constructions of alcohol use during pregnancy and suggest alterations which align with this perspective.

6. Proceeding Chapters

In Chapter Two, I explicate the methodological processes of this study. The data collection for the TP took place in December 2017. I conducted individual interviews with participants. I conclude the methodological section of the chapter by narrating my reflexive considerations with regard to data collection. The second part of the chapter is a discussion of my theoretical orientation. I summarise and discuss key aspects of Foucauldian thought relevant to understanding, framing and interpreting processes throughout this investigation.

Chapter Three is a critical review, using a post-structural lens, of the discourses circulating in the pregnancy and FASD literature. Critical scholars in this field argue that these discourses are foetus-centred and have produced the foetal and responsibilised pregnant women subject positions. They critique the techniques of power which subvert women's health needs. These authors advocate for a reproductive justice approach to FASD related research and prevention efforts.

In Chapter Four I use Willig's (2003) stages of a Foucauldian Discourse Analysis to discuss the discursive objects that emerged in the data. These include the 'wholly bad and issue-ridden' context of living; alcohol consumption as 'a destroyer!' and 'king'; the foetus as 'vulnerable and important'; 'the FASD child'; and pregnant women as 'ignorant, preoccupied and unreceptive'. Participants constructed themselves as transformed subjects and occupied the pastoral role in relation to pregnant women.

In the closing chapter, I review the rationale of the study. Assessment is an important part of pilot interventions, and discourse is a key area of focus due to its constitutive role for the subjectivity of human beings. I review the insights emerging from the data and further discuss the implications for the subjectivity of pregnant women, in particular, and the institutional practices towards them. I suggest alterations to the identified discursive constructions: I propose reconstructing the context of living, alcohol consumption, the foetus and the FASD child using principles of community psychology, the harm reduction model, a social model of disability and the reproductive justice perspective respectively. I conclude the dissertation by discussing the strengths and limitations of this study, and recommending future research based on these as well as the findings of the study.

Chapter Two: Methodology and Theory

1. Introduction

I begin this chapter by discussing the methods of data gathering that took place during one of the TP and one MP training workshop. A Foucauldian Discourse Analysis is described. This is used as a tool to analyse the uptake of available discourses used to construct pregnant women following the training workshops. I also share my reflections on the research and data gathering process, highlighting issues of language, theory, methodologies and positionalities, as well as social desirability that were negotiated in working towards beneficence.

I then discuss the aspects of Foucauldian thought that were used as a lens to identify: the various ways members of the Organisation's workshops discursively construct pregnant women; the context in which these constructions are made; and the possible implications for pregnant women. Specifically, Foucault's ideas around power relations and the emergence of bio-power will be discussed. Further Foucault's conception of the subject and the nexus of power/knowledge are considered. Foucault (1982) argues that the emergent style of governance in the European nations led to the development of bio-power as a means of the construction and regulation of subjects since the classical age. These concepts are elaborated upon, and the scope for resistance, through counter-discourse, is highlighted below.

The study considers the subject positions enabled by discourses deployed by participants in discussions of alcohol consumption during pregnancy. Foucauldian concepts highlight the objectivising effects of interventions on pregnant women. Thus, the role of interventions in reproducing discourse and the scope of resistance that discourse allows are considered.

2. Methodology

Willig (2013) describes research from a social constructionist perspective as "concerned with identifying the various ways of constructing social reality that are available in a culture, to explore the conditions of their use and to trace their implications for human experience and social practice" (p. 49). Accordingly, using a Foucauldian lens, I sought to identify the discursive constructions of pregnant women during interviews with members who attended the TP of the afore-described pilot intervention. I seek to suggest ways in which the approach to intervention could target structural change. I thus took a reproductive justice perspective to the inquiry around alcohol consumption during pregnancy, acknowledging that pregnant

women are situated within a social context in which health experiences are constrained by life conditions (Bailey, 2011).

The following questions guided this enquiry into the discursive constructions of pregnant women during the training of the community educators' aspect of the intervention:

a) What are the discursive constructs of, and surrounding, pregnant women in the interview data?

b) What discourses are used to construct alcohol-consuming pregnant women by the Organisation's community educators and social worker during interviews conducted as part of a formative/developmental evaluation?

Aspects of Foucauldian thought, which will be described below, were used to guide the research process as well as to make sense of the findings. Specifically, Foucauldian Discourse Analysis (FDA) was used as an analytical tool. This tool and surrounding data gathering processes are described directly below.

2.1. Foucauldian Discourse Analysis

This study sought to investigate the constructions surrounding alcohol consumption during pregnancy within interviews with members of the training. To do so, a Foucauldian Discourse Analysis (FDA) was employed to analyse transcripts from interviews.

Willig (2003) considers a FDA as useful in analysing the availability of discourses within a culture. It is a useful tool to analyse the role of discourse in shaping the social world, and in facilitating or constraining ways of being in and seeing the world. Because discourse shapes subjectivity and experience (Willig, 2003), it is strongly implicated in the exercise of power (Foucault, 1972). This is further discussed in the second part of this chapter. FDA helps to illuminate the role of discourse in wider social processes of legitimation and power (Willig, 2003).

Because of the constitutive nature of discourse, it was chosen as the focus of the study. Specifically, I was interested in the discourses deployed by the community educators and the social worker trained by the Organisation to construct pregnant women during interviews.

Furthermore, language is not viewed as a neutral communicative tool. Patterns of language and related practices are seen as actively involved in the construction of knowledge and the social world (Wetherell, Taylor & Yates, 2001). Thus the issue of language, particularly in our multilingual context, was not taken for granted in the use of methodologies in this study. I reflect on issues of language in the Reflexivity section to follow. FDA was used to investigate the role of verbal discursive techniques of power and the possible effects on the constitution of the subjectivity of both the participants and the pregnant women of whom they spoke (Foucault, 1978; Willig, 2003).

2.2. The Study

This research, couched within Study 3, the formative/development assessment of the programmes, sought to identify the discursive constructions of pregnant women who consume alcohol during interviews with community educators that attended the Organisation's TP workshops, and the social worker that facilitated the training.

Overall, for the pilot in the Eastern Cape, the Organisation conducted four three-day training sessions of the TP and two three-day training sessions of the MP. Fifty facilitators were trained by the TP and twenty mentors were trained by the MP from September 2017 to March 2018. Some of the mentors completed both the TP and MP training. My research co-supervisor, conducting the formative/development assessment of the programmes, and I attended one of the three-day TP training sessions in December 2017 and one of the three-day MP training sessions in March 2018. I analysed the discourses circulating in the data from the TP sessions for this mini-dissertation.

2.2.1. The Research Population

There were about 20 facilitators present at the training session we attended in December 2017; and about 20 mentors, some of whom had attended the training in December 2017, at the MP training session we attended in March 2018. One of the Organisation's social workers, employed specifically to work on the pilot intervention in the Eastern Cape, received training in the Western Cape, and conducted both the TP and MP in the Eastern Cape.

In order to gather information on the discourses made available around alcohol consumption during pregnancy during the pilot intervention, we set up individual interviews with some of the community educators and mentors present during training, and the social worker who

conducted the training (these members of training are hereafter referred to as participants). The training programmes utilised a variety of visual aids, in the form of pictures in the training manuals and images from PowerPoint presentations, as well as video clips showing ultrasound imaging showing biological processes in utero. Because images played a central role in the training, we presented participants with three images from the manuals (see Appendix D) to further elicit constructions and discourses potentially circulating during training. The individual interview method was useful in attaining descriptive data of the constructions made (Bernard, 2000) which revealed insightful information about the context in which alcohol consumption during pregnancy happens. I conducted the individual interviews with five participants at both the TP and MP training sessions we attended. My co-supervisor conducted an individual interview with the social worker following each of the sessions we attended - i.e. one during the TP and another during the MP. The data collected from interviews during the TP are analysed and discussed in this study.

2.2.2. The Participants from the Training Programme

From the population of community educators present at the TP sessions, convenience sampling (Etikan, Musa & Alkassium, 2016) was used to recruit participants for the study. Members of the training that met practical criteria such as availability after the training sessions, willingness to participate, and ease of accessibility to the researcher (Etikan, Musa & Alkassium, 2016) became participants in the study.

In December 2017, the research team attended one of the three-day training sessions that took place at a venue on the premises of one of the local Non-Government Organisations in one of the identified regions. The research team consisted of my co-supervisor, conducting the formative/assessment; Sibongile Matebese, a researcher from Study 2 whose home language is isiXhosa; and me. The purpose and nature, ethics and recruitment process of the research were described to members of the training by Ms Matebese - this is further explicated in the Ethical Considerations section below). The members of the training were invited to volunteer to participate in the study.

Participants were asked to stay behind after a day of training to be interviewed for 30 – 45 minutes. The research team drove participants home following the interviews. We were concerned about conducting an interview of the first day of the three-day TP training, wondering if there would be content to explore on the first day; however, we interviewed a participant and were able to elicit helpful data. Two other participants were interviewed on

the second day, and a final two on the third day of training. The interviews with participants were conducted by Ms Matebese, who occupied the role of the isiXhosa speaking co-interviewer, and I in a private venue on the premises. My co-supervisor interviewed the social worker on the last day of training. These interviews were audio recorded. The appropriate consent for participation and audio recordings were established (refer to Appendix A).

Table 2
Participants' Demographic Information:

Pseudonym	Interview No.	Length of Interview (mins.)	Language used during Interview	Role in Organisation	Age (years)	Occupation	No. of Children
Participant B	1	23:50	Nguni & English	Community educator	32	Unemployed	3
Participant P	2	68:35	Nguni & English	Community educator	35	Recently unemployed	2
Participant Z	3	21:30	Nguni & English	Community educator	*	Unemployed	2
Participant T	4	20:46	Nguni & English	Community educator	*	Volunteer community healthcare worker	3
Participant V	5	18:20	Nguni & English	Community educator	*	Social worker	2
Participant N	6	33:39	English	Social worker	29	Social worker	0

*Participant did not mention their age during the interview.

All the community educators that participated in this study described themselves as mothers. Although some of the ages of the participants are unspecified, the age range of participants seemed to be between 29 - 45 years old. Participant T mentioned that two of her children were deceased and that she was the primary caregiver of her grandchild. Four of the five community educator participants were unemployed; and one of them was a community healthcare worker doing volunteer work. The fifth participant was a social worker employed by government and working in the region. The sixth participant was the Organisation's social worker conducting the pilot intervention in the Eastern Cape.

During interviews with the participants, a semi-structured interview schedule (refer to Appendix B) guided the elicitation of discourses used to construct pregnancy and alcohol consumption. Although the same set of questions guided each of the interviews, additional questions were asked of participants to clarify and/or expand on arising issues (Keats, 2001). Interestingly, participant P from the second interview offered a useful additional question:

‘What feelings did the interview evoke in you?’ This additional question was used with other participants thereafter.

During interviews, there was much code-switching, between isiZulu, isiXhosa and English – except for the interview conducted with the Organisation’s social worker which was conducted by my co-supervisor in English. The audio recordings of the interviews were later transcribed and translated by a contracted transcriber/translator referred to me by members of the African Languages Department at Rhodes University. This translator/transcriber is a Nguni speaker. She sent the first interview for review to me as the researcher, before translating and transcribing subsequent interviews. I reviewed the transcriptions by listening to the recordings and concurrently reading the transcripts, making minor changes and clarifications. As a Nguni speaker and the primary interviewer present during the interviews, I did the concurrent listening and reading several times to ensure the interactions during the interviews were well captured. A total of twelve interviews were conducted at the Training and Mentoring Programmes as part of the larger research project; however, the six interviews from the Training Programme were used for this study. I extracted aspects relevant to the purposes of this study for analysis.

2.3. Ethical Considerations

The necessary ethical procedures for conducting research were observed: the appropriate consent from the relevant stakeholders of the project was obtained prior to the recruitment of the participants. In addition, the project received ethical clearance from Rhodes University’s Research Projects and Ethics Review Committee (RPERC).

The purpose and nature of the research, and what their participation would entail, was explained to the participants. It was important to stress that the purpose of the interviews was not to assess the participants’ understanding or performance, but rather to evaluate the training programme. From feedback from the interviews, this seems to have been achieved - as is further described in the Reflexivity section below. The voluntary nature of participation as well as confidentiality was explained to the members of the training at the recruitment stage. These considerations were reiterated with participants at the start of each of the individual interviews.

Ms Matebese, an isiXhosa home language speaker and member of the CSSR, who was also involved in Study 2 of the broader research project, was present at the TP training sessions to

explicate these considerations at the recruitment stage. She was also present at the interviews following the TP training session as a co-interviewer. Ms Matebese was present to ensure the due respect and beneficence to the isiXhosa speaking participants.

2.4. Reflexivity

Due to the stigmatising construction of pregnant women who consume alcohol that I had come across in the review of literature, and the objectivising (Foucault, 1982) nature of research with the marginalised majority in the country, it was important to me to go beyond non-maleficence towards the beneficence principle to guide the research process. Below I discuss a number of issues I consider to be important: beneficence, language, the choice of theoretical lens and positionalities, as well as social desirability.

2.4.1. Beneficence

The ethical principle of beneficence is one I often espoused in my work as a Student and Intern Counselling Psychologist. This principle requires practitioners to (a) prevent harm, (b) provide benefits and (c) balance the benefits against the risks and costs of practice (Beauchamp, 2007). This involves the purposive mitigation of potential harms, risks and costs of intervention. Beauchamp (2007) underscores the "importance of beneficence as a principle beyond the scope of non-maleficence... In healthcare ethics beneficence commonly refers to an action done to benefit others…" (p. 5). Beneficence is a less stringent principle than non-maleficence, but is important in the field of psychology, a field often centred on promoting the welfare of persons (Allan, 2011). Beneficence, and the values of Counselling Psychology[13], can have interesting translations to social justice in relation to South Africa's socio-political history, particularly in relation to (persistently) disadvantaged persons. I remained committed to this throughout the process, particularly as we negotiated the data gathering process which involved gathering from those who can be considered to be persistently marginalised. I discuss considerations that were made towards the beneficence of participants in the following sections.

[13] A profession described as value-based, espousing humanistic values and person-centred approaches of promoting development, health and empowerment, enhancing psychological well-being and preventing psychopathology; emphasising people's strengths, valuing diversity, and embracing multiculturalism (Young, Bantjes & Kagee, 2016).

2.4.2. Language

In December 2017, the research team collecting the first round of data for Study 3 consisted of three members of the CSSR team: my co-supervisor, Nicola Jearey-Graham; Sibongile Matebese; and myself. It was important for Ms Matebese to be present as both Ms Jearey-Graham and I are not isiXhosa home language speakers – the language spoken by our participants. Language is an important mediator for the dissemination of information and, importantly, meaning-making, and thus important for informed and voluntary consent, as well as meaningful and rich engagement.

Keikelame (2018) notes issues of language and translation in her reflections following her qualitative research project in another province in the country. The author notes that issues of language and translation are important in cross-cultural qualitative research in the country. To negotiate the cross-cultural differences between the researchers and the research population, all the documents shared with the population, for informational and informed consent purposes, were in both isiXhosa and the lingua franca of the country, English. To mediate dialectal differences and the gap between written isiXhosa and conversational isiXhosa, Ms Matebese graciously came on board to explain the research process at the recruitment stage and as a co-interviewer during individual interviews with participants. This was useful in ensuring the due respect of participants, facilitating informed consent and contributed to eliminating the potential risk of participants feeling evaluated.

Although the expectation to explicate the research process to the members of training and the duty to conduct the interviews in isiXhosa was anxiety-provoking for me, an isiZulu home language speaker, it was important that the burden of negotiating language differences lay on the side of the researchers rather than the participants. In the absence of Ms Matebese in the second round of data gathering at the MP training in March 2018, as at least a Nguni speaker, I negotiated the language and cultural differences. I negotiated these aspects of interaction in the research field during the TP with Ms Matebese present as well. I found this to be useful in negotiating and building rapport with participants and other members of training. I found that this negotiation of my insider/outsider positionalities (Keikelame, 2018) helped to diffuse the position of power we as researchers are often interpellated into and sometimes helped to establish a commonality and connection with participants.

2.4.3. The Choice of Theoretical Lens and Positionalities

Foucault (1982) states: "anyway, for us it is not only a theoretical question but part of our experience" (p. 328). Similarly, for me, this has not been only an academic exercise in refining my skills in research, but a process of deep significance for me as a Black South African woman, a Black researcher tracing the effects of the power/knowledge nexus on Blackness.

In the process of exploring the literature in the field of alcohol consumption during pregnancy, I became increasingly frustrated and enraged at the constructions of those who drink during pregnancy. It became apparent that most of the research I was coming across was epidemiological in nature, deploying the biomedical model to healthcare. As described in the literature review chapter, young, Black, persistently marginalised women were being constructed as 'the problem' of FASD. In essence, because of my identities, I was being constructed as 'bad', and a problem to health. The constructions were deeply offensive in their racialised and gendered, and ultimately stigmatising, constructions of young women of Colour, such as me.

However, the more I grappled with Foucauldian thought, the importance of such research by researchers such as me became increasingly apparent. As I delved further into Foucault's ideas, the supposed scientific nature and neutrality of the trends in this field of research became increasingly de-legitimate and problematic. The Foucauldian framework, and works by critical scholars in the literature, availed to me the tools to identify, understand and articulate problematic constructions. In other words, it availed the tools for resistance. I came across and began to wonder about concepts such as the bio-politics of race and Foucault's ideas about sexuality and bio-power. Although beyond the scope of this project, these would be interesting to investigate further. Historically, and in the present day, members from the marginalised majority are subjects of research; we endure the objectivising effects of 'knowledge production'. It is of high significance that members from this group, members such as me, become the researchers and negotiate counter-discourses as acts of resistance towards reproductive justice.

My insider/outsider positionalities continue to be invaluable to the research process, for working towards the beneficence of participants and working towards the reproductive justice agenda. Sometimes my linguistic and cultural background positioned me as an insider; and at other times, fumbling with my isiXhosa, an outsider. The socio-political significance of my

youth and race at times positioned me 'in', and at other times my youth positioned me 'out'. Because of these positionalities, and simultaneously in spite of them, I have tried to maintain a reflexive disposition throughout the research process, with the goal of justice in mind.

Lastly, it was paramount for me that the research was indeed beneficial to participants. Scholars often reference the point that the act of interviewing participants is useful in allowing participants to process their experiences, and places them in valued subject positions by soliciting their opinions and experiences. Indeed, evidenced by the nature of reflections that emerged in the interview talk, and in the way participants reflected upon and processed their own experiences, the act of interviewing the participants seemed to be useful and at the least psychically beneficial.

2.4.4. Social Desirability

Bryman (2012) describes the notion of socially desirable responses in qualitative research as those responses which participants believe may be endorsed by the researchers - i.e. what they think would be deemed socially desirable. One of the key ethical concerns, in terms of the methods of data collection, was that the participants may have felt evaluated during the individual interviews - as if we, the research team, were conducting interviews to evaluate their degree of knowledge about pregnancy and FASD following training. This risk to the participants was detected during the proposal stage of the research, and we integrated a number of measures to mitigate this: most importantly, the presence of Ms Matebese to explain that the purpose of our presence was to improve the training, and that their feedback was invaluable to this. Ms Matebese was able to stress this in a comprehensible and appropriate manner both at the recruitment stage with the research population and at the individual interviews with each of the research participants. The manner of questioning by the primary interviewers also corroborated this. Secondly, we managed our presence during the three-day training by negotiating boundaries: we established a connection with the research population by joining in on the ice-breaker on the first day; and created enough distance between us, as the researchers, and the Organisation by remaining outside of the training venue during training on all three days of the training workshops. The excerpt below is from my Reflective Journal from Day 1 of the training sessions and our data collection and speaks to the effects of these established boundaries:

Reflective Journal

> ... We joined the group for the ice-breaker and got to know each other. This was helpful in establishing a connection and building rapport. It would have been nice to stay during the training - and not sit around waiting outside - to be part of the training and continue to build connection. Also, this would have been helpful in getting a sense of the discourse employed. However, perhaps it worked out fine as when the lady [participant B] was talking today she had to explain herself to us and not take for granted that we knew what she was referring to because we had not been there during the training... She [participant B] felt comfortable enough to share sensitive information about herself and her status which attests to the warmth and non-threatening atmosphere we must have been able to create.

The use of personal recounts (i.e. a type of story), the sharing of personal and sensitive information by participants, as well as their feedback on aspects of training that could improve suggested that the level of social desirability bias (Bryman, 2012) was low. It seemed that participants shared their thoughts, opinions and experiences with a noticeable degree of authenticity, irrespective of whether they thought these would be deemed socially desirable or endorsed by the researchers (Bryman, 2012). There were some instances where the participants were concerned that their suggestions for how the training could be improved could reflect negatively on participant N, the Organisation's social worker who facilitated the training. This is exemplified below:

Interview 4

> N: *is there more you'd like to say?*
> T: *there's nothing*
> N: and the interview *how was it? How did it go? As we were just interviewing you?*
> T: *No it's* <u>*not wrong*</u> *you are asking me of things that maybe got to me* [upset maybe] *and those that didn't* //Hmm// *and things that went well* //Hmm// *it's not wrong, and asking about what kind of place I stay in and what should be done… is not wrong* //Hmm// *it was I who mentioned time* //Hmm// *maybe* [clears throat] *I don't know if I was wrong maybe*
> N: Noooo
> T: *maybe we did our teacher wrong and is also upset, cause we won't be interviewing her* //Hmm// *that 'how did we treat you,* teacher?' //Hmm//
> N: *Yeees*
> T: *you see that? That's what I'm talking about.*

Earlier in Interview 4, participant T suggested that time management could be improved in the training workshops. In her closing statement, shown in the excerpt above, she revisited this suggestion. The statement shows an understanding that we as the researchers were asking about her experience of the training; we were interested in what she considered to have been good or needing improvement in the training; and we were interested in her community. To mitigate the potential negative reflection of the time management suggestion on the

facilitating social worker, she suggests that we, as the researchers, should interview the social worker as well. Participant T's closing statement indicates two things: (1) the purpose of our presence as evaluators of the training, and not the participants, seemed to be understood; and (2) the boundaries between the Organisation and the researchers seemed to have been understood by participants as well. Although socially desirable responses may be expected from participants, and cannot be wholly dismissed, in this setting, we took measures to mitigate this as the research team. The responses by the participants suggest that the level of social desirability bias was low.

Further, the additional question that emerged from one of the participants (i.e. 'What feelings did the interview evoke in you?') seemed to indicate that aspects of the training, and the subsequent interviews, evoked personal experiences that the participants were willing to share. The interpersonal skills and training of the interviewers, myself and my co-supervisor, both trained in Counselling Psychology, seemed to be useful in managing the elicitation of discursive constructions, facilitating the meaning-making process, as well as allowing space for personal experiences and their associated emotions, whilst retaining the focus on the evaluation of the programmes. Further, this arising question, and the manner in which subsequent participants responded, suggested that participants did not feel evaluated, and the focus of the interviews remained on the evaluative aspects of the training, whilst creating a space for personal reflections. Lastly, the above-described negotiation of positionalities seemed to diffuse power differentials between the participants and researchers which seemed to contain the level of social desirability bias.

2.5. Data Analysis

The talk within the above-described interviews was transcribed using the transcription conventions specified on Appendix C. Because of the code-switching that occurred during the interviews, conventions such as italicising the translated talk were created. Following the concurrent reading of the transcripts and listening to the corresponding audio recordings to check that the talk during interviews was well-captured by the transcriber/translator, I continued with a grounded reading (Willig, 2003) of the data. I coded the data according to instances where participants made implicit and explicit references to: (1) pregnancy/pregnant women; (2) foetus/unborn baby/baby; and (3) alcohol consumption. Interestingly, a fourth, and relevant, category emerged as prominent in the data: (4) context/social and physical environment. I excluded the parts of the data relevant for the development/formative

assessment of the training, and focused on references to the discursive objects emerging from the interview talk.

I then applied Willig's (2003) six stages of a Foucauldian Discourse Analysis (FDA) in order to identify the discursive constructions used around pregnancy, alcohol consumption and FASD by participants, as explicated below:

I. **Stage one** of the analysis included sifting the data for the discursive constructions of 'pregnancy', 'pregnant women', 'foetus/unborn baby/baby', 'alcohol consumption', and 'context'.

II. **Stage two** focused on placing these constructions within wider discourses and noting which discourses were drawn upon to make meaning of the discursive objects of investigation.

III. **Stage three** considered action orientation, the discursive context in which different discourses were deployed and what was achieved by these constructions.

IV. **Stage four** involved identifying the subject positions which were made available for pregnant women. These are locations from which subjects act and have direct implications for subjectivity.

V. **Stage five** focused on the relationship between discourse and practice, considering how the objects and 'pregnant woman' subject positions contained in the interview talk opened up or closed opportunities for action and reproductive justice.

In conducting the analysis, making careful consideration that my interpretations were grounded, trustworthy and credible, it was helpful to be guided by Willig's (2003) steps. The author's steps provide a useful guide for a Foucauldian approach to analysis. They are also well-established and well-regarded in the field of qualitative data analysis. Both my supervisors were of additional assistance in the illumination and interpretation of the emerging discursive constructs, as well as how these could be represented and discussed in the dissertation. Furthermore, the dialogue with members of the CSSR Research Unit during presentations of the research and the data specifically were invaluable to the analysis processes.

3. Foucauldian Thought

Foucault traces the historical reconfigurations of power in European nations between the eighteenth and nineteenth century, also known as the classical age. With the re-organisations of knowledge during this period, new forms of power and domination emerged (Rouse, 1994). Using this historical analysis, and investigating constructs such as madness, illness, death, crime, sexuality and so forth (Foucault, 1972), Foucault made a case for the inextricable link and a dynamic relationship between knowledge and power. This is known as the power/knowledge nexus and has implications for how human beings become regulated, as will be explicated.

In his book, *The Archaeology of Knowledge*, Foucault (1972) speaks of historically situated fields of knowledge and "the epistemic context within which certain knowledges become intelligible and authoritative" (Gordon, 2000, p. 1). Foucault traces the emergence of the human sciences and the transformation of knowledge of human beings that emerged during the classical age. During this time, new objects of knowledge emerged. These objects "were not already demarcated, but came into existence only contemporaneous with the discursive formation that made it possible to talk about them" (Rouse, 1994, p.2). The transformation produced new kinds of knowledge of human beings while simultaneously creating new forms of social control.

Unlike juridical or sovereign conceptions of power, which previously dominated philosophical thinking, Foucault conceived of power dynamically (Rouse, 1994). He rejected the reification of power and suggested that power is de-centralised and ubiquitous. Power has no location. Power is not possessed. Instead, power is dispersed throughout social networks of actions. The transformation of knowledge of human beings from the classical age induced new forms of power relations (Foucault, 1978). With the establishment of disciplines within the human sciences, what was accepted as truth about human beings induced new forms of domination (Foucault, 1977).

Although Foucault was writing about particular political spaces - mostly European nations - the insights from his work are relevant to the South African context, given globalisation and colonisation processes. The reconfigurations of power in post-apartheid South Africa, particularly a more de-centralised public health system, can be viewed through a Foucauldian lens. The role of non-governmental institutions became increasingly central to the exercise of bio-power - a key concept explicated below.

3.1. Power Relations and Bio-power

In a seminal chapter, 'Right of Death and Power over Life', Foucault (1978) separates the juridical form of power, which is deductive (that is, possessing the sovereign power and right to grant life and proclaim death) from what he calls bio-power, a productive form of power (regulating life). Before the constitution of a so-called government, "the sovereign exercised his right... he evidenced his power over life only through the death he was capable of requiring" (Foucault, 1978, p.136). However, since the classical age, Foucault argues that the West has undergone a profound transformation of the mechanisms of power. Replacing the right of seizure of ultimately life itself, emerged a generative, life-administering power (Foucault, 1978).

Foucault (1978) argued that "the ancient right to take life or let live was replaced by a power to foster life or disallow it..." (p. 138). At the beginning of the seventeenth century emerged bio-politics: that is, a style of government regulating the population. This style of governance centred on the body as a machine, "anatomo-politics of the human body", and the species body, "bio-politics of the population" (Foucault, 1978, p. 139). The organisation of power over life was deployed through the disciplines of the body and the regulations of the population. In this way, the ancient power of death exercised by the sovereign or juridical power, was "carefully supplanted by the administration of bodies and the calculated management of life" (Foucault, 1978, p. 140). Thus, the era of bio-power began during the classical period. This was characterised by "an explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations" (Foucault, 1978, p. 140) and by the art of government (Foucault, 1978) that exercises political power on all aspects of human life. Here, the word 'government' is used in the broad sense, evoking the meaning it had in the sixteenth century, designating "the way in which the conduct of individuals or groups might be directed - the government of children, of souls, of communities, of families, of the sick" (Foucault, 1982, p. 341). In this way, the state exercises power over the body populace.

Further, Foucault (1978) argued that the exercise of bio-power is present at every level of society. He argued that one of the consequences of the development of the bio-power was the "growing importance of the action of the norm..." (Foucault, 1978, p. 144). With the decline of the sovereign's or juridical power's 'right of death', bio-power assumed the responsibility

of the management of life's processes, and undertook to regulate and modify them. In this way:

> Power would no longer be dealing simply with legal subjects... but with living beings, and the mastery it would be able to exercise over them would have to be applied at the level of life itself; it was the taking of life, more than the threat of death, that gave power its access even to the body (Foucault, 1978, p. 142 - 143).

The body thus became involved in the political field; "the human body was entering a machinery of power that explores it, breaks it down, and rearranges it…" (Foucault, 1978, p.182). Whereas life had previously been administered by the sovereign's right to death, bio-power now emerged as a means to the regulation of society. Foucault (1978) labelled this as a 'technology of power', a 'power over life', producing a normalisation of society, where power works to regulate and correct; "to qualify, measure, appraise and hierarchise" (Foucault, 1978, p. 144). This is understood as a productive form of power, regulating life at all levels.

This can be applied to understandings of the constructions of pregnant women; and, more specifically, the bifurcation of the woman's body and the reduction of pregnant women to a disembodied womb (Lupton, 2012). As will be shown in the literature review chapter, certain discourses prevail in the field of alcohol consumption during pregnancy which regulate certain pregnancies.

In order to maximise life, manage health, epidemics, birth-rate and so forth, intervention is rationalised as a form of bio-power, the regulation of human life. In this way emerged the body's involvement in what we have come to know as 'public health'. Foucault (1978) reflected on the immediate hold of power relations on the body; that is, the technology of power over the body. For example, he notes the hysterisation of women: that is, power/knowledge configurations that have produced a highly sexualized female body as well as the female body as an object of medical knowledge. Foucault (1978) notes that since the classical age, women have undergone thorough medicalisation of their bodies and sex "in the name of the responsibility they owed the health of their children, the solidity of the family institution, and the safeguarding of society" (p. 147). Foucault (1978) describes the technology of sexuality as the greatest technique of power of the nineteenth century. Sex was a means to gain access to the body populace: that is, both the individual and the population. Sex thus emerged as a political issue, and became regulated in great detail via power/knowledge relations that produced normalisations. This technology of sex functioned

to discipline the body and regulate populations. It combined disciplinary techniques with regulative methods.

These techniques of power are observed in the field of alcohol consumption during pregnancy, in foetal rights discourses, responsibilisation and individualisation discourses, health policy discourses and so forth, particularly as it concerns Women of Colour, as discussed in the proceeding chapter. Here, pregnant women are key sites for the regulation of human life.

3.2. The Subject

Foucault's focus was on the transformation of human beings into subjects. Although the conception of the emergence of a new form of power relations is key to Foucauldian thought, Foucault (1982) explicates that the goal of his work was not to theorise or develop a methodology of the analysis of power; rather, the objective "has been to create a history of different modes by which, in our culture, human beings are made subjects" (Foucault, 1982, p. 326). The idea of the human 'subject', that is, a scientific knowledge of the person, a knowing and knowable being, is a relatively new construction (Gordon, 2000). Foucault (1982) clarifies what he means by the word 'subject'; he ascribes two meanings to the word: "subject to someone else by control and dependence, and tied to his own identity by a conscience or self-knowledge" (p. 331). Both meanings of the word 'subject', as invoked by Foucault, "suggest a form of power that subjugates and makes subject to" (Foucault, 1982, p. 331). Gordon (2000) describes Foucault as interested in political ways of seeing in order to elucidate the "apparent neutrality and political invisibility of techniques of power" (p. xv) that objectivise the subject.

Hence, via historical analysis, Foucault provides the framework to illuminate the ways in which human beings have been transformed into subjects, particularly within the disciplines of the 'dubious human sciences': psychology, psychiatry, sociology, psychoanalysis, criminology and some aspects of medicine (Foucault, 1972). Foucault (1972) showed how these disciplines, modes of inquiry which give themselves the status of science, transformed human beings into subjects. Foucault "was intent on showing how these forms of knowledge were enmeshed in the problems and practices of power, the social government and management of individuals" (Gordon, 2000, p. xvi).

Foucault's historical analysis of the above-mentioned disciplines produced a particular political perspective and displayed the dynamic relationship between ways of knowing and forms of domination that, over time, have produced the subject. This conceptualisation of the 'subject' will be used to investigate the ways in which pregnant women have become interlocked in a subjectifying power relationship - i.e. a dynamic which transforms human beings into subjects. Furthermore, the discourse on pregnancy and FASD renders them objects of intervention. Critical scholars have critiqued this 'objectification' (Fredrickson & Roberts, 1997), arguing against the bifurcation of pregnant women's bodies (Lupton, 2012). The study seeks to elucidate the discursive techniques of power that objectivise these pregnant women, ultimately constraining the reproductive justice project.

3.3. Technologies of Power, Technologies of the Self and Pastoral Power

Foucault (1982) reflected on technologies of power which produce subjects. Foucault (1982) defined technologies of power as those techniques "which determine the conduct of individuals and submit them to certain ends or domination, an objectivising of the subject" (p. 225). Subsequently, critical scholars within the field of pregnancy and FASD have critiqued the technologies of power that objectivise pregnant women in a range of intervention strategies, including biomedical technologies (Lupton, 2012), media images (Macleod & Howell, 2015), policy (Salmon, 2012) and other such techniques, as will be discussed in the proceeding chapter.

Further, the power/knowledge nexus produces 'truth games', that is specific techniques, which human beings use to understand themselves, referred to as technologies of the self by Foucault (1982). Technologies of the self are those techniques

> which permit individuals to effect by their own means, or with the help of others, a certain number of operations on their bodies, souls, thoughts, conduct and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality (Foucault, 1982, p. 225).

Similar to Foucault (1982), in this study, "I am more and more interested in the interaction between oneself and others, and in the technologies of individual domination..." (p. 225). These technologies interact closely with the mode of inquiry that gives itself the status of science, i.e. 'expertise' (Rose, 1996). These technologies of power are some of the many forms and modes of application of the exercise of bio-power, wherein "knowledge-power is an agent of transformation of human life" (Foucault, 1978, p. 143).

The Organisation can be conceived of as an institution, a site of power, utilising technologies of power as a strategy of intervention. Institutions are implicated in power/knowledge relations and are important sites of discursive power. Foucault (1978) conceived of institutions, which he described as diverse, including "the family and the army, schools and the police, individual medicine and the administration of collective bodies" (p. 141), as instruments of the state. These are described as institutions of power, utilising techniques of power at every level of the social body, to maintain the production of certain configurations of relations (Foucault, 1978). Similarly, the Organisation seeks to decrease the incidence of FASD in order to maintain certain configurations of relations, deemed 'public health'.

Institutions are shaped by discourse and contemporaneously create, impose and reproduce discourse. Mayr (2008) notes that institutions exercise power that "foster particular kinds of identities to suit their own purposes" and that they have the "capacity to produce and disseminate discourses with institutional values, meanings and positions" (p. 1). Thus, reviewing the role of the Organisation in shaping the subject positions made available for women in interventions is important. One cannot escape the governance of bio-power; however, via the introduction of liberatory counter-discourses, one can shift the subject positions availed for pregnant women, and in this way cultivate the conditions for greater agency for women. Institutions are important sites for the reproduction of certain power relations, and are thus important sites for change via the introduction of counter-discourse, more consistent with the reproductive justice project.

One of the primary and explicated goals of the Organisation's programmes is awareness building of the teratogenic effects of alcohol consumption during pregnancy amongst communities in the East London region of the Eastern Cape, as well as regions of the Western Cape and Northern Cape. The principal way in which the Organisation has chosen to build awareness, and thus effect a reduction on the incidence of FASD, is via knowledge dissemination (i.e. sharing insights from biomedicine). Foucault argues for a dynamic relationship between knowledge and power; he argues that knowledge is not neutral and is implicated in power relations:

> I have been trying to make visible the constant articulation I think there is of power on knowledge and of knowledge on power... the exercise of power creates and causes to emerge new objects of knowledge and accumulates new bodies of information... the exercise of power perpetually creates knowledge and, conversely, knowledge constantly induces effects of power (Foucault, 1975, p. 296).

Foucault's insights highlight that the awareness building effects of the Organisation's community educators and social worker are not politically neutral, and have implications for the subjectivities and reproductive lives of the impacted pregnant women. These can be understood as techniques of power which objectivise pregnant subjects, particularly via pastoral power.

Foucault (in Dreyfus & Rabinow, 1982), argued that pastoral power is exercised in organisations that exist to care for and support the body populace. Pastoral power is an extension of disciplinary power. The concept of pastoral power mirrors that of the pastorate: it evokes the image of a shepherd tending to a flock. Previously, the church exercised pastoral care; it was responsible for the salvation and redemption of the individual and society. This role gradually shifted to other state and non-state institutions. For example, with the de-centralisation of public health services in South Africa's current democracy, we see the exercise of pastoral power extending to NGOs who contribute to the surveillance and discipline of the body populace in the health sector. In this way, the range of pastoral functions is spread throughout the social body (Feltam-King, 2015). Central to the exercise of pastoral power is the involvement of members of organisations in the private lives of individuals through various confessional practices, and other such technologies of power. Further, confession, truth, obedience and salvation are core notions to the concept of pastoral power. I noticed this description of interactions (i.e. pastoral in nature) in the interview talk with the Organisation's community educators and the social worker.

The Organisation, which extends the pastoral function of the state, tasks its community educators, mentors as well as the social worker with educating the community about 'knowledge' about pregnancy and FASD. The mentors and the social worker are also tasked with forming mentoring relationships with women to help them reduce their alcohol consumption or abstain from alcohol. All trainees are thus commissioned to play a surveillance and disciplinary function in the private lives of community members, to reduce the incidence of FASD and in this way achieve certain desired body populace. Unlike sovereign power, which dominates and has power over, pastoral power is a productive power which produces and regulates subjects. Interestingly, effecting surveillance induces self-discipline. Thus, the pastoral commission by the Organisation circulates so that trainees exercise pastoral power and let it be exercised on them. In this way, this technique of power is ubiquitous and its technologies are exercised continuously through multiple directions and networks.

Within the field of pregnancy and FASD, critical authors (Lupton, 2012; Macleod & Howell, 2015; Salmon, 2012) further elucidate the exercise of bio-power, via technologies of power, on pregnant women. These authors argue that with the advancement of biomedical technologies, which have resulted in the visibility of the foetus, the interests of the health and well-being of the foetus have been foregrounded at the cost of the interests of the pregnant woman. Further, these authors argue that within neoliberal governance, pregnant women are increasingly encouraged to self-regulate and discipline their bodies: to have a 'healthy pregnancy' and a 'healthy baby' by avoiding various situations, foods and substances, including alcohol (Lupton, 2012). These critical authors show that these imperatives are an effect of the exercise of various modes of bio-power; and the implications of such are constructions of pregnant women and foetal subjects that represent individualisation on matters of health and well-being. These imperatives can become technologies of the self used to construct pregnant women.

3.4. Discourse and Resistance

The Foucauldian conception of discourse highlights the opportunity for resistance due to the dynamic nature of the power/knowledge nexus, central to discourse. Foucault (1972) refers to the ways of constituting knowledge and the accompanying "practices that systemically form the objects of which they speak"; the embodiment of power/knowledge, as discourse (p. 49). Discourse, therefore, is the means by which power reproduces itself; it is the site of power relations (Foucault, 1978; Willig, 2003). A shift in discourse could result in shifted power relations.

Foucault (1982) notes the

> series of oppositions that have developed over the last few years: oppositions to the power of men over women, of parents over children, of psychiatry over the mentally ill, of medicine over the population, of administration over the ways people live (p.329).

In noting these series of oppositions, Foucault made key observations of the changes possible in discursive fields. Rouse (1994) further explains that "it might be that what counts as serious and important claim at one time will not (perhaps cannot) even be entertained as a candidate for truth at another" (p. 2). Rouse (1994) explicates this further by noting Foucault's

> connection... between power and knowledge is not just a particular institutional use of knowledge as a means to domination. Foucault objects to the very idea of a knowledge or truth outside of the networks of power relations. The scope of his objection thus also encompasses the possibility of a critical knowledge that would speak the truth to power, exposing domination for what it is, and thereby enabling or encouraging effective resistance to it (p. 6).

Rouse (1994) in this way highlights the scope of resistance that the nature of discourse avails. What Foucault's (1982) explication of discourse thus suggests is "another way to go further toward a new economy of power relations... It consists of taking the forms of resistance against different forms of power as a starting point" (p. 329). Hence, Foucauldian thought provides some tools and perspectives for resistance. I use these tools to suggest ways discursive constructions of pregnant women can be altered or extended to promote the reproductive justice agenda.

4. Conclusion

In summation, this study aims to identify the discourses used to construct pregnant women that consume alcohol by members of the Organisation's training programmes. The above-described Foucauldian concepts are useful to consider some of the ways in which the discourse of alcohol consumption during pregnancy has transformed pregnant women into subjects. These concepts highlight the techniques of power which have objectivising effects on pregnant women. Foucault's conception of discourse highlights the scope of resistance that may be used towards the reproductive justice agenda in the field of alcohol consumption during pregnancy.

In the proceeding chapter, I identify and discuss the discourses circulating in the field. Discourse is an important site of power relations. I show how certain 'knowledges' of human beings, particularly (pregnant) women and foetuses, have produced responsibilised pregnant women and vulnerable foetuses. I conduct a critical review using a post-structural lens to interrogate the literature. Whereas the techniques of power evident in the pregnancy and FASD discourse have tended to revolve around the individual pregnant body, I take a reproductive justice perspective arguing for intervention at a structural level. The exercise of power cannot be escaped. However, shifts in discursive constructions and practices can be achieved, via advocating for alternate discourses, in order to create room for greater agency for all (pregnant) women.

Chapter Three: Critical Review of Discourses Deployed in Pregnancy and FASD Literature

1. Introduction

Discourse shapes certain versions of reality and ways of being (Foucault, 1978; Willig, 2003). It is an important site of power relations. When discourse is left uninterrogated, the produced subjects, objects and ways of knowing become legitimised and valid. The discourses employed in parts of the globe in pregnancy and FASD research are considered here, together with a discussion of their implications. The review shows that pregnancy and FASD discourses have constructed and centred on foetal vulnerability, which potentially leads to the subversion of women's reproductive health needs. I identify and discuss five prominent discourses circulating in the reviewed literature: the personification of the foetus; foetal rights; 'the problem' of FASD; racialized and stigmatised pregnancies; and responsibilisation.

I conclude the chapter by discussing the propositions of moving towards reproductive justice. Critical scholarship suggests that for the prevalence rate of FASD to decline, intervention efforts should target change at a structural, and thus material, level - rather than targeting individual behaviour, as has been the trend.

1.1. Personification of the Foetus Discourse

Critical scholars argue that in the advent of biotechnologies, such as ultrasound imaging technology, "the once opaque and secret environment of the uterus has been opened to observation" and resulted in the production of the foetal subject (Lupton, 2012, p. 334). Lupton (2012) argues that over the past century these technologies have played a progressively instrumental role in the construction and personification of the foetus: constructing the foetus as a patient, person, citizen and, ultimately, a public social actor (Macleod & Howell, 2015).

The emergence of the foetal subject in 'public' spaces, including print media (Rutman et al., 2000), policy (Lupton, 2012; Salmon, 2011), medicine (Bell, McNaughton, & Salmon, 2009) advertising, and the Internet (Macleod & Howell, 2015) has produced the concept of foetal vulnerability, where pregnancy is no longer conceived as 'natural' but defined in terms of risk - to the foetus (Lupton, 2012). Biomedical technologies are used to identify and manage

so-called ‘risk pregnancies’, shifting the focus from the body of the pregnant women to that of the foetus. Foetuses are constructed as vulnerable and in need of care and protection. The personified foetus is conceived of as not only separate from the pregnant women, but possessing rights too, particularly the right to life (Macleod & Howell, 2015).

1.2. Foetal Rights Discourse

These constructions, of the personified, rights-bearing foetal subject, produce an antagonistic conception of the relationship between the maternal body and the foetal body (Lupton, 2012). Women are reduced to incubators, carrying ‘precious cargo’ (Lupton, 2012); and foetuses are presented as vulnerable and in need of protection (Leppo, 2012). The reproductive health needs of the pregnant women are, by these processes, diminished. The use of biomedical technologies has in this way produced a personified foetal subject, whilst further propagating the objectification of the pregnant women.

This dichotomous construction, between the foetal and maternal subject, is demonstrated in Rutman’s (2000) review of how substance-use by pregnant women was discussed in Canadian print media’s coverage of the supreme court case of Ms D.F.G., an Aboriginal women. The newspaper headlines used to report on this case employed the foetal rights discourse, recruiting public perceptions into the dichotomous construction of the pregnant and foetal subject, as well as advocating for the supremacy of so-called ‘foetal rights’, over women’s rights.

The discourse of foetal rights, based upon the conception of a maternal-foetal conflict (Armstrong, 1998), implies that the interests of pregnant women and their foetuses can be separated (Rutman et al., 2000). Because pregnant women are reduced to carriers of precious foetuses, their reproductive health needs are backgrounded and efforts around FASD prevention become about protecting the foetus.

1.3. ‘The Problem’ of FASD

Leppo (2012) traces the genealogy of this foetus-centred discourse by analysing medical journals and political documents in Finland in the 1980s and 1990s. The author reports that during this time the political discourse oscillated between protecting the substance-using women and protecting the foetus. Leppo (2012) reports that formerly the onus was placed on protecting women’s rights and providing welfare and public services to them. However, this

evolved into negative constructions of substance-using mothers and compulsory treatment as a measure to protect the vulnerable foetus, thus preventing FASD.

Leppo (2012) describes how pregnant women were initially constructed as ignorant, yet well-meaning. This construction affected FASD prevention efforts: prevention entailed providing health education to women of childbearing age. However, since the mid-1980s, FASD prevention discourse has predominately been foetus-centred. The production of the maternal and foetal subjects, in conflict, has affected the problem category of FASD. Pregnant women are constructed as ignorant *and* indifferent alcoholics (Leppo, 2012). This has resulted in the demonization of the drinking pregnant women, exemplified by the conception of heavy-drinking (pregnant) women as more deviant than men who drink at the same levels (Benoit et al., 2014; Rutman et al., 2000).

The emergence of the foetal subject as instigated by biotechnologies, as above-described, converges with liberal ideals of 'good mothering' to further 'the problem' category of FASD discourse. According to these ideals, "a 'good' mother is self-sacrificing, self-disciplined, morally irreproachable and capable of meeting the needs of her family without assistance from the State" (Salmon, 2011, p. 167). Contrastively then, alcohol-consuming women may be considered to be self-indulgent, deviant, immoral and burdensome to public health. Women (who drink) are thus constructed as 'the problem' of FASD. In studies such as Rutman et. al's (2000), women were constructed by health service practitioners as: self-serving, pleasure seeking, substance misusing figures; as transmitting harm directly to the foetus; and incapable of self-care. This is antithetical to the ideals of prospective motherhood (Radcliffe, 2011).

Hunting and Browne (2012) importantly note that, "the way health issues or 'problems' are framed in health policy discourse directly relates to how the issue is understood, thus the type of solutions that are considered to address it" (p. 40). Critical scholars have shown how the construction of women as 'the problem' of FASD has made it permissible for healthcare workers to monitor women's behaviour, in the interest of foetal rights (Benoit et al., 2014; Radcliffe, 2011; Rutman et al., 2000). Salmon (2011) argues that, under Canadian neo-liberal governance, antenatal drinking becomes a political issue, justifying increased regulation by the state of women's behaviour in the interest of the foetus, and the tax-payers (Hunting & Browne, 2012). Similar regulations, such as the Basic Antenatal Care (BANC) guidelines (Pattison, 2007), are observed in South Africa. These guidelines instruct healthcare workers

to engage with women regarding alcohol use during pregnancy during all antenatal clinic visits.

Hunting and Browne (2012) further note that this 'problem category' and 'the solutions' conception fails to contextualise women's health, leaving the structural, social and health inequities, that give rise women's alcohol use, obscured. Additionally critical scholars highlight that the discourses employed around the issue of alcohol use during pregnancy, those that construct women as the perpetrators of FASD, are characteristic of a 'moral panic': a situation wherein an identifiable and typically marginalised entity becomes the scapegoat for a social crisis. This entity is constructed by hegemonic institutions as threatening or antagonistic to the morals, values and interests of a society (Bell et al., 2009). The actions of the pregnant women are "constructed as dangerous to the interests of children, families, communities and nations" (Bell et al., 2009, p. 157). These constructions, which function to monitor and regulate women's lives and are intended to address the issue of FASD, may have inadvertent effects. These constructions, and the interpellation of (alcohol-consuming pregnant) women into 'the problem' category may act to deter pregnant women from accessing healthcare services. Salmon (2011) argues that FASD intervention efforts should thus target state policies that perpetuate colonial conditions and health disparities, rather than scapegoating pregnant women of particular racialized bodies. Because of Australia's colonial histories, these marginalised entities, which become scapegoats for FASD, are typically Women of Colour. Similarly in South Africa, due to our socio-political history discussed in the introductory chapter, it can be argued that Black[14] women become the scapegoats for FASD.

1.4. Racialised and Stigmatised Pregnancies

What is constructed as problematic is "generated in the broader representational hierarchy wherein bodies bound to certain spaces and classes are read and labelled as problematic" (Benoit et al., 2014, p. 256). The issue of FASD has thus been constructed as an issue of 'Blackness' in South Africa since the 1990s. This is evidenced by the research populations of the aforementioned epidemiological studies, including the qualitative investigations of drinking women's narratives: Black participants. This is consistent beyond our borders, with

[14] The term "Black" from now on is used in the Black Consciousness conception of the term, denoting the marginalised Black community which includes people designated as 'non-white' during Apartheid, including Black, Coloured and Indian people.

reference to persistently marginalised and disenfranchised Aboriginal women (Benoit et al., 2014; Lupton, 2012; Rutman et al., 2000; Salmon, 2011). Critical authors repeatedly highlight that it is women of colour, single mothers, and women living in poverty that are recruited into the punitive FASD-related discourses. These women, already subjected to marginalisation and surveillance, are constructed as dangerous and a risk to society (Bell et al., 2009).

Focusing on FASD prevention government policy in Canada, Hunting and Browne (2012) highlight how policies have been instrumental in the construction of Aboriginal women's health and social issues in individualistic, racialized and stigmatised ways. The authors argue that Canadian policy regarding FASD prevention "fails to contextualise Aboriginal women's health within historical, social, and economic systems of power and structural disadvantage" (p.37). They argue that dominant policy discourses, that centre around constructing (Aboriginal) women as 'the problem' of FASD and propagating their responsibilisation, have had the effect of racializing and marginalising the experience and needs of Aboriginal women. Importantly, they foreground that, at a global level, these discourses, albeit well intentioned, have the potential to inadvertently disadvantage indigenous people. In addition, they highlight the co-constructed nature of racialized, gendered, and classist discrimination that shape women's subjectivity, their health and social experiences.

Macleod and Howell (2015) demonstrate how, via public foetal imagery, White, middle-class pregnancy predominates as the normative 'correct' form of pregnancy in South Africa. The authors highlight the reality of pregnancy as different, depending on race, class and location. They highlight the racialized and class-based issues in reproductive health in South Africa. The normative framework from which 'good' and 'ideal' pregnancies emerge, is embedded in the country's socio-political and socio-cultural history. It is for similar reasons that critical scholars such as Salmon (2011) argue for the incorporation of decolonisation agendas into FASD prevention efforts, thus foregrounding the issues faced by under-served, persistently marginalised and disenfranchised women, children and families.

1.5. Responsibilisation: Individualised and Idealised Pregnancies

Critical scholars critique the ways in which within neoliberal governance, pregnant women are increasingly encouraged to self-regulate and discipline their bodies. Women are instructed to have a 'healthy pregnancy' and a 'healthy baby' by avoiding various situations, foods and

substances, including alcohol (Bell et al., 2009). These messages are encoded in government policy (Salmon, 2011) and perpetuated by supporting social institutions, where citizens are encouraged to take up and reproduce the imperatives of self-regulation (Lupton, 2012).

These imperatives have served to constrain the reproductive lives of pregnant women through the many ways in which women, especially those marginalised by race, class and disability, are subjected to these social constructions of 'good mothering' (Bailey, 2011; Lupton, 2012; Salmon, 2011). The constructions of pregnant and foetal subjects represent individualisation on matters of health and well-being that assumes agency: that one is able to make 'healthy choices', irrespective of external conditions (Lupton, 2012).

2. Towards Reproductive Justice

A reproductive justice approach seeks to create structural change and challenge power inequalities that shape the subjectivity of (pregnant) women (Bailey, 2011). It goes beyond the recognition of reproductive health rights, deploying ideas of social justice, and extending understandings of pregnancy and alcohol consumption to the life conditions that hinder or enable women to make health decisions (Bailey, 2011; Chiweshe, Mavuso, & Macleod, 2017).

These life conditions include: women's substance-use patterns as influenced by their partners', social isolation, stressful life events such as a death in the family, challenges of living in poverty, stigmatisation, high incidence of physical and/or sexual abuse as children, lack of social support, need for social services and child care, need for support and education around parenting, relationship counselling, coping skills training, and vocational and legal assistance (Rutman et al., 2000), amongst others. Contextualising the issue of FASD means acknowledging the socio-cultural and political context within which pregnant women act; and considering that socio-economically disadvantaged pregnant women may struggle to conform to imperatives of 'ideal pregnancy' due to physical, economic or emotional hardship or addiction, as exemplified by South African women's drinking narratives discussed in the introductory chapter of the dissertation.

Critical scholars have thus argued for women-centred approaches to intervention, as well as preventative approaches that target structural, and thus material, change. These authors critique (treatment) programmes, that become sites of the exercise of power, when seeking to normalise and adjust individuals to hegemonic ideals of behaviour (Rutman et al., 2000).

They argue for the role of men, communities and society at large in approximating reproductive justice, dismissing the sole responsibility of lifestyle related public health concerns on women. Critical scholars advocate for the incorporation of the decolonisation agenda into FASD prevention and a focus on state policy that perpetuates colonial conditions and health disparities (Salmon, 2011).

Authors advocate for the healing and health needs of pregnant women who use substances. They suggest framing 'the problem' of FASD "... in terms of, for example, the need to identify and address the underlying causes of women's substance use... implicit in these alternative conceptualisations is the idea that by attending to the healing/health needs of women, foetuses will be protected" (Rutman et al., 2000, p. 59).

Working towards reproductive justice entails: recognising the ways in which health intersects with social, historical and structural processes; shifting away from individualising and essentialising notions of FASD as (poor Black women's) personal failure, towards recognising the processes on women's and children's health which result in persistent marginalisation. This shift in conception about change affects the manner of intervention (Hunting & Browne, 2012). There is a need to re-imagine FASD prevention efforts from a reproductive justice perspective, and a need to alter the discourses involved in the constructions of alcohol-consuming pregnant women dominating in the pregnancy and FASD literature.

3. Conclusion

In this critical review of the discourses circulating in the pregnancy and FASD literature, I discussed the emergence of the vulnerable and personified foetus, and the subversion of women's health needs. This foetus is positioned in an antagonistic relationship with the maternal body. Critical scholars argue that particularly Women of Colour have been interpellated into 'the problem' category of FASD. These scholars note that FASD prevention efforts have tended to racialise and stigmatise certain pregnancies and failed to contextualise women's health within colonial histories. They argue that the imperatives of 'good mothering' serve to further constrain the reproductive lives of already marginalised women. Thus, critical scholars suggest a reproductive justice approach to intervention, focusing on change at a structural level.

Interestingly, as seen in the penultimate chapter, the participants of this study deploy similar discourses to the above-described discourses circulating in the literature. Participants summon the personification of the foetus discourse, the responsibilisation discourse, 'the problem' category discourse discussed in this chapter, as well as alcohol consumption as an entrenched practice discourse discussed in the introductory chapter to construct alcohol use during pregnancy in their communities.

In the proceeding chapter, I use Willig's (2003) stages of a Foucauldian analysis to identify the discursive objects present in the interview talk. The participants spoke of their context of living, alcohol consumption, the foetus and pregnant women using the chief discourses of responsibilisation and foetal personhood to construct the discursive objects. I consider the action orientation surrounding particularly the pregnant woman, as well as her positionings in the talk. I use Foucauldian concepts to illuminate the techniques used to discipline (Foucault, 1975) pregnant women. I discuss the implications of these constructions on the subjectivity of pregnant women and explore ways these constructions can be altered in ways that are consistent with the reproductive justice agenda.

Chapter Four: Findings: Discursive Constructions of Alcohol-Use during Pregnancy

1. Introduction

Willig's (2003) stages of a Foucauldian discourse analysis were used to analyse the data, in order to identify the discursive constructions of alcohol-use during pregnancy made by participants of the study who had attended the training programme.

During the various stages of analysis, I was interested in the multiple ways the discursive objects of interest were constructed in the interview talk. A number of discursive constructions were identified surrounding the pregnant women. The foetus was constructed as vulnerable and important, as opposed to the defiled FASD child. Alcohol consumption as a destroyer, as pervasive and a social lubricant. The context of living as wholly bad and issue-ridden. The participants constructed themselves as transformed and knowledgeable subjects. I was primarily interested in the constructions of pregnant women. These included pregnant women as ignorant, preoccupied and unreceptive to knowledge. The discourses of responsibilisation and the personification of the foetus were the chief discourses deployed by participants. The discourse of 'the problem' category of FASD, the discourse of difference and morality, and the discourse of alcohol consumption as an entrenched practice were discourses circulating around pregnant women. The action orientation and positionings of these discourses are expounded upon in the concluding chapter, as well as the implications for practice and subjectivity. The ways in which pregnant women are disciplined (Foucault, 1975) are identified and explored in order to make suggestions of alternate constructions consistent with a reproductive justice perspective.

2. Discursive Constructions

I start the description of the constructs identified during analysis with the context in which pregnant women were constructed and positioned. I continue the discussion by describing the ways in which alcohol consumption, constructed as a key subject acting in the context, was constructed. The participants placed the personified and valued foetus, as well as the defiled FASD child, and the responsibilised pregnant woman in this context. They positioned themselves as transformed subjects, able to play a shepherding (Dreyfus & Rabinow, 1982) role in their communities.

As explicated in the methodology, the interview talk, from which the identified discursive objects emerged, was transcribed by the transcriber/translator the transcription conventions specified on Appendix C. Because of the code-switching that occurred throughout the interviews, some of the text in the extracts below is italicised to indicate the translated talk. Participant N (myself) and Participant S (Ms Matebese) are the researchers. The other participants cited are the participants[15] of this study and trainees from the TP, including the Organisation's social worker who facilitated the training workshops.

2.1. Context: Wholly Bad & Issue-Ridden

There were 14 references made to the context in which participants live. The discursive construction of context emerged as an object of investigation following a grounded reading of the interview data. We, as the researchers, positioned the participants as experts of their communities and asked them to describe their environments and the context in which drinking during pregnancy occurs. Their responses to these questions revealed constructions of the researchers as outsiders, and their communities as absent of any good and as issue-ridden. Pregnant women were positioned within this context.

Interview 1

109 B: ... like *in the places where you stay, you'll never understand these things that are happening but when uh in this place of ours where <u>we</u> stay, you watch a lot of things* //Hmm// you understand?

123 B: ... *I'll keep saying!* (.)*Where I come from //*ja!// *(*?it's really*)* <u>very, very bad</u>

223 B: And <u>*you*</u> *become worried, but at least your yours at least you a God who's put you in a good place, at least… can raise them. When <u>in the streets</u>, they <u>see all of that</u>* (.) //Hmm// *being done there*

As seen in the excerpts above, Participant B positioned herself as knowledgeable and insightful about the issues facing their community, and constructed the interviewers as unknowing. She suggests that one has to be located in an environment to truly understand it. This creates an 'us' and 'you' bifurcation between the community members and researchers. The researchers are said to be fortunate because God put them in a good place. Participant B also suggests that the 'bad things' are visible, referring to community members "watching" and "seeing" a lot of things. She suggests that outsiders cannot understand the breath of the

[15] Refer to Table 1, in the methodology chapter, for the demographic description of the participants.

issues prevalent in their communities, because of their location outside the community and subsequent inability to see the 'bad things'.

Participants labelled these 'bad things' by describing their communities as poverty-stricken and "filled with issues" such as HIV, high teenage pregnancy, substance abuse and drinking during pregnancy. They described the communities as "dangerous" and Participant P described having to take her school-going child "out of this place" due to the stabbings and violence happening at school. Participants described lack of safety in the homes as well, with children being exposed to sexual assault and substances that are easily available. They described pirated electricity, living in squatter camps and one-roomed homes. Participant P further noted that activities, such as weekly rugby games, had been cancelled in their community due to what was described as community-wide alcohol misuse. In the extract below, Participant V, a social worker, describes the effect of the breadth of issues at her workplace:

Interview 5

26 V: ... I always want to (.) help *the* … community. *It has a lot of ISSUES* //*Yeees// A lot!* High teenage pregnancy (2) Everything that's there. As a result in our office no one wants to take that area … //Sho!// Because they don't want to be burdened

Participant V takes a dual position as both an outsider and an insider: she wants to assist in the community as a social worker, but has the option not to (outsider); and, she understands the community and the range of the problematic issues evident there (insider).

The participants constructed their communities as wholly bad and issue-ridden. There was neither mention of any positive attributes of the community nor any enabling factors. In describing the context in the above-described ways to outsiders, it seemed as though participants were suggesting that no outsider could effect change due to lack of understanding ("you'll never understand") of the breadth of issues prevalent in their communities. By highlighting the extensiveness of issues, the participants predicated the context in which they would construct and position the pregnant women they spoke of.

2.2. Alcohol Consumption

Participants made 19 references to alcohol consumption to construct the act of drinking as harmful ("a destroyer") and as pervasive ("alcohol is king") in their communities. Alcohol consumption was often discursively co-constructed with the foetus. These co-constructions

established the vulnerability of the foetus and the harmful effects of alcohol consumption. These discursive objects (alcohol consumption and the foetus) were subjectified, positioning the foetus as the victim and alcohol as the perpetrator.

2.2.1. "A destroyer!"

The construction of the foetus as vulnerable and alcohol as harmful occurred regularly across the data with all participants. In the extract below, Participant Z not only notes the harmful effects of alcohol on the vulnerable foetus, but also notes the harmful effects of alcohol on families and whole communities.

Interview 3

183 N: ... And *YOU something that was* MOST useful, *I mean something you learnt, something* yeah! From *the* course. What is it?

184 Z: *The most* useful *thing I learnt from the* course is that *alcohol* (2) it damages brain cells and OTHER ORGANS in the body. It's not only about the brain cells. It's not about the foetus only it's about (.) FAMILIES //Hmm// it's about yeah, yeah! //Sure// Communities //Yees// Yeah it destroys, it's a destroyer!

It is interesting to note that Participant Z repeats this regularly occurring construction in response to a question asking her to identify the highlight of training. Alcohol consumption as "a destroyer!" seems to be the most useful aspect of training for participant Z. Other participants responded in similar ways to this question.

Participants described further ways alcohol is "a destroyer", noting its implication in partner-, socio-economic, and environment-related stressors. They also made reference to drinking as addictive and useful in coping with stressors, citing pregnancy-related stressors.

2.2.2. "Alcohol is king"

Participants constructed alcohol consumption as pervasive; they constructed it as an entrenched and culturally prioritised behaviour in their communities. This discursive object was positioned as sovereign, determining other behaviours. In so doing, participants constructed alcohol as "king", as demonstrated below:

Interview 2

55 P: [coughs] uhm (2) *here at* Santini (2) uhm alcohol is like king (.) because they used to have activities like uh... likes of rugby //Hmm!// like *kids would COME home from school and go to the* gym and then most of them *would come here then, the smaller ones*. //*Yes*// So (.) Uh at some point due to (.) use of that alcohol still, //Hmm// *they stopped those things… those* games *were stopped* because they had them (.) every Sunday //Hmm//

In positioning alcohol as "king", participant P evokes the idea of alcohol as a powerful, ruling subject that allows no opposition to it ("they stopped those things… those games were stopped"). Participants spoke of drinking as part of everyday life, constructing it as 'normal' and positioning alcohol consumption as entrenched into community life. This positions alcohol as king, and community members as daily 'subjects of the sovereign'. Participants further constructed drinking as addictive, describing persons as having cravings for alcohol and being unable to help themselves because alcohol consumption is a "force of habit" (Interview 2). This further amplifies the power of the sovereign over its subjects.

Interview 3

110 Z: No! LISTEN then. Here, where we stay alcohol gets DRUNK! //Hmm// EVERYDAY //Hmm// *there are those, however who drink on* weekends, RIGHT? But *those who drink on* WEEKENDS, *will drink* from Friday, Saturday, Sunday BUT now there's MONDAY, //Hmm// *That's a NEW one* but it was Sa Sunday at first //Hmm// now *where I stay,* it's a biggest day for *them to* drink //Sho!// *that they even miss* [claps once] *work //*Sho!// *I won't even get started about the* wine *drinkers MPALA-MPALA, Paarl- Perle! Those ones drink every day. A person works… comes back, works for alcohol goes to get* (.) What is it? GARBAGE *there. Pick up nice things, and sell them* //Hmm// or *you give them* something, your goods. *When you give them, they'll go and sell for ALCOHOL money*

Participant Z further underscores the entrenched nature of alcohol consumption in her community. By explaining that the weekend revolves around alcohol consumption and noting the extension of drinking time (she refers to drinking "everyday", "on weekends" and "now there's Monday"), she stresses the pervasive nature of drinking, where all activities (including work on Monday) fall away for this culturally prioritised act. Earlier participant P noted the cancellation of sporting events too. By noting that "they even miss work", participant Z constructs alcohol consumption as bad behaviour. She positions alcohol consumers as unreliable by noting that they sell items for money to purchase alcohol. (These alcohol consumers can be viewed as unreliable or loyal to their sovereign, alcohol).

2.2.3. The co-construction of the foetus and alcohol

The co-construction of the foetus and alcohol emerged as a trend in the data. This is demonstrated in the following excerpt.

Interview 3

77 N: Yes! And during training, *what did you learn* (.) *about about* alcohol-use and pregnancy*?*

78 Z: *I learnt that* (2) *children REALLY get affected* (.) //Hmm// *what was being said there that children get* (.) //Hmm// *so I've learnt that it's real.* I know some of those kids //Hmm//. And *secondly,* alcohol *becomes a thing that messes up the brain* //Hmm// *in the child…*

The co-construction of the foetus and the alcohol seemed to function to underscore the vulnerability of the foetus and the threat of alcohol to its development. As participant Z in the excerpt above explains, "children really get affected" by the 'destroyer'. She also notes that this threat is "real" and that "she knows some of those kids".

Participants explicated the teratogenic effects of alcohol on the developing foetus (i.e. the biological disturbances) - most notably and recurrently "that [alcohol] messes up the brain". By noting its 'damaging' effects, the participants positioned alcohol as a threat. Moreover, in extending the harmful effects of alcohol to communities, alcohol was constructed as wholly bad, positioning it as a powerful threat. This may have the effect of deconstructing potentially presumed understandings of leisurely and permissible levels of drinking and negating any positive attributes to it, in addition to amplifying its 'damaging' effects.

Within the field of alcohol consumption patterns, various levels of drinking are recognised. Authors speak of "alcohol misuse", "risky or hazardous use", "harmful use", "alcohol abuse" and "alcohol dependence" (Du Plessis, Young & Macleod, 2017). Participants summoned these understandings, as exemplified below:

Interview 1

197 B: Yhoo it's very bad! //Hmm// *People drink.* And more especially *they don't drink these things Savanah what what* //Hmm// *these things that "at least" but there's no "at least" in alcohol* (.) *but you get 90 something percent of alcohol, because there are things like* PAARL PERLE //Hmm// *these what what, alcohol that kills* //Hmm// *There's alcohol I heard of here that people say makes one to* (.) *grow facial hair* //Sho!// *when you drink it!* //Hmm// Swells //yeah*!// the BELLY whatever! You see all those thing* //Hmm// *There's nothing you won't find* //Hmm// *in that place drugs, what. And you find that it's small children that get affected* (.) //Hmm// You understand? //Hmm// *There's no type of DRUG you won't find in that place. There's no KIND OF OF ALCOHOL //sorry sorry!// that is not consumed in that place of mine, it's a place that is most* (2) *I'll say* 100% //Hmm// *I won't even say ni.* 100%

In the extract above, participant B describes how one may find all kinds of alcohol and drugs available in her community; she notes that "there is nothing you won't find". She notes that

members do not drink "Savanah" but tend to drink the more harmful alcohol such as "Paarl Perle... alcohol that kills" as well as consume "drugs". Participants summoned the discourse of alcohol consumption as an entrenched practice, constructing alcohol consumption as wholly bad and dismissing potential implicit understandings of 'acceptable', non-harmful levels of drinking ("but there's no 'at least' in alcohol").

Specifically participant P and Z troubled this construction, relaying personal recounts of their alcohol consumption during pregnancy that did not result in the FASD child. An extract from participant P's story is included below:

Interview 2

365 N: … Uhm… *if you would summarize for us maybe, what it is that you learnt in this* course about alcohol and pregnancy just a summary. Do all women that drink (.) produ I mean, does it affect or do you have to drink certain amounts? *What did you learn?*

366 P: Uh uh! What I did get from the whole thing is that (.) there is no certain amount you can or cannot drink for this thing to affect you, because EVEN with the cases where you find that a person was drinking and a child turned out okay… as in my case //Hmm!// cause I was drinking mos. I wouldn't say I was drinking the right amount or the wrong amount //Yeah cause you don't know// Cause it could have happened to me at any rate, you understand? //Yeah// so now, rather than taking the risk with the knowledge that you have //Hmm//, you understand? //Yeah// rather than taking the risk, just make the choice…

Although presenting an exception, participant P continued to reproduce the "wholly bad" story surrounding alcohol consumption. Thus, personal experience did not undo these constructions surrounding alcohol-use during pregnancy.

2.2.4. A Social Lubricant

Alcohol consumption was further constructed as a means of social engagement. Participant P, in the extracts below, speaks of drinking as a means to socialise:

Interview 2

154 P: Ooh they make we make dates to have (.) drinking sessions, *you see*? Dates like, okay this certain day, *you me and so and so we will sit*. So, if *we can't raise a certain amount* then *we will need to know that on Friday we have so much, on Saturday so much, on Sunday so much* //Hmm//, *on Monday when we come home from work* like, *we have THAT of doing that thing so that you wake up on Tuesday feeling okay, you understand*? //yes!// So we make DATES to have drinking sessions.

372 P: … because at the end of the day, it's the only way we socialise nowadays…

Participant P illustrates how alcohol consumption is a catalyst and means for socialising, over the weekend and during the week. She speaks of community members making "dates" revolving around the alcohol consumption, described as "king" above. These "drinking sessions" are described as "the only way we socialise nowadays" and bring people together - it is implied that people would not otherwise come together.

Interestingly, Participant V, whose extract from Interview 6 is included below, evoked *Ubuntuism*[16] and notes some positive attributes of the object.

Interview 6

V: … number 1 (.) they it's a sense of belonging. So when we go to (.) wherever we drink. Nobody is wearing fancy clothes //Hmm// or…whatever //Hmm// it's just about us drinking //Hmm// and we are having a good time. Also we forget //Hmm// all our problems //Hmm//. You know that tomorrow I don't know what I'm gonna eat //Hmm//. And there (.) unlike at home if I don't grocery, if I don't have groceries, maybe I'll have to figure out WHO I'm gonna go to. But when you are at a bar or shebeen (.) we JUST drink //Hmm// whoever's drinking will (.) help others drink you know? //Hmm// whoever's got money, you know? Whoever can afford will just help us all. If we had maybe that mentality even [giggles] in in (.) in our communities to be like, if I have more (.) let me give others. You know? I think it would assist a lot because that's that's how it works //Hmm//. In (? bars) you don't have… like you could not work but you'll be drunk everyday

Participant V constructs alcohol consumption as having some positive features. She constructed drinking as a social lubricant: an object that bonds community members, and encourages communal practices as well as being non-judgmental and selfless. This construction is unlike previous constructions of alcohol as a destroyer. Participant V notes how this entrenched culture of alcohol consumption, established by the 'king' (i.e. alcohol), does not only destroy but its subjects do have the ability to be generous: "whoever drinks will help others, you know". Her analogy also highlights the position of alcohol consumption as a social lubricant where "nobody is wearing fancy clothes" and "we are all having a good time". The role of alcohol consumption as a means to cope, "we forget", in the face of financial lack and limited opportunities for other leisurely or occupational opportunities was also highlighted in the excerpt above. Other participants further described *stokvel* events centred on alcohol, and planning weekdays and weekends around drinking; they spoke of drinking as a habit and a norm in their communities in addition to participant V's association of drinking habits with the notion of *Ubuntuism*. In these ways, participants positioned alcohol consumption as a social lubricant and means for social engagement.

[16] The cultural belief that I am because of others.

Participant B's personal recount (a type of story), from her experience as a (currently) pregnant woman, in the excerpt below illustrates how pregnant women are potentially barred from this social engagement by pregnancy.

Interview 1

183B: It's a painful more especially when you're pregnant, like my husband, *right*? Sometimes I feel like [gasp] very small because sometimes he said "I'm going out but I'm not going (.) with you //Sho!// because you're pregnant!"

In the extract above, participant B speaks of being excluded from this otherwise limited opportunity for social engagement by being left behind at home by her partner who is going to the tavern. Other participants spoke of pregnant women being excluded from *stokvel* plans to drink. Because of alcohol consumption providing an opportunity for social engagement, pregnant women were described as drinking in spite of pregnancy.

Participants constructed the context of living as wholly bad and issue-ridden. Within this environment, they constructed alcohol as king. They constructed alcohol consumption as harmful and pervasive. The co-construction of alcohol consumption with the foetus functioned to position it as a threat and underscore the foetus' vulnerability. The manner in which participants constructed the vulnerability, as well as the importance, of the foetus is described below.

2.3. The Foetus: An Important and Vulnerable Child

The foetus was a central object prevalent in the interview talk. There were 14 references to the foetus/unborn baby/baby. The participants mostly referred to this discursive object as "child", deploying one of the chief discourses, the personification of the foetus. The participants attributed child-like feelings and behaviour to this discursive object. Participants spoke of the "child" in discussing alcohol consumption during pregnancy in their communities, reflecting on and relaying what they had learned during training.

Participants seemed to conflate the construct of a foetus and a child. The construct of the foetus was absent throughout the interview talk. We can make sense of this in light of the predominating foetal personification discourse in which foetuses are viewed as fully-fledged children/babies. Another way of viewing this absence is that the terminology for foetus does

not currently exist in the Nguni language - the language predominantly used throughout the interviews. Because of this absence, it was unclear at times whether participants were referring to an "unborn child" or "born child". This ambiguity is best exemplified from an extract from Interview 3, at a point during the interview when the participant was presented with an image of a pregnant women and a child, of school-going age, with its ear against the women's bulging belly (see Image 3 in Appendix D).

Interview 3

269 Z: *it's that mommy has another baby* [laughter] <u>that's all,</u> I *don't see anything else. I see that mommy has another baby and THIS ONE* (.) *still needs to be loved but there's* //shame// *this ONE who has to be loved, also this child is still a child but* (.) *he has to… to LOVE this child in his mother's tummy* //Hmm// as well
270 N: *the one that's coming* yeah?
271 Z: Yes! ...

During Interview 3, participant Z was physically pointing to reference which subject she was speaking of. However, the ambiguity remained, as exemplified by my need, in line 270, to clarify which child she was referring to. The power of the foetal personification discourse is demonstrated via Participant Z's sentiments above, about how others should relate to the foetus: one child has to love the other (the foetus). Her sentiments illustrate how the foetal personification discourse incites the responsibility of others to the foetus. Whereas the discourse circulating during interviews seemed to have objectivising effects on the pregnant women, particularly the predominating personification discourse, seems to have produced the foetal subject.

The training programme utilised a variety of visual aids, in the form of pictures in the training manuals, video clips showing ultrasound imaging as well images on PowerPoint presentations. Three images from the manuals (see Appendix D) were presented to participants during the interviews. Constructions of the foetus emerged most clearly and prominently when participants were presented with these visual stimuli. The foetus was constructed as a vulnerable child.

Interview 1

236 N: *yes.* So *what does this picture mean to you?…*
237 B: Uhm Like Uh! *It means that it's* wrong *of her* //Hmm// *to drink while pregnant* (.) //Hmm// *you understand? Because all of this goes to this and is consumed by that child* //Hmm// *which means* (.) *the mother is drinking and the child is drinking.*
238N: Sho… (.) *And this one?*
239B: *Here is a woman smoking*, she's also pregnant. And then you can see that *all of that thing is going* (.) *to this child* (//Hmm...), *then the child is also smoking so gets affected by many things like asthma, brain damage,… I mean* it's a lot of things *that s/he will contract*

Interview 3
251 N: ... *Here's the second one* (.) *Picture. What do you see*?
252Z: Ooh [sounding delighted] *I see a* towel *of SMOKE* [giggling] that a child is crying with [all giggle] //Yeah?// AND he's CRYING //Yeah [giggling]// and he's crying shame, because he…. I think she he (.) doesn't have a SPACE to BREATHE I don't know
265 Z: [high pitched voice] it's because of, *this CHILD is* (.) is *not sitting nicely*. H*e's not* comfortable //Hmm// *and he's CRYING* you can SEE that he's panicking. *He's just PANICKING because his mother is smoking*

As exemplified in the above two excerpts, the foetus was given human attributes: the ability to consume (i.e. drink and smoke), cry and panic. It was also constructed as susceptible to illnesses such as asthma and brain damage. Despite the absence of the terminology for 'foetus' in the Nguni language, I continue to use the personification of the foetus discourse as an analytical category because, as displayed in the excerpts above, participants ascribed human attributes and actions to the foetus. This is consistent with conceptualisations of this discourse.

In addition to these attributes, the participants constructed the foetus as an important future social actor, as exemplified in the excerpts below.

Interview 2

374 P: ... so it's gonna take time to CHANGE //Yeah// *the minds of people* about the use of alcohol and everything and everything. But now I think the concern is for the children //Hmm!// because (.) *yes as a parent you would like your children to be* normal

568 P: … our future, kid in the tummy… has to be healthy, so that there can be a productive person //Yeah//

In the first extract from Interview 1 further above, participant B summons an argument appearing across the interview data: 'it is not that pregnant women do not know that they should not consume alcohol; it is that they do not know the detrimental effects of alcohol on the foetus'. With reference to pregnant women, participants introduce elements from a

morality discourse (which constructs what is 'good', what should be done and is desirable, and 'bad', what should not be done and is undesirable). Summoning this discourse, participants note that it is wrong for pregnant women to drink. They assert that this is well understood - by pregnant women, and others. It becomes important then, for the participants who have been tasked to build awareness, to explicate the effects of the alcohol on the foetus. Participants summoned the responsibilisation discourse (which incites responsibility for the development of foetuses and children on pregnant women), using the 'scientific knowledge' of biological processes in utero (e.g. "Because all of this goes to this and is consumed by that child… which means… the mother is drinking and the child is drinking") taught during training. This responsibilisation allows for the construction of particular imperatives of good mothering, which pregnant women either adhere or fail to adhere to.

The goal of these imperatives of good mothering, having a 'healthy pregnancy' and a 'healthy baby' are referenced by participant P in the extract from Interview 2 above. The participants suggest that morality is an insufficient enough motivation for pregnant women to abstain from alcohol. They posit that "normalcy", "our future", "health" and (perhaps economic) "productivity" are the goal. As argued by critical scholars, and exemplified by participant P's sentiments, efforts around FASD prevention become about protecting the foetus: the primary "concern is for the children".

The analogy of bifurcated women as carriers of precious cargo (Lupton, 2012) is evoked by the participant P's reference to "the tummy" and "our future". As described by Lupton (2012), pregnant women are transformed into incubators, carrying precious cargo: the foetus. Additionally, the pregnant women the participants spoke of were seen as responsible for the trajectory of "our future". The participants seemed to conflate the foetus and our future. In this way, the personification discourse was consistently summoned by the participants to define pregnancy in terms of the risk to the foetus, and our future. The imperatives, constructed via 'scientific knowledge', were explicated and seen as useful to manage the so-called risk pregnancies (Lupton, 2012). These risk pregnancies were conceived of by participants as not only a risk to the birth of 'normal' children, but also our future, health and (economic) productivity - as posited participant P in the excerpt from Interview 2 above.

The conflation of the foetus and our future, as if synonymous, recurred in the interview data. Depictions surrounding 'the foetus' seemed to be read as 'our future', as demonstrated in the following excerpt:

Interview 3

249 S: So *she's asking that* (.) *if there's something NICE about this picture, what do you* (.) *think it is?*
250 Z: *a nice thing?* //Hmm// *A nice thing is that this this child is still small, so is a future* leader (.) *to us. So that's what I see that's good.*

In addition to the foetus being consistently constructed as a child, the presentation of images, used during training, was particularly powerful in producing the concept of foetal vulnerability. Reflections about training and pregnancy centred on the risks to the produced child, and thus the risk alcohol presents to our future. Alcohol consumption by pregnant women was in this way constructed as a threat to civil society.

Throughout the interviews, pregnant women were constructed as responsible for our future. This responsibilisation discourse was left undisrupted, except in the excerpt included here:

Interview 4

130 T: "*So and so why are you having another child?"* //Hmm// *"No I want the money to be a bit more* //Hmm// Zuma *to pour for me* //Hmm// *there's a new thing now that's emerging that we heard on the radio that THEY will support them while in the tummy* //Sho// *Did you not hear that? //No!// It was released on this thing on the radio //*Yes// *and on TV*
137 N: *so before a person is born…?*
138 T: *Before the child is born will be supported here, while I'm pregnant //is already getting grant// while I'm pregnant, I'll go get grant for this child. We ask "how… a child that's here //yes// who doesn't even have a book[17]?"* //Hmm// *They say "No he'll get grant, but that hasn't yet been passed"*

Participant T, in the excerpt above, questions the personhood of the foetus and in this way disrupts the prevailing discourse. Underlying the above excerpt too is the idea of support; participant T's sentiments seem to disrupt some of the core tenets of the responsibilisation discourse by suggesting the need for financial and state provision in supporting pregnancy.

2.4. The Other: A Child with FASD

In addition to constructing vulnerable yet precious future leaders, susceptible to illness unless protected, participants also constructed a 'FASD child'. There were 8 references made to this discursive construct by participants.

[17] Reference to a birth certificate or identity document.

Interview 2

183N: And your general impression? *How has the* course been so far?
184P: Hmm! (2) I think it could use a little more graphic //Okay// *You know //pictures//* pictures, in terms of pictures, videos even //Hmm// because I believe *that the* only time *a person will be scared* (.) *truly is when they see that* //Hmm// okay this is what happens AND *if you would show us maybe* let's say, a child with FAS like, mos the descriptions *say*, a description *I read says, a child with* FAS *can have a thin upper lip* //Hmm// *funny-shaped head* //Hmm// *etc. you know when they see a* picture *of such a child* //Hmm// *and have you saying this is HOW a child with* FAS *looks like //yes// a person will* reflect *and think "who do I know that has a child that looks like this?"* //Hmm// *And you'll also think "No! I also don't want my child to look like this"* you understand that thing? That's where you get more of a positive reaction out of a presentation. I'm not saying it's bad.
193N: Yes. You just think that's how they could improve.
194P: Yeah! //Yeah// I think, IF *you could* like, graphic *things*, like if its gruesome let it be gruesome *and they see it*

Participant P describes a 'FASD child' as having a thin upper lip, and a funny-shaped and big head. Participant T, as exemplified in the extract below, further describes the FASD child:

Interview 2

82 T: *I've learnt a LOT because we didn't know that. I didn't know I would just see that a child there is in one crèche I usually go to, when they will when doing vaccination campaigns //yes// while teaching is happening, he goes outside. He's shirtless, with a BIG head* //Hmm// *I was thinking "juuust" but now I've got it here that it's the mother from when he was in the tummy, she didn't treat him well* //Hmm// *I got that from here then…*

88 T: *even when it's raining. Maybe even if you could go there next year, tiptoe and say you want the healthcare practitioner of this place… Tip-toe. NO, we won't tip-toe we will be going there //Hmm// and say "No we're here to see this crèche" you'll find him standing outside it's not because he's neglected! Maybe he's topless, //*Sho// *he's got a BIG HEAD…*

Participant T describes the child as ill-treated by their mother "from when he was in the tummy"; she implies that he is neglected, running around shirtless in the rain. Participants further described the child as hyperactive, poorly behaved and violent. As already cited in the extracts above, participants described the child as susceptible to asthma and brain damage; having coarse skin; and generally unhealthy.

In this way, the 'FASD child' was constructed as the undesirable, defiled Other; an Other produced by the pregnant woman's irresponsible choices, and a disruption to community (that is, in the home or at school) life.

Participants summoned elements from the discourse of difference to construct a 'FASD child'. This discourse is one popularly deployed across the social sciences and humanities; its focus is typically on the differences of gender, age, race, class, sexuality, disability, religion, nationality and so forth (Seidman, 2013). Out of this discourse of difference emerges the construct of the Other. While the discourse of personification is summoned to construct the important and vulnerable child, the discourse of difference is summoned to construct the Other - an undesirable, defiled and threatening Other.

Seidman (2013) usefully delineates the borders between the Other as an outsider and the Other as dangerous. The Other as an outsider typically denotes a non-normative, subordinate status. In constructing the 'FASD child' participants go beyond noting features of difference between a desired foetal subject with a future and an undesirable FASD child, summoning ideas of morality and placing the latter subject in a socio-culturally and structurally disadvantaged position. The desired foetus is attributed personhood, whilst the Other is subjected to stigmatising and hateful representations, as exemplified in the extract from Interview 2 above. The positionings of this Other, and the implications of this, are expounded upon in the disability literature.

2.5. Pregnant Women: Ignorant, Preoccupied & Unreceptive

The sifting of the data revealed 30 references to pregnancy/pregnant women. The participants mainly referred to pregnant women, rather than the pregnancy period. It seems, thus, that the interview talk had objectivising effects on the subject, and the pregnant woman emerged as the most popular discursive object, being referred to the most. Pregnant women were constructed as ignorant, that is lacking in information about the teratogenic effects of alcohol on the developing foetus; preoccupied with the habit of alcohol consumption and their partners; as well as unreceptive to the knowledge of alcohol and FASD.

Particular discourses were deployed to make meaning of this discursive object: The 'problem category' of FASD discourse, the responsibilisation discourse, and a discourse of morality were summoned for the various constructions of the pregnant women. Although used to construct pregnant women, these discourses remained foetus-centred. This remains consistent with indications from literature of the foetus-centred nature of the pregnancy and alcohol use field (Lupton, 2012). The manner in which each of these discourses was deployed to construct and position pregnant women is discussed below.

2.5.1. Pregnant Women as Ignorant

Participants constructed pregnant women as unaware of the effects of alcohol on the developing foetus.

Interview 6:

254 V: ... I think more than anything number one it's a lack of information //Hmm// cause people just don't know that if I drink. < They know that if I > It's not good to drink when you're pregnant...

258 V: you shouldn't drink when you're pregnant //Hmm// but they don't know what it does //Hmm// I mean what are effects. How important is it not for you not to drink //Hmm// ... not of just not knowing the consequences //Hmm// and uh how bad //Hmm// the effects are //Hmm//

Interview 3

120 Z: *she feels good when she drinks but (.) others didn't know the problem*

Participant V presents a nuanced statement concerning knowledge: it is not that pregnant women do not know that they should not consume alcohol. It is that they do not know the detrimental effects of alcohol on the foetus. Thus, although pregnant women are constructed as pleasure-seeking (as exemplified by participant Z's sentiments in the second excerpt above) and not observing moral imperatives - what should and should not be done; they are simultaneously positioned as lacking in knowledge. Although they are positioned as amoral subjects (because they drink), they are also positioned as ignorant, lacking in information through no fault of their own, and in this way absolved of blame.

Interview 6

212 P: Because at the end of the day, now that you have this kind of information //Yeah// *for you it <u>now</u> becomes a* choice

This positioning of pregnant women as ignorant may be viewed as a mechanism to remove blame. This mechanism is further displayed by participant P, in the excerpt above, who presents the following rationale: if one is ignorant and consumes alcohol, one is not really at fault. However, if one is knowledgeable and consumes alcohol (summoning the discourse of responsibilisation and the problem category of FASD) *that* pregnant woman is at fault. Participant P in this way purports that only a knowledgeable, alcohol-consuming, and pregnant woman can be an 'FASD generator'.

Interview 2

130 P: I won't lie, *they drink. Even I* at some point I did that but it was (.) with the second child because *the first one*… the taste of alcohol *just closed me up* from… I think from the first month //*Yes//* just from noticing that okay I think *there's something happening*, I'm pregnant. //Hmm!// So uh… and I didn't have this information I have now.

Participant P shares a personal recount of herself as a drinking pregnant woman during her second pregnancy. This kind of personalisation, through the use of personal pronouns across the interview talk and personal recounts, can be viewed as part of the mechanism to remove blame: pregnant women cannot be blamed because they are ignorant, just as I (a community educator) was. Participant P, for example, uses a personal example to legitimise the proposition that ignorant pregnant women cannot be blamed. Participant P highlights the idea of intentionality as a key component to consider in the processes used to attribute blame. This intentionality requires the knowledge of the effects of alcohol consumption on the developing foetus. Various participants employed mechanisms to remove blame and participant P calls us to review pregnant women's intentionality during these processes. We are asked to review the degree of knowledge of alcohol-consuming pregnant women: some pregnant women know that alcohol consumption is bad; however, this does not warrant blame. Some pregnant women know the harmful effects of alcohol on the foetus. It is this latter 'type' of pregnant woman who is able to occupy the problem category as a generator of FASD. In this way, 'knowledge' is perceived as central to intentionality, and the incidence of FASD.

2.5.2. Pregnant Women as Preoccupied and Unreceptive

Participants seemed to have little faith in pregnant women's receptivity to the information about FASD. They continued to position pregnant women as ignorant. Participant P, in the excerpt below, seemed to suggest that pregnant women's preoccupations would render pregnant women unreceptive to the information the participants had been tasked to share. These preoccupations, i.e. "stressing about her issues", were described to include: discomfort/pain; plans for drinking; life stressors, like unemployment; and their partners. Because of these, pregnant women were constructed as preoccupied and unable to attend to transformative knowledge.

Interview 6

304 P: ... *And you're bringing the presentation where? At the* clinic (.) //Hmm// *when she's sitting there maybe stressing about her issues. She's thinking this time she has a certain discomfort //Yes// mostly she'll be concentrating on her discomfort and we come saying "Eeey! There's this thing like this and that". Response is, "Nah! That is white people's*

sicknesses //Sho!// that will never happen to me, they are jealous because I've already got plans for Friday" //Yes// <u>*that date*</u> to have a spree. *You understand*? //Yeah!//

In the excerpt above, ignorance is racialised. Participant P suggests that this hypothetical pregnant woman at the clinic will use an irrational de-colonising statement ("that [FASD] is white people's sicknesses"). Participant P assumes that I as the researcher will agree that knowledge about alcohol and FASD is scientific, as has been presented in training, and so presumes agreement about the statement being ridiculous. Through this analogy presented by participant P, the resistance to 'scientific knowledge' is unacknowledged, and attributed to racialised ignorance.

In constructing pregnant women as preoccupied with things other than the important foetus, pregnant women were positioned as agentive. However, participants implied that their priorities were inverted and pregnant women misplace their efforts on partners, for example. This is displayed in the excerpt below:

Interview 2

198 P: *and* <u>*UNDERSTAND*</u> *that* okay it's a choice (.) I have to //yes// make for myself and for my child, *you* understand? Because as much as we can say *that* "*No your* boyfriend *as well should… do this and that*" (.) the <u>choice</u> always depends on //the woma //…

209 N: Okay. So, do you think *quitting dinking* during pregnancy is a <u>sacrifice</u> on the woman's part?

210 P: No it's not a sacrifice, it's a <u>choice</u> //Hmm okay// Because at the end of the day, now that you have this kind of information //Yeah// *for you it <u>now</u> becomes a* choice //yes// It's <u>either</u> *you want a big-headed child who will* //Hmm// *be ridiculed in the streets…*

Participant P, in the extract above, underscores the rhetoric of choice by stressing that pregnant women must "understand that okay it's [drinking] a choice" and that "no it's not a sacrifice, it's a choice". She emphasises that knowledgeable yet alcohol-consuming pregnant women are generators of FASD. She further underscores the responsibilisation of women, explicitly dismissing the role of partners.

Poignantly, participants emphasised the lack of receptivity of pregnant women to the knowledge about alcohol and FASD through references to stressors. They noted pregnant women's preoccupations with life and partner stressors, drinking plans and cultural myths and beliefs surrounding drinking during pregnancy. While this may be in line with reproductive justice ideals, where the context in which drinking during pregnancy occurs is foregrounded, the danger is other negative positionings of these women: hapless victims of circumstance. Participants constructed a wholly bad environment and positioned alcohol as

king. It is in this context that pregnant women are positioned as hapless victims of circumstance. Through sentiments like those displayed in the excerpt below, and unlike those presented above, participants interpellated pregnant women into inactive subject positions:

Interview 2

272P: but *another thing that isn't explained is the thing of old people* (.) *It is said it was said to me* //Hmm// *when I got pregnant,* the first time //Hmm// *that* if *I want* to produce MORE milk //Hmm// *when my child is born,* //Hmm// I have to drink Stout (.) //Reaaally?// Yeah. Castle Milk Stout

273N: *Who says this?*

274P: Old people! Yho! //Yho// we've got we've got remedies. And then then I started okay, the stout (.) didn't go down well //Hmm//, *it also tastes horrible,* I had a sip and I was like, "Okay, I'd rather not have milk." //Hmm// So fine! *We'll leave that one,* and then this one time (.) I had this COLD *which was here on my back, it started on my back up to this place* //Hmm//, and that one, *the* remedy it worked because they said I should boil water put a gin- top, and drink that and it worked, and I never needed it again //Hmm//, *you see?* //Hmm//, so it's not like it was constantly coming back, so that I had to drink the thing //Yes// But *you see that we have these* home remedies //Yeeees// *and you find that //made with alcohol// Yes! You hear it now! So now another one will be told of something else* //Hmm//, *and will decide to go* //*Yees// cause* she doesn't know what's right, what's *wrong and people old people don't want to be disproved because you can ask "what what, Heey! When a child coming from this place, you must do a certain thing" you ask "And for what really?" and she'd say "Heey, I don't want children who ask, who have hard ear minds. This and this and this" you see that now* //Yeah!//

Participant P described cultural myths and beliefs surrounding alcohol consumption: Castle Milk Stout will help lactating women produce more milk; and a gin home-remedy helps with discomfort/pain. In addition to the construction of alcohol as king, determining community behaviours, participant P positioned "old people" as authorities to whom pregnant women must listen. Pregnant women are thus subject to both alcohol and their elders. In the above extract, participant P also constructs pregnant women as young by describing that they are referred to as "children". This positioning of pregnant women, as young and subject to more than one authority, may be part of the mechanism to absolve them of blame. The participants thus use the following as mechanisms to absolve blame: the generationally transmitted beliefs about the positive effects of malt, contained in beer; the powerless position of pregnant women in relation to "the king" (i.e. alcohol), context-related stressors and, as introduced in the above extract, "old people" (i.e. the impositions of elders); as well as drinking offering an otherwise scarce opportunity for social engagement.

Pregnant women are thus constructed in multiple ways. They are constructed as ignorant, and participants use this together with the above-listed elements as a mechanism to absolve them

of ‘the blame’ for the incidence and prevalence of FASD. Most pregnant women are further constructed as preoccupied and unreceptive to the knowledge about the harmful effects of alcohol on the developing foetus. Some pregnant women are described as knowledgeable yet remain alcohol-consuming. These alcohol-consuming pregnant are positioned as ‘the problem’: generators of FASD.

2.6. Participants as Transformed Subjects

Participants highlighted the transformative potential of knowledge acquisition. They reported that they themselves, like ignorant pregnant women, were unaware of the teratogenic effects of alcohol consumption to the foetus before undergoing training. Most participants cited acquiring this knowledge as their highlight of training:

Interview 3

87 N: *Something nice about the* training?
88 Z: *For me a nice thing* (.) *I don’t even want to lie* shame (.) *I like the fact that I now have an* experience (.) *one I didn’t have previously have about alcohol* //Hmm// and *one I wouldn’t one I didn’t have about a* pregnant *person* (.) //Eeh// *That when she drinks alcohol as it is said that the child also drinks that* (2) *it messes up the* brain cells //Sho// … but I didn’t know *that there are* brain cells *that die*... //Hmm okay// That’s what I enjoyed.

The participants spoke of the training transforming their ignorance to knowledge. Through the acquisition of knowledge, and sharing some information of the teratogenic effects of alcohol on the foetus during the interviews, participants exempted themselves from the ignorant position. Despite constructing commonalities between themselves and pregnant women in some places, participants also distanced themselves from the discursive object: an ignorant, alcohol-consuming pregnant woman. They too had been ignorant. They too had been pregnant. And, they too had consumed alcohol. However, they presented themselves as transformed subjects due to training and the subsequent ‘knowledge’ acquisition. This predicates their use of pastoral power (Dreyfus & Rabinow, 1982), as discussed below.

3. Discourses Summoned by Participants

Participants summoned particular discourses further described here to establish the multiple constructions of pregnant women. One of the predominate discourses deployed by participants to construct pregnant women was the responsibilisation discourse. ‘The problem’ category of FASD discourse was also imposed on pregnant women. Under the overarching

discourse of difference and morality, dichotomous constructions of "the problem" and "the solution" were produced by the circulation of these discourses. Pregnant women, through the deployment of the responsibilisation discourse, were positioned as "the solution" but simultaneously positioned as "the problem" due to their preoccupations and unreceptivity. Through this dynamic, it is suggested that pregnant women are ill-equipped to effect the kind of change necessary. This necessitates the pastoral role of the community educators who construct themselves as transformed subjects.

'The problem' category of FASD discourse was further deployed to construct 'the kind of pregnant woman' that produces a defiled FASD child (i.e. FASD generator): a knowledgeable yet persistently drinking pregnant women. This discursive construct seems to have been associated with that of a FASD child, summoning elements of bad mothering.

Furthermore, the use of the discourse of responsibilisation by participants exemplified Foucault's (1977) notion of panoptic discipline: the (modern) exercise of power which produces subjects that regulate or police themselves. The circulation of the above identified discourses during the interviews seemed to have effectively produced docility (Bordo, 1989; Lupton, 1999): that is, pregnant bodies positioned to police themselves (by subscribing to imperatives to abstain from drinking, as well as caffeine and sushi, for example), and others (evidenced in the excerpt below):

Interview 4

69 T: Since *I we were presenting there and* I said *"I'm happy now that I have knowledge"* //Hmm// *You yes even when we were at the clinic we were told to speak to pregnant women* //Hmm// *But now I have MORE knowledge, I'll speak about something I know of //yes// If I pass by a girl child who's pregnant, I'll show her that you see this and this is what happens* //Hmm yes// *Leave this thing! //*Yeees// *I've just been taught*

Participant T reproduces the construct of participants as transformed subjects, by referring to the amount of "knowledge" she has attained. The participant goes further to place herself, as a community educator, in a position of pastoral power (Dreyfus & Rabinow, 1982): leading the "girl child who's pregnant" on the rightful path, and sharing the revelations/"knowledges" she has gained through training.

Participants further summoned a discourse of morality to fortify imperatives for pregnant women:

Interview 3

244 Z: Okay. you can see *it's a drinking mother and then the the* cord *goes to the child, he's also drinking the same stuff because this alcohol is BLUE and it goes* straight to the point [claps once]
245 N: Hmm so *what does the picture mean?*
246 Z: *It means that as the mother is drinking the child as well is drinking and its WRONG* because there's an X there //Hmm// it's not right *for her to drink alcohol while* pregnant

As well as succinctly depicted in the image described by participant Z in the excerpt above, participants regularly referred to drinking and smoking as wrong; they regularly referred to what a pregnant women should and should not be doing. They explored ways in which this could be enforced by recruiting others, like tavern owners (who, participants report, should not sell alcohol to pregnant women), to the surveillance and 'shepherding' (Dreyfus & Rabinow, 1982) of pregnant women.

Thus, the discourse of responsibilisation, together with techniques of power such as surveillance (Foucault, 1977), was repeatedly deployed to suggest disciplining the pregnant women via the imposition of imperatives. Participants suggested that the utilisation of elements of pastoral power (Dreyfus & Rabinow, 1982) would assist 'ignorant and preoccupied' pregnant women.

4. Conclusion

I presented a discussion of the discursive objects present in the interview talk with participants from a pool of the Organisation's community educators. The context of living, alcohol consumption, the foetus and pregnant women were identified discursive objects. The context was constructed as wholly bad and issue-ridden. Although the highlighting of the context is consistent with reproductive justice ideals, I flagged the other negative positionings. Participants implied that intervention in this context would require insiders with an understanding of the prevalent issues. They underscored the negative features of the context in which pregnant women would later be positioned. This predicated the positioning of themselves in a pastoral role in relation to pregnant women.

Alcohol consumption was constructed as a destroyer and king. Community members, including pregnant women, were positioned as 'subjects to this sovereign'. Alcohol consumption was constructed as determining many aspects of community life, as well as acting as a social lubricant. The important and vulnerable foetus, as well as the FASD child were constructed and centralised by participants. Most pregnant women were constructed as ignorant, preoccupied and unreceptive. Interestingly, participants utilised the above-described mechanism to absolve these pregnant women of blame. However, some pregnant women were constructed as knowledgeable yet alcohol-consuming, and thus positioned as 'the problem' as generators of FASD.

The responsibilisation discourse was the chief discourse circulating around constructions of pregnant women. However, the personification of the foetus discourse dominated interview talk. Most of this talk remained foetus-centred, subverting the interests of the pregnant women. This is consistent with indications from the literature. Whereas the foetus was personified, the talk had objectivising effects on pregnant women. Pregnant women were predominantly responsibilised, and constructed as responsible for the foetus and "our future". The problem category of FASD discourse and the discourse of difference and morality were further discourses summoned by the participants.

The unstable positionings of pregnant women predicated some of the institutional practices, which I discuss in the proceeding chapter. I uncovered some disciplinary techniques which seemed to be legitimated via the described circulation of discourses around pregnant women. In the final chapter, I suggest some subjective implications of the identified discursive constructions for pregnant women, as well as the legitimisation of certain institutional practices concerning pregnant women.

In the proceeding chapter, I revisit the rationale of the study and briefly review the findings of the study. I suggest alterations to the identified constructions. I consider the implications of these constructions for the subjectivity of pregnant women, as well as the associated (institutional) practice. I conclude the dissertation by identifying the strengths and limitations of this study and making recommendations for future research.

Chapter Five: Discussion & Conclusion

1. Rationale for study and theoretical approach

The strength of a Foucauldian theoretical orientation to research is that it allows for certain constructions of social reality to be revealed, and not taken for granted. It illuminates configurations of knowledge/power, and allows for the exposure of constraining techniques of power. Investigating discourse is a useful way to uncover configurations of knowledge. It is important to investigate discourse due to its constitutive nature (Willig, 2003). In relation to this study, this approach to the assessment of the intervention enabled the identification of constructions around alcohol use during pregnancy. The exposure of ways of constructing certain realities around alcohol use during pregnancy allows for the reconfiguration of discourse to move towards greater agency for all women, particularly those that remain persistently marginalised in our societies.

Assessment is important for any pilot intervention. It helps to improve the design and delivery of programmes. For the Organisation's intervention specifically, because they were piloting two of their programmes in the Eastern Cape, it was important to assess the impact. Historically, and across the globe, women have been sites for power relations. From a reproductive justice perspective, it is important to expose gendered and oppressive techniques of power. Critical scholars in the alcohol consumption and pregnancy field critique the ways in which specifically pregnant women are constructed in a range of interventions addressing FASD. The discourse deployed by the Organisation's trainees has implications for the subjectivity and the legitimation of particular social processes (Willig, 2003). Thus, because of its status as a pilot and because women, particularly those who are pregnant, are the targets of the intervention, it was important to investigate the discourse deployed and, from a critical approach, ensure that it does not unintentionally reinscribe reproductive injustice. I aimed to identify the discourses used by participants to construct pregnancy and alcohol consumption. In this closing chapter, I briefly discuss the implications for pregnant women's subjectivity, and suggest ways these discourses can be altered or extended to promote the reproductive justice agenda.

2. Review and further Discussion of Findings

2.1. The context of living and participants as transformed subjects

The environment and context of living of the participants' communities were constructed as wholly bad and issue-ridden. This is the context into which the participants interpellated the other discursive constructions, including themselves as transformed subjects.

Participants described their communities as poverty-stricken and "filled with issues" affecting housing, occupational opportunities, schooling and safety, and as resulting in epidemics and substance misuse, amongst others. Participants noted that these 'bad things' were visible to those living inside this context and they implied that insider-'knowledge' of the issue-ridden context would be required for intervention. They positioned themselves within this context and demonstrated that they truly 'knew' and understood the context via their descriptions and personal recounts. They constructed themselves as transformed, emphasising their acquired 'knowledge' and positioning themselves in active positions, able to effectively make use of pastoral power (Dreyfus & Rabinow, 1982) and effect change in their communities.

One of the participants of the study was a social worker. Her contributions highlighted the contribution of local social workers as viable trainees due to their outsider-insider positionalities. As recognised by the Organisation, these are strategic partnerships to make in FASD prevention efforts.

By noting the visibility of the issues prevalent in the context of living, participants seemed to imply that these were easily targetable by 'knowledgeable' and equipped insiders. They constructed themselves as knowledgeable and equipped by the training. Thus, although noting some barriers to change, participants communicated optimism about their positionings and thus ability to effect change. This can be understood as the workings of pastoral power as a disciplinary and surveillance technique for pregnant women. The participants constructed themselves as transformed (i.e. knowledgeable) and felt able to exercise influence via technologies of power. Interestingly, this constructed transformation demonstrates Foucault's (1982) conception of the dynamic between power and knowledge. This had subjective implications for participants (and pregnant women, as will be discussed below). In previous evaluations of the Organisation, the trainees were identified as significant beneficiaries of the programme too. However, for these trainees to be able to effect change consistent with a

reproductive justice perspective, I argue that constructions of pregnant women and foetuses require alteration - I discuss this further below.

In the previous chapter, I note that participants mentioned no positive attributes of their communities. In terms of extending constructions of the context, utilising principles of Community Psychology[18] may be useful in FASD prevention efforts. These principles are consistent with the reproductive justice agenda, offering an alternative paradigm to responsibilisation. The facilitator(s) of the training could collaborate with trainees to highlight the assets prevalent in their communities. This would subsequently affect the dynamic and co-construction of the other discursive objects identified in this investigation of alcohol use during pregnancy in this region.

2.2. Alcohol Consumption

2.2.1. The action orientation of the discourse of alcohol consumption as an entrenched practice

Participants summoned the discourse of alcohol consumption as an entrenched practice to discursively construct alcohol consumption as a subject positioned in an authoritative role within the context of living. I encountered this discourse in the epidemiological studies of alcohol consumption during pregnancy during my review of literature for Chapter 1. The literature spoke of patterns of alcohol use, particularly in South Africa, as a remnant of our socio-political history. It spoke of the socio-economic practices which have laid the foundations for elevated alcohol consumption (Parry, 2005). Patterns of alcohol use continue to play a central role in the country's socio-cultural heritage - this is displayed in the data from this study too.

Shebeens[19], also known as and referred to by participants as *taverns*, provided otherwise limited recreational settings, where inexpensive commercial beer, wine and liquor were

[18] Community Psychology (CP) views individual behaviour, health and well-being within a broader social and political context. It offers an alternative paradigm to the individualism that dominates much of psychology. In particular, it focuses on where power lies and how it is exercised in ways that maintain privilege and discriminate against certain groups. In practice, those committed to CP principles of collaboration and sharing of 'knowledges' work in negotiated partnerships, striving to build on the assets of participants. In this way, collectives of people inform themselves, recognising and gathering information about oppressive social arrangements in order to challenge these. Activities include the amelioration of the effects of societal inequalities and working preventatively, aiming for the transformation of policies and interactions, to promote empowerment, liberation and social justice (Orford, Akhurst and Members of the CPS Committee, 2011).

[19] Informal alcohol outlets

available (Parry, 2005), for those discriminated against and disenfranchised by apartheid legislation. This practice, and the socio-economic and cultural conditions within which it thrives, continues post-democracy. Alcohol-serving venues as social settings continue to be popular (Watt et al., 2014). Participants in this study confirm this too, as well as construct alcohol consumption as a social lubricant. The discourse of alcohol consumption as an entrenched practice constructs patterns of alcohol use in South Africa as mostly characterised by binge drinking, particularly over the weekend (May et al., 2000), as a popular recreational activity. Participants identify pregnancy as a barrier for social engagement (Choi et al., 2014; Watt et al., 2014) here too. As exemplified in Chapter Four, participants reproduced this construct. In the literature, this is understood as a remnant of the country's socio-political heritage.

Epidemiological studies of drinking during pregnancy summon the discourse of alcohol consumption as an entrenched practice in order to contextualise drinking patterns that have emerged within social, cultural, political, economic and historical contexts. Participants summoned this discourse when asked to describe alcohol consumption and pregnancy in their communities. They described the socio-cultural and economic context in which community members, and pregnant women and children specifically, live. This demonstrates Foucault's (1982) conception of objects produced within historical, socio-economic, political, cultural, and so forth, processes - i.e. objects constructed by discourse and emerging within the power/knowledge nexus.

The discourse of alcohol consumption as an entrenched practice was further summoned to highlight the gravity of the challenges they, as community educators, are faced with when availing the information they were tasked to spread. They may have done this to show the multiple challenges impeding the change suggested by training. Additionally, by deploying this discourse to construct alcohol as king and destroyer, they may have been alluding to the power relations between them, as community educators, and alcohol, but also between alcohol and pregnant women. This was constructed under an overarching discourse of difference and morality as if to set up "good vs. evil" relations, suggesting the powerfulness and pervasiveness of the "evil". In so doing, participants may have been highlighting the limited capacity for change, due to socio-cultural and economic factors that position alcohol as king. I argued that although the foregrounding of contextual factors is consistent with reproductive justice ideals, the danger is negative positionings of other discursive objects in the context of living. Considering the earlier discussion of participants' construction of

themselves as transformed subjects, the foregrounding of contextual factors and the role of alcohol seems to function as part of the mechanism to absolve pregnant women of blame - i.e. this affects the positioning of women (constructed as hapless victims), and not the positioning of community educators.

This foregrounding of contextual factors and the role of alcohol affects the construction of the FASD child and the context in which this child emerges. As demonstrated in Chapter 1, the prevalence of FASD is sensationalised and evidenced as a result of the entrenched nature of consumption in the country. In the data, the discourse of personification was deployed together with the discourse of difference and morality as well as alcohol consumption as an entrenched practice, constructing the foetus as a child, and important future social actor, and alcohol as the destroyer of this prospect. In this way, alcohol was constructed as king over the present and future. These discourses circulated to produce and demonise constructions of the responsibilised pregnant women, the defiled FASD child, and issue-ridden communities.

2.2.2. Alterations to constructions of alcohol consumption

Alcohol consumption is positioned as "king" in the context of living of participants. All other objects are positioned as 'subject to this sovereign'. This authoritative construction avails submissive and vulnerable positions for the surrounding discursive objects. For example, alcohol-consuming pregnant women are positioned passively in relation to it. The personified foetus is interpellated into a vulnerable position, inciting responsibility for its protection and development. The FASD child as well as the issue-ridden context of living are positioned as defiled by it.

This constructed powerfulness can be reconfigured by introducing the concept of alcohol reduction via harm reduction strategies (Du Plessis, Young & Macleod, 2017). The 'burdens of alcohol' are noted in the epidemiological studies, noted in Chapter 1. Harm reduction strategies focus on the reduction of the potential adverse consequences of hazardous and harmful patterns of alcohol misuse. Rather than constraining the notion of harm to the teratogenic effects of alcohol on the foetus, this could be extended to its harmful effects on health, families and whole communities (the latter two are acknowledged by Participant Z, as noted in the previous chapter). The participants also noted the addictive properties of alcohol, citing cravings for alcohol and alcohol consumption being a force of habit as well as community members not being able to stop drinking. It would thus be further useful to note alcohol treatment programmes and support structures available for (pregnant) women.

Participant B seemed to dismiss the idea of leisurely and permissible levels of drinking, by noting that "there is no 'at least' in alcohol". Other participants too positioned alcohol as a threat. This had the effect of amplifying alcohol consumption's 'damaging' effects, fortifying its construction as "a destroyer!". Reconstructing this discursive object by reintroducing the idea of levels of drinking could be useful in diffusing its constructed power.

These alterations could diffuse the constructed power of alcohol consumption. In addition, rather than focusing on individual behavioural change, FASD prevention efforts could focus on structural change, other leisurely, social, occupational or skills-development opportunities, and in that way offer other subject positions for community members to occupy. As aptly noted by scholars in the occupational sciences, maternal drinking becomes an imposed occupation among those persistently marginalised and disenfranchised (Cloete & Ramugondo, 2015). Targeting structural change avails more agentive positions for those persistently marginalised. For example, the trainees construct themselves as transformed subjects, no longer occupying the submissive roles in relation to alcohol but occupying community educator roles now. The space created during the interviews for personal reflection and the sharing of their personal alcohol-related stories contributed to this transformed construct of participants. Incorporating basic skills in counselling or interpersonal skills training in the programmes could open up opportunities for other community members to experience this transformation.

2.3. The Foetus

Critical scholars repeatedly note the foetus-centred circulations of FASD prevention discourse, and critique the ways in which this subverts the health needs of women. The personification of the foetus was a predominating discourse deployed by participants. Summoning this discourse, participants made two prominent conflations in constructing the foetus as an important and vulnerable subject: conflating the foetus and the child, and conflating the foetus with 'our future'. These conflations produced the foetal subject as an important, future social actor.

The foetal personification discourse circulated with the responsibilisation discourse to incite the responsibility of others for the foetus. Participant Z's sentiments that one child should love the other (the foetus) demonstrates that, in some cases, this responsibility is extended beyond pregnant women, to siblings for example. I noted how, despite the absence of the

terminology for foetus in the Nguni language, the continued use of the foetal personhood discourse remained warranted due to the manner in which participants constructed the foetus - a manner consistent with conceptualisations of this discourse, as evidenced in the Findings. I further noted the efficacy of visual stimuli in the production of the foetal subject, and disembodied, bifurcated and objectivised pregnant women.

It is interesting to reflect on instances during the interviews when participants were presented with visual stimuli to comment on. These images produced the recurring conflation of the personified foetus with "our future", as if synonymous. Participant P's response to the stimuli, referring to "the tummy" and "our future", for example, evoked the analogy of bifurcated women as carriers of precious cargo (Lupton, 2012). As described by Lupton (2012) pregnant women are transformed into incubators, carrying precious cargo: the foetus; additionally, the pregnant women the participants spoke of were seen as responsible for the trajectory of "our future". The personification discourse was consistently summoned by the participants to define pregnancy in terms of the risk to the foetus, and our future. These risk pregnancies were conceived of by participants as a risk to the birth of 'normal' children, also read as important, future social actors. The imperatives of 'good mothering' (responsibilisation discourse), constructed via 'scientific knowledge' that has been advanced by the advent of biotechnologies, were explicated and seen as useful to manage the so-called risk pregnancies (Lupton, 2012).

2.3.1. The subjects of 'scientific knowledge'

It is important to note that these constructions hinged on so-called 'scientific knowledge' of biological processes in utero. This demonstrates Foucault's conception of the power/knowledge nexus and how the dynamic transforms knowledge of human beings. Lupton (2012) notes the emergence of the foetal subject which "came into existence only contemporaneous with the discursive formation that made it possible to talk about them" (Rouse, 1994, p. 2). Leppo's (2012) investigation of the genealogy of the foetus-centred discourse in Finland's medical journals and documents demonstrates this too. FASD prevention practices emerged contemporaneously with the emergence of new constructions of alcohol-consuming women.

The 'scientific knowledge' of biological processes in utero had two significant outcomes in this study: (a) it produced the vulnerable foetal subject; and (b) it transformed participants, from ignorant to knowledgeable. Acquiring the 'knowledge' of the teratogenic effects of

alcohol on the foetus was consistently cited as the highlight of training for participants. These new ways of knowing produce and transform discursive objects, while simultaneously creating new forms of social control: for example, surveillance and the exercise of pastoral power by these trained community educators emerges as a strategy to regulate (potentially) alcohol-consuming pregnant women. The exercise of this power has effects on the positionings of participants themselves, as discussed above; and, as I discuss in the sections below, the subject positionings for the produced FASD child and pregnant women.

2.4. The FASD child

The circulation of the discourse of difference and morality, the foetal personhood discourse and the discourse of responsibilisation in the data produced the undesirable, defiled and threatening Other. As demonstrated and discussed in the Findings chapter, the constructed FASD child was subjected to stigmatising and hateful representations. It was constructed as undesirable and defiled, evoking ideas of difference and deviance, as well as threatening which positioned the child as a burden and disruption to community life.

2.4.1. Towards A Social Model of Disability

Disability scholars problematise the construction and subsequent positionings of disabled people via the discourses circulating in mainstream society. As underscored throughout the dissertation, discourse has constitutive implications for being (Willig, 2003). Kearney and Griffin (2001) highlight the dominance of the medical discourse in understanding and relating to disabled people. This discourse, and the medical approach to disability which pathologises individuals, frames disability from an individual and tragic perspective. As a result, "people with disabilities have long been viewed as burdens of society" (Kearney & Griffin, 2001, p. 583). The personification discourse, hinged on the medical approach, produced the foetal subject which is contrasted with the produced defiled FASD child.

Critical scholarship is shifting the discourse on disablement by highlighting the issue of disability as one of the quality of life and participation of disabled people in community life (Badia, Orgaz, Riquelme & Montayo, 2015). This perspective alters constructions of disablement from conception of people with disabilities to people disabled by the environment. This environment includes the physical, attitudinal and social world (Badia et al., 2015). This contrasts the common construction of disability as 'deviant from the normal', which participants of this study reproduced.

Whereas disability was previously considered a medical diagnosis, the social model of disability defines disability "in terms of consequences for functionality of a physical, sensory or cognitive impairment and impact on social participation, including barriers to participation in particular societies" (Schneider, 2006; Badia et al., 2015; Bines & Lei, 2011, p. 420). This shift does the important work of removing the burden of an environment that discriminates and disables off of the individual and allows for advocacy around the ways societies can be restructured to indeed allow for justice for all - i.e. to cultivate conditions for social justice for a humanised pregnant women and the child, in this case.

Rather than inadvertently constructing stigmatising and hateful representations of children with FASD by idealising the foetus, the training material could incorporate aspects of the social model to disability in addressing and highlight the effects of the prevalence of FASD.

2.5. Pregnant Women

Whereas the discourses circulating in the data produced alcohol consumption as 'king' and the foetal subject, they were evidenced to have objectivising effects on pregnant women. The discourses used by participants remained foetus-centred - this remains consistent with indications from the literature consulted. Pregnant women were constructed as: ignorant, that is lacking in information about the teratogenic effects of alcohol on the developing foetus; preoccupied with the habit of alcohol consumption and their partners; and unreceptive to the knowledge of alcohol and FASD. Participants used mechanisms to remove blame from pregnant women which hinged on 'knowledge'. Most prominently, participants used mechanisms to interpellate pregnant women into the ignorant position and thus remove them of FASD-related blame. They used personal recounts to fortify their suppositions. FASD-generators were constructed as knowledgeable yet still alcohol-consuming pregnant women.

Participants proposed the assessment of intentionality when attributing blame for FASD. They emphasised how intentionality requires 'knowledge'. Thus, 'knowledge' was constructed as central to intentionality and the incidence and prevalence of FASD. The 'ignorant pregnant women' were constructed as preoccupied and thus unable to attend to this glorified and transformative 'knowledge'. Participants spoke of four barriers to change: (1) preoccupations with things other than the important foetus; (2) racialised ignorance: the belief that FASD is a 'white peoples' thing', for example; (3) cultural myths and beliefs surrounding alcohol: the belief that Castle Milk Stout will help lactating women produce

more milk, for example; and (4) elders impositions on women. Concerning the impositions of elders, alcohol-consuming pregnant women were constructed as subject to more than one authority: elders' and alcohol consumption. They were also positioned as hapless victims of circumstance.

The positioning of pregnant women oscillated between being positioned in inactive positions in some moments, and being positioned in active positions and constructed as agentive in others. I discuss these positions, and the discourses summoned to do so, below.

2.5.1. Positionings of Pregnant Women

Having identified the various discursive constructions present in the interview data, and placing them within wider discourses, I was interested in the locations from which to speak and act that were availed by participants for, particularly, pregnant women. Although other positionings were present in the data, and are briefly discussed prior to this, I focused on the discursive positions established by participants for pregnant women, implications for their subjectivity and the relationship between subjectivity and practice.

The chief discourse used to construct pregnant women, responsibilisation, deploys the rhetoric of choice and places pregnant women in agentive subject positions. Participants placed women in agentive subject positions, deploying the discourse of responsibilisation, setting up imperatives, and presuming the possibility of choice: i.e. pregnant women have the liberty and means to subscribe to constructions of good mothering. However, this positioning was not stable. The construction of the version of reality in which pregnant women live, namely the wholly bad and issue-ridden context, troubled this agentive subject positioning. Pregnant women were also positioned as victims of circumstance. They were positioned as hapless subjects to 'the king' (i.e. alcohol), context-related stressors and elders, for example. Participants in this way resisted the responsibilisation of pregnant women by deploying mechanisms to absolve certain pregnant women of blame.

The pregnant women constructed as knowledgeable yet alcohol-consuming were presented as the distanced subjects and interpellated into 'the problem' category. Summoning elements of a discourse of morality, participants placed these pregnant women in agentive positions and presented them as making amoral, irresponsible choices. These choices were presumed to be conscious and directed action that negatively impacts (i.e. defiles) the developing foetus. This positioning of knowledgeable yet alcohol-consuming pregnant women remained stable.

The rhetoric of choice, underlying the above-mentioned discourses, constructs pregnant women as incubators and thus positions pregnant women as protectors of foetuses. All pregnant women were objectivised in this manner. The responsibility for the 'proper' development, health, happiness of the foetus, and "our future", was placed on the pregnant women.

In constructing pregnant women as preoccupied with things other than the important foetus, pregnant women were again positioned as agentive; however, participants implied that their priorities were inverted and pregnant women misplace their efforts on partners, for example. Participants emphasised that knowledgeable yet alcohol-consuming pregnant women are FASD-generators. One of the participants further underscored the responsibilisation of women, explicitly dismissing the role of partners.

Pregnant women were in this way presumed to be agentive, despite the contextual factors described by participants across the data. It is interesting to note that participants presumed pregnant women are 'immune' to the constraining factors they highlighted. In direct opposition to this, pregnant women were also placed in inactive subject positions when participants described the influence of older people on their actions, and the socio-cultural and economic context in which pregnant women live. For the latter positioning, the defilement of the foetus (i.e. what is implied as the production of a FASD child) is attributed to the actions of the pregnant women - despite the inactive subject positioning. Participants, in these various, unstable positionings, produced complex dynamics.

Pregnant women were positioned as both agentive and occupying inactive subject positions. Participants deploy the discourse of difference and morality to deem certain pregnant women incapable of protecting the precious foetus and thus incapable of effecting the change necessitated, and in this way predicated the legitimacy of the practices described below.

2.5.2. The Legitimisation of Institutional Practice

I explore the relationship between the discourses that participants deployed, and the contemporaneous non-verbal, verbal and institutional practices employed below. I was interested in whether the identified discursive constructions of pregnant women opened up or closed down opportunities for action (Willig, 2003).

These discourses prevalent in the data set up and reproduced normalising judgements which discipline the pregnant body, and regulate populations (Foucault, 1975). These discourses

legitimise institutional practices, such as the Organisation's programmes, and reinforce normalising judgements which produce the docility of the pregnant women. Because of their reproductive capacities, pregnant women are key sites for the regulation of human life, and the application of techniques of power. These techniques of power are supported by institutional practices, such as intervention particularly surrounding pregnancy.

Constructions of pregnant women, via circulating discourses, produce docility. Cummins (2014) usefully notes that "the notion of docility does not necessarily mean passivity; rather, docility is about creating bodies that are useful for policing themselves" (p. 35). The author notes the potentially empowering effects of either ascribing to the imperatives or resisting them. Participants utilised personal recounts and usefully demonstrated this. For example, participant B of Interview 1 illustrated the empowering effects of ascribing to imperatives: she constructed herself as a currently pregnant woman who ascribes to the imperative of not drinking while pregnant. She took pride in this and welcomed further imperatives to abstain from raw meat. In this way, she found ascribing to these imperatives affirming of her 'good mothering'. Institutional practices of ascribing imperatives for good mothering can thus have empowering effects for pregnant women.

The techniques of discipline encoded in intervention strategies such as that of the Organisation, produce 'self-surveillance' (Foucault, 1975) but also invite others to police the pregnant women via normalising judgements or deploying the pastoral role. This was displayed in the interview talk: participants spoke of the awareness building strategies they would employ in clinics, the streets and so forth; and also the recruiting of others, such as tavern owners and pregnant women themselves, to police and self-regulate respectively. Institutional practices, such as commissioning community educators to build awareness, can thus achieve discipline of the body populace (i.e. individuals and communities).

2.5.3. Subjectivity

At this last stage of Willig's (2003) stages of analysis, I explored the relationship between discourse and subjectivity. The strength of this particular theoretical orientation is operationalised at this point. I began to trace the implications of constructing certain versions of reality via discursive constructions. I was interested to explore, and envisage, the implications of the positionings for pregnant women's subjectivity - what they could potentially feel, think and experience from within the version of reality constructed by the participants (Willig, 2003).

The subjectivity that may result from the circulation of certain discourses is broad and difficult to capture. My positionalities add to this difficulty. Studies exploring the subjective experience of pregnant women, through their narratives for example (like those studies conducted by my fellow research team members) are invaluable to the agenda for reproductive justice. I offer a few suggestions below.

The guilt response of those participants who positioned themselves as pregnant women, relaying personal pregnancy recounts, indicates possible feelings of pregnant women due to prevalent discourses. Pregnant women may experience themselves as inadequate, due to socio-cultural and structural factors that constrain them from fulfilling the prevailing imperatives of good mothering. Pregnant women may also experience themselves as inadequate because of previously not having had access to certain information. In the context of alcohol as an entrenched practice, pregnant women may experience alcohol dependence and find it difficult to fulfil these imperatives. These imperatives may also cause women to feel isolated from social engagement, or feel shame for engaging in certain behaviour. Constructing pregnant women as incubators may result in pregnant women experiencing themselves as bifurcated, repressing their own experience, needs and wants. This may lead to feelings of duty (to the foetus and the future) which may inspire feelings of privilege and pride, or burdensome feelings of obligation. Ultimately, the constructions and positions availed for some women exclude them from enjoying quality of life and experiencing what is a communal effort in maintaining public health.

2.5.4. Applying a Reproductive Justice Perspective

Importantly, Cummins (2014) underscores the necessity of achieving social order - i.e. this discipline of the body populace. The author notes that in order to achieve this social order, regulation of human life must exist; thus, techniques of power will always be in operation. However, the goal of the reproductive justice agenda, incrementally achieved through endeavours such as this project, is to identify techniques of discipline and gradually change them in order to achieve greater agency for all pregnant women.

As specified, rather than focusing on individual change in behaviour, a reproductive justice approach focuses on structural change. This approach aims to establish life conditions (i.e. access to reproductive health services, employment and leisure activities, mental healthcare and so forth) that enable all pregnant women, despite race, SES, age, etc., to make health decisions (Bailey, 2011). The drinking narratives of pregnant women (Choi, 2014; Cloete &

Ramugondo, 2015; Kelly & Ward, 2017; Watt et al., 2014) as well as discursive constructions of alcohol consumption, the context of living and pregnant women who consume alcohol that emerged from this study offer useful insight into the life conditions of South African women living in marginalised communities and who are often the target of FASD prevention efforts. The design and delivery of intervention strategies could be developed in response to these insights.

The Organisation uses a variety of visual media. As Macleod and Howell (2015) have demonstrated, White, middle-class public foetal imagery dominates the ideal form of pregnancy in South Africa. Developing alternate constructions, responsive to the realities of pregnancy depending on race, class and location, for example, could be a means by which we move towards reproductive justice. Thus, deconstructing imperatives surrounding the 'ideal pregnancy' could be useful. Emphasising the communal role in maintaining public health, and supporting reproductive health, by positioning partners, family and community members as constitutive parts of the pregnancy journey could be further useful.

Critical scholars advocate for the incorporation of the decolonisation agenda into FASD prevention and a focus on state policy that perpetuates colonial conditions and health disparities (Salmon, 2011). Deploying critical discourses that acknowledge how health intersects with social, historical and structural processes could be liberatory for women, and those surrounding them. Ultimately, I'm arguing for the reconstruction of FASD as a lifestyle related public health concern.

Using the findings that emerged in this study, the Organisation could utilise the empathy that emerged from community educators to reconstruct the discursive object of pregnant women. There were moments where participants closed the gap between 'them' (pregnant women) and 'me' (community educator). This could be used to construct their role in relation to reproductive justice, rather than surveillance, for example. As suggested, collaboration between trainees and the Organisation could be developed to co-construct the context of living, alcohol consumption, the foetus and the FASD child using principles of community psychology (Orford et al., 2011), the harm reduction model (Du Plessis et al., 2017), a social model of disability (Badia et al., 2015) and the reproductive justice perspective (Bailey, 2011) respectively.

3. Strengths and limitations of this study

One of the key strengths of this study is its constitutive role in the broader mixed-method study of alcohol-use during pregnancy in a region of East London. There were multiple studies to investigate the Organisation's pilot intervention programme in the Eastern Cape. We had quarterly meetings as members of the CSSR working on this project with the stakeholders. Although I could not be present at all of these meetings, I received updates and feedback. This collaboration, between various researchers and stakeholders, allowed for grounded and reflexive research processes throughout the study period.

A further strength of this study was the theoretical orientation. As noted above, a focus on the power/knowledge nexus illuminates constructions of social reality, so that they are not taken for granted. There are trends in the alcohol use during pregnancy field that cannot be left unquestioned. A focus on discourse helps to explore power dynamics, the conditions in which they function and their implications for human experience and social practice (Willig, 2003). For this project, this meant that certain disciplinary measures on pregnant women were revealed, as well as stigmatising representations of FASD. Because discourse is dynamic, shifts towards counter-discourses that avail greater room for the exercise of agency can be advocated for.

Additionally, the study contributes to the literature on the assessment of intervention strategies in the FASD prevention field. Importantly, it offers insights from a critical, post-structural lens which reveals how power is exercised in ways that maintain privilege and discriminate against certain groups by (inadvertently) re-inscribing reproductive injustice, for example. Lastly, my positionalities, which I reflected on in Chapter 2, as a researcher mitigated the power differentials in the data collection field and shaped my reading of the literature and data. I argue that my positionalities enhanced the illumination of certain discursive constructions.

A limitation of the study is that the findings reveal the discursive constructions formed during the individual interviews. I can infer that these were circulating during the training, and subsequently deployed during the interviews. However, participants may have drawn on discourse circulating elsewhere in their lives to construct alcohol use during pregnancy. The insights that emerged are nonetheless useful as they provide a description of the constructions that are being made by participants (in spite of the dynamics from which they emerge). In improving the programme design and delivery of FASD prevention programmes, these

descriptions give useful insights on the discourses that could be further emphasised during training to achieve constructions more consistent with a reproductive justice approach.

The choice of sampling method, convenience sampling, limited the trainees I was able to hear from due to practical constraints. The scope of this mini-dissertation also limited the amount of data from the field I could include here and the range of interpretations and analyses I could explore. For example, although I conducted interviews at the MP, I had to exclude this data due to the limited scope. In addition, I focused on the implications for the construction of pregnant women, in particular, due to this limitation. For these reasons, I make suggestions for future research below.

4. Recommendations for future research

In this study, there was a particular focus on the positionings of pregnant women, and implications of these for subjectivity and practice. Future research could extend this focus by considering the positionings of the other discursive constructions identified here, the transformed community educators, the foetus and the FASD child, for example. The subjective implications and the institutional practices towards these discursive objects could be further explored. Whereas feminist scholarship addresses the emergence of the foetal subject, it would be interesting to further engage with the construct of the FASD child in relation to the disablement literature. Secondly, a psychosocial analysis of this data could produce useful insights. For example, the guilt response of the participants could be further investigated using a psychoanalytical lens.

A Foucauldian Analysis could be applied to the MP data to investigate the emerging discursive constructions of alcohol use during pregnancy with the cohort of mentors, most of which underwent the TP training as well. A comparative analysis could be conducted on the emerging constructions and discourses used in the TP and the MP.

As Hunting and Browne (2012), Salmon (2011) and Leppo (2012) have done in Canada, Australia and Finland respectively, it would be further insightful to conduct a discourse analysis of health policy in South Africa. This could further illuminate the discursive constructions and positionings of Black South African pregnant women. In addition, further investigation into the bio-politics of race in the South African public healthcare system could be useful to the decolonisation and reproductive justice agenda.

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Appendix A

Appendices

RHODES UNIVERSITY - DEPARTMENT OF PSYCHOLOGY

AGREEMENT BETWEEN STUDENT RESEARCHERS AND RESEARCH PARTICIPANT (training sessions)

I _____ (participant's name) agree to participate in the research project of Nicola Jearey Graham and Nqobile Msomi on the Organisation's programmes.

I understand that:

1. The researchers, Nicola Jearey Graham and Nqobile Msomi, are students conducting the research as part of the requirements for post graduate degrees at Rhodes University. Nicola may be contacted on 076 259 2303 (cell phone) or n.graham@ru.ac.za (email). Nqobile may be contacted on 083 228 4111 (cell phone) or g11m0125@campus.ru.ac.za. The research project has been approved by the relevant ethics committees, and is under the supervision of Prof Catriona Macleod in the Psychology Department at Rhodes University, who may be contacted on 046 603 7377 (office) or c.macleod@ru.ac.za (email).

2. The researchers are interested in helping the Organisation to become even more effective. They are NOT going to evaluate my individual performance.

3. My participation will involve:

    a. Agreeing to be video and audio recorded during the training sessions which I am facilitating/participating in;

    b. Filling out a questionnaire after the training sessions;

    c. Possibly being interviewed by Nqobile after the training sessions. This interview will be audio recorded and will last between 30 and 60 minutes. Questions will be asked about how I experienced the training sessions, and how I got involved with FASfacts. I may be asked to answer questions of a personal nature, but I can choose not to answer any questions about aspects of my life which I am not willing to disclose.

4. Only Nicola and Nqobile, their supervisor, a transcriber/translator, and selected researchers in the CSSR research programme at Rhodes University will have access to the recordings and transcriptions. These people will not divulge my name or identity to

others. Recordings and transcriptions will be stored electronically in password protected files. Paper copies of transcriptions will be stored in a locked cupboard.

5. I am invited to voice to the researchers any concerns I have about my participation in the study, or consequences I may experience as a result of my participation, and to have these addressed to my satisfaction. If my participation causes me any distress, embarrassment or offence, I may seek once-off emotional support from the researchers, who are Counselling Psychologists. Alternatively, I may speak to the Organisation's social worker, or the researchers can arrange for me to have counselling at FAMSA (in East London) or the Masimanyane Women's Support Centre (which has branches in both Duncan Village and Mdantsane).

6. I am free to withdraw from the study at any time – however I commit myself to full participation unless some unusual circumstances occur, or I have concerns about my participation which I did not originally anticipate.

7. The report on the project may contain information about my personal experiences, attitudes and behaviours, but that the report will be designed in such a way that it will not be possible for me to be identified.

Signed on (Date):

Participant : _____

Age : _____

Researcher : _____

IDYUNIVESITHI YASE RHODES – ISEBE LEZIFUNDO ZE-SAYIKHOLOJI

ISIVUMELWANO PHAKATHI KWABAFUNDI ABENZA UPHANDO NALOWO UTHATHA INXAXHEBA KUPHANDO (IISESHINI ZOQEQESHO)

Mna _____ (igama lomthathi-nxaxheba) ndiyavuma ukuthatha inxaxheba kuphand luka Nicola Jearey Graham no Nqobile Msomi ngeenkqubo ze-Organisation.

Ndiyaqonda ukuba:

1. Abaphandi, uNicola Jearey Graham no Nqobile Msomi, ngabafundi abenza uphando oluyinxalenye nemfuneko yeedigri ziphakamileyo kwiDyunivesithi yase Rhodes. UNicola angatsalelwa umxeba ku 076 259 2303 (inombolo yefowuni) okanye ku n.graham@ru.ac.za (nge-imeyile). UNqobile angatsalelwa umxeba ku 083 228 4111 (inombolo yefowuni) okanye ku g11m0125@campus.ru.ac.za (nge-imeyile). Oluphando luvunyiwe ziikomiti zemkhwa esesikweni kwaye longanyelwe ngu Njingalwazi uCatriona Macleod kwisebe lezifundo ze-Sayikholoji kwiDyunivesithi yase Rhodes, ongatsalelwa umxeba ku 046 603 7377 (iinombolo ye-ofisi) okanye ku c.macleod@ru.ac.za (nge-imeyile).

2. Abaphandi banomdla wokunceda i-Organisation ibe neziphumo eziluncedo, ezintle, nezinokunceda abanye. **Abazokuvavanya indlela mna endisebenza ngayo**.

3. Ukuthatha kwam inxaxheba kuzakuquka oku kulandelayo:

    a. Ukuvuma ukurekhodishwa kusetyenziswa ividiyo neteyipu ngexesha iiseshini zoqeqesho endithatha inxaxheba kuzo okanye endiziququzelelayo ziqhubeka;

    b. Ukwenza okanye ukugcwalisa iphepha elinemibuzo emva kweeseshini zoqeqesho;

    c. Mhlawumbi ndithathe inxaxheba kudliwano-ndlebe oluzakwenziwa nguNqobile emva kweeseshini zoqeqesho. Olu dliwano-ndlebe luzakurekhodishwa ngeteyipu kwaye luzakuthatha phakathi kwemizuzu elishuni elinesithathu (30) ukuyokutsho kwimizuzu elishumi elinesithandathu (60). Imibuzo ezakubuzwa iyakuba ngamava am ngeeseshini nangendlela endiye ndaba yinxalenye ye-Organisation. Ndingacelwa ukuba ndiphendule imibuzo ngam nobomi bam kodwa ndingakhetha ukungayiphenduli imibuzo edibene nento ethile ngobomi bam endingafuni ukuyichaza.

4. UNicola, noNqobile, umongameli wabo, umntu oqeqeshelwe ukukhuphela oko ndikuthethileyo/umtoliki okanye umguquleli nabaphandi abakhethiweyo kwinkqubo

yophando e-CSSR eDyunivesithi yaseRhodes ngabo bodwa abazakufikelela koko kurekhodishiweyo nokukhutshelweyo bendikuthethile. Aba bantu abazokulichaza igama lam okanye bandazise kwabanye. Oko kurekhodishiweyo noko kukhutshelweyo bendikuthethile kuzakugcinwa kwiifayile ezinenombolo yokuvulwa. Iikopi zoko kukhutshelweyo bendikuthethile zizakutsixelwa ekhabhathini.

5. Ndiyamenywa ukuba ndibuze imibuzo kwabaphandi nangantoni na enxulumene noluphando nangantoni na endikhathazayo ngokuthatha kwam inxaxheba koluphando, lemibuzo iphendulwe ngokweemfanelo zam kwaye ndaneliseke ziimpendulo endizinikwayo. Ukuba ukuthatha kwam inxaxheba koluphando lundenze ndahlupheka, ndahlazeka/ndanentloni okanye ndakhubeka, ndingafumana inkxaso ngokukhawuleza kwabaphandi abazi Sayikholojisti. Ngokuchaseneyo, ndingathetha no nontlalontle we-Organisation, okanye abaphandi bangandilungiselela ndifumane uncedo e-FAMSA (apha eMonti) okanye e-Masimanyane Women's Support Centre (enamasebe e-Duncan Village nase-Mdantsane).

6. Ndikhululekile/Ndivumelekile ukuba ndirhoxe koluphando nokuba kunini na – kodwa ndiyazinikela ukuba ndithathe inxaxheba ngokupheleleyo ngaphandle kokuba kwenzeke into ebendingayilindelanga okanye ndiye ndakhathazeka ngento ethi yenzeke ngokuthatha kwam inxaxheba ebendingayilindelanga.

7. Ingxelo ngoluphando/ngaleprojekthi ingaba neenkcukhaca ngamava, izimvo, nokuziphatha kwam kodwa lengxelo izakubhalwa ngendlela engazokwenza ukuba ndaziwe.

Isayinwe ngo (Umhla):_____ Iminyaka: _____

Umthathi-nxaxheba: _____ Umphandi: _____

RHODES UNIVERISTY - DEPARTMENT OF PSYCHOLOGY

USE OF AUDIO RECORDINGS FOR RESEARCH PURPOSES PERMISSION AND RELEASE FORM

Name of participant	
Participant's contact details	Email: Cell number:
Name of researcher	Nqobile Msomi
Level of research	Master's in Counselling Psychology
Title of project	Discursive constructions of alcohol-consuming pregnant women in an intervention aimed at reducing foetal alcohol spectrum disorders.
Name of supervisors	Ms Nicola Jearey Graham and Prof. Catriona Macleod

DECLARATION

(Please initial/tick blocks next to the relevant statements)

1.	The nature of the research and the nature of my participation have been explained to me.	Verbally	
		In writing	
2.	I agree to allow recordings to be made of the training interview that I am taking part in.		
3.	The audio recordings may be transcribed only by the researcher and a transcriber, both of whom will maintain the strictest confidentiality.		
4.	I give permission for the audio recordings and transcriptions to be retained after the study and for them to be utilised by the researchers of the Rhodes CSSR research team for future research.		

Signature of participant :

_____

Date :

_____

Witnessed by researcher :

_____

Date :

_____

IDYUNIVESITHI YASE RHODES – ISEBE LEZIFUNDO ZESAYIKHOLOJI

UKUSETYENZISWA KWEZINTO EZIREKHODISHIWEYO NGETEYIPU KUPHANDO – IFOMU YOKUNIKEZELA IMVUME YOKUSETYENZISWA KOKO KUREKHODISHIWEYO

Igama lomthathi-nxaxheba	
Iinkcukacha zonxibelelwano zomthathi-nxaxheba	I-imeyile: Inombolo yefowni:
Igama lomphandi	Nqobile Msomi
Izinga lophando	Uphando lwenzelwa iiMaster's ze Counselling Psychology
Isihloko sophando/seprojekthi	Discursive constructions of alcohol-consuming pregnant women in an intervention aimed at reducing foetal alcohol spectrum disorders.
Amagama abongameli	Nkosikazi Nicola Jearey Graham no Njingalwazi Catriona Macleod

UBHENGEZO

(Tikisha iibloko eziqulathe oko kufenelekileyo)

1.	Isimo sophando nesokuthatha inxaxheba ndisichazelwe kwaye ndisicaciselwe:	Ngokuthetha	
		Ngokubhaliweyo	
2.	Ndiyavuma ukuba udliwano-ndlebe endithatha inxaxheba kulo ngoqeqesho ebendilwenzile lurekhodishwe		
3.	Oko kurekhodishiweyo kungakhutshelwa ngumphandi okanye umntu oqeqeshelwe umsebenzi wokukhuphela okuthethiweyo. Bobabini aba bantu bayakugcina konke oko kubuthethile njengemfihlo, bangaxeleli mntu.		
4.	Ndinika imvume/Ndiyavuma ukuba okurekhodishiweyo noko bendikuthethile kugcinwe emva kokuba uphando luphelile zize ezizinto zisetyenziswe ngabaphandi beqela le-CSSR kwiDyunivesithu yase Rhodes kwixesha elizayo.		

Isayiniwe ngumthathi-nxaxheba :

_____

Umhla :

_____

Ingqinwe ngumphandi :

_____

Umhla :

_____

Appendix B

Isicwangciso sodliwano-ndlebe sabaququzeli nabacebisi/abaqeqeshi abathathe inxaxheba kwiinkqubo zoqeqesho

Semi-structured interview schedule for facilitators and mentors/trainees who took part in the training programmes

Begin with:

- Introducing yourself and the co-interviewer (Sibongile)
- Going over consent form (already signed before training session)
- Discuss audio recording consent form
- Thank participant for agreeing to interview
- Setting up recording device
- Ask participant what questions s/he has for you before the interview

1. Ndicela undixelele kancinane ngawe – ingaba ungumntu onjani?
   Please tell me a little bit about yourself.

2. Apha ebomini bakho, unethemba lokwenza ntoni?
   What are some of your hopes for your own life?

3. How did you hear about FASfacts?
   Uve okanye weva njani ngo-FASfacts?

4. Yintoni eyakubangela okanye eyakwenza ukuba ufikelele kwisigqibo sokuba ubeyinxalenye ye-FASfacts?
   What made you decide to get involved with FASfacts?

5. (Lo umbuzo ngowabaququzeli) Yintoni okanye ziintoni ozifundileyo ukusukela ngoku ubuqala ukuba ngumququzeli uqhuba iikhosi zoqeqesho ze-FASfacts?
   (For facilitators) What have you learnt since becoming a facilitator and running the training courses for FASfacts?

6. Lemibuzo ilandelayo ijolise kakhulu kwizinto ezintle nezimbi ngekhosi?

    a) Yeyiphi okanye zeziphi izinto ocinga ukuba zihambe kakuhle nozithandileyo?
    b) Yeyiphi imiba okanye zeziphi izinto ocinga ukuba kufuneka ziphuculwe okanye zitshintshwe nongakhange uzithande?
    c) Ingaba lekhosi ingaphuculwa okanye yenziwe bhetele njani?

    Focus on the strengths and weaknesses of the course?

    a) What aspects do you think went well/you enjoyed?
    b) What aspects do you think need improving/did you not enjoy?
    c) How could the course be improved?

7. Umququzeli usebenzise oluphi ulwimi okanye eziphi illwimi kwinkqubo yoqeqesho kuleveki?
    a) Ibinjani into yokusebenzisa kwakhe olulwimi okanye ezilwimi?
    b) Ngolwakho uluvo, ucinga ukuba loluphi ulwimi olufanele oluqeqesho okanye ekufuneka lisetyenziswe koluqeqesho?

    Which language(s) did the facilitator use during the week's training?

    a) How did you find that?
    b) In your opinion, which language would be best for this training?

8. **If someone were to ask you, "What was the most useful aspect of the training?" what would you say?**

9. (Lo umbuzo ngowabaququzeli) Ukuba umntu angakubuza athi "Yintoni eyayiluncedo kakhulu koluqeqesho" ungaphendula uthini?
    (For facilitators) Id someone were to ask "What was the most useful aspect of the training" what would you say?

10. (Lo umbuzo ngowabacebisi/abaqeqeshi). Ufunde ntoni ngobutywala nokukhulelwa kuleveki?
    (For trainees/mentors) What have you learnt about alcohol and pregnancy through this course?

11. Ndicela undixelele ngokusetyenziswa kobutywala kwingqingqi yakho okanye kwindawo ohlala kuyo.
    Tell me about alcohol use and pregnancy in your community.

12. Ucinga ukuba i-Organisation inganceda njani ukwehlisa okanye ukunciphisa ukusetyenziswa kobutywala ngexesha umntu ekhulelwe?
    How do you think the Organisation can help to reduce alcohol use during pregnancy?

13. Ingaba uthemba ukudlala eyiphi indima ekunciphiseni ukusetyenziswa kobutywala ngexesha umntu ekhulelwe?
    What role do you hope to be able to play in reducing alcohol use during pregnancy?

Bonisa imifanekiso emithathu eyahlukeneyo ebonisa ukukhulelwa evela kwiincwadi zoqeqesho. ***Introduction: I'm going to show you three different pictures depicting pregnancy from the training materials. You may take your time to look at them carefully before responding to the questions.***

14. Ingaba intsingiselo yalomfanekiso kuwe yintoni?
    What do you see? What is the meaning in this picture for you?
    a) Ukuba kukho into embi/entle, ingaba yintoni?
       If there is something negative/positive, what would it be?

Appendix C

Transcriptions Conventions

Symbol	Meaning
//	overlap in talk
(.)	Brief pause
(2)	timed pause (2 seconds)
...	Omitted material
Word underline	meaning emphasis
WORD uppercase	pronunciation emphasis
WORD	meaning and pronunciation emphasis
(?)	Uncertainty over content or accuracy
(? *Text*)	Guessed text
< or >	indicates significant change in rate of speech, faster or slower pace respectively
Text	Italicized text indicates speech in isiXhosa or isiZulu
[]	explanatory/ clarificatory material/ brief comments
(00:21)	Audio timed at end of page for ease of reference
	Text is numbered for ease of reference

Appendix D

Image 1 from the training manual.

Image 2 from the training manual.

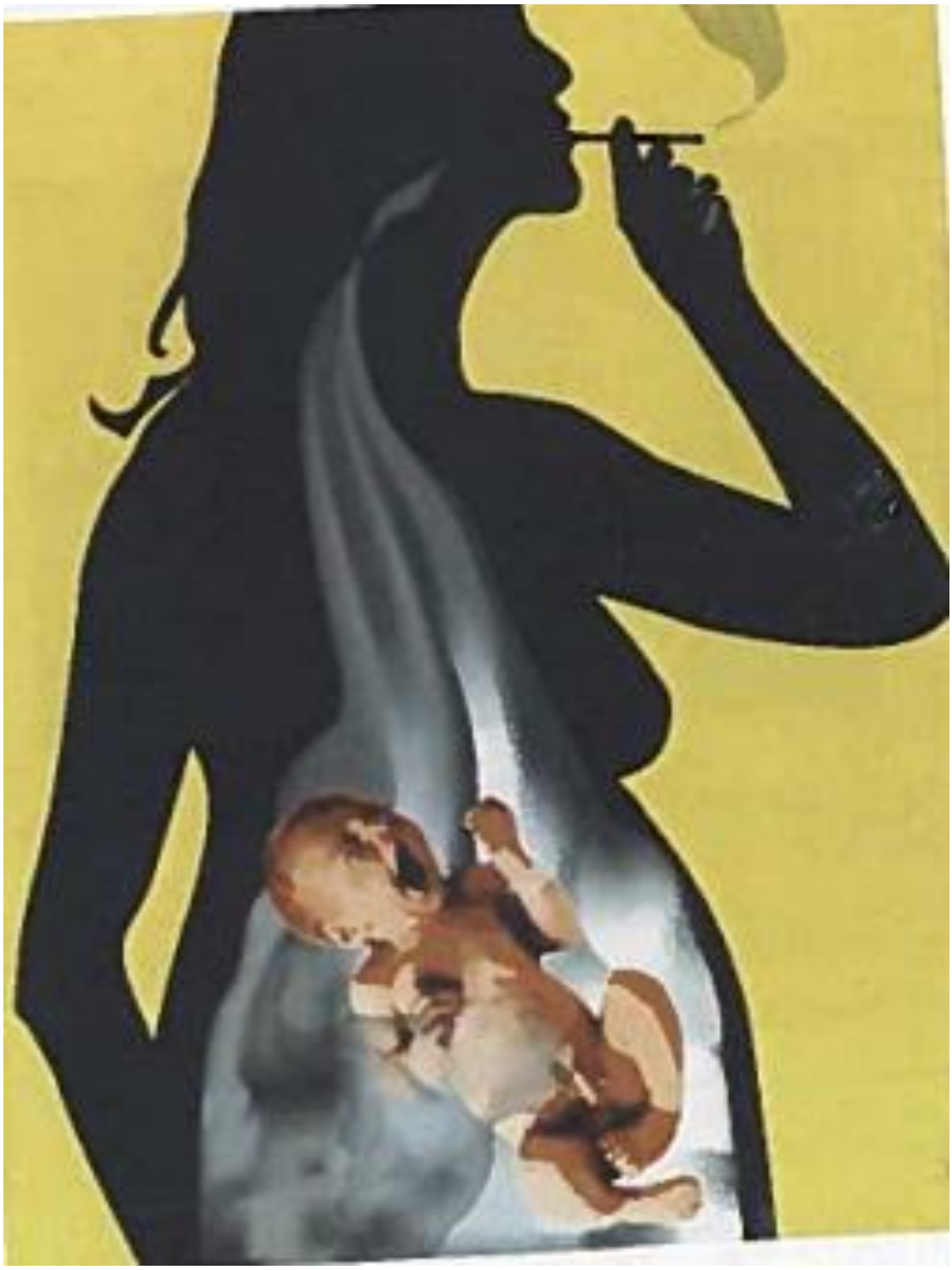

Image 3 from the training manual.