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GOVERNING PREGNANCY IN SOUTH AFRICA: POLITICAL AND HEALTH DEBATE, POLICY AND PROCEDURES

by

ULANDI DU PLESSIS

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Supervisor: Catriona Macleod

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Statement of originality

This is to certify that to the best of my knowledge; the content of this thesis is my own work. This thesis has not been submitted for any degree or other purposes.

I certify that the intellectual content of this thesis is the product of my own work and that all the assistance received in preparing this thesis and sources have been acknowledged.

Ulandi du Plessis

Abstract

South Africa democratised in 1994. However, due to the discriminatory and segregationist character of the preceding regime, vast swathes of the country's spaces and people entered the democratic period heavily deprived of essential government services. This was the case with health care in general, including maternal health care. There were also little to no national data available on maternal deaths, especially among the black population. One of the first tasks of the new National Department of Health (NDoH) was to target the high maternal mortality rate. The NDoH made maternal deaths notifiable by law and instituted auditing and information gathering systems in the health sector; health infrastructure was expanded exponentially, and maternal health care was made free. Despite this, the last 24 years have seen the maternal mortality escalate. The latest statistics show that between 1200 and 1300 women die in the South African public health sector each year during pregnancy and the puerperium. This puts the current institutional maternal mortality rate (MMR) at around 154/100 000 live births. The international target for 'developing' countries was to reduce the MMR rate by three quarters by 2015, which would have meant a reduction to 38/100 000 live births. The aim of this dissertation is to examine how the democratic South African government (influenced heavily by global health thinking) has laboured to reduce that statistic. I analyse, using Foucauldian discourse analysis, all relevant health and maternal health policies, procedural documents and reports produced by and for the NDoH in the last 24 years. I draw on Foucauldian concepts, specifically those related to Foucault's work on governmentality. In this dissertation I introduce a new perspective towards the maternal health practices implemented in South Africa, practices that have generally remained unquestioned, been perceived as self-evident, and thus often escaping critical analysis. Through an analysis of the intended operation of the public antenatal clinic (within the larger institutional system) I show how 'development' has come to operate as a truth regime in South Africa – facilitating the introduction of liberal governmentality (including some advanced liberal practices) into public health service provision.

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List of acronyms

ANC	African National Congress
ART	Anti-retroviral treatment
AU	African Union
BANC	Basic antenatal care
CARMMA	Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa
CHC	Community health centre
CHW	Community health worker
C-IMCI	Community integrated management of childhood illness
COSATU	Congress of South African Trade Unions
DED	Department of Economic Development
DHS	District health system
DPME	Department of Planning, Monitoring and Evaluation
ESMOE	Essential steps in the management of obstetric emergencies
FANC	Focused antenatal care
FAS	Foetal alcohol syndrome
FASD	Foetal alcohol spectrum disorder
FDA	Foucauldian discourse analysis
GEAR	Growth, employment and redistribution
FINNRAGE	Feminist International Network of Resistance to Reproductive and Genetic Engineering
HAART	Highly active antiretroviral therapy
HIV/AIDS	Human immunodeficiency virus infection and acquired immune deficiency syndrome
IEC	Information, education and communication
IFP	Inkatha Freedom Party
IGO	Intergovernmental organisations
IMF	International Monetary Fund
MCH	Mother and child health

MCWH	Maternal, child and women's health
MDG	Millennium development goal
MDNF	Maternal death notification form
MMR	Maternal mortality rate
MNCWH	Maternal, neonatal, child and women's health
MNCWH&N	Maternal, neonatal, child and women’s health and nutrition
MRC	Medical Research Council
MUAC	Mid-upper arm circumference
NaPeMMCo	National Perinatal and Neonatal Morbidity and Mortality Committee
NCCEMD	National Committee on Confidential Enquiries into Maternal Deaths
NDoH	National Department of Health
NDSD	National Department of Social Development
NGO	Non-governmental organization
NHISSA	National Health Information System for South Africa
NHS	National health system
NPM/NPA	New public management/new public administration
NPC	National Planning Commission
NPO	Non-profit organization
NRT	New reproductive technology
NSDA	Negotiated Service Delivery Agreement
PHC	Primary health care
PPIP	Perinatal Problem Identification Programme
RDP	Reconstruction and Development Programme
RSA	Republic of South Africa
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization
WITS	University of Witwatersrand

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1. Introduction

When South Africa became a democracy in 1994, there were no health statistics for most of the population and maternity care was not distinguishable in terms of health policy, nor did it have its own programme. Most of the population had been systemically excluded and discriminated against, and access to health care, especially quality health care, was very scarce, specifically in the former Bantustans.[1] As such, the democratic South African government had both a massive task and a clean slate, in a manner of speaking, to contend with, and many international and local organisations were enthusiastic in lending a hand in helping produce democratic government systems for this new and youngest African democracy.

This dissertation presents a history of the development of maternal health care in South Africa from 1994 to the present. Studying the slew of documents produced since 1994 provides a unique opportunity to understand how governing pregnancy is set up in a post-colonial (or post-apartheid) context. I present this history within the framework of governmentality (Burchell, Miller & C. Gordon, 1991; Foucault, 2007, 2008). Utilising Foucauldian discourse analysis (FDA) I analyse all relevant health and maternal health policy and procedural documents, audit reports, clinic guidelines, handbooks and protocols produced for use in the South African public health sector (see appendix one).

An analysis of policy and practices drawing on Foucault's work involves making a zone of intervention and its knowledge/power structure intelligible. Issues of health policy are viewed as "products of particular problematisations" (Osborne, 1997, p. 174) and health practices are viewed as sites of intervention. Governing is the directing of people's behaviour or conduct,[2] and behaviour is directed through the establishment of relations of power between people and people, and institutions and people. Knowledge production plays an important role in this process. In this way 'governmentalisation' refers to the process through which aspects of life are brought into relations of power. In its aim to shape conduct, power produces subjects. By

[1] The 10 Bantustans or 'homelands' were produced during the apartheid era as a means through which to remove superfluous black people from the South African urban centres. It comprised around 8% of the country's land, much of which were not arable. The Bantustans were justified by a racist notion of separate development.
[2] By now the reference to governmentality as the "conduct of conduct" is well-established (see C. Gordon, 1991, p. 2).

‘the government of pregnancy’, as this dissertation’s title suggests, I therefore describe the process through which pregnancy has been *meant to be brought* into relations of power in post-apartheid South Africa.

By ‘meant to be brought’ I am referring to a specific character of the analysis as well as a limitation: I am analysing documents on maternal health-related knowledge produced within South Africa and procedures and strategies produced to be implemented in clinics. I did not do interviews or study the clinic setting in person. Whether the proposed practices and guidelines are properly implemented, whether they are resisted or whether they succeed or fail in their intentions are not the focus of this dissertation. This project is thus a study of the government of pregnancy in the South African public health setting in terms of the “intended consequences of action” rather than the “unintended consequences of action” (Osborne, 1997, p. 176).

Relations of power are ‘directed’, in a sense, by *technologies.* A technology, in the Foucauldian sense, is the logic that coherently makes all the techniques work together to produce a set of power relations. A technology of government produces relations of power that allows for the government of people. To analyse health practices, it is useful to focus on technologies of health. A technology of health, in metaphorical terms, can be described as a workspace organised according to a specific logic in which a set of techniques operates to produce ‘health’. Usefully, Thomas Osborne (1997, p. 181) describes technologies of health as “all the diverse means, projects and devices through which the impossible dream of a healthy population has been made an object of realisation”.

These technologies, again, function within a larger political rationality of government. This is not the rationality of the state; instead it refers to the rationality that guides all forms of governing, even beyond the state. A fundamental aspect of a Foucauldian analysis, drawing on governmentality, requires tying identified technologies to wider rationalities of government (Osborne, 1997). It is an aim of this dissertation to identify this underlying rationality, i.e. the “system of thinking about the nature of the practice of government (who can govern; what governing is; what or who is governed)” (C. Gordon, 1991, p. 3) through an analysis of maternal health policy and practice. These concepts are all part and parcel of the FDA method, since they are identified within discourses (identifiable and uniform systems of statements and/or objects).

The first pregnancy-related goal of the Department of Health was to produce a “national programme for the delivery, organisation and management of health services for mothers,

newborns, children… and women" (NCCEMD, 1999). Drawing heavily on World Health Organization (WHO) thinking, the government embarked on a complete restructuring of the South African medical system. This restructuring involved instituting a primary health care (PHC) system based on a district health system (DHS) model.

Underlying this health programme (along with perhaps most other aspects of government at the time) I identified the discourse of development. Development can be described as an ideology that has attained a level of hegemony across the world. It is a version or view of reality where modernity is a continuum which starts with the discarding of the traditional. Each country can be placed in a specific space on this continuum, and the ideal is to reach the most modern end. A fundamental aspect of developmentalism is the belief that there is a necessity for intervention, even if it means lending money from international organisations such as the World Bank (WB). A much more elaborate discussion of development is provided in chapter four.

In this dissertation I discuss how development functions as a technology of government to specifically governmentalise those spaces that had not yet been governmentalised, drawing individuals into relations of power, and turning them into subjects of health. A discussion on how development is instrumentalised in the health sector is provided. I show how the WHO's PHC approach is adopted as a means of instrumentalising a specific notion of health that functionalises the project of health promotion. The PHC approach's institutional framework, the DHS was, in turn, a means through which relations of power were extended to previously ungoverned areas: the governmentalisation of communities of health and the production of citizens of health, who are both objects of government, as well as subjects facilitating the government of their own health. The various mechanisms through which technologies of health function, and are functionalised, including empowerment, participation, and community, is analysed and discussed in chapter five. I show how the PHC approach, along with its institutional model, the DHS, facilitated this project, in turn, producing very particular subjects of government, and very particular subjects of health.

After discussing the rationality of government in terms of health in South Africa, and as such the conditions of possibility that shaped the maternal health policies and practices that were systematically introduced, I shift gear towards the pregnancy-related policy issues encountered by the South African Department of Health over the first few decades of democracy. In chapter six I show how the introduction of an audit system of maternal deaths (gathered and analysed

by the NCCEMD) changed the focus of the Department of Health away from the government of pregnant women, and their conduct, towards the government of health workers. A variety of techniques are introduced to manage the performance of health workers. These include, among others, the introduction of a new management framework that is functionalised by a fragmentation of the more holistic notion of health initially drawn on. The expansion of surveillance systems is also discussed, both in terms of the surveillance of the pregnant woman, as well as the health worker in the antenatal clinic. An analysis of the antenatal clinical guidelines also shows a shift towards risk management – both of the pregnant woman and the health worker.

This type of inquiry inevitably requires historical fieldwork. This dissertation, therefore, is also a contextualised history of maternal health policy and antenatal practices, insofar as they can be connected to the conditions of possibility that marks South African policy and practice.

Pregnancy-related practices have a rich and controversial history, and many changes have taken place over the last few centuries. Current pregnancy practices consist of an intricate web woven over time with a multitude of threads. In the initial chapters I focus on three threads that lay the foundation of my analysis: first there is the 'dialogic partnership' (see Weir, 1996) between biomedicine and feminism in their attempts to produce the truth about pregnancy (see chapter two). The exchanges between biomedicine and feminism have turned pregnancy into a fruitful area of study, as well as a zone of multiple and often conflicting ideas.

South African maternal health policy is, since 1994, heavily enmeshed in global health thinking. Global health thinking is developmentalist in nature. The second thread that is discussed in detail before the analysis, regards the fact that South Africa is in the Global South, and as such, developmentalist organisations, such as the WHO, have played an important role in shaping the health discourses of the country. Colonialism, modernisation and development practices, and other external influences, cannot be ignored in an analysis of a health system of a country in the Global South. This discussion follows the chapter outlining my method and methodology, since much of the discussion is within the governmentality tradition.

The third thread concerns a theme that has emerged in governmentality literature in the last few decades: the technology of risk. As a technology of government, risk is a means through which policy issues, including in health, are problematised and dealt with. Feminists have brought attention to the fact that pregnancy is increasingly being constructed as an at-risk state. Drawing on the thinking of Lorna Weir (1996, 2006), as well as other governmentality writers,

I provide an exposition of risk as a technology of government and how one can approach it when analysing the government of pregnancy. I will now provide a quick overview of the international context and history of modern pregnancy practices followed by an introduction to my theory, method and data. I then discuss the historical context of South Africa generally, and in terms of health and maternal health policy and practice.

1.1. Context and history: Pregnancy practices in the West

In 1973, the eminent socialist feminist, Sheila Rowbotham, stated that "for the first time in human society it is possible for women to choose when they become pregnant" (p. 113). On the one hand, contraception has become freely available in most countries while, on the other, pregnancy has, at least theoretically, become a safer process than in previous eras. The possibility of dying during childbirth – something that was an accepted part of life a few centuries ago – is now virulently fought against by medicine, development agencies, feminists, health activists, and governments, and dying during childbirth is not, or at least in the West, something that is foremost in the minds of women when they discover they are pregnant or think of becoming pregnant. As such, women's experiences of pregnancy and childbirth have fundamentally changed in the last few centuries as pregnancy and childbirth practices have changed.

These changes are most often credited to new medical advancements. In the eighteenth century, medicine started focusing on the pregnant body, gazing at its functioning, producing knowledges on its processes, aiming to understand it fully, and producing new ways of intervening when complications arise. Of course, pregnancy and childbirth were not the only bodily processes that medicine aimed to understand. Michel Foucault (2003b, p. x) described this new curiosity in medicine more generally as "a transformation in the discourse on the body". This 'clinical gaze' started producing truths by looking into the darkness of the body and forming a rational language around it: "a scientifically structured discourse about [the] individual" (Foucault, 2003b, p. xiv).

Until at least the mid-seventeenth century the standard childbirth process in the West was managed by female midwives. Their practices, like most healing practices before the advent of scientific medicine, were based on handed down lore (Green, 2009). European and North American literature of the eighteenth century shows the early stages of an intense professional rivalry in which physicians attempted to take over the territory that had, up to then, been almost exclusively the realm of women practising midwifery (Allotey, 2011). These developments did

not go unchallenged. Recent historiography of midwifery in Europe and the United States of America (USA) shows that midwives defended their territory virulently through a variety of tactics, which involved both embracing and opposing scientific and technological developments (Allotey, 2011; Green, 1989; Hobby, 1999).

While there are some differential views, historians agree that the medicalisation of pregnancy involved the de-legitimation of traditional midwifery, a process which included, to varying extents, the rise of man-midwifery, or accoucheurs, the deliberate rejection of women for medical training and the intensification of gender roles in society that would come to exclude women from most forms of employment (Donnison, 1976; Leavitt, 1986; Marland & Rafferty, 1997; Wilson, 1995). Midwives came to be portrayed in derogatory ways exemplified by Charles Dickens' (1844) *Martin Chuzzlewit* character Sairey Gamp – dirty, drunk and untrustworthy. Heather Stanley (2012, p. 49) shows that, "man-midwives used gendered language to help create identities for themselves, female midwives, and other rivals in order to legitimize their own professional identity and practice and to delegitimize the professional identities of their competition". In the eighteenth century the contest over who was to provide care to pregnant and birthing women took the form of a struggle between scientific and traditional knowledge, as well as between men and women.

Modern medicine prevailed, and physicians, or more specifically in this case, obstetricians, became the authoritative voice in matters of childbirth and pregnancy. This phenomenon in which childbirth care was systematically taken over by physicians and eventually moved into the hospital came to be referred to as the *medicalisation of pregnancy* (Shaw, 2012). Midwifery has also undergone fundamental changes in the West since the seventeenth century. The process of medicalisation of pregnancy also included the incorporation of midwifery into the scientific medical domain which entailed practices of regulation such as registration and certification, i.e. the professionalisation of midwifery. This process also required midwives to receive formal training, usually from male physicians, which had the effect of rooting out folk medicine and traditional and 'unscientific' practices (Deacon, 1998).

Hilary Marland (2003) shows how the changes in Dutch midwifery in the early twentieth century was missionary in character. Marland's example demonstrates that the aims of the new midwifery school in Heerlen were to displace and delegitimise traditional birthing attendants. It taught poor pregnant Dutch women the ways of hygiene, and in the process, got rid of "dangerous, superstitious and dirty practices" (Marks, 1997, p. 206). Shula Marks (1997) uses

Marland's example to draw similarities between modern medicine's operation in the West and the colonies. The similarities are so prominent that Marks questions whether there is, in fact, anything colonial about colonial medicine. As Harriet Deacon (1998) shows, parallels can be drawn between the transformations in midwifery in South Africa, and that of Britain and other European countries. Focusing on the nineteenth century, she argues that in the Cape Colony the regulation and professionalisation of midwifery was used to root out traditional folk methods. Man-midwifery developed in tandem with its counterpart in Britain, and physicians were heavily influenced by the modern medical practices of the West since they were all trained in Europe, at least until the twentieth century.

While midwifery was incorporated into the Cape medical system, black midwives specifically were subjected to the stereotypes that aimed to delegitimise them: "In the Cape, 'Sairey Gamp' was a 'Hottentot'" (a derogatory term for the Khoisan) (Deacon, 1998, p. 275). Within colonial discourses, African women were perceived to be especially dangerous: a "repository of all that was dark and evil in African culture and social practices" (Vaughan, 1991, p. 23). African women, especially older women, were often perceived to be the carriers of knowledge about traditional cultural practices (Roth Allen, 2004). Reproduction-related practices, such as traditional midwifery and fertility cults, were viewed with suspicion and "the maternal body often served as the starting point from which British colonial interventions to modernise and transform native populations were launched" (Roth Allen, 2004, p. 13).

Because of the medicalisation of pregnancy, contemporary childbirth and pregnancy care is underlined by a biomedical model that relies on a variety of technical and biomedical interventions. These interventions range widely and include, for example, the testing of the foetus for potential abnormalities and complications, intervening during birth to reduce pain or induce labour, and intervening directly in foetal abnormalities and potential birth complications. There is also a variety of new methods falling under the rubric of 'artificial reproductive technologies' such as in vitro fertilisation and surrogacy. Most prominent, and perhaps simply, biomedical intervention involves giving birth in a clinic or hospital setting and having a variety of tests and procedures administered during the pregnancy in the name of ensuring a positive birth outcome.

While they have become standard practices, these medical interventions have not gone unchallenged. Since the 1970s, feminists have called out the medicalisation of pregnancy as a mechanism of patriarchy. The feminist work outlined in chapter two represents a struggle in

the West against the knowledges and practices that have become dominant since the eighteenth century. Chapter two also discusses how contemporary practices and the historical narratives in which they are presented have been shaped by critical voices that take the position of activist, dissident or reformer. Not only have feminists had an important role to play in the shape and development of current thinking and practices in pregnancy and childbirth, Global Southern feminists have often joined hands with development workers to face the unique difficulties affecting these countries, and as a result, shaping practices here.

The provision of maternal health services is not only considered important because of the status of health care which has come to be seen, at least to some degree, as a 'right', but it is also politically motivated on different levels since pregnancy is the way in which a population reproduces itself. Thus, government administrators may, at times, want the rate of reproduction to accelerate, such as during periods of war when a country needs soldiers, or at times of rapid industrialisation, when a country needs large numbers of workers. As a result, as Clare Hanson (2004, p. 6) points out: "pregnancy is by no means a private matter, but is peculiarly susceptible to social intervention and control". Reproduction is a particularly unique example of where "a medicine of pathological spaces" and the "medicine of the social space" (Foucault, 2003b, p. 38) intersects with the agenda of the government because reproduction is so closely connected to the health of the population as well as being a physical process easily appropriated by medicine. Intervention in birth rates is both an issue for demography as well as medical science and, as such, an important political issue for governments.

Often supporting the governmental agenda, epidemiology has come to play an increasingly important role in shaping clinical practices regarding pregnancy and childbirth. Foucault (2003a, 2003b, 2007) described how the clinical gaze[3] was followed by the 'discovery' of the population,[4] which allowed for the science of statistics to arise and subsequently, epidemiology. Epidemiological research utilises statistical data and concerns itself with

[3] In *The Birth of the Clinic* (2003b), Foucault describes the emergence of the clinical gaze in the late 18th century. At the time there was a visible change in the way doctors viewed disease in the body: "It is as if for the first time for thousands of years, doctors, free at last of theories and chimeras, agreed to approach the object of their experience with the purity of an unprejudiced gaze" (Foucault, 2003b, p. 195). What underpinned this change, Foucault argues, was: a change in "the forms of visibility"; a new way of seeing or looking at the body; "a syntactical reorganization of disease in which the limits of the visible and invisible follow a new pattern; the abyss beneath illness, which was the illness itself, has emerged into the light of language" (Foucault, 2003b, p. 196). In *The Birth of the Clinic* Foucault describes the conditions of possibility of this clinical gaze.
[4] Associated with the production of biopolitical power (see chapter three), the 'discovery' of the population refers to the coming together of a variety of techniques (as well as the production of new ones) which took, for the first time, the population of a state as its object of inquiry. This inevitably required a great deal of data to be gathered on the individuals living within a territory.

patterns of ill-health in populations. In the process of calculating the factors that produce these patterns, it both draws from and produces knowledge on the causes of illness and complications in pregnancy and childbirth. Since the discovery of the population turned life itself into an object of control for government, a variety of new political problematisations have been produced, such as rates of illness affecting the whole of the population. New practices such as public hygiene and eventually modern public health systems followed (Foucault, 2003b).

Maternal health practices and the management of pregnant and birthing women have not been impervious to these changes. The rationalities that underlie the management of pregnancy and childbirth (the subject of this dissertation) have both a unique and a general history. Lorna Weir (1996, 2006) argues that current prenatal practices are predicated on an amalgam of clinical and epidemiological knowledges. A particularly prolific area of study that is a result of the coupling of clinical and epidemiological research is the focus on risks in pregnancy. This "technico-scientific" (Lupton, 1999, p. 1) research aims to identify risks to the foetus and the mother during pregnancy and childbirth, as well as to identify ways in which to mitigate these risks. After discussing the governmentality tradition that stems from Foucault's 1975-1979 lectures at the Collège de France (Foucault, 2003a, 2007, 2008) in chapter three, chapter four will review the governmentality literature that focuses on the role that risk has come to play in the government of the living, and then, specifically, in the government of pregnancy.

1.2. Context and history: Pregnancy practices in the Global South

During colonial times, the question of *who should reproduce* loomed large, and interventionist tactics to control reproduction were many. The medical system played an important role in enforcing the colonial agenda. The pronounced preoccupation with the populations of Global Southern countries centred on the fear of over-population. Animated by paternalistic, racist, classist, and environmentalist concerns, the Western attitude regarding population growth in the Global South had been to encourage tactics to reduce population sizes (Mohanty, 1991a; Todaro, 1977). Whether it was during the colonial or the contemporary post-colonial period, these tactics often engaged Global Southern women, urging them to use contraceptives. Some tactics historically took an abusive turn as had been documented by many writers on the topic of sterilization, including in South Africa (Brown, 1987; Kluchin, 2009; Luker, 1984; Pillsbury, 1990).

The end of colonialism opened the way for the emergence of a new internationalisation of health. Various international organisations, including the newly-formed League of Nations

(now the UN), took it upon themselves to eradicate diseases in the former (and some current) colonies, and also to introduce basic Western medical and health models. Africa, particularly Sub-Saharan Africa, became a 'living laboratory' (Tilley, 2002) for medical research, epidemiological studies and intervention. These agencies promoted, and still promote, 'development'. My analysis in chapter five shows that development plays an important, if not one of the most important roles, in the way in which knowledge is applied in practice in maternal health care in South Africa today. Current maternal health facilities are based on a global maternal health framework expounded by agencies such as the WHO. As is shown in chapter five, the forms of governing coming out of developmentalist thinking shapes the ways in which women, especially poor women, experience pregnancy and childbirth. As such, 'development' and the agencies embodying it, will be given a great deal of attention, both theoretically (chapter four) and analytically (chapter five).

As a result of these various events, located on many (often intersecting) levels, "differing in amplitude, chronological breadth, and capacity to produce effects" as Foucault (1980, p. 114) said, the experience of pregnancy is likely to be varied. To some women, the pregnancy experience is transcendental, a special time during which new life is slowly being produced in their bodies. For others, it is a process best managed by medical experts in clinical settings. For others still, it is a painful, fearful, inconvenient or unwanted process, exemplified with a lack of bodily autonomy. An important scholarly activity, introduced by feminists as a response to the male dominated nature of scientific inquiry, has been to focus on these subjective experiences of women to make sense of pregnancy in a way that goes beyond positivist medical exposition. Feminist scholars have shown that the experience of pregnancy is influenced by a variety of phenomena. Women of different races, classes, nationalities, ethnicities, or temperaments experience pregnancy and childbirth in different ways – depending on where they live, how much access they have to health and medical services, how many resources or how much support they have during their pregnancy, and what type of information about pregnancy is available to them. While there are identifiable variables that impact either positively or negatively on the pregnancy experience, pregnancy is nonetheless acknowledged as a very subjective affair (Young, 1984).

Subjectivities[5], feminists argue, are also often shaped by the regimes of knowledge and truth available for women to draw on. In a pro-natalist society, the woman who chooses not to have

[5] Subjectivity in scholarly work is "concerned with the subject" (Kristeva, 1980, p. 237); in this case the pregnant woman. Since most scholarship has focused on clinical, medical and epidemiological issues, some

children might feel out of place, judged, or guilty. In consumerist societies, poor women who are unable to purchase the many products advertised to pregnant women might feel pressured not to become pregnant until they are able to afford such products, or, if they are pregnant, to feel like inadequate or failing mothers (McRobbie, 2006). Western society, especially, has been for centuries and still is awashed with images of the perfect pregnancy experience, whether it is to pursue a natural birth, to access the best medical care, to exercise, what to eat, how to behave, what to wear, what to expect, what to feel, and how to perform their pregnancies. Women are also made more and more aware of the risks they can pose to their foetuses and are educated, or expected to educate themselves, on how to avoid those risks. Expert advice on pregnancy and childbirth abound, and documents pertaining to desired conduct during the pregnancy period have been around for centuries. There is also a focus on producing the perfect baby: to give it the best chances in its future life by eating specific foods, behaving in specified ways, or by doing activities such as reading or playing music to a pregnant belly.

While consumerist pressures are unevenly distributed in the Global South, pregnant women in these countries are not immune to pressures and expectations placed on them, especially in terms of consumerism (Macleod & Howell, 2015). Writers who focus on the experience of pregnancy among Global Southern, poor or working-class women show that pregnancy is often a very difficult and hazardous time for these women, who are especially vulnerable to being discriminated against, being judged, and being subjected to domestic violence (R. J. Chadwick, 2016). Pregnancy and childbirth is considered a very risky time for Global Southern (especially poor) women.

Non-profit organizations, international development agencies, and activists agree. A hypothetical example provided by the WHO is that of Mrs X (see figure one). Mrs X is the hypothetical exemplar of every Global Southern woman. Her potential pregnancy experience is used as a teaching instrument for student developmentalists (see WHO, 1988b, p. 16). Mrs X is always on the road to death, as she is facing a multiplicity of negative factors that, the WHO argues, can be avoided if they were recognised and remedied quickly enough. The lesson of Mrs X is to identify "why did Mrs X die?" and what the development worker can do to stop Mrs X from dying. The point of the exercise is to identify the various social, psychological, and environmental phenomena that contribute to the maternal death rates in the Global South. Clinically speaking, Mrs X died of antepartum haemorrhage due to placenta praevia, but on

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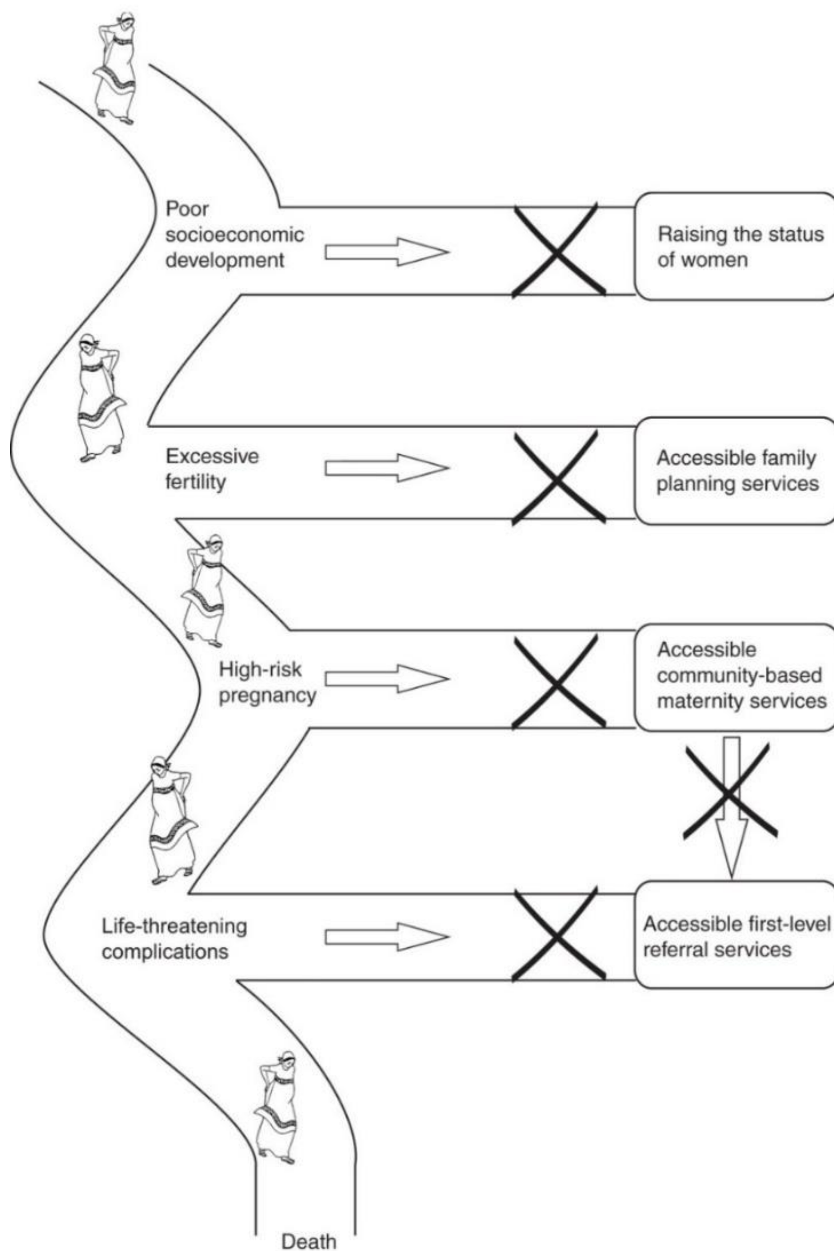
feminists have argued that "pregnancy does not belong to the woman herself" (Young, 1984, p. 45). As a result, these feminists emphasise the subjective experience of pregnancy from the viewpoint of the pregnant woman.

her road to death a wide variety of determinants can be identified: poor clinic service, lack of transport, her lack of knowledge on risks and complications, lack of proper nutrition, lack of a healthy lifestyle, unwanted pregnancy, age and parity, lack of family planning, lack of information, illiteracy, poverty, and gender inequality. These are the factors *development workers* have to tackle.

Figure 1: "There are millions of Mrs Xs still travelling along The Road to Maternal Death." (WHO, 1988b, p. 19)



The way in which these internationalist ideas impact on health systems – in their definitions of what causes death and illness, and how these causes should be tackled – also play an important role in shaping the experience of pregnancy and childbirth for women in the Global South.

There is no denying that the experience of pregnancy has changed considerably over the ages. Discourses of scientific medicine and development centre on technological, medical and public health advancement as the main reason women should be experiencing pregnancy differently, and more positively. Advances in medicine and public health have made pregnancy and childbirth safer and less painful. Anthropologists might point to the cultural aspects that have changed: where women once gave birth surrounded by female acquaintances and friends, they now lie on their backs in a sterile hospital bed giving birth into the hands of a most-likely male expert in childbirth. This was quite accurately the case in the mid-twentieth century when the women's movement took it upon themselves to critique this, arguing that obstetricians have stolen from women the control they had over the reproductive process and were using it to discipline and control women (Ehrenreich & English, 1973a). In the process, feminists introduced a myriad of possible subjectivities that not only provided women with an array of new experiences, but also a pool of possible new knowledges.

In the Global South, critique on pregnancy and childbirth is constrained by a lack of antenatal services, poverty, and a low quality of life. Southern feminists who concern themselves with the types of critiques made by Western feminists, often have to focus on the middle and upper classes in their countries. The poor are very often the domain of development workers. Their needs are perceived to be straight-forward. What poor pregnant women in 'developing' countries need, is *development*.

This points to the fact that a phenomenological inquiry is not enough in the process of studying the experience of pregnancy. Thus, despite this curiosity about the 'experience of pregnancy' the focus of this dissertation will rather be on the *conditions of possibility* for experience. Such a project does not require collecting individual experiences, but rather to ask, as Foucault (1979, p. 240) did,

> In what way are those fundamental experiences [of madness, suffering, death, crime, desire, individuality] connected – even if we are not aware of it – with knowledge and power?

The project is then rather to uncover the conditions of possibility for the experience of childbirth and pregnancy by women attending the public health system in South Africa, as such

its *connection to knowledge and power*, utilising the conceptual framework of governmentality. This question is synonymous with that of how pregnancy is governed in South Africa.

1.3. Theory, method and data

To analyse the connection between experience, knowledge and power, I utilised a variety of Foucault's theoretical and methodological tools, most importantly his work on governmentality and the method that was subsequently extracted from his oeuvre, and what has come to be known as Foucauldian discourse analysis (FDA). Governmentality is a process through which aspects of life, such as "biological existence" (Foucault, 1978, p. 142), are brought into relations of power to be *governmentalised*. But governmentality is also a tool for historically analysing how 'government' has problematised issues and produced solutions to the *need* to govern. Chapter three reviews the process described by Foucault in which biological existence was governmentalised. Foucault specifically called the current governmentality 'liberal', since it draws on the economic principles of the physiocrats and their *laisser-faire* doctrines. Liberal governmentality is also characterised by governing "at a distance", which incorporates a process of "persistent self-critique" or "perpetual self-problematization" (Bratich, 2003, p. 77).

> It constitutes—and this is the reason for both its polymorphism and its recurrences—a tool for the criticism of reality: criticism of a previous governmentality from which one is trying to get free; of a present governmentality that one is trying to reform and rationalize by scaling it down; or of a governmentality to which one is opposed and whose abuses one wants to limit. (Foucault, 2008, p. 320)

This is a specific characteristic of a liberal governmentality: in which it constantly produces mechanisms through which reality can be reflected on. It does so by positioning its subjects as both autonomous/free, as well as still 'unfree', and by laying the basis for claims that freedoms are limited, or that some groups are still subjected to restrictions. In this way "liberal governance [is] prestructured for conflict" (Weir, 1996, p. 385). These conflicting forces play an important role in determining and shaping the ways in which people are governed. Writing the history of these conflicts is what Foucault called 'histories of the present', or genealogies. While this project is not a genealogy, I shall nonetheless give an overview of some of the most important conflicting forces identifiable in the sphere of childbirth and pregnancy, beginning, in chapter two with what Lorna Weir (1996, p. 385) calls biomedicine's "dialogic partner" regarding the government of pregnant women: that of feminism.

Pregnancy is a unique period in that a foetus is growing *inside* the body of a woman. Across the world people hold different views as to when this foetus becomes an individual. Up until

the beginning of the twentieth century, birth marked the point at which individuality was conferred. A set of developments occurred in the twentieth century that unsettled this threshold, and the foetus was turned into a patient in its own right (Weir, 2006). Since the 1960s, debates have proliferated around the autonomy of pregnant women, especially in terms of abortion. Feminists, especially, connected the 'appearance of the foetus' due to the increased use of ultrasound, with a new assault on women's reproductive autonomy (Hubbard, 1982; Luker, 1984; Petchesky, 1987). Legislation restricting abortion, and the criminalisation of certain behaviours during pregnancy that might put the foetus at risk, has increased. The pregnant 'dual' subject – woman and foetus – presents a unique dilemma for liberalism since it complicates the fundamental question around which liberalism's 'self-critique' revolves: how to govern individuals liberally. If a liberal subject is essentially governed as an autonomous subject, how do you govern bodies that are not self-identical? The new status of the foetus as an individual located inside the body of another individual, is "a violation of a central presupposition of liberal governance" (Weir, 1996, p. 386). From a governmentality point of view, this dilemma plays a fundamental role in shaping contemporary childbirth practices.

Drawing on Foucault's conceptual framework requires adopting a specific definition of 'power'. Power is, according to Foucault, not possessed by or imbued in persons or institutions, nor is it the domination of one group, class, or sex, over another. Power is relational, and it aims to produce certain types of behaviour in subjects; as such, power *produces subjects*. Not only can these subjects resist and shape these power relations, but also, "power is bound up with knowledge" (I. Parker, 2002, p. 131), or 'truth'. The exercise of power functions in a circular relation with knowledge production wherein the production of subjects is dependent on the production of knowledge and the accumulation of information (Foucault, 1980). This is referred to as 'power/knowledge'.

Methodologically speaking, identifying these power relations requires an analysis of discourses. Subjects are presented with and participate in discourses. A discourse, or discursive formation, is not only a set of statements, or a linguistic formation, as understood in traditional discourse analysis; discourse in a Foucauldian sense is "a set of statements that construct objects and an array of subject positions" (I. Parker, 2002, p. 198). A discourse encompasses the language, or logic, of a subjectivity, and functions according to specific rules that are connected to a particular body of knowledge. The process of doing FDA is discussed in chapter three, along with Foucault's theoretical toolbox.

These tools are used in this dissertation to identify how pregnancy is governed in South Africa, directed by the following questions:

a) How does the rationality of government in South Africa frame interventions in pregnancy health care?
b) Through what mechanisms and strategies does power gain access to pregnant women in South Africa?
c) What discourses are deployed in policy documents, committee and audit reports and implementation guidelines on the governance of pregnant women in public institutions in South Africa?
d) What systems of knowledge that take pregnancy as its object are employed in these documents?
e) What are the technologies of power employed in the governance of pregnancy in South Africa?
f) What are the technologies of the self implicated in the governance of pregnancy in South Africa?

Various documents that inform the procedures and strategies of the state apparatus relevant to the object of pregnancy are used to answer these questions. These documents encompass the 'post-apartheid' time frame. They were identified systematically as well as through a 'snowball' effect: one document leading to another, starting with the first official policy outline of the democratic government, the *Reconstruction and Development Programme (RDP)* (ANC, 1994b) and its subsequent health-oriented document the *National Health Plan* (ANC, 1994a). All health-related documents produced in South Africa were screened for maternal health-related content and all the main maternal health-related policies, plans, programme outlines, institutional guidelines, protocol documents, and reports of commissions produced since 1994 were included in the analysis. Population policies were not included. All documents were downloaded from the South African government's website (https://www.gov.za/) and the department of health's website (http://www.health.gov.za/). Where documents were not available from official government websites they were sourced from the library or the internet (see the reference list for sources).

A total number of 34 documents were included in my final data pool. 12 documents were not focused on maternal health care specifically but included relevant maternal health data. Eight documents were maternal health-related clinic and hospital guidelines and protocols. Three documents were specific maternal health-related documents. 11 documents were reports of the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD). These documents were coded using NVIVO software and analysed using the Foucauldian discourse analytic, described in chapter three. Appendix one comprises a list of all the documents in my

data. Section 1.6 of this chapter provides not only an outline of these data, but also some contextual information on each document and event.

Despite my focus on the post-apartheid era, it is nonetheless important to supplement the contemporary context with what came before. There is no denying that South Africa's history has impacted the current state of health of the population as well as the shape of its health institutions and policies. And it continues to do so. The colonial and apartheid eras animate this dissertation as much as it still animates life in South Africa. As such, it is important to clarify some basic concepts that occupy our current vocabulary.

1.4. Categories and the modernisation project

The concept of 'the West' has become an established shorthand in literature and academia. Historically, 'the West' consists of those countries that were, in some form or another, subject to the advent of Christianity, the Reformation, the Enlightenment and the Renaissance, as well as the fabricants of the imperial and colonial projects (Kurth, 2001). While the West initially consisted only of European countries, during the Cold War the West was counterpoised with the Soviet Union. Various settler colonies such as the USA and Australia were brought into this category. Considering who is left out of this category, Stuart Hall provides a simple articulation of this rather complex 'idea' of the West:

> By 'western' we mean… a society that is developed, industrialized, urbanized, capitalist, secular, and modern… Nowadays, any society which shares these characteristics, wherever it exists on a geographical map, can be said to belong to 'the West.' The meaning of this term is therefore virtually identical to that of the word 'modern'. (Hall, 1992, p. 186)

During the twentieth century one of the major projects of these nations was to promote *Westernisation*. However, perhaps due to intensifying critique of the notion[6], in literature this project has been replaced by that of *globalisation* (Kurth, 2001), a project that has been claimed by some to be nothing more than *global Westernisation* – a mere continuance of Western imperialism (A. K. Sen, 2002).

Taking inspiration from Hall (1992), these terms can be said to be reiterations of the notion of modernisation, all of them being discursive formations within a larger system of power. While the concern with modernising those countries that were not on par with industrialised 'modern' states only really became an international prerogative after World War II, the modernisation

[6] The term was critiqued for conflating 'modernisation' with the West, that certain countries need the West to develop, and that it justified colonialism.

process, based on a notion of 'progress' and a dichotomy between the traditional and the modern, is part of the very foundations of the social sciences (Eisenstadt, 1974). In Foucauldian terms, these knowledge systems produced discourses that posit states, and individuals, on a continuum of modern progress, calling for further knowledge production and the institution of practices that aim to produce modernisation effects. The process of modernisation requires the creation of various institutions such as schooling and health systems, the removal of traditional practices that are not based on Enlightenment reason, the construction of secular governmental infrastructure, and perhaps most importantly, it requires the creation of a market economy that is capable of functioning on a global scale; i.e. it requires *governmentalization*.

The question of what to call 'the rest' of the countries has been a constant matter of dispute. The institutions which aim to 'globalise' them – to insert their economic systems into the global market system by governmentalizing these countries – such as the WB, International Monetary Fund (IMF) and the UN – categorise them per their level of development. The initial First, Second and Third World categories which described countries' Cold War alignment status were replaced by 'developed' and 'underdeveloped', or 'developing', by the WB. These categories were eventually refined according to gross national income per capita: low, lower-middle, upper-middle, and high income, as well as by region. As such the WB categorises South Africa currently as an upper middle-income economy in the Sub-Saharan Africa region (WB, 2016). The WHO also categorises according to region and income – low or middle-income – and South Africa falls into the broad 'African Region' and qualifies as a middle-income country (WHO, 2016a).

Categorisation plays an important role in the process of governing states on an international level. These categories are productive in the sense that they have "real effects"; the idea of 'the West' "enabled people to know or speak of certain things in certain ways. It produced knowledge. It became *both* the organizing factor in a system of global power relations *and* the organizing concept or term in a whole way of thinking and speaking" (Hall, 1992, p. 187). Within this discourse, 'the rest', regardless of the specific term applied to them, refers to the *opposite of modern*.

Foucault spent a great deal of time studying the classificatory project and the role it plays in the development of the sciences (Foucault, 2006b). It is easy to see that "without classifying we have only individuals and therefore no possibility of scientific study" (Pratt, 1977, p. 163). Classification was key to the development of the modern human sciences, including biology,

botany, medicine, linguistics, ethnology, penology, psychiatry, and the science of governing: political economy. A system of knowledge such as political economy depends on discursive categories; they do not merely produce a sense of structure in an otherwise chaotic world, they also allow power/knowledge to operate. Just as in psychiatry (cf. Foucault, 2006a), classification is a normalising practice that serves to identify, exclude, gather knowledge on, or reform *deviant types*. In the realm of the global politics of development, categorisation is a discursive strategy that links these categories to "structures of power that produce effects of truth" (Merlingen, 2003, p. 366).

Despite the general critique of these terms, they are still used widely, particularly within the development community and official government documents. The South African government considers South Africa a 'developing' country, as is seen in its most recent *National Development Plan* (National Planning Commission [NPC], 2012) and shapes its entire project around the goal of *developing* – whether it be its economy, its people, its institutions, or the entrepreneurial spirit of its citizens. Particularly since 2004, the government has referred to South Africa as a *developmental state* and has elaborated specific goals in achieving this status. The notion of the developmental state is mostly associated with the Asian Tigers'[7] approach to state-led macroeconomic planning that has led to high levels of economic growth (C. Johnson, 1982; Leftwich, 1995). While some have pointed out the potential authoritarian aspects inherent in such an approach to governing, and others have argued that the South African conditions are incompatible with a developmental project (cf. Fine, 2010; Fryer, 2009; Van Dijk & Croucamp, 2007), the South African government has insisted that their blend of democracy, growth and equity is the way forward with its definition of a developmental state as "an activist state that intervenes decisively in the economy with a generally progressive agenda" (African National Congress [ANC], 2007, see glossary).

The aim of my project is not to functionalise or agree with any type of classification. Instead these classifications illuminate my project. What is important is to understand how categorisation operates. For Foucault, categories are discursive formations based on a set of rules that is organised around a system of knowledge. This begs the questions of what these categories produce, and enable, and how technologies of measurement and comparison function. In terms of referencing, the progressive rule to follow is usually to refer, quite simply,

[7] The Asian Tigers include Hong Kong, Singapore, South Korea and Taiwan: four Asian countries that experienced rapid industrialisation and managed to maintain a high growth rate since the 1960s, a period in which most countries of the Global South were lagging.

to a country by its name. For simplicity's sake I will refer to the 'Global South' when generally discussing phenomena that can be reasonably argued to have a shared attribution of those countries with a history of colonialism, imperialism and modernisation forced on them by the West – in the spirit in which the term 'Global South' was first selected (Grovogui, 2010). In doing so it is always important to remember the massive variance among these countries, whether it be in their 'traditional' practices, the way they were colonised, the way resistance took form, and the various tactics deployed in colonizing and modernising them.

1.5. Colonial context of South Africa

As a post-colonial country, South Africa has been subjected to the vagaries of Western states. European association with what is now called South Africa dates back to the end of the fifteenth century when the Portuguese circumnavigated what they called the Cape of Good Hope. The Dutch East India Company established a base in the seventeenth century, in the main to provide medical care and food to ships passing by on their way to India (Davenport & Saunders, 2000). Several swathes of settlers would arrive over the next few centuries from various European countries including the Netherlands, Germany and France. Slaves were also imported by the Dutch from the East-Indies (now Indonesia). The variety of settlers and slaves, as well as the local inhabitants, mainly the Khoi-San in the Cape, and the Xhosa, Zulu, Basotho and Bapedi in the East and North, make up the genealogical origins of most current South Africans.

One of the results of the Napoleonic Wars (1803 – 1815) was that the British were given the Cape as a prize. The British proceeded to outlaw the use of the Dutch language. This resulted in many Cape settler inhabitants, who came to be known as the Boers, to head inland. Thousands of British settlers were also 'imported' and settled in what is now the Eastern Cape. Clashes between the locals, especially the Xhosa, Basotho, Ndebele, Bapedi and Zulu, and the Boers and British Settlers were numerous. The Boers claimed their own republics, which included the Transvaal (now provinces of Gauteng, Limpopo and Mpumalanga) and the Orange Free State (now Free State province) which the British ceded to them in the mid-nineteenth century. This peaceful arrangement between the Boers and the British lasted only until the discovery of diamonds and gold in the independent republics. The British annexed the Transvaal in 1877, leading to the two Anglo-Boer Wars. The victorious British unified the various colonies into the Union of South Africa, an independent Dominion of the British Empire. Black people were denied the franchise and the 1913 Natives' Land Act identified 8% of South African land and apportioned it to the 'natives' (referred to as the 'Bantustans'). These

types of segregationist and discriminatory laws would only intensify when the National Party took power in 1948, officially launching the apartheid era (Davenport & Saunders, 2000). South Africa became a republic after a referendum was held in 1960 in which only white people voted. After increasing opposition, both locally and abroad, especially by the ANC and other revolutionary parties and groups, the National Party agreed to the introduction of universal franchise, and the first democratic elections were held in 1994.

During apartheid white South Africans enjoyed one of the highest living standards in the world.

> In terms of education, health facilities, housing, pensions, and recreation whites are served as well as any advanced industrial country and non-whites in grossly inadequate terms. (Legassick, 1975, p. 229-230)

This had a significant impact on the shape of the health system that the democratic government inherited. The (relative) autonomy granted to the Bantustans meant that these 10 homelands served as dumping grounds for superfluous black South Africans who were not needed to work on white-owned mines, farms and homes. This autonomy also meant that the impoverished homelands were responsible for providing social services, including health care, to their occupants. As a result, the new democratic government inherited both world class public health facilities (such as the academic training hospital, Groote Schuur, also the site of the world's first heart transplant in 1967) as well as large swathes of rural areas with either no, or severely poor health service provision.

South Africa historically had some interesting developments in public health policy and practices such as the 1944 Gluckman Commission's proposals for a cross-race risk-sharing system of universal health care and Sidney and Emily Kark's experiments in social medicine at the Pholela Health Care Centre (Geiger, 1993; Digby, 2008). However, the defining feature of the inherited system in 1994 was its two-tier character. The apartheid government had chosen not to regulate the private health sector and thus by 1994 the majority of those who could afford medical aid or out-of-pocket private health costs were no longer using the public health sector. This phenomenon has not changed. The South African public health system is generally perceived to be of inadequate quality compared to the private sector and, as a result, those who can afford it utilise the private sector. As a result, resources, both financial and human, flow to the private sector. This negatively affects the public health sector by, among other things, inhibiting the redistributive characteristics that make systems such as the British National Health Service successful (Du Plessis, 2013). This has enabled the enduring trend in which middle and upper-class South Africans utilise the private health system and working

class and poor South Africans the public system. There are intentions to remedy this situation by instituting a National Health Insurance, which is currently in its pilot stage.

1.6. The context of maternal health policy in democratic South Africa

In 1994, South Africa held its first democratic elections in which an alliance consisting of the ANC, the South African Communist Party and the Congress of South African Trade Unions (COSATU) won just under two thirds of the majority vote. The Interim Constitution, which had been drafted prior to the elections as part of a negotiated settlement by various parties, ordered that a Government of National Unity be formed between the three dominant political parties at the time. As such, the first democratic government of South Africa included the ANC, the National Party and the Inkatha Freedom Party, with Nelson Mandela as president. The production of new policies to replace apartheid era rule was high on the agenda of the new government and after some negotiation between the alliance partners, various national interest groups, as well as major international organizations, the ANC's social and economic framework and election platform, the *Reconstruction and Development Programme* (*RDP*) (ANC, 1994b, often refered to as the 'Base Document') was adopted and drafted into white paper format (Republic of South Africa [RSA], 1994)[8]. Based on the *RDP*, the ANC health group produced a *National Health Plan* (ANC, 1994a).

Along with a complete restructuring of the health system based on a primary health care (PHC) model, the *RDP White Paper* set, as one of the objectives of the Department of Health, the development of a maternal and child health (MCH) programme "that includes free services to needy pregnant and lactating women and children under 6 years" (RSA, 1994, p. 65). The focus was to be on access through the provision of the necessary infrastructure and services. The ANC's *National Health Plan* (ANC, 1994a) outlined the MCH policy. Apart from calling for 24-hour free health care for women and children under six at community health centres, the

[8] As the programme that was to direct the reorientation of the entire process of government, the *RDP* has been subject to detailed analyses, most of which have focused on the economic framework outlined in it; whether it is neoliberal or socialist intentions that dominate; and how much the negotiations compromised the vision of the *Base Document* (cf. Adelzadeh & Padayachee, 1994; Corder, 1997). After its perceived failure in the economic arena, a macro-economic policy framework, the *Growth, Employment and Redistribution* (*GEAR*), was introduced to target the country's fiscal deficit particularly (National Treasury [NT], 1997). The social objectives of the *RDP* remained largely intact, but COSATU, specifically, criticised *GEAR* heavily for it neoliberal approach. In 2005 *GEAR* was replaced by the *Accelerated and Shared Growth Initiative for South Africa* (*ASGISA*), updated to produce an economy that provides employment. The *New Growth Path* (*NGP*) of 2010, as well as the *National Development Plan* (*NDP*) introduced in 2013 are also socio-economic development policies focused particularly on the reduction of unemployment through economic growth. While the *RDP* played an important role in guiding the restructuring of the health system, the subsequent documents have had little effect on health care provision, nor maternal and antenatal health services.

interventions also focused on public health interventions such as “prevention and promotive activities, school health services… contraceptive services, [and] nutrition support” (ANC, 1994a, p. 4).

The *National Health Plan’s* proposals were translated into white paper format in 1997. As the *Health Plan* put forward, the *White Paper on the Transformation of the Health System* (NDoH, 1997) produced a framework for the implementation of a health system based on the PHC model, advocated by the WHO, as well as the PHC model’s institutional framework, the DHS. PHC is predicated on a specific definition of health that has played a fundamental role in shaping health services in South Africa. Along with its institutional framework, PHC is the subject of analysis of chapter five. This analysis will lay the groundwork for that of pregnancy-related policies and interventions which is the subject of chapter six.

The MCH programme was outlined by the National Maternal, Child and Women's Health (MCWH) Committee (MCWH, 1998). This document outlined the delivery, organisational and management structure for the health care provided to women and children within the overall structure of the newly restructured health system. The framework drew on the DHS and PHC approaches stipulated in the *Health Plan* and the *Health White Paper*.

The late 1990s saw the introduction of a variety of general surveillance mechanisms, including a census in 1996 and the first Demographic and Health Survey, deployed in June 1999. While the Minister of Health established a Committee in 1994 to facilitate the development of a national strategy for the implementation of a comprehensive National Health Information System for South Africa (NHISSA) (NDoH, 1997), the system had not yet produced data. In 1997 a measure was introduced making maternal death notifiable by law. This instrument, the Department of Health argued, “would enable us to investigate every maternal death and take steps to deal with preventable causes” (NDoH, 1999, p. 20). To make use of the information on maternal deaths, the Department of Health established the NCCEMD. The NCCEMD, modelled on the British clinical audit system, was tasked with identifying the major causes of death among pregnant women and recommending strategies for preventing these deaths, including management protocols for specific causes of death, assessing staffing norms, and recommending guidelines for a variety of reproductive issues. The NCCEMD produced their first report in 1999 entitled *Saving Mothers: Report on Confidential Enquiries into Maternal Deaths in South Africa, 1998.* The NCCEMD has published full reports triennially with interim reports scattered in between (Moodley, 2003; NCCEMD, 1999, 2000, 2002, 2004, 2006, 2008,

2012, 2014, 2015). The latest available full report (the sixth) was published in 2014 with an interim report in 2015.

Guidelines for the management of specific issues related to the management of pregnancy and childbirth were commissioned and appeared regularly after the reports, such as: the five most common conditions (NDoH, 2001b, 2007a), HIV/AIDS (NCCEMD, 2004; NDoH, 2015c), genetic disorders, birth defects and disability (NDoH, 2001a), intrapartum care (Medical Resource Council [MRC], 2005), and postpartum haemorrhage (NDoH, 2010a). Policy and management guidelines for public institutions were produced by the Collaborative Guidelines Group (eventually renamed the National Maternity Guidelines Committee).

The NCCEMD and the MCWH Committee identified several issues that were contributing towards the high maternal mortality and morbidity rates in South Africa. These are discussed in depth in chapter six. Most important, however, was the severe lack of quality care available to pregnant women utilising the public health system which was especially compounded by a lack of expertise among health workers. Thus, in the years following the introduction of the audit system, the focus was on improving standards of maternal health care. These interventions are discussed and analysed in chapter six.

From around 2008, several developments occurred in the health system in terms of maternal health. These developments were in line with several global trends. The first was a renewed focus on community health workers (CHWs). CHW is an umbrella term for a type of resident aide, usually informally trained, and drawn from a local community (Lehmann & Sanders, 2007). They are usually volunteers trained to perform a specific task or to perform a wide range of developmental or health-related tasks in their immediate vicinity. These informal workers are considered by the WHO to be an integral part of the DHS framework, facilitating many of its core aspects such as participation, mobilisation and health promotion (WHO, 1989, 2006b). CHWs were widespread in South Africa between 1970 and 1994. Although CHWs were mentioned in the initial *Health Plan*, the democratic government did not immediately incorporate them into the system and most of the previous CHW programmes collapsed (Van Ginneken, Lewin, & Berridge, 2010). New and existing non-profit organizations (NPOs) have been operating in South Africa since 1994, doing CHW-related work, especially around HIV/AIDS and child health. Many of them were funded by the National Department of Health (NDoH) and the National Department of Social Development (NDSD).

A renewed interest in CHWs was initiated in 2003 following a national Lekgotla on CHWs (Friedman, 2005). A *National Community Health Worker Policy Framework* was drafted, and its most recent iteration appeared in 2009 (NDSD & NDoH, 2009). The document changed the contractual basis of the funding of CHW-related NPOs and proposed that CHWs would become state employees. The changes caused some chaos as the government funding for NPOs was removed while the promises to employ existing NPO community workers did not materialise (Malan, 2014). Movement in CHW policy complemented the WHO's refocus on CHWs (see WHO, 2006b) as well as the Minister of Health's visit to Brazil in 2010. Health Minister Aaron Motsoaledi proposed a 're-engineering of PHC', based on the Brazilian model. Among proponents of CHW, Brazil's Family Health Programme is often referenced as a good example of a successful CHW project (Lehmann & Sanders, 2007).

Fulfilling the Millennium Development Goals (MDGs) was extended to 2015. However, nearing the new deadline, South Africa was not getting any closer to meeting them. The under-five mortality rate remained constant around 60 per 1 000 live births and the maternal mortality rate (MMR) was still around 150 per 100 000 live births (NDoH, 2010b). The goal was to reach an under-five mortality rate of 20 per 1 000 and a MMR of 38 per 100 000 live births by 2015.

In 2008 the WHO embarked on a "renewal of primary health care" outlined in the *World Health Report* (WHO, 2008, p. xi). This renewal exemplified the incorporation of a variety of new practices and ideas that had come to dominate over a few decades, known now as New Public Management (NPM). NPM represents a philosophy and practice about public sector administration, organisation and management that emerged with the incorporation of behaviourist theories into the 'science' of public administration (Minogue, Polidano, & Hulme, 1998). NPM focuses on reorienting the public sector towards being more accountable, reducing waste and inefficiency, and being more flexible in the face of globalisation.

These developments were evident in Minister Motsoaledi's 're-engineering' of the South African health system. Re-engineering followed the signing, by all government departments, of the *Negotiated Service Delivery Agreement* (NSDA), a performance agreement in which Outcome Two was focused on the health system entitled "A Long and Healthy Life for All South Africans" (NDoH, 2010c). The NSDA provided targets, or outputs, that had to be met by 2014.

The Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA), an African Union (AU) Commission initiative, was launched in 2011. The AU

refocused their attention on the MDGs that had been most inadequately achieved – such as that of improving maternal, newborn and child health (goals four and five). The *Continental Policy Framework on Sexual and Reproductive Health and Rights* was endorsed in 2006 by all AU heads of states and the *Maputo Plan of Action* was produced to meet the extended MDG deadline of 2015. The *Plan* was eventually revised to inform the continental Sexual and Reproductive Health Rights policy direction post-2015. CARMMA was their campaign for reducing maternal and child mortality within this overall framework (NDoH, 2012a). CARMMA was an attempt to garner political will and produce movement in an area that had received little attention on the continent.

Following the NSDA agreement and the renewed focus on the MDGs, especially the shortfall on the goals on maternal and child mortality, a *Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Afric*a (NDoH, 2012b) was produced. This time the focus was on community-level interventions and the introduction of "ward-based PHC outreach teams". These teams were to provide "community-based services" (NDoH, 2012b, p. 9). Drawing on the *Framework for Accelerating Community-based Maternal, Neonatal, Child and Women's Health and Nutrition Interventions,* the *Strategic Plan* incorporated the suggested community services into that of the outreach teams. These services included home visits, recruiting and organising mothers into support groups, and organising health promotive outreach work.

Drawing, among others, on the policy frameworks, audit reports, and clinic guidelines, I provide an analysis in this dissertation of the interventions proposed and instituted by the South African government to affect the health and survivability of pregnant women in and through the public health system. From a governmentality point of view, a state would aim to affect the health and survival of individuals by drawing them into relations of power so that their conduct can be conducted, or, so that they can be *governed*. The aim, then, is to describe how pregnancy is governed in South Africa. I identify and analyse the discourses which were intended to accomplish the project of governmentalising health.

Despite the focus on government policy and procedure, I will not be doing a straight-forward health policy analysis. When using Foucault, the focus is instead on *problematisations* and *practices*. Practices that were introduced to reduce maternal mortality and morbidity are 'products' of these problematisations. As such this dissertation is a description, from a Foucauldian point of view, of how current maternal health practices have come to take the form

they take today and what rationality lies behind these practices. The next chapter focuses on the struggles over the shape and meaning of pregnancy and childbirth-related practices, especially linked to clinical practice. While these struggles have been most prominent in the West, they have had fundamental effects on the shape and meaning of pregnancy-related practices imported and adopted in the Global South.

2. Knowledge production on childbirth and pregnancy

One of the fundamental aspects of liberal governmentality is it “polymorphism” (Foucault, 2008, p. 320): a liberal rationality employs persistent self-critique as a means of constantly reforming itself. This rationality employs technologies of freedom; that is, it positions its subjects as both free and unfree, thus laying the basis for claims that freedoms are limited. Feminists have generally approached the government of pregnancy from the point of view that biomedicine has produced practices which conflict with the autonomy of pregnant women. This chapter provides a brief historical overview of feminism’s various approaches and argument for and against the current government of pregnancy and childbirth, both in the West and in the Global South.

Mainstream historiography of modern obstetrics reads like most orthodox accounts of scientific, medical and technological developments. These narratives are usually triumphalist in nature and the motives of key players are presented as self-effacing. In these orthodox historiographical accounts, the concept of ‘progress’ stands in direct opposition to pre-modern practices as well as those that are not based on pure scientific principles or Enlightenment reasoning. Underlying these orthodox historical narratives is a technological determinism that suggests that all interventions in pregnancy and childbirth are automatically progressive, and thus “having directly transformed women’s lives for the better” (Wajcman, 1994, p. 155). All favourable evidence such as a reduction in maternal mortality rates are attributed to these scientific, medical and technological advancements. These narratives often reinforce the gendered division of healthcare provision:

> Traditional historians describe the development of modern obstetrics as a process wherein childbirth was removed from a female realm of ignorance and superstition to the enlightened realm of male physicians with the scientific knowledge and technical skills needed to rescue women from the risks and pain of childbirth. (Sawicki, 1991, p. 75)

This process of the production of ‘authoritative’ knowledge is constantly being challenged both from outside and inside medical disciplines. From within, scientific findings and methodologies are continually being refined and/or challenged by new knowledges. For instance, in the 1970s there was the emergence of a renewed focus on the social aspects of

disease causation and an additional focus on the psychological dimensions that impact on, for instance, pregnancy outcomes (Engel, 1977; Porter, 2011). The uneven adoption by scientists of this new 'bio-psychosocial model' represents the contestations within medicine concerning the framework that should be adopted to study the causes of illness. The new medical model opened new areas of study and one result has been that in the last half a century empirical research on pregnancy and childbirth has been prolific.

As for challenges from outside, this chapter begins with a discussion of what is perhaps the greatest and most prominent onslaught against the medicalisation of pregnancy since the seventeenth and eighteenth-century midwives published their treatises and manuals to defend their profession.[9] This new onslaught formed part of a general health movement that began in the 1960s in the USA in which women revolted against what they deemed an oppressive sexist medical system. This health movement was itself only one aspect of a greater resistance against a patriarchal culture in the West. As such, feminists were not necessarily fighting the hegemony of science and the discrediting of their profession like some of their pro-feminist midwife forebears, but rather strategically drawing on a variety of tactics to attain their goal of equality between the sexes. This literature set a precedent for subsequent critical work on pregnancy and childbirth. What follows is a review of critical work on pregnancy and childbirth that has shaped, or attempted to shape, the way pregnant women are governed in the West.

A great many of these ideas also animate or have animated discussions and anxieties in countries that are not deemed 'Western'. After the discussion of critical feminist scholarship on pregnancy and childbirth, I move on to discuss the various approaches to these topics in the Global South. While there are feminist writings on childbirth and pregnancy in the Global South, they tend to reproduce Western ideas. In the Global South the topic of childbirth and pregnancy is dominated by developmentalist ideas, both inside and outside feminism.

Perhaps the most prominent voice globally in policy development and implementation in childbirth and pregnancy, especially in the Global South, is that of the UN agency, the WHO. Developmentalism is introduced alongside its theoretical considerations in chapter four and is

[9] See for instance midwifery manuals and treatises produced in the seventeenth and eighteenth century such as Elizabeth Nihell's defence of traditional midwifery practice and attack on the use of forceps in *A Treatise on the Art of Midwifery: Setting Forth Various Abuses Therein, Especially as to the Practice with Instruments* (1760). Other examples include Jane Sharp's *The Midwives Book, Or the Whole Art of Midwifery Discovered* (1671), and Sarah Stone's *A Complete Practice of Midwifery* (1737). For contemporary histories on these midwives see Monica Green (1989, 2009), and Elaine Hobby (1999) for good introductions.

followed by a historical outline of the UN's, and the WHO's focus on women and the evolution of these organisations' maternal health policies.

2.1. The 1970s: Feminism's re-interpretation of the medicalisation of pregnancy

In the 1970s a powerful feminist critique of the medicalisation of pregnancy and childbirth emerged. These texts were part of a more general critique of medical practice and its effect on women that began in 1969 with the creation of the Women's Health Movement in Boston, USA. The Women's Health Movement emerged in an environment where radical activism had become an important aspect of American politics and where major ideological and institutional changes were apparent within the Left (Morgen, 2002). While the Women's Health Movement emerged in the USA, it quickly spread to England and the rest of Europe. Consciousness-raising was already an important feminist tactic and the famous text produced by this movement, *Our Bodies, Ourselves* (Boston Women's Health Collective, 1970) focused on educating women with the aim of allowing them to "take their health care into their own hands, to wrest back some control over their sexuality, their reproductive lives, and their health from their doctors, and particularly their obstetrician-gynaecologists" (Morgen, 2002, p. 3).

Campaigns for reproductive rights became widespread and although the main foci were on the right to abortion and safe contraception, many campaigns criticised the societal pressure on women to be mothers. These groups often tackled very practical and localised issues such as campaigning for adequate antenatal care (cf. Maldonado, 2013). Barbara Ehrenreich and Deirdre English (1973a, p. 1) provide a particularly poignant example of the perceived need for critique in the 1970s:

> The medical system is strategic for women's liberation. It is the guardian of reproductive technology – birth control, abortion, and the means for safe childbirth. It holds the promise of freedom from hundreds of unspoken fears and complaints that have handicapped women throughout history. When we demand control over our own bodies, we are making that demand above all to the medical system. It is the keeper of the keys.

In the academic sphere the critique of the male-centeredness of medicine featured most commonly and the majority of texts focused on the historical transformations in healing practices, specifically the medicalisation of childbirth (Barker-Benfield, 1976; Daly, 1978; Donnison, 1976; Dworkin, 1974; Ehrenreich & English, 1973a, 1973b, 1978; Leavitt, 1983; Oakley, 1976) showing, among other things, how medical practices have produced and reproduced gender roles (Ehrenreich & English, 1978; H. Graham & Oakley, 1979; Oakley,

1979; Scully & Bart, 1973). In these texts the general tendency of mainstream medical historiography to present medical men as great minds with good intentions is turned against itself; this is representative of what Juliet Mitchell and Ann Oakley (1976, p. 7) call an "anti-text:" "a text that could be set against the ideological message of orthodox literature on the position of women."

In these texts, the critique of patriarchy is premised on the shared conviction that there existed at some point in history a time when women monopolised practices associated with childbirth and pregnancy: a time that is represented as a type of 'golden age' for pregnant women. This era is sometimes depicted in overly romantic terms where women were in control of their own reproductive choices, and the labour process was happy and fulfilling. In these texts ancient women healers are represented as having practiced a "more humane, empirical approach to healing" (Ehrenreich & English, 1973b, p. 20). The women-centred approach to childbirth is depicted as playing an important role in creating bonds and reproducing a 'domestic culture' among women (cf. Leavitt, 1983; drawing from Smith-Rosenberg, 1975). The scientific advancements that occurred in pregnancy and childbirth, the establishing of obstetrics, the appearance of male-midwives and the hospitalisation of birth since the eighteenth century are described as having been a *negative* development. The sordid details of (male) medical advancements are unearthed, particularly those that impacted negatively on women. In the process, the great mythical medical men were provided with new biographies. J Marion Sims, celebrated by medical historiography as the father of gynaecology, for instance, is described as having been "known for his hatred and abhorrence of female organs," which he "remedied … (becoming very rich in the process) by ruthlessly cutting up women's bodies" (Daly, 1978, p. 225).

The high maternal mortality rate in the West was attributed to the type of care women received from obstetricians in clinical settings. Obstetricians were accused of subjecting women to stress and discomfort. Along with this type of medical care, the pressures of society and the roles women were required to fulfil resulted, according to these authors, in a very negative experience of pregnancy and childbirth:

> Childbirth has been transformed from an awesome personal and social event into a medical phenomenon, from a heroic ordeal into a meaningless and chaotic one; physical pain which we can bear has been transformed into mental stress, which we are less well geared for. (Greer, 1984, p. 22)

> The cultural need to socialize childbirth impinges on the free agency of women who are constrained by definitions of womanhood that give maternity an urgency they may not feel. (Oakley, 1979, p. 608)

This feminist focus has become known as the *medicalisation of childbirth thesis*. This thesis bears resemblance to a larger movement and intellectual tradition that critiqued the process of medicalisation, generally referred to as 'anti-medicine' or 'the medicalisation critique' (Lupton, 1997). Proponents of anti-medicine are critical of the process of medicalisation and view medical authorities with some disdain (Carlson, 1975; Illich, 1977; Szasz, 1971, 1972).[10]

Within these feminist texts the medieval witch plays an important role and anchors the critique of patriarchy (cf. Daly, 1978; Dworkin, 1974; Ehrenreich & English, 1973b, 1978; Oakley, 1976; Rich, 1976). In this narrative, the medieval witch is redefined as a healer and a midwife. These writers draw specifically from the 1486 manual for witch burnings *Malleus Maleficarum*[11] wherein midwives are called witches. The connection between the witch and the healer was first brought forward by anti-psychiatry writer Thomas Szasz (1971) who presented the inquisition as having paved the way for the development of psychiatry. Several of the most prominent feminist writers discussed here drew extensively from the work done in anti-psychiatry and anti-medicine and take the witch/midwife argument from Szasz' *The Manufacture of Madness* (1971). In this new narrative, all witches were women and the witch trials were well-orchestrated attempts at destroying women, specifically their 'unscientific' healing practices, or their evil femininity, as part of a greater aim of bringing women under men's control. The witch-hunts are depicted as the first concerted attack on women by patriarchy, and these hunts paved the way for psychiatric and medical institutions to take over the role of providing medical services.

The witch-hunts heralded the production of this all-male authoritarian medical system and the rise of scientific medicine. The subsequent professionalisation of the medical domain from the seventeenth century onwards is seen as having been an "active *takeover"* of medicine "by male professionals" (Ehrenreich & English, 1973b, p. 20). It was often reasoned that medicine is a new form of patriarchal religion and that it has replaced religion as the "prime source of sexist

[10] This includes not only the medicalisation of the body, but also the mind. The literature that focuses specifically on critiquing the development of psychiatry is often referred to as *anti-psychiatry*.

[11] Ehrenreich and English (1973b, p. 25) call the *Malleus* "the unquestioned authority on how to conduct a witch hunt"; Mary Daly (1978, p. 180) calls it "the most important catechism of demonology." She also argues that due to the fact that "'maleficarum' is the feminine form of the word for evil-doer/witch… it contributed mightily to the overwhelming focus on women during the following centuries" (Daly, 1978, p. 188).

ideology and enforcer of institutional sexism" (Ehrenreich & English, 1973a, p. 87; see also Raymond, 1982).

The more radical feminists argued that the intentions of men, and as such the very reasons for the development of medicine, were to get rid of women entirely and to replace the functions of women with their technologies. What Mary Daly (1978, pp. 226-227, 245) calls "gynocide" is men's "final solution" in the form of medicine; a patriarchal "will for male motherhood".[12] More often, though, the reasons are presented as political and economic and towards the ends of "profits and prestige" (Ehrenreich & English, 1973b, p. 20). These writers, however, share the conviction that 'control' is the ultimate goal as Ehrenreich and English (1973b, p. 20) notes: "total control of medicine means potential power to determine who will live and will die, who is fertile and who is sterile, who is 'mad' and who is sane".

In these texts Western practices are often contrasted against a homogenous 'other world' referred to as 'traditional cultures', the likes of which anthropologists like Margaret Mead 'uncovered', and which these writers took as a point of reference to explain how the West practiced childbirth before it was modernised. Some anthropologists aim "to show the effectiveness in scientific terms of such alternatives to medicalized systems" as well as attempt to persuade people "that human 'hard-wiring' suggests that other cultures' practices may be preferable to ours for birth and perinatal care" (Ginsburg & Rapp, 1991, p. 312). Those writers who are willing to admit maternal and infant mortality rates may be higher in these 'traditional cultures,' do so in such a way that presents these cultures as better off for it, since it teaches them to accept death in a way 'Westerners' have forgotten:

> Clearly, infant and mother mortality is greater in traditional births, but in our anxiety to avoid death we may have destroyed the significance of the experience for the vast majority who live. (Greer, 1984, p. 22)

[12] This critique can be better understood by taking a look at the ideological premise of these writers – a group of feminists who call themselves 'radical feminists' (cf. Daly, 1978) and whom Linda Alcoff (1988) and Alice Echols (1983, 1984) prefer to call "cultural feminists" since they "define women by their activities and attributes in the present culture" (Alcoff, 1988, p. 407). These writers were part of a movement of feminists who rejected the arguments made towards an androgynous feminist politics by the likes of Betty Friedan and Simone de Beauvoir (Eisenstein, 1984). The new 'real' radical feminists reclaimed the difference between the sexes, as Daly (1978) herself argues in *Gyn/Ecology: The Metaethics of Radical Feminism*, as a form of protest against reform and co-optation (Makus, 1996). Within this movement then the tendency to denigrate everything connected to men and masculinity was strategic and inevitable since the project of liberation was connected to reclaiming and reinforcing the essential characteristics of women. Radical feminists were not a homogenous group and it also did not mean they were not critical of the given definitions of 'woman' – indeed they saw gender roles as having been created by patriarchy and therefore in need of redefinition – women, they argued, were to be provided with a more accurate feminist description (Alcoff, 1988, p. 407).

It is this (modern) fear of death that transforms birth into a cycle of anxiety and terror that is argued to have ultimately allowed women to believe the promises made by medical men (cf. Leavitt, 1983).

The medicalisation of childbirth thesis relies on a narrative based on a dichotomy between natural and unnatural birth where homebirth attended by a midwife is depicted as natural, and hospitalised birth attended by (male) physicians 'unnatural'. As such the historical narrative depicts the transformation of birth from a natural into an unnatural phenomenon (cf. Oakley, 1976; 1984). The traditional midwife treated pregnancy as a "normal process" based on "an empiricism which values experience rather than 'professional' training"; medically trained obstetricians instead saw pregnancy as a "medical condition fraught with all sort of dangers: a condition that can only be 'cured' by the authoritarian benevolence of professional medicine" (Oakley, 1976, p. 18).

This narrative inspired the 'natural childbirth movement'. This movement often referred to the continuing and perhaps intensifying medical management of pregnancy and childbirth as the "*childbirth crisis*" and called for a "*childbirth revolution*" (Treichler, 1990, p. 113). An important ideological driver for this movement was Suzanne Arms' book *Immaculate Deception* (1975) in which she argued that medicine redefined pregnancy as unnatural in order to make hospital birth and medical interference the norm. The *deception* was the *promise* of a 'no-risk' birth, *if* women allowed medical men to take control of their births. The movement attempted to reclaim a more 'real' childbirth experience by wresting it away from obstetricians and gynaecologists. The medicalisation of childbirth thesis exposed the 'motherhood mystique'[13] and painted modern reproductive practices as brutal. Oakley (1984, p. 236) argues that this caused a "consumer revolt" as women formed formal organisations and rallied against certain medical childbirth practices.

Apart from radical feminist organisations, a variety of alliances were formed between childbearing women and those who stood to benefit from a 'natural childbirth' revolution, including midwives and a variety of consumer organisations. At their beginning they were perceived by organised medicine to be nothing more than "a kind of wild and crazy conglomeration of nonprofessionals" (Treichler, 1990, p. 113), but few would argue that this movement did not have an impact, at least in the USA and Britain. At the least it sparked a

[13] The motherhood mystique predicates that women are meant to be mothers and that motherhood provides the ultimate fulfilment to all women (Skott, 2016).

confrontation with the dominant voices speaking for pregnancy and childbirth and challenged the legitimacy of the truth claims made in the name of biomedical and technologized practices.

2.2. The 1980s: The critique of 'man'-made technologies

The initial attack on the medicalisation of childbirth was exemplified by its focus on agents in medicine – gynaecologists, obstetricians, and midwives – and the power relations and gender stereotypes that accompanied their practices. From the 1980s onwards, the focus shifted systematically towards a critique of technological advancement in reproductive medicine. These technologies came to be referred to as New Reproductive Technologies (NRTs) and were considered to have their birth along with that of the first test tube baby in 1978 (Arditti, Klein, & Minden, 1984b). NRTs were defined as "a broad constellation of technologies aimed at facilitating, preventing, or otherwise intervening in the process of reproduction" (People's Health Movement, 2011, p. 304). It involved technologies of fertility control (diaphragms, intra-uterine devices, sterilisation, abortion, condoms, etc.), for managing labour and childbirth (forceps, the birthing chair, stirrups, caesarean sections, chemicals that induce labour, episiotomies, etc.), for finding or fixing potential problems and defects in the foetus (amniocentesis, foetal therapy, sex selection, etc.), and finally technologies that aimed to control infertility (artificial insemination, fertility drugs, and in vitro fertilisation).

The criticism of NRTs was part of the feminist critique of the medicalisation of childbirth, premised on the fear that the process of reproduction was turning into a technological and unnatural event and that a variety of unnecessary procedures were being ritually incorporated by male doctors to bolster their legitimacy as experts over the female body. The critique of the use of instruments in the childbirth process was not new. Female midwives launched a powerful condemnation of the forceps in the seventeenth century (Nihell, 1760; Sharp, 1671). Modern procedures that formed part of the criticism of obstetricians as patriarchal agents in the 1970s included shaving pubic hair, giving enemas, episiotomies, clinically induced labour practices, and administering anaesthesia (cf. Oakley, 1976).

In the 1980s, however, the Western media focused on the controversial recently-invented reproductive technologies such as test tube babies, embryo transplants, and cloning (Rapp, 1984). Alongside it a new burst of feminist literature appeared in a variety of academic disciplines focusing on the effects of such technologies. Jana Sawicki (1991, p. 73) notes how, within the broader history of male domination, this new phase was preoccupied with ways in which "domination perpetuates itself *as* technology." Historically, innovative technologies

were considered a new form of patriarchal control because “the locus of male control” shifted “from individual men in the context of the family to medical experts who derive their authority from science” (Sawicki, 1991, p. 76). NRTs were seen to be the latest and most deleterious of these developments.

While some technologies such as donor and self-insemination were embraced (cf. Hornstein, 1984; Klein, 1984) and libertarian feminists praised the choice-providing capabilities of NRTs, generally feminists, and particularly radical feminists, refused to take at face value assurances made by scientists “that women should be grateful for their inventions and that they had been developed because women wanted them” (Arditti, Klein, & Minden, 1989, p. xi). NRTs were not new and neutral inventions, it was argued, but instead “offer[ed] the possibility of controlling the lives of women at a level previously unheard of through the patriarchy’s public support, control and regulation of the technologies” (Arditti et al., 1989, p. xv). Robin Rowland (1984, p. 356) warned that these technologies gave men so much control over the reproductive process that very soon women would be marching “for our *right* to bear children and give birth if we want to.” All women were at risk of becoming ‘test tube women’ – the

> risk of being subjugated to a variety of controls: from technological interference when we are pregnant, to legal regulations that declare the fetus and the woman bearing it to be two separate ‘patients’, to workplace policies that pressure women employees to become sterilized. (Arditti, Klein, & Minden, 1984a, pp. 6-7)

These new technologies not only posed new and unknown risks to women, they also “allow for a greater scope for the application of eugenic policies” as well as potentially turning the “‘precious gift’ of a baby into something that money can buy” (Stanworth, 1987a, p. 1). In line with Daly’s (1978) fear that men are bent on total ‘gynocide’, Gena Corea (1985) argued that the development of NRTs is the next and final step in stealing the last source of women’s power – their procreative ability.

In 1984 The Feminist International Network of Resistance to Reproductive and Genetic Engineering (FINNRAGE) was formed. By 1985 the movement against reproductive technologies was so popular that an (all-woman) international conference was held in Germany with over 2000 delegates. More conferences were held in 1986, 1987, and 1989. Several proceedings were published including *Made to order: The myth of reproductive and genetic progress* (Spallone & Steinberg, 1987) and the journal *Reproductive and Genetic Engineering: A Journal of International Feminist Analysis.* Most of these feminists condemned reproductive technologies as a movement towards the eugenic programmes of the Nazi regime (Klein,

1989a). In Germany, some of these groups protested, sometimes violently, in the name of their cause. Labelled terrorists, they were harassed and arrested by the police. These women did not believe in the 'libertarian' idea that if women controlled these technologies they would not have as negative an impact, nor did they believe the argument that NRTs were about providing women with more choice (Hubbard, 1984; Klein, 1989a; Rothman, 1984).

These opinions were validated by widely publicised health calamities such as the Diethylstilbestrol crisis and the Dalkon Shield malpractice suits[14]; negative accounts by pregnant women of their experiences with reproductive technologies as well as with abusive clinical trials; damaging contraceptives; forced sterilisation; castration; and the exploitation of poor women for experiments (Corea, 1985; Gomez Dos Reis, 1987; Klein, 1989b; Klein & Rowland, 1988; Spallone & Steinberg, 1987).

These FINNRAGE writings involved closely examining new and artificial reproductive technologies and exposing the consequences involved in their development, experimentation, failure, continuing effects, as well as the power relations at play in their utilisation. The technologies critiqued included: prenatal diagnosis techniques such as amniocentesis (Kenen, 1981; Nielsen, 1981; Rapp, 1984, 1988b, 1991), in vitro fertilisation (Albury, 1984; Corea, 1984, 1985; Murphy, 1984), genetic manipulation/gene therapy (Minden, 1984; Rapp, 1988a), surrogacy (Dworkin, 1983), sex choice technologies (Hoskins & Holmes, 1984; Roggencamp, 1984; Rowland, 1985), foetal therapy[15] (Hubbard, 1982, 1984), contraception (Bunkle, 1984; Pollock, 1984), sterilisation (Clarke, 1984; Rodriguez-Trias, 1982), surgical abortion (Kaufmann, 1984) and ultrasound (Hubbard, 1984). Artificial reproductive technologies were seen by these feminists as new inventions to 'cure' infertility, encourage procreation, and reduce infant and maternal mortality *not so much in the name of women's well-being* but rather for population control and financial interests (Arditti et al., 1984a, 1989; Balasubrahmanyan, 1984; Bunkle, 1984; Murphy, 1984).

Speaking on the sudden popularisation of the use of ultrasound, Ruth Hubbard (1982, p. 202) noted how "the womb is no longer dark and opaque and with that the fetus is open to medical

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[14] Diethylstilbestrol is a type of synthetic estrogen that was prescribed to pregnant women between 1938 and 1971 in order to reduce the risk of miscarriage. The drug was outlawed for prescription to pregnant women in 1971 when a variety of health risks were linked to it. The Dalkon Shield was an intrauterine device (IUD) provided in the1970s as an alternative to oral contraceptives. The IUDs inventor AH Robins did not test his device for safety or efficacy issues. A variety of health problems were soon linked to the use of the IUD and Robins became subject to numerous lawsuits that eventually bankrupted his company.
[15] Foetal therapy is a set of medical and surgical techniques that is used to modify and improve the health of the foetus (Hubbard, 1984). See Hubbard (1982) for a detailed discussion.

manipulation”. One of the major foci in this area has been on the effects and aftermath of the visual appearance of the foetus. Ultrasound, Hubbard (1982, p. 202) argued, would lead to legal intervention in pregnancy. A few years later Hubbard argued that the visual appearance of the foetus resulting from the proliferation of ultrasound images was creating “a conflict of ‘rights’ between a fetus and the pregnant woman whose body sustains it” (Hubbard, 1984, p. 331).

Kristin Luker (1984) also connected the explosive abortion debate at the time to discussions around ‘foetal personhood’. Following on this theme, Rosalind Petchesky (1987) made the distinction between the ‘public foetus’ (representations of foetuses found in the public domain) and the ‘private foetus’ (the foetus that resides in the woman’s body). The ‘public foetus’ became an important concept in feminist writing/thinking. Joanne Boucher (2004, p. 70) distilled the definition of the public foetus from the various authors who utilised it:

> It is an autonomous being. The public fetus exists as a being in its own right, floating independently in the cosmos. Further, the public fetus represents ‘life itself.’ It stands for the origins of life. Its image, a product of medical/scientific technologies, ‘proves’ beyond a doubt when life begins. Finally, the public fetus has a powerful presence and personality. It is a gentle, peaceful creature embodying innocence.

It was the public contestations over the right to abortion that led to questions about foetal personhood (E. M. Armstrong, 2003). The new focus on the foetus influenced the preoccupations of research in the area of pregnancy and the various new social and psychological foci introduced into medical research in the 1950s led to scientists ‘discovering’ children born with Foetal Alcohol Syndrome (FAS, later renamed to Foetal Alcohol Spectrum Disorder (FASD)) in the early 1970s (cf. Jones & Smith, 1973). A variety of other scientific links between maternal behaviour and childbirth have since been made and there has also been an increased focus on the identification of risks to the foetus. These developments, along with the proliferation of visual images of the disembodied foetus, are argued to produce the image of the pregnant woman as violating the rights of the unborn child, which in turn leads to attempts to control the behaviour of pregnant women. This is possible since ultrasound technology disembodies the foetus which thereby excludes or renders the pregnant woman peripheral (Petchesky, 1987). In the public imagination, the foetus is provided with its own personhood and subsequently its own rights. The “social confusion about where women end and foetuses begin” leads to a “maternal-fetal conflict,” argues Monica Casper (1998, p. 5). According to this thesis, the rights of the unborn foetus are potentially directly opposed to the rights of the mother. In being the very body that keeps the foetus alive, the mother is held responsible for every possible negative outcome of the pregnancy.

Debates surrounding the temporary suspension of the rights of women during pregnancy were rampant in the 1980s (Petchesky, 1987), and continue today. As Hubbard (1984) feared, legal controls were put in place to force women to undergo medical procedures or treatments, and to criminalise a mother's refusal to take adequate precautions in the name of her own and her foetus's health.[16] Towards the more radical camp, Corea (1985) argued that the separation of mother and foetus was part of the process whereby the reproduction was fragmenting: an activity that was once unified was being broken up into separate parts from egg donation to adoptive motherhood. This process, she argued, is dangerous in the way it can take essential functions away from women which will allow for the final destruction of women.

2.3. Beyond radical feminism

To reclaim women from the inferior position they had come to occupy, the radical feminists utilised these typified distinctions between men and women to construct the image of the resourceful, powerful and quintessential feminine midwife-witch who practised a holistic care in a framework of universal sisterhood. As a point of reference, the *natural* midwife-witchcraft and its successor, modern midwifery and home birth was pitted against the 'man'-made *technological* practices of obstetricians and gynaecologists. The radical thesis underlies the criticism of the medicalisation of childbirth and the use of technological interventions in pregnancy. The critics of NRTs saw the choice that these new technologies brought as something more akin to a covert eugenic and patriarchal project and argued for a return to a 'natural' way of birth. Within the radical thesis, women are portrayed as being fooled and manipulated by a system wherein they have little agency and their only choices are "either total rejection of them or collaboration in our own domination" (Sawicki, 1991, p. 14).

An inherent problem that results from using essentialised and structuralist accounts of patriarchy as a tactic is that women's agency starts disappearing. On the one hand, a focus on structure reduces the level of *agency* accorded to individual women, and on the other, drawing on essentialised discourses leads to a neglect of *different experiences*. Margrit Shildrick (2004, p. 67) argues that it made sense for radical feminists to advance their project using this type of "oppositional thought and action" considering their agenda and the political climate of the time. These feminists were "part of a larger movement by Western feminists to re-claim their bodies

[16] See Reena Wani and Niraj Mahajan (2014) for an updated discussion on maternal versus foetal rights. They discuss how the shift towards foetal rights have allowed for laws to be put in place to force "noncompliant" pregnant women to undergo hospital procedures they have initially refused to do such as: "court ordered Caesarean sections, mandatory diet restrictions and incarceration for failing to follow medical advice" (Wani & Mahajan, 2015, p. 781).

and reassert the legitimacy of 'natural' self-care" (Snow, 1994, p. 147). Unfortunately, in the process of identifying those aspects of childbirth and pregnancy that men controlled, radical feminists became quite prescriptive about what the enlightened pregnant woman should do and for this, radical feminists came to be heavily criticised.

Most of the critical work done on pregnancy and childbirth in the 1970s and 1980s, as outlined above, were produced by radical feminists and therefore their underlying assumptions dominated and drove the field of inquiry. From the late 1980s onwards work on pregnancy started drawing less and less on the radical feminist frameworks and findings. An emerging feminist literature criticised the exclusively-negative descriptions of technological advancement in medical care (Stanworth, 1987b). These critics argued that "feminist critiques of 'the war against the womb' often suffer from certain tendencies towards reductionism" (Petchesky, 1987, p. 71). This narrative was argued to reproduce the very same views that are held by scientific and medical practice: a biological determinism, the male/female, technology/nature, mind/body dichotomies that are used to define women's place and the very "inflated view of science" that feminists were supposed to be fighting (Stanworth, 1987b, p. 17). This new focus put strain on the hereto seamless medicalisation of childbirth thesis which had been the basis of feminist work on childbirth and pregnancy. Feminists started to point out the problems with the immediate assumption that all reproductive technologies were products of patriarchy because technological practices in medicine were largely controlled by men. They argued that there were "many possibilities for a technological transformation of pregnancy that might benefit women" and that despite the fact that men were still controlling the majority of these practices, there were nonetheless "good reasons to avoid reducing patriarchal domination to its technologies" (Sawicki, 1991, p. 89).

The content of the radical critique was argued to be based on 'middle-class' and white preoccupations, and their tendency to present it as a universal experience of women was criticised. Black feminists had long argued against the universal model of women put forward by the white middle-class feminists (cf. The Combahee River Collective, 1977) and feminists within the disciplines of anthropology and history had been showing for some time how women's experiences were different across the world and did not conform to the universalising criteria often attributed to women by feminists in the West (MacCormack & Strathern, 1980; Riley, 1988; Rosaldo & Lamphere, 1974). Furthermore, feminists started noticing the discrepancy between the radical feminists' theoretical account of the medicalisation of childbirth as a negative experience and empirical research, showing that more and more women

were willingly choosing to use technological interventions (Denny, 1994). Studies were showing that since the 1950s in America the number of women who chose high-tech hospital births had increased substantially and continuously (Rapp, 1984).

As part of a general tendency in feminism at the time to provide women with more agency, research on NRTs started focusing on the ways in which women shaped their own experiences of pregnancy, and studying the conditions which constrained or promoted them in doing so (Firth, 2009). It was noted that:

> …women's relationship to reproductive technologies and images differs depending on social differences such as class, race and sexual preference, and biological ones such as age, physical disability and personal fertility history. Their 'reproductive consciousness' is constituted out of these complex elements, and cannot easily be generalised or, unfortunately, vested with a privileged insight. (Petchesky, 1987, p. 73)

Feminist anthropologists introduced agency into their analyses and started focusing on the processes "through which women are both subjects of and advocates for the medicalization of birth" (Ginsburg & Rapp, 1991, p. 322; see also Leavitt, 1986; Sarah, 1987). Others, particularly black feminists, started focusing on the intersecting inequalities that were embedded in patriarchy (hooks, 1981; Lorde, 1984a). Instead of studying a homogenous patriarchal mechanism, the focus moved towards individual or group experiences, and the notion of global sisterhood started to disintegrate (Ramazanoglu, 1989).

This new emphasis on difference and personal experience opened a productive area of inquiry for feminists. Women were now shown to embrace, resist and even shape these technologies according to their own needs. The focus of research moved on to the various classed, religious, and ethnic intersections that affected the choices pregnant women make (or can make) and how experiences can differ (Davis-Floyd, 1987, 1988; M. McDonald, 1981; Nelson, 1983; Rapp, 1984, 1991). For instance, initial studies framed by the medicalisation thesis showed how women's experience of childbirth depended on how much control they could exert over their childbirth process by *remaining conscious* (Doering, 1983; Entwisle & Doering, 1981). Later this argument was complicated when it was shown that while middle class women might desire this type of control, working class women preferred different controls – such as the control of pain – and thus might welcome intervention (Davis-Floyd, 1988; J. Gordon, 1988; Lazarus, 1994; McIntosh, 1989; Sargent & Stark, 1989).

This new focus also aimed to provide a more complex account of the ways in which women gained or lost control in the use of NRTs (Farrant, 1985; Franklin, 1990; Lorber, 1987;

Rothman, 1984; Sandelowski, 1990, 1991; Williams, 1988). Some writers were now willing to go as far as calling reproductive technologies a 'mixed blessing' (Woliver, 1989, 1990). There was also a focus on the social construction of NRTs: the discourses on reproduction that were shaped by them and the policies and procedures that were a result of their emergence (G. Sen & Snow, 1994; Wajcman, 1994). The focus on the relations between men and women came to be supplemented more and more with a focus on relations between women. The image of the woman as a universal victim of man-made reproductive technologies was to a great extent discarded and instead research came to focus on how these technologies were complex in the way that they "crystallize issues at the heart of contemporary controversies over sexuality, parenthood, reproduction and the family" (Stanworth, 1987b, p. 18).

It is out of these contestations over representation, agency, structure, and essence – where the 'woman' is both the object and subject of study – that 'third wave feminism' emerged (Gillis, Howie, & Munford, 2004).

> The concept 'woman' seemed too fragile to bear the weight of all contents and meanings ascribed to it. The elusiveness of this category of 'woman' raised questions about the nature of identity, unity and collectivity. Appearing to undercut the women's movement, fundamental principles of the feminist project were hotly contested. (Gillis et al., 2004, p. 1)

While not all agreed with the name, or even calling it another 'wave,' it was at this point when internal criticism in the feminist movement became a fundamental aspect of the movement itself. The solidarity that characterised the second wave was said to have led to the marginalisation of internal critique (Aronson, 2003). 'Third wave feminism' was generally associated with an explosion of new identity categories. With the deconstruction of sexuality, third wave feminism embraced queer theory, lesbian and transgender politics.

2.4. Black feminism in the West

Many of the most prominent third wave feminists were black and as such there was a renewed focus on the way black women specifically were affected by patriarchy, particularly in a context of white normativity. Postcolonial and black feminists criticised Western and white feminists[17] for being ethnocentric, discounting the experiences of those women who were not middle-class and white, and portraying women from developing countries as passive recipients of empowerment by Western feminists (Lorde, 1984b). Some argued that Western feminism's

[17] 'White feminism' was a definition coined to describe feminists who rallied around issues that affected privileged women, especially in terms of their skin colour, and who ignored, or remained unaware of the specific struggles affecting minority or black women (c.f. Blay & Gray, 2015).

understanding of women is based on “internal racism, classism and homophobia” (Mohanty, 2003, p. 50). Many of these debates still animate the present and since the 1990s there has been an explosion of research and writing on the subject, drawing on a wide variety of theories and methodologies.

Perhaps the most important concept that flowed from black feminism was that of *intersectionality*. Kimberlé Crenshaw, a black American feminist working in the discipline of critical race theory, introduced the term in a paper in 1989 in order to counter the tendency prevalent at that time “to treat race and gender as mutually exclusive categories of experience and analysis” (Crenshaw, 1989, p. 139). She argued for the replacing of the “single-axis framework” with that of a multidimensional one (Crenshaw, 1989, p. 139). This strategy would contribute to the understanding that race affected the way gender was experienced, and as such there was no universal ‘woman’s experience’. With the fracturing of the definition of ‘woman’, feminism was circumscribed by an identity politics. On the one hand, identity politics provided a level of inclusion for marginalised identities, legitimating difference in experience; on the other, it fractured the woman’s movement into a finite project of classification. For black feminists, identity was used to empower, legitimise and increase self-worth. In 1990 Patricia Hill Collins published *Black Feminist Thought* in which the empowerment of black women is described as that which adjoins the struggle for social justice. Emancipation and empowerment is thus a project that goes hand in hand, as the one promises the other. Empowerment is essentially connected to the project of being able to craft and then insert your own agenda into existing political and social structures (Hill Collins, 1990; see also 2nd edition, Hill Collins, 2000).

2.5. Contemporary work on childbirth and pregnancy

Since the 1990s, critical work on pregnancy has drawn from a variety of threads that developed in feminist theory during the final decades of the twentieth century. The theme of the public foetus and the maternal-foetal conflict that arises from foetal disembodiment has remained important in feminist work on pregnancy and childbirth, particularly with reference to its connection to anti-abortion rhetoric (Palmer, 2009; Rodrigues, 2014) and FAS/FASD (E. M. Armstrong, 1998; Leppo, 2012). Connections are also made between the existence of the public foetus and maternal behaviour such as consumerism (Boucher, 2004; Macleod & Howell, 2015; Taylor, 1993, 2000, 2008) and the experience of pregnancy (L. M. Mitchell & Georges, 1998). Work has been done on the use of visual technologies in bolstering the medical

profession and the production of authoritative knowledge (E. M. Armstrong, 1998; Georges, 1996). Connections to contemporary preoccupations with the protection of children (cf. Hacking, 1991), foetal rights, and state intervention have also been made (Bell, McNaughton, & Salmon, 2009).

Others have argued that as a result of the proliferation of a discourse around the foetus and the responsibilisation of the pregnant women, the pregnant body has been turned into a 'public figure' (Longhurst, 2000, 2008; Root & Browner, 2001). As Lupton (2012b, p. 332) notes:

> Her body is on display for others to comment upon, and even to touch, in ways not considered appropriate of any other adult body. Pregnant women find themselves subject in public to a critical and censorious gaze which judges them on their choices to inhabit smoking environments, to smoke themselves or to drink alcohol and which expects them to conform rigidly to expectations of 'decency' in their manner of comporting their bodies.

Writers who have continued to focus on the theme of the public foetus come from a variety of disciplines including anthropology (Georges, 1996; Ginsburg, 1990; L. M. Mitchell & Georges, 1998; Morgan & Michaels, 1999), sociology (Casper, 1998; Leppo, 2012; Lupton, 2012b, 2013; Petchesky, 1987), political science (Boucher, 2004; C. Daniels, 1993), cultural studies (Franklin, 1990; Hartsouni, 1998; E. A. Kaplan, 1994) and history (Duden, 1993). Feminists have aimed specifically to deconstruct and demystify the public foetus (Firth, 2009). This involved "*re-embodying* the foetus" (see Petchesky, 1987, p. 79): refocusing attention onto the pregnant woman and away from the foetus which included contextualising "the production and consumption of foetal images" (Firth, 2009, p. 54).

2.5.1. Childbirth and pregnancy experiences: Embodiment and phenomenology

The question of representation in feminist theory led feminists to problematise their own methods, theories and underlying assumptions. A result of this was that feminists started doing empirical research on women's *experiences*. For some feminists, this focus on experience represented a radical new form of theorising which would empower women. Sonia Johnson (1987), for instance, called for a "show your work" approach to feminist writing which entailed using descriptions of women's experiences as a means of writing theory.

> Feminist analysis, more than any other analysis of the human situation, has its origins in direct experience. All feminist theorists first observe and draw conclusions from their own lives; all feminist theory results from the transformation of that experience and observation into principle. (S. Johnson, 1987, p. ii).

This new focus was women's weapon against the mass of theories and histories produced by men and this challenge "rested its claim to legitimacy on the authority of experience" (J. W. Scott, 1991, p. 776). As Iris Marion Young (1984, p. 45) pointed out

> We should not be surprised to learn that discourse on pregnancy omits subjectivity, for the specific experience of women has been absent from most of our culture's discourse about human experience and history.

Much of this work drew specifically on phenomenological theories which focused on individual experiences in relation to structural phenomena. A feminist phenomenology held that "some knowledges are experienced, not conceived" (Pietsch, 2002, p. 2). Feminists drew on the work of phenomenologists such as Gilles Deleuze and Maurice Merleau-Ponty to overcome the pitfalls that were a result of the use of 'experience' as an epistemological tool. One such pitfall with focusing on experience was that the constructed nature of experience was ignored. As Joan W Scott (1991, p. 777) noted

> The evidence of experience then becomes the evidence for the fact of difference, rather than a way of exploring how difference is established, how it operates, how and in what ways it constitutes subjects who see and act in the world.

Alongside phenomenology, the focus on the *body* helped to overcome these concerns and to describe the ways in which women were both agents and victims within a larger structure. The focus was then on *lived experience*, but in a way that did not negate the contrived nature and systemic context of individualised experiences. Drawing on Merleau-Ponty's conceptualisation of the 'body subject,' embodiment "indicates one's sense of living within the body: a "life-text where we live in felt experience" as well as "construct knowledge" (Abbey & O'Reilly, 1998, p. 327; quoted by Pietsch, 2002, p. 1).

This work focused a great deal on the production of knowledge of the body and an important aspect of this thesis is the critique of the 'mind/body dualism' inherent in Western scientific and philosophical texts. The 'mind/body dualism' is the legacy of an old metaphysics which defined the "mind and body as at odds with each other" (Rúdólfsdóttir, 2000, p. 339). Feminists argue that femininity has historically been associated with the body and therefore a variety of oppressive assumptions about women are embedded in 'malestream' work. In opposition to the mind/body dualism the concept of embodiment is predicated on the idea that there is a "necessary interdependence of psychical interiority and corporeal exteriority" (Pedwell, 2007, p. 200).

The mind/body dualism has also played an important role in the production of medical knowledge and has therefore shaped general assumptions about health and illness. Young (1984, p. 56) pointed out that the mind/body dualism inherent in medical research operates on the definition of health as "a state in which there is no regular or noticeable change in body condition". This puts the pregnant body in a precarious position – it is not strictly diseased, but cannot be defined as healthy. The result is that "the condition of pregnant women is rendered abnormal and their bodies problematic" (Rúdólfsdóttir, 2000, p. 339).

Many feminists have taken on these concepts in their work on pregnancy and childbirth and 'pregnant embodiment' and the experience of pregnancy has become a popular area of research. Some have drawn from phenomenology to analyse the experiences of their research participants or even their own pregnancy experience (Battersby, 1998; Bondas & Eriksson, 2001; Chang, Chao, & Kenney, 2006; Clark, Skouteris, Wertheim, Paxton, & Milgrom, 2009; Lundgren & Wahlberg, 1999; Nash, 2012a; Pietsch, 2002; Tyler, 2000; Upton & Han, 2003; Young, 1984).

Others draw from an amalgamation of concepts that have been introduced by feminists to make sense of pregnancy and childbirth experiences (Donovan, 2006; Earle, 2003; Neiterman, 2012; Rúdólfsdóttir, 2000). For instance, Annadís Rúdólfsdóttir (2000) utilises Foucauldian discourse analysis (FDA) alongside a variety of concepts, including the 'mind/body dualism' thesis to analyse the representation of women's agency in booklets and handouts on pregnancy. She argues that the result of these normalising representations of women in these media contributes to the reason experts and authoritative figures in medicine "ignore women's views and wishes" (Rúdólfsdóttir, 2000, p. 348). Sarah Donovan (2006) analyses the experience of prenatal screening and the 'disembodiment' that results. Donovan's analysis bears close resemblance to the oppositionality inherent in the medicalisation of childbirth thesis. As a trained midwife, she argues that the ideological difference between midwife practice and hospitalised practice centres on pregnancy as a normal/diseased state. Visual technologies, she argues, "deprived" the participants in her study of experiencing their pregnancies as "normal" (Donovan, 2006, p. 402).

Elena Neiterman (2012, p. 372) analyses how pregnant women are socially regulated, through examining "the social context and social interactions that facilitate the process of pregnant embodiment." For Neiterman pregnant embodiment involves a process of performance by the pregnant woman in line with a variety of regulatory norms. Deborah Lupton (2008, 2011,

2012a) has focused on pregnancy in her conceptualisations of illness, discourses of risk and pregnant embodiment. Many of the studies focusing on experience of pregnancy are concerned with the prominent feminist topic of body image (Carter, 2010; Earle, 2003; P. Fox & Yamaguchi, 1997; Harper & Rail, 2011, 2012; Nash, 2012b; Schmied & Lupton, 2001; Seibold, 2004; Wiles, 1994). Within the same topic there has been an emergent focus on the entrance of the pregnant woman into a neoliberal consumerist culture which utilises (or perhaps appropriates) a variety of feminist empowerment tactics as consumerist as well as moral tools (Dubriwny & Ramadurai, 2013; Nash, 2012a).

2.5.2. Yummy mummies and the postfeminist pregnant woman

Towards the end of the twentieth century pregnant celebrities became a topic of intense media interest. Most iconically was the August 1991 *Vanity Fair* cover featuring a heavily-pregnant and naked Demi Moore. Since then the pregnant celebrity has become a prominent feature in the popular media, being displayed on the covers or in the pages of women's magazines, tabloids and newspapers. These images have been differentially interpreted as: the sexualisation of the pregnant body, the reinforcement of normative beauty standards by expecting women to look sexy even while pregnant, or, by some, as the rewriting of these very dominant beauty standards (Nash, 2012a). There has also been an increase of articles in media outlets on exercise and fat loss (or fat avoidance) during pregnancy, some with an explicit focus on teaching women how to remain sexy during pregnancy. The quintessential symbol of the perfect pregnant subject has come to be called a 'yummy mummy.' These are usually young, attractive, wealthy or famous pregnant women who dress in designer outfits, carrying their pregnancy with seemingly no discomfort, and who lose their 'baby-fat' very quickly after they give birth. The yummy mummy can remain sexy and appealing throughout pregnancy and after, and navigates all her children with ease while in high heels. Not only are these women displayed regularly by various media outlets, but articles on how to attain the same standards are prolific.

There has been some popular backlash against the yummy mummy phenomenon (Donnelly, 2008; Jenkins, 2009), focusing on the detrimental effect they have on pregnant women's body image and the obvious requirement of great wealth. In terms of scholarly research, Meredith Nash (2012a, p. 202) has analysed how this phenomenon has produced "a new visual and cultural vocabulary for dealing with pregnancy and pregnant bodies," deeply entrenched in consumer culture. Nash argues that these representations of pregnancy and motherhood, despite

their glamorous appeal, do not resemble the experience of most Australian pregnant women. A prospective yummy mummy must conform to highly disciplined regimes of eating and exercise during pregnancy and after birth; they are most likely white, and require a great deal of wealth to uphold this lifestyle. The popular images of yummy mummies and pregnant celebrities are, as Angela McRobbie (2006, para. 1) argues, the extension of "the grip of consumer culture" to pregnant women and new mothers, based on the premise that 'empowerment' is achieved "by exerting their consumer agency with bodies that are slim and disciplined" (Nash, 2012a, p. 204).

The representation of the yummy mummy is connected to the recent rise of postfeminism[18]. In the USA, postfeminism was first described by critics as part of a conservative 'backlash' against the feminist movement. Susan Faludi (1991) argues that the media constructed the image of the young 'postfeminist' generation, a group of women disaffected with or renouncing the women's movement.

Rosalind Gill (2007, p. 147) argues that postfeminism can be better described as a *sensibility.*

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[18] This postfeminist sensibility was predicated on several myths – that the feminist movement had succeeded in creating equality between the sexes, and that the effect was that women were now miserable. Apart from the 'backlash' thesis, there are various definitions for postfeminism. While more recent understandings of postfeminism associate it with the notion that feminist politics are no longer necessary and as such it embodies an idea of society that is no longer bound by gender binaries, it was originally construed with the French feminist psychoanalysts (Phoca & Wright, 1999) as well as the 'third wave' generally, particularly postmodernist, postcolonial and post-structuralist feminisms (Brooks, 1997; Hollows, 2000). Sometimes the third wave is described as the academic tradition to postfeminism as popular iteration. The distaste of second wave feminism among many of these 'third wave' feminist movements reinforces this link. There are many debates and contestations on what postfeminism is, or represents. Yvonne Tasker and Diane Negra (2007, p. 1) describe postfeminism as such: "Postfeminism broadly encompasses a set of assumptions, widely disseminated within popular media forms, having to do with the "pastness" of feminism, whether that supposed pastness is merely noted, mourned or celebrated." For Tasker and Negra, as well as other critical feminist scholars today, postfeminism as 'backlash' is inadequate for useful critique. They see a more "complex relationship between culture, politics, and feminism" (Tasker & Negra, 2007, p. 1). Postfeminism, to them, represents a discourse mainly found in popular culture, that consists of a "selectively defined feminism," (Tasker & Negra, 2007, p. 1) i.e., a limited form of equality between the sexes. This equality is presented as having been achieved already. The effects of this new equality are presented as universal – all women have the same desires and are now capable of accessing them. In this way postfeminism naturalises important aspects of feminism such as access to education and employment, freedom of choice and sexual empowerment. Unfortunately, postfeminism tends to ignore the lack of choice that many women face due to discrimination and financial constraints; as such "postfeminism is white and middle class by default" (Tasker & Negra, 2007, p. 2). Trends among those who identify as postfeminists includes a renewed celebration of femininity as a form of power (cf. Baumgardner & Richards, 2004) as well as discourses of choice and empowerment which is often contrasted against the victim status that is argued to be embodied by the second wave feminist subject (Tsaliki, 2001). Perhaps the most critiqued aspect of postfeminism is its close connection to consumerism. While some postfeminists have endorsed consumerism as a form of power (Baumgardner & Richards, 2004), critics are suspect of this close relationship (and reliance) on consumerism (Lazar, 2009). For postfeminists 'empowerment' is often achieved through consumption. Kerreen Reiger (1999, p. 388) argues that the movement within feminism, away from a single solidarity towards embracing difference, opened elements of feminism up to being co-opted by a "discourse on private consumerist choice." More likely, consumer interests co-opted the newly formulated feminist ideas of 'difference' to shape a popular image of the contemporary girl or woman who can be used as a sales object.

> Postfeminism is best understood as a distinctive sensibility, made up on a number of interrelated themes. These include the notion that femininity is a bodily property; the shift from objectification to subjectification; an emphasis upon self surveillance, monitoring and self-discipline; a focus on individualism, choice and empowerment; the dominance of a makeover paradigm; and a resurgence of ideas about natural sexual difference.

She goes on to connect this sensibility to neoliberalism. Other than Gill (2007, 2008, 2009), the most prominent writers on and critics of postfeminism have focused on what the postfeminist female subject embodies by analysing media and popular content (Lazar, 2009; McRobbie, 2004; Negra, 2008; Tasker & Negra, 2007). The arguments made by these writers are important and their analyses range widely to include makeover and fashion culture, girlhood, aging, domesticity, motherhood, punk, and body anxiety.

In terms of the postfeminist pregnant woman, Diane Negra (2008) writes that in popular culture motherhood has been re-equated with full womanhood and thus, pregnancy becomes a unique time during which women "look, feel, and are at their best" (Negra, 2008, p. 63). Pregnancy is no longer "a taboo status;" pregnant women are represented everywhere and thus "subject to new forms of fetishization and eroticization" (Negra, 2008, p. 63). Pregnancies are no longer to be concealed, but flaunted and celebrated, which often entail taking advantage of the full range of consumerist products and services specifically produced for the pregnant woman, from magazines and books, clothing lines, exercise and health regimes, to prenatal photography shoots. The pregnant woman, within the postfeminist sensibility, has become the exemplar of femininity.

Another increasingly popular postfeminist discourse is that of motherhood as redemption. Perhaps most surprising and illustrative is Third Wave feminist Rebecca Walker's account of her pregnancy in *Baby Love: Choosing Motherhood after a Lifetime of Ambivalence* (2007). The book redeems motherhood as part of the natural order and a form of salvation for women; something which the 'witch-feminists' of the second wave, including her own mother, Alice Walker, tried to ignore. It is both an exposition of her mother's (and by extension second wave feminists') bad mothering skills and Rebecca's own realisation, after being influenced for so long against motherhood, that it brings salvation to women. These themes are prominent in recent literature and film: the feeling of completeness suddenly following childbirth, the sudden disappearance of depression or inertia, the realisation that motherhood is in fact more fulfilling after having it thrust on a character either due to an unexpected pregnancy or suddenly

becoming a guardian, and the magical connection/communication between the woman and her unborn foetus.[19]

This new discourse of redemptive motherhood has allowed for maternity to be "incorporated into the language of self-perfectibility" (McRobbie, 2006, para. 2). What is deemed particularly problematic is that this perfectibility is dependent on consumption practices. The result is that poor pregnant women fail in their femininity, not only because they cannot afford to keep up the lifestyle and perform this subjectivity, but also because they did not choose to *not* have children until they finally could afford it.

> Without a disposable budget for the accessories that are deemed essential, young women judge themselves more harshly than ever before. Being poor within this new moral economy incurs the additional stigma of failed femininity. The idea of having to sacrifice what are now vital features of female self-presentation becomes another way of warning young women from embarking on motherhood before all financial details are in place. (McRobbie, 2006, para. 2)

Poor pregnant women and single mothers (unless they are rich) are re-stigmatised. These discourses that interweave choice of motherhood and financial responsibility have the effect of reducing backing for government programmes that support pregnant women and poor mothers; and the collective childcare programmes in the West that feminists have fought so hard for and took so long to build are broken down in favour of an expensive 'nanny culture' (McRobbie, 2006).

2.5.3. Social and psychological determinants of healthy pregnancy outcomes

There is also a body of literature that lies on the border of critical and mainstream scientific work on pregnancy. This work involves utilising a social science perspective to identify features of what is generally known as the biopsychosocial model of disease causation. In terms of reproduction this involves identifying social or psychological aspects that influence the outcomes of pregnancy. Many feminist writers have taken to researching or reviewing research on individual aspects of the social or psychological determinants of pregnancy outcomes. For instance, Oakley (1985), in her focus on the social organisation of childbirth and pregnancy,

[19] Negra (2008) provides an interesting outline of recent literature and film that features the discourse of maternal redemption. Rosalind Gill (2007) analyses three films about unexpected and unwanted pregnancy wherein the protagonists choose to carry to term. Not having an abortion, Gill shows, is part of the post-feminist sensibility which presents this choice as more mature and empowering, as well as the decision that would eventually bring redemption and happiness.

reviewed the scientific literature on the impact of support structures on birth weight in pregnancy in order to make a case for a stronger focus by the state on these aspects.

Drawing attention to social and psychological aspects influencing pregnancy outcomes has become a tactic in the process of affecting government policies and the mind-sets of medical personnel and researchers who tend to focus predominantly on biomedical causes of negative pregnancy outcomes.[20] Some of these writers have utilised individual aspects of the biopsychosocial model of disease causation to engage with theoretical and conceptual issues that have plagued feminist work on pregnancy. For instance, Bonnie Fox and Diana Worts (1999) aimed to reconcile the disjuncture between the argument that the medicalisation of childbirth has had a negative effect on childbirth experience and the argument in line with the empirical evidence that many women are willingly choosing interventions. They do so by showing how a lack of social support in pregnancy leads women to choose interventions – medical procedures and medical staff stand in for the lack of support provided in communities or at home.

'Support structures' have become a prominent focus of research and have been taken up by various authors (Dunkel-Schetter, Sagrestano, Feldman, & Killingsworth, 1996; Elbourne, Oakley, & Chalmers, 1989; B. Fox & Worts, 1999). These studies draw from empirical work on pregnancy support (N. Collins, Dunkel-Schetter, & Lobel, 1993; Norbeck & Tilden, 1983; Nuckolls, Cassel, & Kaplan, 1972; Rini, Dunkel-Schetter, Wadhwa, & Sandman, 1999) that is part of a larger focus of inquiry on social support as a social determinant of health (Cassel, 1976; Cohen & Syme, 1985; B. Kaplan, Cassel, & Gore, 1997).

The empirical work on support is mostly epidemiological in character, while the more critical work focuses on institutional arrangements and analyses on the level of experience. They all draw on a biopsychosocial model of disease causation that focuses on behavioural, social, psychological and cultural determinants of health (Dunkel-Schetter et al., 1996). The biopsychosocial model is argued to have replaced the medical model in determining the cause of disease and has driven the move towards primary care provision. The sociological work on social support is rooted in a Durkheimian conception of solidarity which argues that industrial society alienates people from traditional forms of social solidarities which results in poor health – or, in the case of his example – higher rates of suicide (Durkheim, 1897; Orr, 2004).

[20] For an example of how such research influence policy, see the WHO's new focus on 'positive pregnancy experiences' (WHO, 2016b).

2.6. *Pregnancy in the Global South*

In a recent special issue on Southern feminisms in *Feminist Theory*, Celia Roberts and Raewyn Connell (2016) argue that while there is a great deal of feminist scholarship being produced in the South, the use, by these feminists, of Western theories, is stark (see also Connell, 2015). Drawing on Paulin Hountondji's (1997) notion of 'extraversion' – the phenomenon where theories and methodologies are produced in the West, and data are extracted from the South – Roberts and Connell argue that feminists from Southern countries have, for a variety of reasons, been unable to break out of this cycle.

They argue, furthermore, that Southern feminist scholarship is to a large extent absent in textbooks and courses in the West (see also Woehrer, 2016). Where this scholarship is mentioned, it is presented as a sub-discipline or specialisation. Chandra Talpade Mohanty (2003) argues that there is a general tendency within Western academia: 'postcolonial studies' is now an add-on (usually towards the end of a course) in the Western curriculum, and critical work emanating from the South is bundled together within this specialisation. In these courses feminism is described as having emerged in the West while African and other Southern feminisms are discussed as 'contemporary debates' within it. The inaccuracy of this process is highlighted by the fact that the "discovery of 'intersectionality' in the metropole was long preceded by debates about gender, race, class and caste in the colonised world from India to Brazil" (Roberts & Connell, 2016, p. 137). This reinforces the cycle of extraversion, as Roberts and Connell note, since scholars and students only need superficially engage with these 'critiques'.

> Paying attention to the intellectual production of colonised and postcolonial societies is different from recognising a postcolonial critique in the metropole. It is much harder for the mainstream economy of knowledge to do. Paying attention means learning about intellectual traditions in contexts that one may never materially visit; it means accessing good translations and/or learning new languages; and it requires mental flexibility and careful, situated listening. It is a challenging educational task to move beyond familiar curricula and methods, to re-think what seems central in the contemporary age, to find time both for 'canons' and for knowledge formerly on the margins. (Roberts & Connell, 2016, pp. 136-137)

While Roberts and Connell seem enthusiastic about the contributions of peripheral feminist scholars within Africa, the ontological characteristics of feminist work produced in the West, coupled with African intellectuals' desire to distance themselves from Western epistemologies, have created an ambivalent space which has not been fertile for the fostering of a strong African 'feminist' tradition.

The major problem that any African encounters when looking to Western theories is that these theories present a particular 'world' in which Africa and Africans tend to be portrayed in homogenous terms. Many Western feminist theories depict African women as dependent and subordinated by African men and customs (Mohanty, 1991b). Africans must grapple first with how they are represented in these theories. A history of negative and stereotypical representations of Africa and Africans have left deep scars on the continent, and contemporary Western theories, while moving beyond the racist colonial discourse of the previous century, instead of fundamentally reforming their theories, have merely updated them to be more politically acceptable: an 'Africa' needing colonisation and modernisation has been replaced with an 'Africa' that needs development, human rights, democracy and economic growth. While there is a new type of agency afforded to Africans in development rhetoric, this agency, as I discuss in chapter five, aims not so much to give people personhood as it is to bestow on them a responsibility for their own development. Bearing this in mind, the adoption of feminist rhetoric, ideas, methods and theories by people in Africa is understandably being resisted.

Some female African scholars have chosen not to call themselves feminists. They refuse the title of feminism on the grounds that it is 'un-African'. When queried, these writers often cite the radical feminist 'hatred' of men to be against their culture (Mikell, 1995; Ogunyemi, 1985), while others use it as a convenient excuse to promote conservative agendas (Ogundipe-Leslie, 1994). This reaction by African women is a result of the way Western intellectual traditions and writings generally, but also Western feminists, particularly, have stereotyped African men, the perceived tendency within some Western feminist traditions of attempting to 'turn women into men,' or the fact that African women do not isolate their activism to issues of gender alone – their struggle against racism requires them to be in solidarity with black men. Western feminists have historically depicted African women with a lack of agency (and often still do). This has led some African women to retort by inscribing African women with an agency that willingly chooses the roles that some Western feminists were critical of – such as the role of mother and wife – and instead subscribing it to tradition and culture.

In other cases, African women have refused the title of feminist because it is a Western term, despite embracing the notion and legacy of collective group action by women in various parts of Africa (Goredema, 2010).

> Although many African languages have no synonym for feminism as it its defined by the West, the concept of group action by women, based on common welfare in social,

> cultural, economic, religious and political matters is indigenous and familiar to a majority of these women. (Kolawole, 2002, p. 31)

African women's attempts to define their own unique types of women-based action founded on African ideas and values, along with the discourse of situated and differential experiences, have led to a proliferation of many 'feminisms' on the African continent. African feminists have taken on different problematics in their research, sometimes couched deliberately in such a way as to highlight the differences between Western women and their own situated experiences. Goredema (2010, p. 35) notes that these revolve around questions of tradition and culture, socio-economic and socio-political issues, the role of men, the role of race, and sex and sexuality.

There are also epistemological questions that African female scholars and writers have asked themselves. The desire of African 'feminists,' to distance themselves from the theoretical and methodological bases that underpin Western feminisms has led some to question whether the feminist project is flawed in the way that, like any other form of knowledge production, it cannot escape the process of 'othering'. In referring to the inevitable class divide between African female scholars and writers doing research or development work, and their working class subjects, Mohanty (1991b) argues that even when these African feminists are critical of Western feminism, they nonetheless treat their subjects in the same way Western feminists treat their African counterparts.

Due to the fact that many feminists on the continent, particularly in South Africa, are white, the question of who gets to represent the interests of women in Africa is also at the forefront; as Goredema (2010, p. 41) asks, "what entitles one to be an expert, or to study a subject if you have no legitimate claim to that reality?" The Western tradition of representing Africans' reality has had (and still has) a significant effect on the continent. The legacies of colonialism and imperialism and the continuing representation of Africa as a deprived continent filled with failed states, dictators and famine means that critical African scholars are resisting, and rightly so, the adoption of Western theories such as those of feminism or allowing non-Africans claims to representation. While these resistances have fragmented woman-centred or gender-focused solidarities on the continent, it is perhaps exactly what disciplines such as feminism need to grapple with fundamental questions around in the way it produces truth.

The questions posed by female African scholars loom large in the South African context (Goredema, 2010). Due to its relatively recent democratic transformation, the fact that the white settler population is particularly settled compared to other African countries, as well as

the weak, but nonetheless existent anti-apartheid academic tradition during apartheid, most active academic feminists in the country are white. Many of them were, to various extents, active in the anti-apartheid struggle (Morrell, 2016). Helen Moffett (2014) provides an interesting and detailed account of the feminist traditions in South Africa, and their roots and inspirations, many of which were from Western feminist movements, theories and ideas, particularly among white academics and activists. Moffett particularly focuses on the feminist tradition (or lack thereof) within ANC structures, including the Women's League and shows how the tradition of disregarding women's issues has animated the present.

2.6.1. The production of knowledges on pregnancy and childbirth in South Africa

There is a general tendency among critical scholars in the Global South, especially those writing in areas such as pregnancy and childbirth, to engage less in theoretical discussions and more in practical matters since there is some expectation in the South African academy to produce policy-relevant scholarship. While they will often draw on theoretical debates produced in other areas, academic scholars tend to tackle the structural shortcomings in their countries. For instance, critical scholarship on pregnancy and childbirth in South Africa tends to focus on such issues as teenage pregnancy, health care seeking practices, FASD, shortcomings in policy and implementations, and issues of race. There is also scholarship that exists on traditional practices and remedies that are still in use in rural areas. Most childbirth-related feminist scholarship is in the psychology tradition and draws heavily from phenomenology in their focus on subjectivity and experience.

Most South African scholarship in the area of childbirth and pregnancy is written in the public health tradition, tackling issues such as policy and implementation (Berer, 2003; D. Cooper et al., 2004; Fonn, Xaba, San Tint, Conco, & Varkey, 1998), fertility and population policy (Garenne, Tollman, & Kahn, 2000; Makiwane, Desmond, Ruchter, & Udjo, 2006), maternal mortality and morbidity (De Wet, 2016), and health seeking practices (Abrahams, Jewkes, & Mvo, 2001; Myer & Harrison, 2003; Tlebere et al., 2007). At times these writers draw on a reproductive rights framework (Ramkissoon, Searle, Burns, & Beksinska, 2010). This type of work is mainly produced by research institutes within and outside academia such as the Human Sciences Research Council, the Health Systems Trust, the Medical Research Council (MRC), the Women's Health Project, the School of Public Health and Family Medicine at the University of Cape Town, the Centre for Maternal, Adolescent and Child Health at the University of the Witwatersrand (WITS), Johannesburg, the Reproductive Health Research

Unit and the Demography and Population Studies Programme, both also at WITS. Studies investigating clinical issues are mostly done at university medical departments and medical schools. The Foundation for Alcohol Related Research has also conducted many epidemiological studies related to alcohol use during pregnancy, often in collaboration with other research departments and institutes (May & Gossage, 2011; May et al., 2005; Viljoen et al., 2005).

Among feminists producing critical scholarship, individual scholars tend to explore specific issues, and produce scholarship in that area and often in collaboration with their students, postdoctoral fellows, or research associates. As such there is a small number of topics identifiable in South African scholarship on pregnancy and childbirth. For instance, University of Cape Town researcher, Rachelle Joy Chadwick, has produced a significant number of childbirth-related articles, mostly drawing on the phenomenological tradition. Her doctoral dissertation in psychology focused on 'birth stories', and her subsequent work has been around the themes of embodiment and subjectivity. Her PhD student has picked up this theme in her own work (N. M. Daniels, 2015). Along with Don Foster, Chadwick dabbled in risk from a sociocultural perspective (see chapter four) and drew on the Foucauldian notion of technologies of power (R. J. Chadwick & Foster, 2013). Since the mid-2010s she has focused her work on the quality of care provided to pregnant women, specifically what she calls 'obstetric violence'. Obstetric violence is a relatively new concept that describes "violence against women and girls during labour and birth" (R. J. Chadwick, 2016, p. 423). A group of activists in Spain and Latin America adopted this term to fight against obstetric violence. Chadwick aims to bring this concept into use in South Africa.

Another feminist scholar is Lou-Marié Kruger from the Psychology department at the University of Stellenbosch. She also researched women's experiences of childbirth, but unlike Chadwick and Daniels, she has focused on "low-income women of colour" (Kruger, 2005, p. 2). Kruger is concerned with how master narratives, whether medical or feminist, "obscure the birth experiences of some women", especially those on the margins (Kruger, 2005, p. 1). Her research uncovers a new attempt to relate to being out of control and in pain, one in which there is a "breakdown of narrative order", exemplified by and filled with "silences, cries, whispers, laughter, dismissive words, incomplete sentences, broken narratives" (Kruger, 2005, p. 18). She urges psychologists to embrace this "temporary chaos", not with the aim to find a meaning or to force a premature closure with some master narrative, but to allow the patient in pain to "situate herself differently" (Kruger, 2005, p. 19). In a collaboration with Tanya van der Spuy,

and using a feminist psychoanalytic perspective, Kruger interviewed low-income pregnant women to get a better understanding on why some pregnant women do not disclose their pregnancies. They found that the disempowerment that low-income women face in a patriarchal society leads to "intense psychological conflicts about pregnancy" (Kruger & Van der Spuy, 2007, p. 18), and denial.

At Rhodes University, Catriona Macleod heads up the Critical Studies in Sexuality and Reproduction. Her doctoral work focused on teenage pregnancy and she used a feminist post-structuralist approach (Macleod, 1999b). Many governments see teenage pregnancy as particularly problematic and as a result a great deal of research and policy work is done on it. Macleod, along with some other researchers (Ngabaza, 2011), critically engages with the way governments problematise teenage pregnancy (Macleod, 1999a, 1999c; Macleod & Durrheim, 2002). Macleod, along with Simon Howell (2015), has also analysed how, in online media, foetal images regulate middle class pregnancy (see chapter four for a discussion).

Despite the existence of feminist and postcolonial voices in the Global South, the major players in pregnancy and childbirth have been non-governmental organisations (NGOs) and intergovernmental organisations (IGOs) that aim to influence and change the way childbirth and pregnancy is managed. While these groups are not always critical of dominant Western approaches, they play an important role in shaping the discourses that describe how pregnancy and childbirth should be managed in these countries.

2.6.2. Pregnancy and childbirth in the colonial context

There is a great deal of historical literature on South African medicine and medical institutions from a variety of disciplines. Most work that was produced before the 1980s on colonial medicine is in a 'triumphalist' tradition that celebrates scientific medicine's victory over superstition. From the 1980s onward, a variety of texts appeared that were more critical of the orthodox approach, focusing rather on the ways in which the imperial project and racist theories shaped the medical practices in colonies. Two 'watershed' compilations included Roy MacLeod and Milton Lewis's *Disease, Medicine and Empire* (1988) and David Arnold's *Imperial Medicine and Indigenous Responses* (1989).

Postcolonial theorists have also taken up the topic of colonial medicine. They argue that since the modernisation project was deeply rooted in racism and imperialism – in the production of categories of normality, abnormality, and 'otherness' – medical practices and scientific

research in the Global South has a particularly pernicious character that continues to play out in the post-colony (Azevedo, 2017).

The discipline most likely to interrogate the wholesale importation of the Western medical tradition has been that of history. Initially histories of South African medicine focused on biomedicine, public health, and economics, and tended to follow the orthodox 'triumphalist' approach to historiography that sequenced individual (white, usually male) contributors to the medical field (Burrows, 1958; J. Collins, 1983; Hadley, 1972; Laidler & Gelfand, 1971; Logan, 2003; Mackenzie, 1981). In terms of pregnancy and childbirth, female midwives attended the birthing process among the European settler population, most of whom trained in Europe. After the Cape was captured by the British, the first midwifery school was established in 1810 to produce licenced midwives and to help systematically reduce the number of unlicensed midwives. European settler women were trained to serve as midwives for the European population while the Malay and Black populations were provided with trained Malay and Black midwives. Towards the mid-1800s references were made of trained accoucheurs, and, at the same time, there was a great deal of chatter on the inadequacies of midwives in the colony ultimately led to regulation and accreditation (Laidler & Gelfand, 1971).

More recently, historians of medicine and health have broadened their treatment to include sociological, critical race, gender and postcolonial lenses. There has been much focus on the sociological histories of public health interventions (Packard, 1995; Phillips, 1987, 1990; Swanson, 1977), with some focusing on the mining industry, labour, and ideas about race and disease (Jochelson, 2001; Katz, 1994; McCulloch, 2002; Packard, 1987, 1990) as well as contagious diseases (Deacon, 1994; Van Heyningen, 1984). There is also a long tradition of histories of medical institutions (Digby & Phillips, 2008; Gelfand, 1984; Hattersley, 1955; Louw, 1969). Some writers have focused on the theoretical aspects of medical historiography in colonial settings (Marks, 1997; Vaughan, 1994), and how racist science shaped the South African landscape (Deacon, 2000; Lalu, 1998), while others have focused on traditional practices or investigated the ways in which medicine and traditional medicine have interacted in South Africa (Bhat & Jacobs, 1995; Burns, 1996; Digby, 2005; Flint, 2001, 2008; Hirst, 1993; Ngubane, 1977, 1981, 1992). In terms of reproductive practices, historians have particularly focused on contraception and abortion (Bradford, 1991; Burns, 2004; Klausen, 2001, 2002, 2004a, 2004b, 2010, 2014, 2015; Van Heyningen, 1984) and reproductive control (C. E. Kaufman, 2000).

The topic of childbirth and pregnancy practices has also received attention. Deacon (1998) draws parallels between the transformations in midwifery in South Africa and that of Britain and other European countries. Focusing on the nineteenth century she argues that in the Cape Colony the regulation and professionalisation of midwifery was used to root out folk medicine. Man-midwives developed in tandem with their counterparts in Britain, and physicians generally were heavily influenced by the modern medical practices of the West since they were all trained in Europe, at least until the twentieth century.

Catherine Burns (1995, 2000) argues that, compared to the rest of the continent, South Africa has had a long tradition of hospitalised childbirth that surpassed race and class divides, although it is likely that the vast majority of women living in rural and impoverished areas during apartheid had little to no access to clinics and hospitals. By 1989 South African women were more likely to be attended by a physician than a midwife, and the rate of caesarean section-use was the highest in the world (Burns, 2000). During apartheid, South African medical schools trained "some of the world's most renowned specialists in obstetrics and gynaecology" (Burns, 2000, p. 1). This does not mean, however, that midwifery was neglected: in 1998 over 300 000 African women had been trained in biomedical midwifery and nursing (Burns, 2000). As in a variety of countries, midwives were trained in a biomedical setting to be assistant and subordinate to physicians and obstetricians.

2.7. Conclusion

Important players in the process of conceptualising an experience are the producers of knowledge and truth. There is no doubt that the takeover of childbirth and pregnancy care by medicine had, and continues to have, a profound effect on the way pregnancy and childbirth is experienced and conceptualised by women across the world. In the eighteenth century, medicine modified "the rules of formation of statements" that can be considered as "scientifically true" (Foucault, 1980, p. 112). Because Foucault saw history as something akin to a "war" or "battle" (Foucault, 1980, p. 114), one could argue that a new player entered this war full force in the 1960s. The mainstream clinical government of pregnancy and childbirth came to be challenged by feminists, and while feminists did not manage to fundamentally transform the rules on which it was based, they nonetheless introduced into this rationality a set of questions that would alter practices around pregnancy and childbirth significantly.

Changes in the way pregnant women have been governed, particularly in the last half-century, has not been due to the inherently progressive features of medicine, as it would claim in its

historiography. The women's movement, and subsequent feminist writings and activisms, both in the West and the Global South, have influenced the way we understand and conceptualise the pregnancy and childbirth experience, as well as the way in which pregnancy has come to be governed. But especially in the Global South, feminism has not been the only player. In fact, internal to medicine itself were many players, and the knowledge produced by them would come to play even more important roles in shaping pregnancy and childbirth practices and experiences in the Global South. Externally, there has been specific governmentalities that shaped medicine – and the way it governed people in the Global South – colonialism, modernisation, and development.

Later I discuss how development, as an overarching philosophy that has come to govern the Global South, has replaced colonialism as a governing force that produces the relevant relations of power that modernity requires to function in a liberal manner. Development has shaped the rules of medicine as well. This important player is described in chapter four, but to allow for the full understanding of this 'discursive regime', I give an overview of Foucault's ideas, as well as the contributions by other writers that have allowed me to analyse what currently animates the government of pregnancy and childbirth in South Africa as well as its genealogy, at least as far back as the size of this dissertation can allow.

3. Method and methodology

Foucault's 'theorising' has been described as "temporary scaffolding", which he erected with a specific objective in mind, and which he would happily "abandon to whomever might find them useful" (Gutting, 2005a, p. 16). It would perhaps be equally accurate to describe Foucault's theorising as a 'toolbox', as many writers do (Garland, 2014; Zwart, 2005), and as Foucault himself encouraged:

> I would like my books to be a kind of tool-box which others can rummage through to find a tool which they can use however they wish in their own area... I would like the little volume that I want to write on disciplinary systems to be useful to an educator, a warden, a magistrate, a conscientious objector. I don't write for an audience, I write for users, not readers. (Foucault, 1994, pp. 523-524)

Although he wrote histories, he did not consider himself a standard historiographer. In fact, he often viewed standard historiography with some disdain (Gutting, 2005b). He called his work histories of the present, and, at times, histories of experience, which meant he was…

> concerned to describe the basic categories that structure the way a given age perceived and thought about objects such as madness or disease. Such a description is derived from historical facts about discourse and behaviour during the given age. (Gutting, 2005a, p. 15)

In this dissertation, I utilise a variety of tools in Foucault's toolbox. This includes what has become known as FDA. Foucault's elaboration of his methods was never very systematic. Scholars such as Ian Parker (2002), Michael Arribas-Ayllon and Valerie Walkerdine (2008), and others, have taken up Foucault's notions about power, discourse, technology etc., and transposed, or in some cases reformulated, their application in a more systematic and uniform way. This has come to be known as FDA. Drawing on these and other writers' expositions of FDA, as well as Foucault's own discussion of his method, this chapter provides a detailed description of FDA. This method is employed to analyse the data outlined in the introductory chapter.

Another important tool that I utilise is that of governmentality. During his time teaching at the Collège de France in Paris, Foucault's lectures consisted of reports of his own research. The themes covered in these courses were sometimes "preliminary explorations" of what would

later end up as books (C. Gordon, 1991, p. 1). He covered topics between 1978 and 1979 in the courses titled *Security, territory and population*, and *The birth of biopolitics*, that did not, unfortunately, get the book-form elaboration that many would have appreciated. As Colin Gordon (1991) noted, however, he worked at the time with a group of researchers at the Collège, who took on the governmental theme and produced a variety of papers on the subject. In 1991 the *Foucault Effect: Studies in governmentality* (edited by Graham Burchell, Colin Gordon and Peter Miller) was published which contained the first English translations not only of some of the lectures in this series, but also of many of Foucault's colleagues' papers. As such it became a guide for further elaboration on the topic, especially for English speaking scholars.

The Foucault Effect (1991) also contained several papers by scholars of what came to be known as the 'Anglo-Foucauldian school'. They took on Foucault's notion of governmentality and applied it to a variety of aspects of modern society, from criminology, to economics, to risk. Most of the writers focused on the ways in which the neoliberal art of government is extended and embedded in Western countries. The volume presents a particular 'reading' of Foucault's notion of governmentality. There are other 'readings' of governmentality (for an outline see Jessop, 2011), the difference between readings often depending on *when* translations of the governmentality lectures were available to the writers.

The Foucault effect and its specific iteration of Foucault's governmentality has been widely used, particularly its reading of neoliberalism, and risk as a technology of government. In using the analytical tools of governmentality, the most contemporary art of government – what is generally referred to as neoliberalism, or as Nikolas Rose (1993) calls it 'advanced liberalism' – is seen as more than merely a doctrine of the 'retreat' of the state. Instead, as Andrew Barry, Thomas Osborne and Rose (1996, pp. 11-12) put it, it is viewed as a transfer of governmental functions to non-state actors via "the fabrication of techniques that can produce a degree of 'autonomization' of entities of government from the state". Neoliberalism does not mean less governance. It would be more useful to describe this rationality as a transfer of governance functions from the state to the enterprise – the enterprise being the individual.

Governmentality does not stand alone, and just as the execution of FDA relies on a thorough understanding of the mechanisms embodied by Foucault's description of power/knowledge, so governmentality is a cog in the wheel of his greater contributions: a cog that specifically focuses on "the different ways in which an activity or art called *government* has been made

thinkable and practicable" (Burchell et al., 1991, p. ix). Thus governmentality is part of Foucault's toolbox (Rose, O'Malley, & Valverde, 2006). In this chapter I provide an outline of Foucault's concepts, presenting the platform for the understanding and use (in this dissertation) of governmentality. I then move on to review Foucault's discussions of liberalism as well as that of the Anglo-Foucauldian governmentality writers insofar as they provide insights into the current art of government. With theoretical and methodological tools in hand, I then move on to describe my method. The majority of the writers covered in this chapter are situated in the West and write about Western phenomena. Despite this, these insights are fundamental to my analysis of current South African maternal health practices. The next chapter draws together writings on governmentality and the Global South.

3.1. Foucault's toolbox: A new conceptualisation of power

Within orthodox conceptions, power is imbued with an economistic function: the classical juridical theory of power, which liberalism employs, considers power as a *right* which is possessed as one possesses a commodity; even in critical theories such as Marxism power is imbued with an "economic functionality" where "political power finds its historical *raison d'etre* in the economy" (Foucault, 2007, p. 14). With an economic functionality power can then be understood to reproduce the relations of production (and as such class domination). This juridical-economic definition currently represents the dominant mode of analysis of power in the West. Foucault argued that this conception of power plays an important role in mystifying the various techniques through which people are disciplined, regulated and governed.

For Foucault, power is not possessed by or imbued in persons or institutions, nor is it the domination of one group, class, or sex, over another. Rather, power comes into being with the establishment of relations between individuals, and between institutions and individuals. Even those who occupy a lower echelon of a hierarchical relation of power are not considered merely 'objects' of power – the oppressed or repressed. Instead, all actors within relations of power are active, and while it can produce repressive instances, power (in modern society) aims rather to produce certain types of *behaviour* or *conduct*. Power, in a Foucauldian sense, is intensely productive: relations of power *produce subjects*. Subject positions in relations of power can either be taken up by the subject or resisted. As such "individuals are the vehicles of power, not its points of application" (Foucault, 1980, p. 98).

> Power is bound up with knowledge, and those who are subject to power continually remake it and their subjection to it as they participate in discourse and regulative practices. (I. Parker, 2002, p. 131)

Power in its very character is constantly being shaped and contested on a local level by the endorsement by and resistance of subjects.

For Foucault, there is a fundamental connection between the operations of power and the production of knowledge or 'truths'.

> We should not be content to say that power has a need for such-and-such a discovery, such-and-such a form of knowledge, but we should add that the exercise of power itself creates and causes to emerge new objects of knowledge and accumulates new bodies of information. (Foucault, 1980, p. 51)

This 'power/knowledge' relationship is not linear, but circular:

> 'Truth' is linked in a circular relation with systems of power which produce and sustain it, and to effects of power which it induces and which extend it. (Foucault, 1980, p. 133)

Foucault made the connection between knowledge and power, as Michael Behrent (2013, p. 71) notes, when he focused on the field of psychiatry. This is where Foucault "discovered a distinct relationship between a particular form of knowledge and a method of controlling human beings." It was in the relationship that psychology has with positivity that the relation of power begins – when a "dubious" science such as psychiatry claims a positive knowledge of human beings, it "authorize[s] and enable[s] the technical control of human existence" (Behrent, 2013, p. 73). Later Foucault started describing this method for control as a "technology of power" (Foucault, 1995, p. 23).

In French, the words 'technology' and 'technique' are, to some extent, synonymous. While it seems like Foucault used them interchangeably, techniques tend to describe specific and localised practices while technology encompasses a collection of techniques. Techniques are simply the way in which something is done, or the practice is performed: the discursive and technical rules of a practice. A technology is the logic that coherently makes all the techniques work together to produce a set of power relations. In metaphorical terms technology is the workspace organised according to a specific logic in which a set of techniques operates to produce something – in this case, subjectivities. Technologies assign relations of power through an apparatus (*dispositif*). Techniques operate according to practices such as that of regulation, normalisation, or control. As part of an apparatus these various techniques produce

subject positions. Not only is technology employed as a metaphor to describe the way human beings are controlled in society, but Foucault also used the terms technique and technology to reflect “the fact that, since the seventeenth century, the same kind of rational, scientifically informed procedures that were being used to control nature, production, time, and so on were being used to manage human beings, particularly in institutional settings” (Behrent, 2013, pp. 59-60).

3.2. Biopower

Foucault’s histories encompassed the analysis of the emergence and transformation of modern forms of power. In his histories, Foucault identified a new type of power emerging systematically since the seventeenth century that no longer utilised repressive, but rather *productive* mechanisms. This power took life itself as its object which allowed for an interface between biological and political existence to come into being.

> For the first time in history, no doubt, biological existence was reflected in political existence; the fact of living was no longer an inaccessible substrate that only emerged from time to time, amid the randomness of death and its fatality; part of it passed into knowledge's field of control and power's sphere of intervention. (Foucault, 1978, p. 142)

Evolving initially in two different forms, this ‘biopower’ centred “on the body as a machine: its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and docility, its integration into systems of efficient and economic controls:” an *anatomo-politics of the body* (Foucault, 1978, p. 139). Biopower also transformed existing mechanisms that could take the ‘population’ as its object: a *biopolitics of the population:* “focusing on the species body, the body imbued with the mechanisms of life: birth, morbidity, mortality, longevity” (Rabinow & Rose, 2006, p. 196).

The spectacular disciplinary mechanisms of the pre-modern era such as public trials and beheadings were waning in their influence and being replaced systematically by less visible power mechanisms: surveillance and documentation, practices of confession and the production of knowledge about individuals and on the dynamic connection between the economy and the population. Driven by a political rationality that itself was generated as a result of the possibilities of these new relations of power, a whole ensemble of institutions and techniques appeared that were concerned with the growth of the population and the fostering of life (Gastaldo, 1997).

Techniques put in place were immediately practical: the spatial distribution of individuals in order to optimize surveillance and visibility; attempts at increasing individuals' productivity in the workplace as well as through practices such as exercise and drill, bookkeeping, and inspections, among others (Foucault, 2003a). These techniques were individualising, aiming to *discipline* the human body. These practices aimed to change individual behaviour and functioned

> …by creating desires, attaching individuals to specific identities, and establishing norms against which individuals and their behaviours and bodies are judged and against which they police themselves. (Sawicki, 1991, p. 68)

This power also took as its object the *species body* which allowed for the creation of mechanisms to *regulate* the population, such as public health measures, housing etc. While initially in the eighteenth century these two 'poles' or 'techniques' of biopower developed in their separate institutions and according to their own agendas, they were very soon joined up "in the form of concrete arrangements" (Foucault, 1978, p. 140). Collectively they could form "great technologies of power" of which Foucault's most well-known example is *sexuality* (Foucault, 1978, p. 140).

The joining up of these two techniques, the emergence of a fully-formed *biopower*, was the condition of possibility for what we call 'modern society' (Foucault, 1978). This control was subtle and not a forceful coercion. It did not destroy its target, it created it with mechanisms that altered and created gestures, attitudes, habits, actions and movements through spatial or timing arrangements, supervision and assessment: "a procedure… aimed at knowing, mastering and using" (Foucault, 1995, p. 143). Biopower views human bodies as "resources and manageable objects" (Hakosalo, 1991, p. 9) and turns the body into an object of knowledge. Disciplines use knowledges of the body to make people more docile, useful and productive. It operates on the micro level – on the body itself – 'disciplining' its movements and habits through institutions such as the school, the hospital, the army, and the family.

Biopolitical power re-organised politics around a problematic that involves both disciplinary relations as well as new tactics that were made possible by a simple transmutation of the notion of 'population.' The 'population' in its modern sense was 'invented' in the eighteenth century. It no longer represented simply a group of individuals, but rather 'the population*,'* a natural entity and a living species with its own characteristics. These new characteristics allowed for the population to become an object of intervention. As a living species, it could now be calculated, understood, and regulated.

> …the milieu appears as a field of intervention in which, instead of affecting individuals as a set of legal subjects capable of voluntary actions – which would be the case of sovereignty – and instead of affecting them as a multiplicity of organisms, of bodies capable of performances, and of required performances – as in discipline – one tries to affect, precisely, a population. I mean a multiplicity of individuals who are and fundamentally and essentially only exist biologically bound to the materiality within which they live. What one tries to reach through this milieu, is precisely the conjunction of a series of events produced by these individuals, populations, and groups, and quasi natural events which occur around them. (Foucault, 2007, pp. 36-37)

Biopolitics infiltrated and embedded itself in already existing disciplinary techniques as well as the remaining sovereign-juridical techniques and modified them according to its needs[21]. It did not displace disciplinary power; just as disciplinary techniques did not displace juridical power – instead it appropriated and transformed existing techniques in terms of a new logic.

The knowledge that biopolitics took as its object was statistical: birth-rates, mortality-rates and population health. As an eighteenth-century bureaucrat and demographer put it:

> There can be no well-ordered political machine, nor enlightened administration in a country where the state of the population is unknown. (Montyon & Moheau, 1778, p. 20; as quoted in Pasquino, 1991, p. 115)

This knowledge came with its own set of economic and political problematisations. It was during the eighteenth century that demography appeared – "the evaluation of the relationship between resources and inhabitants" (Foucault, 1978, p. 140) and as statistical techniques were refined, it coupled with clinical knowledge to produce a system of knowledge that allowed for the health of this living entity that is the population to become subject to even more refined measurement – epidemiology.

This is the field on which biopolitics operates and its aim is to intervene on the level of the population based on the targets set by these economic and political problematisations. Epidemics were no longer the main issue – instead 'endemics' became the dominant concern – "the form, nature, extension, duration, and intensity of the illnesses prevalent in a population," (Foucault, 2003a, p. 243), in other words, illness affecting the population became one of the principal points of intervention for biopolitics and out of this birthed public hygiene. As Foucault (1978, p. 142) pointed out:

> Western man (sic) was gradually learning what it meant to be a living species in a living world, to have a body, conditions of existence, probabilities of life, an individual and

[21] In fact, Foucault argues that these various individual technologies of security "consists to a great extent in the reactivation and transformation of the juridico-legal techniques and the disciplinary techniques" that he discussed in the previous years' courses. (Foucault, 2007, pp. 23-24)

> collective welfare, forces that could be modified, and a space in which they could be distributed in an optimal manner.

In the eighteenth century the first enquiries into practices of contraception were conducted and policies appeared that aimed to intervene in all phenomena concerned with the birth rate (Foucault, 2003a). As biopolitics extended itself into new areas, a variety of mechanisms formed. For instance, to deal with the phenomenon of old age, insurantial mechanisms were introduced; and a concern with the effect of the environment on the population led to the institution of various urban and environmental techniques of intervention.

3.3. Governmentality

In his later work, Foucault introduced a new focal point for an analysis of a political rationality that had as its condition of possibility the emergence of biopower, and which drove the generation of a variety of institutions that could take hold of the individual body as well as regulate the population. This is the process of governmentality. As "biological existence" systematically "passed into knowledge's field of control and power's sphere of intervention" (Foucault, 1978, p. 142) so too did the art of governing transform and allow for new institutions to be produced. The first institution produced was the state itself – that is, geographic space was governmentalised.

On the one hand, governmentality is a process through which aspects of life are brought into relations of power for them to be governmentalised. On the other hand, governmentality is a tool for historically analysing how 'government' has problematised issues and produced solutions to these issues. Utilising this tool, Foucault provided a genealogy of the process of governmentality in his 1977-79 courses (Foucault, 2007, 2008). Foucault introduced the term 'governmentality' to provide an overarching way of identifying and distinguishing between 'regimes' of governing. To speak of a governmentality is to speak of "a system of thinking about the nature of the practice of government" (C. Gordon, 1991, p. 3) (a system which is contingent and invented: its analysis foregrounds these characteristics). Governmentality is Foucault's neologism for a rationality of government and he used it interchangeably with 'art of government' (C. Gordon, 1991, p. 2).

Governmentality provides us with a lens through which one can analyse not only the rationality that guides the 'government', as an institution of state, but the rationality that guides all forms of governing, even those beyond the state. To analyse how relations of power operate to govern people, Foucault suggested:

> This word [government] must be allowed the very broad meaning it had in the sixteenth century. 'Government' did not refer only to political structures or to the management of states; rather, it designated the way in which the conduct of individuals or of groups might be directed – the government of children, of souls, of communities, of the sick … To govern, in this sense, is to control the possible field of action of others. (Foucault, 1982, p. 790)

In other words, 'governing' is here not defined as 'what the state does', but rather the state is seen to be one of many institutions that have been governmentalised – that is, it was produced to institutionalise 'governing'. Although my project will focus on official government and health policies and procedures, this does not mean that governing, in the sense that will be utilised, transpires or even originates in 'the government' alone.

Foucault's use of the word 'conduct' (*conduire; conduits*) was strategic since it played linguistically on its various meanings. *Conduct* refers to behaviour; *to conduct* can mean to manage or control, or to guide or lead something or someone; *to conduct oneself* is to behave in a particular way, to manage yourself or your affairs. As such, one can govern others and one can govern oneself and what is governed is others' or one's own *behaviour*. If government means to conduct others' conduct, then 'governmentality' is the specific and identifiable rationality that is connecting (and directs) a series of technologies of government[22].

A genealogy of governmentality, as Foucault conducted in his 1977-1979 courses at the Collège de France (Foucault, 2007, 2008), focuses on a "system of thinking about the nature of the practice of government (who can govern; what governing is; what or who is governed)" (C. Gordon, 1991, p. 3). Such an analysis aims to show how these overarching systems of ideas around governing have come to be – how they are made "thinkable and practicable" (C. Gordon, 1991, p. 3). Until the mid-1970s Foucault studied institutions from the point of view of technologies of power as seen in his projects on the disciplines – the school, the prison, the army, the hospital, and so forth. This entailed studying these disciplines by way of an "non-institutional-centric" approach which meant a) viewing institutions from the outside; b) focusing not on institutional functionality but rather analysing the "general economy of power" i.e., an institution's strategies and tactics; c) and finally detaching the privileged object from the institution, the already formed prisoner, mental patient, or pupil, and rather focusing on how they are constituted as subjects in the process of knowledge production (Foucault, 2007, pp. 161-164).

[22] If technologies of power produce relations of power, then technologies of government produce the relations through which people's conduct can be governed.

However, as technologies of power are 'freed' from institutions, questions arise such as one Foucault asked himself in 1978:

> After all, do not these general technologies of power, which we have attempted to reconstruct by moving outside the institution, ultimately fall under a global, totalizing institution that is, precisely, the state? By stepping outside these local, regional, and precise institutions of the hospital, the prison, or families, are we not referred back, quite simply, to another institution, so that we will have abandoned institutional analysis only to be enjoined to enter into another type of institutional analysis in which, precisely, the state is at stake? (Foucault, 2007, p. 164)

In an answer to the questions, Foucault suggested employing the very same methods of analysis to the state itself. This conceptual shift also heralded a move, by Foucault, away from focusing on the disciplinary formation of the subject towards the analysis of the "double character" of subject formation that included both practices of subjugation through technologies of power, and self-constitution through practices of the self (Bröckling, Krasmann, & Lemke, 2011, p. 2).

Within governmentality as an analytical framework one examines the activity that covers a type of *power* – a power that succeeding arts of government, since the sixteenth century, have aspired towards through the process of the governmentalisation (*étatisation*) of the state – a state which was systematically achieved since the eighteenth century. The state that was thus achieved is also referred to as governmentality:

> …by "governmentality" I understand the ensemble formed by institutions, procedures, analyses and reflections, calculations, and tactics that allow the exercise of this very specific, albeit very complex, power that has the population as its target, political economy as its major form of knowledge, and apparatuses of security as its essential technical instrument. (Foucault, 2007, p. 144)

Governmentality is therefore an ensemble of apparatuses through which power governs populations. The focus should not be on the state; instead it should be on understanding how the state has been governmentalised, turned into (as it were) a vehicle within which relations of power operate.[23] As Rose (1999b, p. 18) notes:

> These links between the political apparatus and the activities of governing are less stable and durable than often suggested: they are tenuous, reversible, heterogeneous, dependent upon a range of 'relatively autonomous' knowledges, knowledgeable persons and technical possibilities.

[23] Donzelot (1979) was in fact the first to publish an argument along these lines, drawing from Foucault. He was a colleague of Foucault's and in his article 'The Poverty of Political Culture' he argues for the usefulness of employing genealogy in analysing political culture, that is, the whole ensemble of both political forces as well as critics, that together play a specific role in the formation of current political practice.

State apparatuses only penetrate the lives of citizens because they have been governmentalised.

3.3.1. The governmentalisation of the state

Rationalities of government utilise regimes of truth, ideas about rule, who should rule, and how to operate and extend their boundaries. The governmentalisation of the state quite simply is

> …the invention and assembly of a whole array of technologies that connected up calculations and strategies developed in political centres to those thousands of spatially scattered points where the constitutional, fiscal, organizational and judicial powers of the state connect with endeavours to manage economic life, the health and habits of the population, the civility of the masses and so forth (Rose, 1999b, p. 18).

Since the state is not the origin of government the question that should rather be asked is how the state is governmentalised? How, "at a certain historical moment, had the formal apparatus of the state come to embroil itself with the business of knowing and administering the lives and activities of the persons and things across a territory?" (Rose et al., 2006, p. 87). It is this development that Foucault discusses in detail in his 1977-78 course titled *Security, territory and population* (2007). Foucault identified a characteristic in the general theme of governing people that is fundamental to all forms of Western governmentality. This characteristic is that the relations of power put in place are on the one hand *individualising* in their power effects, and on the other, *totalising*: *omnes et singulatim*, 'all and each' (Foucault, 1979, 2007). Foucault identifies its emergence with the rise of the governmental rationality based on a pastoral ethic where the shepherd "does everything for the totality of his flock, but he does everything also for each sheep of the flock" (Foucault, 2007, p. 173). Foucault showed how this ethic allows for the institutionalisation of the Christian religion and the creation of the Christian Church, through which this pastoral power could operate and produce a variety of mechanisms and techniques which firmly established relations of power that would govern individuals to heaven.

He goes on to trace this ethic as it is adopted, at the end of the sixteenth century, as a model for the government of people which could become the source of power over people within the institution of the state. What he describes is a new governmental rationality that takes on the pastoral notion of the government of souls, with reference to the family, and systematically adopts, adapts and incorporates established pastoral mechanisms of power to govern the population. In the myriad of treatises and texts in sixteenth and seventeenth centuries Foucault identified this shift where the notion of 'government' comes to be both formulated and questioned for the first time in terms of the pastoral principles. It is at this time when a new

theoretical position, *ratio status* (or *raison d'État;* reason of state) appears, which is, in simplistic terms, the secularisation of the state – considered at the time as scandalous as Galileo's discoveries. However, with strong proponents such as Cardinals Richelieu and Mazarin in France, Francis Bacon in England, and the Dutch statesman Phillip von Chemnitz (known as the *Politiques*), among others, the logic of *raison d'Etat* soon established itself and spread across Europe.

The state itself was a completely new institution and as such a fundamental aspect of *raison d'État* was to establish 'the state' as "a given", as well as "an objective to be constructed" (Foucault, 2008, p. 4). As an objective to be constructed, statesmen maintained to govern according to the objectives of what a state should be, with the aim of establishing the state as "sturdy and permanent", "wealthy" and "strong" (Foucault, 2008, p. 4). Foucault pointed out that mercantilism was not an economic doctrine but rather a form of government. It was configured in accordance with the principles of *raison d'État* and as such its practices conformed to the strengthening of the state – enriching itself and growing its population. Its internal management practices were aimed at disciplining a growing urban population to produce a strong state.

About two centuries after its emergence, the reasoning of the *Politiques* came to be challenged, and it was challenged first in its economic functioning (Foucault, 2007, p. 443). It was this challenge that allowed for the emergence of *governmentality*. The physiocrats devised a theory based on the natural circulation of grain which they argued would lead to a true price and abolish scarcity. The physiocratic ideas rewrote the fundamental principles of economic theory – or as Foucault argued – found economic thought itself (Foucault, 2007, p. 55), based on the functioning of nature. Consequently, a variety of transformations in the techniques of government and the production of knowledge took place that made *reason d'État* break apart, and allowed for apparatuses of security to become the dominant characteristic of the way we are governed, a reality that continues today.

Foucault called the governmental rationality he associated with technologies of security liberal for several reasons. The most obvious reason is the connection he drew between the economic doctrines of the physiocrats and the subsequent transformations associated with their ideas in the realm of the market. Another reason is because the power relations liberal governmentality employs takes "freedom itself as the soul of the citizen" (C. Gordon, 1991, p. 5). Liberalism is thus not understood as a theory (political or economic) nor as an ideology. Rather, it is seen as

political rationality – “a way of doing things that was oriented to specific objectives and that reflected on itself in characteristic ways” (Rose et al., 2006, p. 84). As such its formulation and development can be traced empirically.

Gordon (1991, p. 92) argues that the establishment of governmentality coincided with “the introduction of economy into political practice”. Thus, the now commonly used economic notion of *laisser-faire* comes to be taken as a general governmental rationality, an ‘art’ of government based on the principle of ‘self-limitation’ when it comes to the economy. The freedom of circulation of grain is based on a logic in which fluctuations in the availability of grain and resultant fluctuations in the price of grain, if left alone, will allow the market to *naturally* take its course and as such scarcity will become “a chimera” (Foucault, 2007, p. 61).[24] “*Laissez-nous faire”*: leave us alone, “in the sense of ‘letting things take their course’” (Foucault, 2007, p. 64) becomes the “essential principle which all governments must follow” in terms of economic matters (Foucault, 2008, p. 20). There is an “internal limitation” built into this form of governmentality (Foucault, 2008, p. 13). Physiocratic economic reflections are based on the idea that the market is “natural” and consequently works according to “spontaneous mechanisms” (Foucault, 2008, p. 31). If the market is natural, then any form of intervention will distort it. The price of a product will naturally be determined by the market, based on its value.

Before this doctrine appeared in the mid-eighteenth century, the market was viewed as a structure that needed to be modified and regulated, particularly in favour of the buyer. The market was a site for justice – the just price of a product had to be set by those who governed. Liberal governmentality is thus based on a particular truth: the market functions as ‘nature’ does, and if left to function naturally, the prices it creates are the ‘true’ prices. This ‘natural function’ also operates as the means to judge whether a particular governmental practice is in fact ‘correct’ or ‘erroneous’ based on whether it allows for the true price to emerge (Foucault, 2008, p. 32):

> …it is the natural mechanism of the market and the formation of a natural price that enables us to falsify and verify governmental practice when on the basis of these elements, we examine what government does, the measures it takes, and the rules it imposes.

This mechanism of judging the outcome of governmental action transforms the role of government.

[24] Foucault is quoting Louis-Paul Abeille (1719-1807) *Lettre d’un négiociant,* S.l. : s.n. (1763).

> The market determines that a good government is no longer quite simply one that is just. The market now means that to be good government, government has to function according to truth (Foucault, 2008, p. 32).

The population has a very particular role to play in this market mechanism since the perfect circulation of grain depends on very specific economic behaviour from the population. As the physiocrat Louis-Paul Abeille pointed out in 1763, if the members of the population, the producers and consumers, do not behave in the right way, then a variety of negative consequences will follow, including revolt and monopoly (Foucault, 2007). As such, the population emerges as an object towards which mechanisms and techniques are directed with the aim of bringing them in line with the natural flow of market mechanisms. As subjects, the people are directed towards conducting themselves in a way that is beneficial to the market through mechanisms that regulate and normalise their behaviour.

> From this moment on, those who inhabited a territory were no longer understood merely as juridical subjects who must obey the laws issued by a sovereign nor as isolated individuals whose conduct was to be shaped and disciplined, but as existing within a dense field of relations between people and people, people and things, people and events. Government had to act upon these relations that were subject to natural processes and external pressures, and these had to be understood and administered using a whole range of strategies and tactics to secure the well-being of each and of all (Rose et al., 2006, p. 87).

We see here a variety of transformations in disciplinary and sovereign practices that not so much do away with them, but alter them according to a new rationality. Apparatuses of security are *regulatory* in character. Security's purpose is to gather knowledge on the processes towards which it orients itself, and a surveillance of activities in their 'natural' state. From there it deploys regulatory tactics: modulating the "health, wealth and longevity" of the population, "its capacity to wage war and engage labor, and so forth" (Rose et al., 2006, p. 87).

Governing according to truth means that a mechanism for ascertaining truth is necessary. 'Political economy', emerging in the eighteenth century, meant "the analysis of the production and circulation of wealth," but much more broadly it stood for "any method of government that can procure the nation's prosperity" (Foucault, 2008). It also meant, as Foucault took from Rousseau's text from 1755, a "general reflection on the organization, distribution, and limitation of powers in a society" (Foucault, 2008, p. 13; Rousseau, 1755). Thus, political economy emerged as an intellectual instrument in this new governmentality, an instrument that helped the government reflect on what it does and what it should be doing.

Political economy does not question whether governmental practices are legitimate – instead, it asks whether their outcome or effects are in line with 'good economic government'. Political economy does not divide its potential sphere of activity into that which can be governed and that which is fundamentally free from intervention. The question political economy asks is not whether it is right, or just, for instance, to raise taxes. Previously the question of taxes, regulation of prices, and so forth, were rationalised within a regime of truth where truth was based on the legitimacy and rights of the ruler. The new governmentality and the question it was preoccupied with is rather that of: What effect would raising taxes have and would this effect be positive or negative? This question is based on a regime of truth in which the market is a natural entity that can reveal whether a practice is correct through price mechanisms. Governing becomes about dividing what is to be done into "*agenda*" and "*non-agenda*" (Bentham, 1954; quoted by Foucault, 2008, p. 12). Good government is governing with enough insight into how the market will react. Legitimate or illegitimate government is replaced by good or bad government; "success replaces legitimacy" (Foucault, 2008, p. 16).

The dawn of the "age of critical government reason," as Foucault (2008, p. 12) put it, emerged when government started critically evaluating its own practices. On the one hand, political economy's aims were created within the same framework of *raison d'État*: the enrichment of the state, and, in terms of foreign policy, to maintain a certain competitive equilibrium between states. If this art of government is based on the principle that the economy is natural, an "indispensable hypodermis" (Foucault, 2008, p. 16), it means that when the economy is blocked or impeded by something, then certain governmental actions are the cause. Political economy makes the functioning of the economy intelligible; it reveals the "phenomena, processes, and regularities" of the economy which exist due to "intelligible mechanisms" (Foucault, 2008, p. 16). Political economy shows the governors where to intervene and how much to intervene.

Liberalism is not just a "doctrine of how to govern", rather, "it is an art of governing that arises as a critique of excessive government" (Rose et al., 2006). It is constantly preoccupied with the issue of governing "too much"; political economy aims to reveal not only where the state should intervene, it also continually shows the state its own limitations.

3.3.2. The Foucault Effect*: Reviving governmentality*

One of the first and most important contributions to the elaboration of the notion of governmentality was that of Jacques Donzelot. Utilising genealogical tools, Donzelot (1991)

shows how the theme of the welfare state first developed in the mid-nineteenth century in France in relation to the question of the role of the state in a democracy. He showed how the theory of the welfare state was formulated and posed as one solution to a savage antagonism between two views on the function of right; central to which is the right to work and the rights of property.[25] The question of the role of the state emerged as an important topic in an extensive literature in which the main arguments revolved around how to find the right way in which to balance social interventions by the state with the rights of individuals and particularly the natural associations between people that liberals and traditionalists associated with nature itself.[26] Interventionist policies were understood as a threat to the natural bond, a bond which was seen as being prior to any other form of social organisation. For welfarist interventions to be accepted, its ideologues needed a justification on two grounds: on the one hand they needed to be able to formulate a theory which would provide the necessary limitations to assure that welfare would not overstep its boundaries and threaten the natural bond. On the other hand they had to find a justification for intervention in what was considered a thereto off-limits sphere for intervention – the 'natural' familial bond that develops between people (Donzelot, 1991).

The theoretical justification that unblocked welfarism came in the form of the theory of *solidarisme*[27]. Emile Durkheim (1994) proposed that social organisation developed among people, to begin with, around a 'mechanical' solidarity based on similarity and a common identity – the kind of solidarity traditionalists aimed to preserve. However, faced with similar threats associated with industrialisation and modernisation, individuals formed groups to withstand them together and hence ensure survival. Society systematically developed an 'organic' solidarity due to the increasing precarity of life. State intervention *as* organic solidarity was thus justified in an industrialised society.

> The concept of solidarity, with the rationalization that sociologists, especially Durkheim, gave it, was used to redefine the juridical context of state intervention, its justification and its limits. The notions of public service (Léon Duguit) and institutions

[25] Donzelot is here referring to the revolutions of 1848 which started in France and quickly spread across more than 50 other states, mainly European and some Latin American. The revolutions aimed to dissolve feudal structures, but generally it was, as Donzelot notes, a struggle between various ideas about what a democratic state should look like. While Marxists denounced the revolution as a failure for the proletariat, slowly but surely reforms were enacted which would take the form of attempts at reconciling the various interests in the various states.

[26] This is during the time of the Second Republic, yet across Europe major and influential classical texts dealing with the State are written including Alexis De Tocqueville's *L'ancien regime et la Revolution* (1853), Karl Marx's *Der 18te Brumaire des Louis Napoleon* (1852), and Charles Dupont-White's *L'individu et l'état* (1856), among others (Donzelot, 1991, p. 170).

[27] Formulated by the statesman Leon Bourgeois (1896), drawing from Durkheim, solidarisme was presented as a new doctrine of the state to be taken up by the Third Republic.

> (Maurice Haureou) are developed wholly out of this concept of solidarity. These notions make it possible to specify the scope of state intervention: when it is entitled to encroach on the prerogatives of citizens, and when citizens are justified in challenging it. (Donzelot, 1991, pp. 172-173)[28]

Solidarisme gave the state a new agenda and non-agenda and a new internal limitation. The state was given the prerogative of acting as a mechanism that *stood outside of society* (still allowing society its sovereignty and autonomy) and that aimed to *guarantee the progress* of society by strengthening the social bonds that were being eroded by modernity, industrialisation and "unrestrained economic processes" (Donzelot, 1991, p. 173; Foucault, 2008, p. 142). Welfare presented a middle way between traditionalists, liberals and socialists and therefore it would make sense that a governmentality based on the imperative of security would find a way to mitigate antagonisms and aim to create 'a consensus society'. The rationality of welfare remained the creation of more freedom by way of the mitigation of risk through insurantial mechanisms. The *knowledge produced* (a theory that justifies intervention, an expansion of statistical approaches that aims to explore more and more modern risks and therefore more 'rights', and the generation of an entire discipline: sociology) and the resultant *practices put in place* (new institutions, forms of intervention, and a whole set of administrative apparatuses that would coordinate it) accorded to a rationality of government that took the security of the population as its foremost agenda – a security that was threatened by violent opposition between liberals and traditionalists, and workers.

As with the discovery of the 'population', social statisticians discovered the 'social' and extended the boundaries for intervention. The 'social' was turned into a reality, an "existential sphere of human sociality" (Rose, 1996, p. 329). As Deleuze (1997, p. ix) noted, 'the social' is not merely an "adjective that qualifies the set of phenomena which sociology deals with", but rather "*the* social refers to a *particular sector* in which quite diverse problems and special cases can be grouped together, a sector comprising specific institutions and an entire body of qualified personnel ('social' assistants, 'social' workers). Not only did the population have a birth rate, a mortality rate, and so forth, but now various processes – such as cause and effect between order and poverty, inequality and delinquency, ill health and population growth –

[28] Léon Duguit (1859–1928) and Maurice Haureou (1856-1929) were French scholars of administrative law. Duguit, a colleague of Durkheim, formulated a theory where the state is considered to consist merely out of a group of public servants. Haureou developed a theory of the institution based upon a particular definition of democracy as a "system which maximises the consciousness and the responsibility of each person" (Gigacz, 1996).

could be identified within it. The identification of these phenomena allowed for its governance and the institutionalisation of a variety of regulatory mechanisms.

Systematically the social sciences turned the 'social' into a stable field of play. The 'social' became the field on which all intellectual, political and moral terms were set, the stage on which was acted in the interests of a collectivity within a national boundary. On this stage, politicians would make their demands on the population in the name of the collective interest – "in the interests of social protection, social justice, social rights" (Rose, 1996, p. 329) – and society would make their demands within this reality, on these terms, towards the state. While different political rationalities produced different versions of the social state, they had one thing in common: "the nation must be governed, but the question of how to govern must be posed from 'the social point of view'" (Rose, 1996, p. 329).

Several technologies had to adapt their rationalities: political economy had to adapt to this new reality as it saw the rejection of its "totalizing claims … to prescribe and delimit the legitimate means to be used for the government of economic life" (Rose, 1996, p. 329). Law, too, had to give up its role as "the sole and sufficient legitimate means for achieving order and security" as the new rationality argued for a security through the social. Law also adapted to the social by considering 'social realities' in its rulings. As new areas for intervention were discovered by the social sciences, and new demands were made on the state in the name of the social, this new rationality allowed for a massive expansion of state institutions and the proliferation of specialisations and experts.

In the 1960s and 1970s, the welfare state was declared to be in crisis (Donzelot, 1991). Both neo-social democracy[29] and neoliberalism presented themselves as diagnosis and cure to the problem of how to re-organise state resources. The question Donzelot (1991, p. 169) asked, was "if these were presented as cures, what was the crisis?" Unless one wanted to make a moral argument based on personal ethical preferences, or draw from experts who formulated their arguments based on these criteria, one inevitably found oneself in an ideological standoff. A solution out of this impasse required a shift in focus which Donzelot provided in a brief genealogy of the question 'how should we govern a democracy?' If we analysed the emergence

[29] The reference to neo-social democracy is here based on the name of a conference 'on neo-social democracy' held in 1982. Donzelot's reference to neo-social democracy refers to 'leftist' liberal critiques of welfare, most significantly the debates that eventually culminated in Third Way politics.

of welfarism based on the criteria of the role it had to play in a liberal democratic society, then we should look at the critiques launched against it in a similar fashion.

Welfarism was attacked for not being in keeping with the limitations it set for itself – the welfare state had become too expansionist and would eventually envelop all forms of social organisation. Neoliberal arguments followed that the welfare state had appropriated society's natural mechanisms of evolution "by capturing the powers of decision" (Donzelot, 1991, p. 174). As such society's very sovereignty had been seized by the state. It was no longer strengthening the bonds in society, but rather eroding it; the result was a "loss of civil feeling", which, if anything, was halting progress. Furthermore, it was argued that welfare's original logic of being a type of external guarantor for progress had been discarded and the welfare state had turned into a "manager directly responsible for society's destiny" (Donzelot, 1991, p. 174)[30].

Critics of welfare on the left disapproved of the notion of progress that the welfare state employed, and the decisions made by the state for the people in the name of progress. These forces occupied the space left empty when trade unions and social movements joined the state in the project towards state-led progress. These movements also argued that society's sovereignty had been usurped by the state through the way that the welfare state determined progress and the statistical and technocratic methods employed in the process. Their solutions were to return to a bottom-up approach to organising institutions exemplified by workerism and communitarianism (Donzelot, 1991).

This analysis drew Donzelot (1991, p. 176) to the conclusion that what critics saw as the crisis of the welfare state was its inability to merge solidarity and sovereignty – reconciling *keeping its distance* with the project of *bringing about solidarity*. The welfare state was seen to have promised something it could not deliver: a conjoining of two contradictory ideas, the promotion of the social as well as the freedom of the individual. This, Donzelot (1991) argued, was due to the inflationary logic built into the mechanisms of security in a liberal governmentality. The liberal "freedom-function", coupled with the "social", meant the more security, or rights, that are provided, the more will be demanded, to the point where people believe that the state should take responsibility for every problem in society (see also Foucault, 2008, pp. 68-69). When this point is achieved, 'freedom', in the sense of individual autonomy, it was argued, would have

[30] Donzelot here draws mainly from French criticisms around this time, specifically the highly influential debating clubs, Club Jean Moulin, Citoyen 60, and Échanges et Projets. In *The Birth of Biopolitics* (2008) Foucault outlines the arguments of the Ordoliberals in Germany to show the critiques launched against welfare.

no more substance. The welfare state could not but exaggerate the very inherent tensions of liberalism it aimed to reconcile in the first place. Despite this conflict, the end of welfare, Donzelot (1991) argued, could not be explained fully by this apparent failure.

It would be more useful to conceive of the end of welfare if it were understood that welfare and its critiques were not ideologies. Instead, welfare was formulated as a solution to antagonisms within society; antagonisms that at that time took the form of a brutal civil war. In February 1848, France signed a proclamation of rights which, among many other things, decreed the right to work. In June of the same year, the Spring of Nations broke out, with tens of thousands of people dying as it spread across Europe. The welfare state was formulated to quell the ongoing violence. However, as Donzelot (1991, p. 177) showed, the fears of the danger of conflict that reigned supreme at that time were not the fears of today. In fact, considering the form debates were taking then, "the whole conception of the social order which was obsessed with the need to avert dangers of conflict" which could be seen in the preoccupation of Enlightenment thinkers, and was seen to lie at the heart of the irreconcilability of the individual and the social, had ended.

Social democracy as a strategy did not 'fail.' Rather, its organising principles became redundant. The welfare state came to be understood as in crisis at the very time the initial antagonists "fell away to nothing" (Donzelot, 1991, p. 177). If we considered the welfare state as the establishment of "a line of development for society between tradition and revolution, liberalism and communism", then the 1960s in Europe could be summed-up as the liquidation of both revolution and tradition.[31] The nature of the debates, at that time, on how society was to be organised exemplified a complete lack of concern with confrontation. The new preoccupation was "around the choice of the best way of utilizing conflicts to make society more dynamic" (Donzelot, 1991, p. 177).

What Donzelot (1991; see also Rose, 1996) identifies happening here was a reconfiguration of the social. This process could perhaps more clearly be seen in the preoccupations of social

[31] Here specifically Donzelot is referring to the 1968 student revolt. We see in this revolt the rejection of Marxism as a emancipatory force, or perhaps more accurately – the rejection of the very basis of Marxism's theory of emancipation because it is dogmatic and ultimately powerless to provide answers to very real questions that lay outside the sphere of the relations of production. Historical materialism, it was argued, was no longer relevant as an analytic of social reality and the failure of the proletariat in bringing about a revolution was heavily criticised. The communist party had lost all credibility and as Jean-Paul Sartre put it, had become a "revolutionary party ... determined not to make a revolution" (Kritzman, 1988, p. x; quoting Sartre, 1974, p. 38). More globally intellectuals turned against the idea of revolution as a method of emancipation and sought rather to analyse specific mechanisms of power, to leave the general use of revolt to the people themselves and instead provide "strategic knowledge" where necessary (Kritzman, 1988, p. xiv).

theory from the 1950s onward. Postmodern approaches in a variety of fields were rejecting or redefining the social in line with what they considered the 'end of modernity' and critiquing the very bases of modern social theory.[32] The modern conception of linear progress was denounced and replaced by a radical and relativist individualism. Singular human actions came to be seen as able to write history 'from below'. A general tendency within certain sectors in social theory was evident in moving away from the analysis of the social towards group and community dynamics (Antonio & Kellner, 1994; Kritzman, 1988). And as Mark Bevir and Francesca Gains (2011) noted, political parties such as Britain's New Labour had actively taken up these new ideas from the social sciences on communities and institutions to formulate their policies.

Since the 'social' and the type of interventions implemented – such as social insurance, the social wage and universal free healthcare – are bound up with the political rationality of socialism, 'progressives' found themselves in a crisis of identity since they were not part of, and were forced to disagree ideologically with the most radical transformations in social theory. Jean Baudrillard's (1983) famous inference, that since the social as an imaginary space for governmental intervention has fragmented, anyone who attempts to reify it as a reality is naïve, means that postmodernism has often been seen as antagonistic towards socialist, *and therefore* progressive, ideas.

Neoliberalism, Third Way politics, and contemporary critical culture in general, can be better understood as the reorganisation of politics around a new theme that was *not the social*. The debates of the 1970s centred around "alternative modalities of the social bond" (Donzelot, 1991, pp. 177-178). The social, as a target of government strategies exemplified by social democracy, and the very basis of its existence, has, to some extent, been liquidated and fragmented. It has still not completely disappeared, but it is in the process of being replaced by a different modality, one that is seen especially by proponents of the Third Way to be more relevant and flexible to contemporary problem-solving in a globalised and heterogeneous society.

> …while themes of society and concerns with social cohesion and social justice are still significant in political argument, the social is no longer a key zone, target and objective of strategies of government. The rise of the language of globalization indicates that

[32] At the extreme Baudrillard argues that modern sociology "can only depict the expansion of the social and its vicissitudes. It survives only on the positive and definitive hypothesis of the social. The reabsorption, the implosion of the social escapes it. The hypothesis of the death of the social is also that of its own death." (Baudrillard, 1983, p. 4) "The mass" does not exist; it is merely an end-point of theoretical models.

> economic relations are no longer easily understood as organized across a single bounded national economy (Rose, 1996, p. 327).

At least in the West, the social is no longer the *a priori* of political thought, whether of state agents or activists. In various other countries, which includes South Africa (as I demonstrate in chapter five), it is evident that the social is in a process of fragmenting into *communities*.

> Community has become a new spatialization of government: heterogeneous, plural, linking individuals, families and others into contesting cultural assemblies of identities and allegiances. Divisions among the subjects of government are coded in new ways; neither included nor excluded are governed as social citizens. Non-social strategies are deployed for the management of expert authority. Anti-political motifs such as associationism and communitarianism which do not seek to govern through society, are on the rise in political thought (Rose, 1996, p. 327).

A movement to 'community' as a new target of governmental intervention is evident in a great many societies. Where it does not have its origin in original thought within countries, it is imported through models of good governance by international organisations and non-profit organisations that spread the new logic as common-sense principles (cf. Carton & King, 2004; McGrath & Badroodien, 2006). Community is seen to allow for a new sovereignty to be given back to the individual citizen along with a solidarity that is not conceived on a national scale but rather in relation to specific allegiances. Citizens are therefore to make demands of the state not in the name of the 'social', but rather in the name of group identities. A proliferation of interest groups can be seen in various places, organised around a multiplicity of allegiances – whether marginalities, environmental concerns, political demands and so forth. One also sees the emergence of new configurations of delivering services: community homes, community care, community safety, community development programmes. Debates on plurality are displacing homogenising rhetoric, whether along the lines of culture, ethics, and religion, or in activist circles on differential or specific experiences, identity politics, communitarianism, or intersectionality (Rose, 1996, pp. 333-334).

It is true that communities have existed for a long time, but what is new is that 'community' has been used by governmentality as a framework for governance, the space through which it can intervene – as opposed to the social. Fragmenting the social could be seen a type of divisional tactic promoted on grounds of interest and fidelity, but divisional tactics are not particularly new to a neoliberal rationality of government. Instead, it would be useful to see 'community' as a *form of government*. On the one hand, it allows the individuals within the sovereignty to choose their allegiance and articulate their issues through forming communities, something that social solidarity was not particularly good at. On the other hand, issues can be

identified, groups can be constituted and objectified along articulated lines, knowledge gathered on them and specific techniques can be formulated in order to govern them. A good example here is the identification of ‘at risk’ communities. With the help of new statistical methods, problem areas or groups can be identified, and interventions can be tailored for them utilising experts. For instance, instead of providing a generic social wage for the unemployed, this new rationality attempts to identify specific pockets of unemployment, and utilising expert knowledge, would attempt to intervene within ‘communities’, or ‘groups’ themselves by, for instance creating skills workshops, financing small enterprises, or providing the necessary infrastructure to connect the unemployed to the general workforce. In case of decaying urban spaces, for example, the government would use a multiplicity of methods to intervene and either provide the means for the community to mobilise itself or fund or support organisations already formed within these communities. An example relevant to this dissertation, for instance, involves identifying, through research, pockets of problematic drinkers who are also pregnant, and focusing interventions to identify these individuals within their communities. Using communities not only to identify, but to intervene, is a current method of intervention on reducing the FASD rate.

Therefore, ‘community’ has become an “*imagined territory”* for the current governmentality to administer collective and individual existence (Rose, 1996, p. 331):

> I do not think this is merely a matter of changing professional jargon: it is indicative of a mutation, rather profound, if still uncertain, in the ways of thinking and acting that used to be conducted in a ‘social’ language.

It allows for political culture, whether on the left or the right, to problematise issues in a specific way. Within this *imagined territory* individuals are defined as active agents in their own fate and connected to governmentality through their personal allegiances with others. In this way, ‘community’ allows for a new organisation principle for government and is a new formulation for bringing together the social and the individual. However, whether this new form of governing will survive for long remains to be seen, and is dependent, largely, on whether citizens themselves are willing to be governed in this way. While neoliberal policies might allow for less governmental spending, they do not mean less governance. Neoliberal governance does not mean that the ‘marginal’ are to be left to their own devices. On the contrary, its focus is most commanding on the marginalised.

3.3.3. *Advanced liberalism and the retreat of welfare*

As is the case in most countries, the logic of community is still interspersed with that of the social. This is the same in South Africa as evidenced with the co-existence of a social security system with community development projects. The adoption of neoliberal forms of governing should not be seen as an all-encompassing shift, but rather a shift towards a new logic that is adopted systematically. The neoliberal logic attempts to dominate thinking (which means its usefulness in solving problems is articulated more firmly) and the logic of the social declines (which can accord to seeing the state as somehow incompetent in the provision of a collective security). Some of the most evident transformations can be seen in political rhetoric on what should be considered the *ideal role of the state* from being a *manager* of all things pertaining to life, or a *partner*, or *facilitator*. The symbolism of 'steering' as opposed to 'rowing' is often invoked by its proponents (Rose, 2000, p. 324). The logic behind this symbolism reinforces the fundamental element of liberalism – that of governing at a distance (Larner, 2000).

A variety of new practices based on the neoliberal logic are introduced into organisations including privatisation, consumerisation and marketisation, "accompanied by the increased use of techniques of accountability such as centrally set but locally managed budgets, and the practices of evaluation and auditing" (Rose, 2000, p. 324). These developments have come to be referred to as New Public Management (NPM). NPM represents a philosophy and practice about public sector administration, organisation and management that emerged with the incorporation of behaviourist theories into the 'science' of public administration (Minogue et al., 1998). NPM focuses on reorienting the public sector towards being more accountable, reducing waste and inefficiency, and being more flexible in the face of globalisation. The way it proposes to do so is through decentralisation of decision-making, introducing a notion of entrepreneurialism among civil servants, reorganising hiring practices to be closer to those of the private sector, and replacing the traditional bureaucratic system with a new system of management.

3.3.4. *Practices of the self*

Towards the end of the 1970s Foucault started focusing on the topic of ethics. Ethics, for Foucault, signified the work that an individual does on herself, subjecting and conducting herself according to recommendations, codes of behaviour or what Foucault called "modes of subjectivation" (Foucault, 1990, p. 28). Foucault described the notion of practices of the self as "an ascetical practice", where the word ascetical is used in its general meaning, "not in the

sense of abnegation but that of an exercise of self upon self by which one tries to work out, to transform one's self and to attain a certain mode of being" (Foucault, 1987, p. 113). Historically the care of the self was somewhat more autonomous than it is now. Since the mid-eighteenth century, the logic of care of the self was taken up by religious, pedagogical, medical and psychiatric institutions, among others, as a method through which to govern people. These practices were initially coercive and operated with the aim to discipline. What we have in contemporary liberal societies are practices that focus on the self-formation of the subject in the name of regulation.

Practices of the self are in fact *taken up by the subject*, and constituted according to particular subject positions, yet these positions are not invented by the subjects themselves. Instead, these practices are presented *to* the subject – it could be "proposed, suggested and imposed" on her by her culture, or her society or social group (Foucault, 1987, p. 122).

> …political rationalities have what one might term an epistemological character. That is to say, they are articulated in relation to some conception of the nature of the objects governed – society, the nation, the population, the economy. In particular, they embody some account of the persons over whom government is to be exercised… these can be specified as members of a flock to be led, legal subjects with rights, children to be educated, a resource to be exploited, elements of a population to be managed… (Rose & Miller, 2010, p. 277)

Subject positions are part of regimes of truth – such as the feminine subject of patriarchy, enjoined to act in particular ways. These practices fundamentally revolve around the question of 'truth': we form ourselves based on 'truth' – whether it be the truth of the "equilibrium of the processes of living things" (Foucault, 1987, p. 126), which belies ecological movements, the truth of our social nature which is fundamental to modern social theory as well as the welfare state, or whether it is the truth of the *homo economicus,* the calculating and calculable entrepreneur who consumes freedom through her own agency and choice.

We are drawn to take up these practices because they are presented to us as "practices of freedom".

> The new governmental reason needs freedom; therefore, the new art of government consumes freedom. It must produce it, it must organize it. The new art of government therefore appears as the management of freedom, not in the sense of the imperative: "be free," with the immediate contradiction that this imperative may contain…[T]he liberalism we can describe as the art of government formed in the eighteenth century entails at its heart a productive/destructive relationship with freedom. Liberalism must produce freedom, but this very act entails the establishment of limitations, controls, forms of coercion, and obligations relying on threats, etcetera (Foucault, 2008, p. 63).

Freedom conceptualised in welfarism takes a particular form – a promise of freedom towards which the entire society is enjoined to labour. To be governed according to the social, we are accorded personal responsibility, but this responsibility is always "traversed by external determinations" (Rose, 1996, p. 333). These include those identified by the social sciences: family and class background, psychological and physical disposition, the various changes in the economy and so forth, all of which are, of course, continually in dispute. These disputes also affect the organisation of compensatory mechanisms.

Neoliberalism appeals specifically to the *self-liberation of the subject* through consumptive practices and thus it presupposes a particular subject position which is different from social democracy.

> For neo-liberalism the political subject is less a social citizen with powers and obligations deriving from membership of a collective body, than an individual whose citizenship is active. This citizenship is to be manifested not in the receipt of public largesse, but in the energetic pursuit of personal fulfilment and the incessant calculations that are to enable this to be achieved (Rose & Miller, 2010, p. 298).

Community is a new way through which these autonomous subjects can be governed. As a subject in a community, "bonds of obligation and responsibilities for conduct … are assembled in a new way" (Rose, 1996, p. 333). The subjects of a community are considered self-responsible and their interests are calculated in terms of their connection to the community. National citizens are no longer part of a "single integrated national community", but rather are individuals who "identif[y] existentially, traditionally, emotionally or spontaneously" (Rose, 1999b, p. 177) with a chosen allegiance within a plural and cosmopolitan universe. Of course, this allegiance might be something we are to be made aware of, which points to the contradiction within it. Community is something to be achieved, and a variety of forces is put to work in making us aware of our potential allegiances.

Once a particular community or allegiance is produced, it can be *instrumentalised* through "a variety of strategies … in the service of projects of regulation, reform or mobilization" (Rose, 1996, p. 334). This new reconfiguration also assumes a new *economic position* for the subject. The idea of 'national economy' gives way to zoned areas in which the new economic subject needs to be integrated with the help of a particular form of governance.

> The economic fates of citizens within a national territory are uncoupled from one another, and are now understood and governed as a function of their own particular levels of enterprise, skill, inventiveness and flexibility. (Rose, 1996, p. 339)

The activation of the citizen is an activation of entrepreneurship. No longer connected to the fate of the national economy, citizens are to become entrepreneurs of their own happiness and economic success in an international economy: the individual is now an 'enterprise'. Consequently, unemployment is no longer governed according to the logic of the social through the provision of a living wage, or unemployment insurance, but rather unemployment becomes actively governed through a continuing transference of skills. Strategies created around this logic are multiple and can take positive and negative forms, depending on one's particular ideological standpoint. For instance, the provision of unemployment insurance can be made conditional on an active and calculable search for employment, as is evident in the USA (Piven, 1998). Another tactic is for governmental bodies to provide the unemployed with the skills to find work, either by funding such practices, providing scholarships, or providing the private sector with the necessary appeals to do so. The foregoing ensemble of techniques and practices, despite their seeming incoherence, can be subsumed under 'technologies of the self'.

Governing individual conduct in a neoliberal manner requires a reactivation of ethical values and with it a space, which Rose (1999a, pp. 477-478) has termed "etho-politics":

> By etho-politics I mean to characterize ways in which these features of human individual and collective existence - sentiments, values, beliefs – have come to provide the 'medium' within which the self-government of the autonomous individual can be connected up with the imperatives of good government. Etho-politics seeks to act upon conduct by acting upon the forces thought to shape the values, beliefs, moralities that themselves are thought to determine the everyday mundane choices that human beings make as to how they lead their lives.

New ways of problematising the subject as an *autonomous* and *ethical* agent are emerging which renders them governable. Medical and nutritional science is producing substantial knowledge on previously defined 'social diseases', which allows people to take personal responsibility for their own health management. Along with these new knowledges a variety of health practices have emerged that draws on neoliberalism's 'freedom function' to encourage people to consume in the name of their own health. Primary health care services are reoriented to encourage taking responsibility for one's own health through 'preventative practices' and health service workers are provided with new roles in guiding people towards managing their own diseases or problems (cf. Liebenberg, Ungar, & Ikeda, 2015; WHO, 2008).

The production of the 'enterprising' subject is also a productive area of study. The enterprising subject is 'human capital,' (Mincer, 1993): she has various levels of 'social' and 'cultural' capital (Bourdieu, 1986). She is part of a happiness and wellbeing index (i.e. United Nations

Development Programme [UNDP], 2015), a human development index (i.e. UNDP, 2015). She occupies a position on a scale of deprivation (A. K. Sen, 1985) and she lies either below or above a poverty line (Ravallion, 2010). While under a regime of the social, these factors would have meant that the government took up certain of her responsibilities. Under the new regime the government takes an active role in empowering her to traverse these circumstances herself. The foregoing exemplify some of the ways in which previously autonomous, albeit perhaps marginalised, individuals and groups are linked "in new ways into the political apparatus" (Rose, 1996, p. 336) which immediately renders them governable.

3.3.5. Technologies of freedom

Governmentality is based on an internal limitation that does not preoccupy itself with legitimacy as much as with agenda. In the current art of government, *liberty* or *freedom* has instead taken on characteristics of a practice of the self. As an "immediate and concrete actuality" we apply a liberal politics to ourselves (Foucault, 2008, p. 22). Freedom in governmentality is a technology of the self. Power is not so much a matter of imposing constraints on citizens as of 'making up' citizens capable of bearing a kind of regulated freedom. Personal autonomy is not the antithesis of political power, but a key term in its exercise, the more so because most individuals are not merely the subjects of power, but play a part in its operations (Rose & Miller, 2010, p. 272).

Donzelot (1979, p. 77) describes how power is deployed in governmentality by being fitted with "a motor" – "that of philosophico-political theories which issue the promise or rather the injunction of liberation through voluntary consent to new constraints, theories amongst which Marxism appears in the foremost place". Unlike disciplinary power's attempts at total control, biopolitics aims towards a regulation of the population in the name of freedom, with reference to self-regulation, in the pursuit of one's own personal freedom.

The ethics of how to 'care for the self' transformed along with the way power operated. Governmentality no longer required coercive practices, instead it needed subjects to constantly work toward their own freedom. Liberalism, in this respect, marks the moment when the dystopian dream of a totally administered society was abandoned, and government was confronted with a domain that had its own naturalness, its own rules and processes, and its own internal forms of self-regulation (Rose & Miller, 2010, p. 277).

This is what is meant by biopower taking "freedom itself as the soul of the citizen" (C. Gordon, 1991, p. 5). Employing "philosophico-political theories", we are presented with a myth of

repression from which we are to free ourselves. These theories and ideologies draw on essentialist narratives that argue that there “exist a nature or a human foundation which, as a result of a certain number of historical, social or economic processes, found itself concealed, alienated or imprisoned in and by some repressive mechanism” (Foucault, 1987, p. 113). As such, any grand or liberatory theory that draws on an essentialist or humanist framework is in effect playing its part in the game of truths which makes up the liberal governmentality.

The best-known example of such a repressive myth is presented in *The History of Sexuality* (Foucault, 1978) where Foucault showed that the desire to liberate ourselves sexually is based on the hypothesis that we are in fact sexually repressed. The consequence was that a variety of forms of practices were put in play that, in the process of ‘liberating’ ourselves, created a framework through which we are regulated sexually – an entire ‘technology of sexuality’ through which knowledge is produced and gathered, and techniques and mechanisms are taken up by a variety of institutions from the family to psychiatry, educational and religious institutions and the market. In this way, the ‘repressive hypothesis’ enabled the production of a whole network of institutions and knowledges through which our sexuality is governed.

This is not to say that there exists no liberation and that oppression is a myth. Liberalism requires free subjects; it is fundamentally “a power thought of as regulation that can only be carried out through and by reliance on the freedom of each” (Foucault, 2007, p. 71). Relations of power require that people can resist it. Where people are not free to resist power, true oppression does exist. Foucault offered the example of a colonised people in the process of liberating themselves. The moment the coloniser is removed, Foucault argued, the liberal process of the production of freedom is put in place.

Liberalism is, as was discussed earlier, the “age of critical government reason,” (Foucault, 2008, p. 12), emerging when government started critically evaluating its own practices. The fundamental question around which this critique is centred is: how can we govern, or be governed, liberally? Or, how can we govern people “in accordance with their autonomy and freedom?” (Weir, 1996, p. 384). An entire apparatus is constructed around every potential ‘unfreedom’. This shows liberalism’s polymorphism: “its capacity continually to refashion itself in a practice of autocritique… liberalism guarantees that these practices of freedom will be sustained and elaborated by critiques of the existence of unfreedom” (Weir, 1996, p. 374).

Feminists have preoccupied themselves for a long time with the question of “how to govern pregnant women liberally” (Weir, 1996, p. 385), as was shown in chapter two. In this way

feminism can be described as a ‘counter-discourse’, or ‘counter-conduct’, that characterised medicine as an assault on pregnant women’s autonomy and freedom. The medieval midwife-witch and ‘golden age’ in which women monopolised childbirth practices grounded the ‘repressive hypothesis’ of pregnancy and childbirth care, at least for some time. Medicine has responded ‘reflexively’ to the challenges made by these counter discourses, as can be seen in the various developments that have characterised the field since the 1970s. This points to liberalism’s “polymorphic” character:

> [liberalism’s] capacity continually to refashion itself in a practice of autocritique. To the extent that governing in accordance with freedom is part of the political rationality of liberalism, the polymorphism of liberalism guarantees that these practices of freedom will be sustained and elaborated by critiques of the existence of unfreedom…. The contemporary government of pregnancy provides an excellent case study of the polymorphic development of the practices of freedom within liberal governance. (Weir, 1996, p. 374)

In the age of biopower, counter-conduct takes on this new form: counter-conduct is itself generated *through* biopower: “As governmental practices have addressed themselves in an increasingly immediate way to ‘life’, in the form of the individual detail of individual sexual conducts, individuals have begun to formulate the needs and imperatives of that same life as the basis for political counter-demands.” This is known as the “strategic reversibility” of power relations (C. Gordon, 1991, p. 5). We see then that the history of government as the ‘conduct of conduct’ is as much the history of dissenting ‘counter-conducts’. Freedom is a precondition of power which makes power relations a strategic game of confrontation. Once victory is claimed, mechanisms are established that “can direct, in a fairly constant manner and with reasonable certainty, the conduct of others” (Foucault, 1982, pp. 790, 794).

3.4. Method: Foucauldian discourse analysis

There are many approaches to discourse analysis. FDA, despite not being a definitively delineated method, is distinguished, nonetheless, from other approaches to discourse analysis by the identifiable epistemological stance of the researcher. This framework involves a “characteristic eschewing of claims to objectivity and truth” (L. J. Graham, 2005, p. 3). That there are “no universal truths or absolute ethical positions” (Wetherell, 2005, p. 384) means that an important aspect of a FDA is to take care not to substitute one truth for another, or even to maintain, as an aim, the verification or refutation of a stated truth. In a similar vein, another characteristic trait of poststructural research in general is not to demand from its methodologies the ability to produce objective, scientific or precise truths. As Margaret Wetherell (2005, p.

384) notes “the process of analysis is always interpretive, always contingent, always a version or a reading from some theoretical, epistemological or ethical standpoint.” While this has resulted in some criticism, including that it might render the approach uncritical, Stephen J Ball provides a justification of FDA’s critical capabilities when he argues

> The point about theory is not that it is simply critical. … The point of theory and of intellectual endeavour in the social sciences should be, in Foucault’s words, ‘to sap power’, to engage in struggle, to reveal and undermine what is most invisible and insidious in prevailing practices. Theories offer another language, a language of distance, of irony, of imagination. (Ball, 1995, pp. 267-268)

FDA thus provides the researcher with a role of “cultural critic offering perspective rather than truth” (Ball, 1995, p. 268).

FDA is also characterised by a movement away from *language* as the main focus of discourse analysis (Arribas-Ayllon & Walkerdine, 2008). Orthodox discourse analysis approaches define discourse as “passages of connected writing or speech” (Hall, 2005, p. 72) which means that linguistic aspects are foregrounded. In FDA, discourse is considered both more encompassing and more particular. Various scholars define it as “a set of statements that construct objects and an array of subject positions” (I. Parker, 2002, p. 198), as a “system of representation” (Hall, 2005, p. 72) i.e., “a group of statements which provide a language for talking about - i.e. a way of representing - a particular kind of knowledge about a topic” (Hall, 1992, p. 201) or, as Arribas-Ayllon and Walkerdine (2008, p. 99) argues, Foucault used discourse when “describing rules, divisions, and systems of a particular body of knowledge.” In Foucault’s own words:

> Whenever one can describe, between a number of statements, such a system of dispersion, whenever, between objects, types of statement, concepts, or thematic choices, one can define a regularity (an order, correlations, positions and functionings, transformations), we will say, for the sake of convenience, that we are dealing with a *discursive formation* – thus avoiding words that are already overladen with conditions and consequences, and in any case inadequate to the task of designating such a dispersion, such as 'science', 'ideology', 'theory', or ' domain of objectivity'. (Foucault, 2006b, p. 37)

These definitions give us some idea of what is spoken about when referring to discourse, or ‘discursive formations’. Most strikingly are discourse’s effective qualities and its connection to knowledge. When speaking of discursive formations, what is referred to are both the presentation of knowledge according to specific rules, as well as “*practices* through which certain objects, concepts and strategies are formed” (Arribas-Ayllon & Walkerdine, 2008, p. 99). The objects, concepts, forms and themes of a discursive formation adhere to these rules,

or *rules of formation,* which provide it with identifiable discursive regularities. The rules are also its conditions of possibility (Foucault, 2006b). What this means is that discursive formations are both produced through rules of formation as much as they perpetuate them through the production of objects, concepts and strategies which are in line with these rules. A system of knowledge, such as the law, operates through very specific mechanisms that are different to, for instance, a system such as religion. Religious practices reinforce religion as a system of knowledge by operating according to a discursive regime. Agents of religion will not utilise a judge's bench since it will undermine its own system. The history of each practice within a system of knowledge can be traced to show how it was formulated, adapted or appropriated in order to produce the desired relations of power.

3.4.1. The process

In a technical sense, a discourse can be defined as a set of *statements* that is identifiably governed by a particular logic or set of rules emanating from a particular system of knowledge or multiple systems of knowledges connected to a regime of truth. A statement 'functions'; it enables "groups of signs to exist, and enable rules or forms to become manifest" (Foucault, 1972, p. 99). Foucault (2006b, p. 231) said that a discursive formation consists of an "ensemble of discursive events". A discursive event is, in the simplest interpretation, the appearance of a statement along with its connections with the series of which it is part. Discourses are thus more than merely a set of statements; rather they include the *meaning* that operates between and within statements. A set of statements can be described as a discursive formation where a unity or regularity can be described operating within it.

Arribas-Ayllon and Walkerdine (2008, p. 98) provide the following guidelines in selecting a corpus of statements. The process includes

a) selecting samples of text that constitute a 'discursive object' relevant to one's research;
b) selecting samples that form 'conditions of possibility' for the discursive object;
c) identifying the contemporary and historical variability of statements, i.e. how is the same object talked about differently? Or, how and why do statements change over time?
d) identifying and collecting texts: i.e. policy documents, intellectual texts, newspapers, semi-structured interviews, autobiographical accounts, ethnographic observations and descriptions, etc.

The process of FDA then involves detecting discursive formations by identifying connections between statements/discursive events.

> …we must grasp the statement in the exact specificity of its occurrence; determine its conditions of existence, fix at least its limits, establish its correlations with other statements that may be connected with it, and show what other forms of statement it excludes. (Foucault, 2006b, p. 27)

These connections are made visible through a thorough reading and comprehension of the discursive field, or the field on which discourse analysis is being done, as well as a good understanding of the process he called 'power/knowledge'.

Drawing on the work of Arribas-Ayllon & Walkerdine (2008) the following aspects can be identified within discursive formations and their identification can guide the process of analysis:

Problematisations: The event in which objects or practices are problematised is useful to the analyst since it makes the object or practice "visible and knowable" (Arribas-Ayllon & Walkerdine, 2008, p. 99). Problematisations are also analytically useful to the extent that they show how truths, or knowledges, are put to work to produce relations of power. Not only do problematisations "render a certain kind of thought possible" (Arribas-Ayllon & Walkerdine, 2008, p. 99) or render it 'thinkable', reducing complexity and providing "a field of delimitation regulating what can and cannot be said" (Osborne, 1997, p. 175), but it also allow for a particular object to become subject to governing through the institution of practices and interventions. Through the identification of problematisations the analyst can identify how objects are constructed.

Technologies: As the practical forms in which a governmental rationality aims to govern others, technologies play an important role in FDA. There are two types of overarching technologies: technologies of power and technologies of the self. As Arribas-Ayllon & Walkerdine (2008, p. 99) note, "technologies are also 'truth games' realized either on a larger political scale or among local and specific instances of interaction – e.g. the rhetorical function of language".

Subject positions: The 'location' provided to subjects within a moral structure allows analysts to identify the truth claims of a discourse. Subject positions aim to provide subjects a space through which they can manage their own conduct as well as their interactions with institutions, structures or other people. This position is a "vantage point": not only does it provide the subject a location from which to manage their moral conduct, it also "offers… a perspective from which to view a version of reality" (Arribas-Ayllon & Walkerdine, 2008, p. 102). Subject positions are constructed through a variety of discursive strategies: for instance, in institutional

settings a variety of strategies can be used to produce the positions of ‘expert’, ‘layperson’, or ‘patient’, or alternatively ‘boss’, ‘employee’, ‘visitor’.

> Discourse sets out a range of ‘subject positions’, places in the discourse which carry certain rights to speak and specifications or what may be spoken, places which people must assume for it to work (Davies & Harré, 1990). Discourse also recruits readers into subject positions by ‘interpellating’ them, calling out to them and constructing forms of identity that they must experience for the discourse to make sense (Althusser, 1971). (I. Parker, 2002, pp. 131-132)

Subjectification: the process of subjectification is that of the construction of the subject. Ontologically speaking the process of subjectification, according to Foucault (1982), is always prior to any subject. There is no pre-existing subject. Nor does any individual occupy a single subject position at any point. Technologies of power and the self sets in motion the process of subjectification. Technologies of power constitute subjects through ‘subjection’. Technologies of the self produce subjects by providing them with a moral order through which they govern themselves through “more or less conscious ethical goals” (Arribas-Ayllon & Walkerdine, 2008, p. 103). “Subjectification refers to an ‘ethics’ of self-formation” (Arribas-Ayllon & Walkerdine, 2008, p. 99). As such the production of subjectivities is driven by an ethics that guides individuals towards the production of their own identities and positions, and which includes a particular position on ethical conduct. In liberal society ‘freedom’ plays an important role in the process of subjectification. In some form or another freedom is operationalised as an ethical goal towards which people should strive.

3.4.2. Analysing policy

The data corpus of this dissertation consists of policy and procedural documents, audit reports, and clinic guidelines, handbooks and protocols (see appendix one). All of these documents are products of one or more departments of the Republic of South Africa (RSA), or have been commissioned by them. Several World Health Organization (WHO) documents were also investigated in order to supplement my discussion of the various discourses identified in my data corpus. Despite the focus on government policy and procedure, I will not be doing a straight-forward health policy analysis.

There are various approaches to doing health policy analysis. The more common approach considers the policy process and/or its content in a relatively straight-forward manner, attempting to explain ‘what happened’, while a more ‘critical’ analysis often introduces a bit of historicism. In the Global South, health policy analysts often do not make their theoretical

and conceptual frameworks, or their methodologies explicit (Walt et al., 2008). While there are various social policy-specific theories, research designs and frameworks, analyses are most often based on positivist theory. Foucault's concepts do not immediately seem useful to the analysis of health policy; and where he has been mobilised, it has been "under the banner of an *anti-medical approach*", which often entails a "kind of radical constructionism" (Osborne, 1997, p. 174) premised on the notion that the issues that health policy addresses are all subjective constructs, even, sometimes, illness itself. This is, of course, not what Foucault meant when he discussed how something was historically constituted.

> That is to say, what I would like to show is not how an error – when I say that which does not exist becomes something, this does not mean showing how it was possible for an error to be constructed – or how an illusion could be born, but how a particular regime of truth, and therefore not an error, makes something that does not exist able to become something. It is not an illusion since it is precisely a set of practices, real practices, which established it and thus imperiously marks it out in reality. (Foucault, 2008, p. 19)

It is not that power "produced lunatics, criminals, or sick people where there were none", but rather that arts of government "have played a determining role in the different modes of objectification of the subject" (Florence, 1995, p. 260).

Osborne (1997) provides some pointers on what one can and cannot expect from an analysis of health policy when drawing on Foucault. Instead of *constructions,* he suggests rather a focus on the notion of *problematisations*. Issues of health policy are not constructs, but rather "products of particular problematisations" (Osborne, 1997, p. 174). Identifying the event in which an object is problematised is a fundamental aspect of FDA. However, it is important to remember:

> Problematisations are not modes of constructing problems but active ways of positing and experiencing them. It is not that there is nothing 'out there' but constructions but that policy cannot get to work without first problematising its territory. (Osborne, 1997, p. 174)

Making these problematisations intelligible is the project of an analysis.

Osborne furthermore points to the fact that a governmentality approach does not concern itself with *institutions*, but rather with *practices*. Practices are not "'applications' of policy or ideology", but relates rather "to a zone or space of governmental intervention" (Osborne, 1997, p. 176); instead of identifying the "unintended consequences of action", often a focus of policy evaluation, the point is to analyse the "intended consequences of action" (Osborne, 1997, p. 176). To analyse health practices, it is useful to focus on technologies of health: "all the diverse

means, projects and devices through which the impossible dream of a healthy population has been made an object of realisation" (Osborne, 1997, p. 181). A health policy analysis, drawing on Foucault, would then be "conducting a kind of historical fieldwork of problematisations in technologies of health; and a question, perhaps, of attempting to tie such technologies to wider political rationalities of government" (Osborne, 1997, p. 181).

3.5. Conclusion

The tools I use have been described in this chapter. My method, FDA, as elaborated by Parker, Arribas-Ayllon and Walkerdine, is applied, in chapters five and six, to the data outlined and contextualised in the introductory chapter. This method draws on Foucault's methodological considerations and the myriad concepts he introduced, which is fundamentally based on his reconceptualization of how power operates. As power took life itself as its object and allowed for an interface between biological and political existence to come into being, so it provided the conditions of possibility for the emergence of governmentality. As the art of government transformed over the last few centuries, new institutions and practices were produced, and old institutions were transformed according to new rationalities. Bringing all aspects of life into relations of power is the *raison d'etre* of governmentality, and FDA provides us with the means to analyse how this happens. The process involves identifying the various technologies of government, that is, the technologies that allow for the governmentalisation of life. My analysis of maternal health policy and practices in South Africa brings to the fore several of the technologies currently in play in the process through which pregnant women are brought into relations of power to be governed. The next chapter focuses on these technologies.

One of these technologies is *risk*. Many governmentality writers have focused on risk and the way it is deployed under different rationalities (cf. Donzelot, 1991; Ewald, 1991), while others have argued that it is indeed the "differing approaches to risk [which] give shape to different forms of liberalism" (O'Malley, 2008, p. 68). Due to the prominent role risk plays in my own analysis, it is given a thorough overview in the next chapter. This includes a focus on risk as a technology of government and the various ways in which this technology is operationalised, and it includes the work of Weir who, in her 2006 book *Pregnancy, Risk and Biopolitics*, provided a genealogy of perinatal mortality and shows how risk attached itself to the Canadian antenatal clinic.

Having discussed in depth the changes in knowledge production on pregnancy and childbirth, it would be important to assess Foucault's ideas through the lens of feminism. Pregnancy and

childbirth, is, as was shown in chapter two, a topic close to the heart of feminists. After discussing risk within governmentality literature, the next chapter also provides an overview of feminist critiques and elaborations of Foucault's ideas.

The writings discussed in this chapter focus on the Global North. In most cases it is specifically noted that these developments are characteristic of European states, as well as the USA, Canada and Australia. The most prominent technology identified in my analysis is that of *development*. The technology of development is identified as the bridge between the Western ideas of modernity and the functioning of states in the Global South. Of course, development was preceded in a similar way by that of colonialism. The next chapter will not only discuss literature on development, but also of colonialism, bringing us full circle with a discussion of the main global players in development and maternal health.

4. Elaborations on the theme of governmentality

This chapter provides a review of literature and theorising on the theme of governmentality in line with the foci that are necessary when analysing the policies and practices of something such as maternal health, and in a Global Southern country such as South Africa. This requires an overview of both feminist critiques and postcolonial elaborations of governmentality, and due to its important place in my analysis, also risk.

The chapter begins with a review of literature as well as discussion of risk. Within a governmentality approach, risks are not considered intrinsically real, nor are they evaluated for their accuracy or fairness.[33] While they are not denounced as myths, the focus is rather on how they are utilised in a system of governance. As a technology of government, risk is put into operation according to the specifics and needs of different rationalities. Risk has received a great deal of attention from Anglo-Foucauldian scholars and it is necessary to provide a thorough overview of the concept.

I then move on to discuss feminist critiques and engagements with Foucault's ideas, specifically in relation to pregnancy and childbirth. I discuss feminist interpretations of risk, which is mainly within the risk society tradition, associated with Ulrich Beck and Anthony Giddens. I also discuss feminists who have adopted the Foucauldian interpretation of risk and applied it to the themes of childbirth and pregnancy.

The final section of this chapter provides a review of critical engagements with the concept of governmentality from the point of view of postcolonialism. For, while the Europeans were gradually producing and adapting to their new modernity, they were also sailing around the globe, claiming distant lands as theirs, settling, gradually extracting these countries' wealth and with that, imparting, or perhaps forcing, their modern project onto the 'pre-modern' people and

[33] While there is of course a whole range of social and biological scientific traditions that take risk as 'real', another way of looking at risk where it is not considered 'real' is in 'Risk Society' literature which should not be confused with the governmentality approach. For those sociologists who believe we now live in a 'risk society', risk is an ideology utilised by the political elite and the powerful in order to mask the catastrophic events that modernity has brought on the world. According to the risk society literature, not only are risks not real, they are essentially incalculable and therefore pure myths. The powerful present them in a risk format in order to maintain the myth that these risks are manageable (Beck, 1992, 1997; Giddens, 1994).

spaces they encountered. As was discussed in the introductory chapter, in postcolonial parlance, colonialism was a 'modernisation project', replaced in the mid-twentieth century with globalisation, or 'global Westernisation' in the guise of development (Kurth, 2001; A. K. Sen, 2002). As I will show, the fundamental project of governmentality, whether in the West or the Global South, is producing the 'modern', which entails the de-legitimation of anything traditional or 'pre-modern'. 'Development' has come to be an important vehicle through which Global Southern countries are governmentalised. This is done by various international and non-governmental organisations, as well as by Global Southern states themselves. The focus of this dissertation is on health and medicine, and, pregnancy and childbirth-related health development. As such this chapter ends off with a review of the most important international organisation in terms of health, the WHO, and the history of its focus on women and maternal health.

4.1. Governmentality and risk: Risk as a technology of government

As a technology of government, risk embodies "a particular way in which problems are viewed or 'imagined' and dealt with" (O'Malley, 2008, p. 57). This is because risk is calculable; it defines the whole while being able to provide individualised proposals for intervention: *omnes et singulatum*. It is these characteristics which governmentality can utilise since it is "intensely practical". The world exists in a state that can be governed: "problems are construed in ways that make them subject to practicable solutions" (O'Malley, 2008, p. 56). Furthermore, risk's claim to scientificity provides it with an air of legitimacy as well as objectivity. While risk is simply a probabilistic and statistical technique, "great bodies of data are turned into predictive formulae" (O'Malley, 2004, p. 2); risk can be put into operation towards different ends and in different ways. For instance, in insurance the aim is to spread risks amongst a group, but in psychiatry the aim is risk reduction (Castel, 1991).

Risk is usually seen as a technique of insurance. However, Francois Ewald (1991) shows how insurance is actually just one of the many possible applications of the technology of risk. Risk is not just a synonym for danger. In insurance technology, risk is "a specific mode of treatment of certain events capable of happening to a group of individuals" (Ewald, 1991, p. 199). The form insurance technology takes in an institution at a given moment depends on an "insurantial imaginary": that is to say, on the ways in which, within a particular social context, profitable, useful and necessary uses can be found for insurance technology. The remarkable plurality of insurance institutions, their "variability of form," is accounted for by the particular and

transforming social conditions that provide it with a "market for security" (Ewald, 1991, p. 198).

Apparatuses of security require "standing back sufficiently" in order to "grasp the point at which things are taking place, whether or not they are desirable" i.e. "grasping them at the level of their effective reality" (Foucault, 2007, p. 69). This requires the use of a variety of practices typical of the technology of risk such as statistical calculation, supervision and surveillance. Risk is therefore very useful to security. Within apparatuses of security, risk has a function that allows for the technology of security to operate efficiently. For instance, Foucault showed how, in the eighteenth century, risk was a mathematical support for the justification for widespread inoculation against smallpox. He quotes Daniel Bernoulli's remarks in 1760[34]:

> If inoculation is adopted, the result will be a gain of several thousand persons for civil society; even if it is deadly, as it kills children in the cradle, it is preferable to smallpox that causes the death of adults who have become useful to society; if it is true that the generalization of inoculation risks replacing the great epidemics with a permanent state of endemic disease, the danger is less because smallpox is a generalized eruption and inoculation affects only a small part of the surface of the skin (Foucault, 2007, p. 87).

Risk has been changing and developing ever since it was first deployed. During the era in which discipline was the dominant system around which relations of power were formed, individuals were principally governed through a dense mesh of disciplinary techniques. With the discovery of the population and its norms, risk could be deployed in ever more innovative ways to ensure the security of the population. For a variety of reasons, the last century saw the growing popularity and expansion in many countries, particularly in the West, of a social insurance form of risk in line with a rationality that aimed to dispel hostility and produce a collective security through spreading risks across society. Within a neoliberal rationality, risk is utilised in similar ways, but it has been extended and transformed to govern individuals at a distance.

4.1.1. Risk as a technology of the self

Risk plays a particular role in the government of the self and is, as such, a technology of the self (Rose, 1994, p. 88). Utilising discourses of risk, neoliberalism has produced and reorganised various programmes for the way people govern their own personal lives. Not only are we to 'enterprise ourselves', we are also constantly enjoined to make ourselves knowledgeable about the various risks in society and to take steps in mitigating these risks.

[34] Daniel Bernoulli (1700-1759) was a Swiss mathematician who studied the inoculation problem from a mathematical point of view. The article which Foucault quotes is entitled *An attempt at a new analysis of the mortality caused by smallpox and of the advantages of inoculation to prevent it* (1760) (Bacaër, 2011).

Insurance is no longer a mechanism of social security, it has become "part of a politics of choice and lifestyle, sold through market mechanism, and promoted through consumerised dreams of desired futures" (Rose, 2000, p. 328). Consumption is driven by the 'exacerbation of anxiety' as more and more risks are identified, and new markets for risk reduction are created. This anxiety is utilised in order to produce subjects who increasingly attempts to mitigate risks in their personal lives through an "internalised surveillance" (Ruhl, 1999, p. 95).

Lealle Ruhl (1999, p. 95) argues that "pregnancy is increasingly portrayed as a state requiring careful and detailed risk prevention", and that, at least in the West, the foetus is the focus of risk reduction. She analyses risk discourses in pregnancy advice manuals and shows how a technology of self-governance is mobilised to produce a "'responsible' pregnant woman" with advice on diet, exercise, etc. The contemporary regulation of pregnancy is not punitive in character; rather, it aims to regulate pregnant women through responsibilisation: through what Ruhl (1999, p. 97) calls "individualized risk". Risk 'trains' women by affording them the agency in taking care of their foetuses but also invoking the fact that an 'irresponsible' pregnant woman might indeed be the ultimate danger to her foetus.

The majority of literature focusing on risk and pregnancy falls into two categories: "technico-scientific" research (Lupton, 1999) which takes risk as an objective phenomenon, and sociological-theoretical work that focuses on how risk discourses permeate and shape women's experiences of pregnancy (cf. Coxon, Sandall, & Fulop, 2013; D. J. Kaufman, Bollinger, Dvoskin, & Scott, 2012; Lee, Ayers, & Holden, 2012; Leppo, Hecksher, & Tryggvesson, 2014; M. Mitchell & McClean, 2013; Scamell & Stewart, 2014). Technico-scientific research aims to identify risks through clinical and epidemiological investigation. In South Africa, for instance, the NCCEMD draws on a variety of clinical knowledges to identify the causes of death among pregnant women. These causes are then statistically analysed and transformed into risk factors. Chapter six analyses this process and describes how, in South Africa, risk is deployed as a mode of governance in the prenatal clinic.

While most of those feminists utilise sociocultural theories in analysing risk discourses, what they show is nonetheless useful in explaining the phenomenon of risk as a technology of the self. Lupton (2012b, p. 329), for instance, shows how discourses of risk subject pregnant women "to imperatives which expect them to engage in an intense ascetic regime of self-regulation and disciplining of their bodies". The 'public foetus' thesis argues that biomedical technologies such as ultrasound have rendered the foetus visible, turning pregnancy into a

public and political experience, as opposed to what Duden (1993) would prefer – for it to remain an individual and private affair. Nonetheless, embracing the use of biomedical technologies is promoted as a responsible practice through which women are able to negotiate the risks of pregnancy (Hallgrimsdottir & Benner, 2013). Defining pregnancy as pathological, and identifying more and more risks associated with pregnancy is argued to exacerbate anxiety among pregnant women who, in turn, consume more risk-identifying and mitigating technologies.

4.1.2. Risk management

Risk is also deployed as a management technique. Risk has become one of the dominant ways of knowing the world and has, in most state and non-state institutions, become central to the formulation of interventions. As Ewald (1991, p. 199) points out, "A category of risk is a category of understanding" and as such we use risk to understand and order our reality. While the subject of welfare is governed as an individual facing socialised risks, the advanced liberal governmentality repositions the subject of health to one who is governed "based on the management of individual risk" (Joyce, 2001, p. 594), which relies on an expansive set of surveillance mechanisms. Under such a rationality, epidemiological knowledges are put to work in different ways.

In terms of pregnancy, Weir has analysed the deployment of risk in antenatal care in Canada. Weir (1996, 2006) shows how in the 1970s and 1980s a type of prenatal testing that relied on population-based epidemiological knowledge as its main form of diagnosis became prominent in Canadian clinics. This allowed for an elaborate system of risk management to establish itself in the prenatal clinic. With the foetus as the primary patient the "pregnant body has become the subject of sampling, imaging and surgical techniques articulated to the category of risk" (Weir, 1996, p. 379).

The socio-cultural and Foucauldian-inspired feminist interpretations of risk in pregnancy and childbirth is discussed, along with feminist interpretations and critiques of Foucault, in the next section.

4.2. Foucault and feminism

Chapter two is an exposition of the development and transformations of critical knowledge production, or 'counter-discourses' on pregnancy and childbirth. As is shown – the main drivers on this topic are feminists. The appropriation of Foucauldian concepts and frameworks

by feminists is part of the general development of feminist critique. Indeed, there is a long tradition of feminists drawing from the works of French poststructuralists such as Jacques Lacan, Jacques Derrida and Foucault (Alcoff, 1988, p. 415), although up until the 1990s there has been almost no focus on childbirth and pregnancy by those feminists. Foucault, who is often described by feminists as a poststructuralist, is argued to be one of the biggest influences on contemporary feminist theory, especially with respect to sexuality, subjectivities and power. As Susan Hekman (1996, p. 1) argues, it is exactly Foucault's challenge "of the basic underpinnings of Western philosophy" and its central tenets such as the subject, truth, knowledge, and power that has grabbed the attention of feminists.

Foucault's work on the production of knowledge has been particularly attractive to those "who have been excluded from the canon [of Western philosophy] since its inception" (Hekman, 1996, p. 1). As Monique Deveaux (1994, p. 223), herself falling into the following category, notes: "even scholars who dispute this thinker's claims are compelled to acknowledge the contribution represented by his work in these areas." From the beginning, there were extensive debates on how useful Foucault was for feminism. A variety of texts and edited volumes were produced that tried to negotiate the 'tensions' between Foucault and feminism (Deveaux, 1994; Diamond & Quinby, 1988; McNay, 1992; Ramazanoglu, 1993; Sawicki, 1991). Many criticisms against Foucault lay in the way various feminists had read his work, as well as the parts of his oeuvre with which they engaged. As English translations of his books and lectures became available, feminist writings drew from it and adapted their arguments, critiquing previously written criticisms and pointing to new ways in which Foucault's work could contribute to feminist concerns.

Initially feminists drew from Foucault's *Discipline and Punish* (1995) to describe the way disciplinary practices produce the feminine subject. The Panoptic theme[35] was appropriated to explain the women's self-disciplinary collusion with patriarchal standards (Bartky, 1988; Bordo, 1989; Oakley, 1984). Jennifer Terry (1989) and Naomi Pfeffer (1993) drew from Foucault's notion of biopower and technologies of sex to make the connection between NRTs and the regulation of women's bodies. These writers made an association between the rise of new practices in childbirth and pregnancy and biopolitical issues concerning the population such as birth, health, and eugenics.

[35] In *Discipline and punish* (1995) Foucault used Jeremy Bentham's circular prison, or Panopticon, as a metaphor for the way in which disciplinary power operates as a form of constant surveillance, turning individuals into docile subjects.

Deveaux (1994) argues that these writers left out an account of how women were struggling, either individually or collectively, against these normative regulatory practices. This is argued by some to be due to the fact that these writers draw on Foucauldian texts such as *Madness and Civilization* (1965)*, The Birth of the Clinic* (first published in English in 1973), and *Discipline and Punish* (first published in 1975), which are "replete with vivid descriptions of the oppressed and tortured bodies of the ill, the mad or the criminal, and efforts to render these bodies knowable, docile and productive" (Lupton, 1997, p. 102). Despite a continuous emphasis by Foucault on the role of resistance in the shaping of power relations, these texts nonetheless present power in such a way that subjects come across as passive receptacles within a society where power is everywhere (Deveaux, 1994). This issue was to some extent solved by Foucauldian feminists who took on the amended agonistic model of power and concept of resistance in Foucault's later works such as the *History of Sexuality* series (De Lauretus, 1987, 1990; Hekman, 1990; Sawicki, 1986a, 1991).

The 'updated' Foucauldian notion of power takes into consideration the struggles and resistances against the forms of control put in place by biopower. It does not do so as an end in itself, but rather, as Foucault held, because resistance itself is part of the game of power. As such the narrative that is written is one in which power and resistance transform and create the present. Donna Haraway (1985) and Petchesky (1987) drew from Foucault in their analysis of NRTs. Both emphasise the role of resistance in their analyses. According to Sawicki (1991, p. 13) these writers, along with herself, represent a group of Foucauldian feminists "who acknowledge domination but center on cultures of resistance to hegemonic power/knowledge formations and on how individuals who are the targets of this power can play a role in its constitution *and* its demise".

Sawicki, already a strong proponent of Foucauldian feminism (see 1986a, 1986b, 1991), shows how useful the biopower thesis is for an analysis of reproductive politics. She points to the advantages (such as providing women with agency without turning them into their own oppressors) of a criticism of NRTs rooted in Foucauldian feminism. As a result she proposes the writing of a new history of women's procreative bodies which does not rely on an origin story or patriarchal myth, but rather show its transformation on a social field which is "a network of intersecting practices and discourses, an interplay of non-egalitarian, shifting power relations" (Sawicki, 1991, p. 80). On this social field power is not possessed, but rather groups and individuals "occupy various and shifting positions" (Sawicki, 1991, p. 80). It is therefore

not only important to describe the forms of control, but also the resistance to it since they both shape the present.

Drawing from Foucault's argument that the development of biopower was a condition of possibility for the development of capitalism in the way that it made possible the "controlled insertion of bodies into the machinery of production" (Foucault, 1978, p. 141), Sawicki argues that biopower must also be "indispensable to patriarchal power insofar as it provided instruments for the insertion of women's bodies into the machinery of reproduction" (Sawicki, 1991, p. 68). What this means then is that neither capitalism nor patriarchy is the driving force of relations of power, but rather that their emergence was made possible within a framework of biopower. Foucault would deny any deep-seated or essential psychological trait such as a male 'desire' to control women to be the root of the development of any relationship of power. There are no patriarchal conspiracies, but as Susan Bordo (1988, p. 91) points out, certain motivations may be present, even if they do not direct the entire process:

> [This] does not mean that individuals do not consciously pursue goals that advance their own positions and advance certain power positions in the process. But it does deny that in doing so they are directing the overall movement of relations, or engineering their shape. They may not even know what the shape is. Nor does the fact that power relations involve the domination of particular groups – say, prisoners by guards, females by males, amateurs by experts – entail that the dominators are in control of the situation, or that the dominated do not sometimes advance and extend the situation themselves.

A variety of Foucault's concepts have been incorporated into broader theoretical analyses of issues concerning childbirth and pregnancy. A concept that has been widely utilised is Foucault's 'clinical gaze.' Monica Casper (1998, p. 16) has drawn on Foucault's notion of the 'clinical gaze' and his archaeological method to show how the foetus has "been constructed, individually and collectively, as a shocking new object of the 'clinical gaze': the unborn patient". As a theoretical addition to the thesis on the public foetus she shows how the developments associated with the increased visibility of the foetus are direct achievements in the service of Western medicine. Jennifer Shaw (2012, p. 110) inserts the pregnant body into Foucault's *Birth of the Clinic,* arguing that "pathological corpse of the *Clinic* can conceptually serve as a double for the pregnant body as it emerged in modern medicine in the twentieth century." Another focus has been the construction of subjectivities through discourses. For instance, FDA, most prominent in the discipline of psychology, has been used to show how motherhood is constructed in educational breastfeeding material (Wall, 2001), and how the pregnant subject is constructed in medical discourses (Rúdólfsdóttir, 2000).

Shifting the focus away from an overemphasis on disciplinary practices, Weir (1996) suggests instead a focus on the *government* of pregnancy. This, she argues, will provide a thorough analysis of the contemporary changes occurring in the realm of pregnancy care. She draws from the governance literature initiated by the *Foucault Effect*. A shift towards governance, Weir (1996, p. 375) argues, provides feminists with a means to move "away from an overconcentration on medical innovations and their supposedly invariant effects to placing more emphasis on the means by which the conduct of pregnancy is organized"; focusing on discipline is not enough to understand the changes in the area of pregnancy care. The feminists' thesis on NRTs is argued to be stuck in a cycle of presenting technology as a means of male domination.

> From a feminist perspective, the keying of investigation to government rather than to technologies in the narrow sense moves the beginning point of inquiry away from critical and reactive commentaries on technical innovations to a very thick description of the administrative and discursive construction of pregnancy. (Weir, 1996, p. 389)

Weir points out that in its narrow focus on the proliferation of the image of the foetus in popular culture and its production through imaging technologies, the public foetus thesis has neglected "the formation of the foetus as a history of *written* statements imputing properties to the foetal body" (Weir, 1996, p. 375). She shows just how much the feminist critique of the visualisation of the foetus has left out in a short sketch of written work on the foetus that does not rely on, or use a minimal number of images, including in bioscience research and diagnostic testing. Since the medical gaze is "an alignment of saying and seeing" (Weir 1996, p. 176; drawing on Osborne, 1992), so should an analysis of the production of the foetus as subject focus on all forms of representation, visual and textual. Drawing on governance literature, a genealogy of these representations shows the formation of the foetus as a "second patient" (Weir, 1996, p. 377) which allows for a variety of techniques to develop around it in order for it to be governed. The foetus as a subject is governed through the assessment, screening and testing of the pregnant woman because "it is at that moment that the foetal body as biomedically defined is projected onto the bodies of pregnant women on a population basis" (Weir, 1996, p. 377). This new patient had particular characteristics, as Weir notes

> The foetal patient has a crucial spatial distinction from the array of patients previously found in clinical practice: it can be treated only through the body of another patient, the woman who carries the pregnancy. (Weir, 1996, p. 377)

In a liberal political rationality this phenomenon causes some tension in medical practice, because governing the foetal patient invalidates the autonomy of the pregnant patient. The

various feminist concerns with the violation of the pregnant patient's autonomy have shaped current discussions on abortion, legal intervention in pregnancy, as well as the use of NRTs[36], with the public foetus thesis as the point of departure. On the other hand, anti-abortionists focus their attention on the rights of the foetus, positioning the pregnant woman as protector, as well as potential violator, of the foetus' autonomy and freedom.

Macleod and Durrheim (2002, p. 42) argue that governmentality specifically can be useful to feminists: "governmentality provides feminists with a broad-ranging and incisive theoretical tool for the analysis of gendered relations on a micro- and macro-level". The writers argue that feminists who critique Foucault with reference to the micro/macro divide (such as those who argue that Foucault does not provide tools for analysing "overall structures of domination" (Macleod and Durrheim, 2002, p. 43)) are not familiar with what governmentality has to offer. The authors take on this micro/macro conceptualisation and argue that governmentality represents the introduction of the macro in Foucault's work. They suggest that governmentality "could become an important tool in feminist inquiry and practice" since it allows for "this dissection of the multiplicity and the interconnections of micro- and macro-strategies of power" (Macleod and Durrheim, 2002, p. 44). Furthermore, they argue that the analysis of "multiple sites of resistance" (Macleod and Durrheim, 2002, p. 58) allows for the universal application of Foucault's analytic since it overcomes the issue of the lack of subject agency in structuralist and grand theories.

4.3. Risk and pregnancy I: Socio-cultural interpretations

The focus on risk as a socio-cultural phenomenon is a prolific area of inquiry within feminism. Technico-scientific research on risks rarely takes this sociocultural perspective into account (Lupton, 1999). The socio-cultural focus on risk does not assume that risk is an objective phenomenon and writers in this area have shown that the proliferation and perseverance of the risk narrative "is illustrative of how social contexts are more at play in influencing the biomedical framing of the risky pregnancy rather than the advance of medical knowledge" (Hallgrimsdottir & Benner, 2013, p. 8; see also Markens, Browner, & Mabel Preloran, 2010; K. McDonald, Amir, & Davey, 2011; Root & Browner, 2011).

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[36] Drawing on the same mode of analysis, Weir and Jasmin Habib (1997) examined the Canadian Royal Commission's report on NRTs. They show the interaction between feminist movements and the commissioners in the production of knowledge and show how both groups are grappling with the question of how to govern pregnant women as liberal subjects - an extension of the central problematic of governmentality into the area of pregnancy.

Initially feminist writers discussed risk as an objective phenomenon, but criticised the medical establishment for deceiving women into believing that there could be such a thing as a risk-free birth (Arms, 1975). This deception was used to 'lure' women into the hospital and accept a wide variety of interventions. Similarly, Oakley (1984, p. 214) showed how risk talk drove the hospitalisation of birth. Signild Vallgårda (1989, p. 48) argues that the increased obstetric intervention observed in Denmark since the 1960s can be explained by a "supplier induced demand" effect created by doctors by redefining categories of health for pregnant women – more and more previously considered 'normal' pregnancies are being categorised as 'at risk' as more and more potential risks are identified to bolter these phenomena. The result is that women are influenced to demand interventions. Vallgårda does not question the scientific accuracy of risks, but does point out that there is little evidence that shows that for women childbirth is, for whatever reason, actually becoming riskier; instead, obstetricians are trying to fill their hospital beds by overselling the risks of pregnancy.

Continued work on risk has identified with or drawn from one or more of three strands of risk theorisation that appeared in the 1980s and 1990s. These theories all take a more critical stance towards the ontological character of risk, its construction and use, and subsequent effects on people. This includes theories of risk provided by the likes of anthropologist Mary Douglas (1992; 1982), the sociological thesis on the 'risk society' (Beck, 1992, 1997; Giddens, 1990, 1991, 1999) as well as governmentality, wherein risk is a 'technology of government' (Burchell et al., 1991; Ruhl, 1999; Weir, 2006). Lupton (1999, p. 2) collectively calls these theories "socio-cultural":

> For exponents of these perspectives, a risk cannot simply be accepted as an unproblematic fact, a phenomenon that can be isolated from its social, cultural and historical contexts. Rather, what are identified as 'risks', by 'experts' as much as lay people, are understood as inevitably the outcome of sociocultural processes. Further, such risks tend to serve certain social, cultural and political functions.

Most work on pregnancy, childbirth and risk draws on this broad socio-cultural conceptualisation of risk. In this literature, epidemiological and biomedical risks are not taken for granted but rather interrogated for their potential socially constructed nature. The sociocultural tradition questions risk, but continues to treat science as the mechanism through which truth is ascertained, which means their arguments are often contingent on showing how the prevailing treatment and production of risks *are not scientific enough* or that certain risks are not real. For instance, Lisa Handwerker (1994, p. 665) argues that "risk does not represent scientific certainty," yet despite this, "health care providers and the legal system make

decisions as if risk is unambiguous 'fact.'" It is in this discrepancy between science and social construct that pregnant and birthing women are being oppressed. The effect, Handwerker argues, is the criminalisation of non-conformist conduct of pregnant women, such as drinking alcohol.

Risk presents a new medium through which feminists can critique the medicalisation of childbirth. This is seen in the way the prominent radical feminist Barbara Katz Rothman, is able to adapt her original critique (1984) of medical technology to risk:

> Is the drug use the real risk? Or the state's knowledge of that use? Is it the glass of wine? Or the response? Is it going a week or 10 days past your due date, or is it the medical induction? Is it prolonged labour or a surgical intervention to end the labour? (Rothman, 2014, p. 6)

Rothman's article is an editorial for a special issue on risk and pregnancy in the journal *Health, Risk & Society*. The majority of articles in this issue focus on the negotiation of pregnancy and childbirth-related risks on the part of women and midwives, as well as the various ways in which risk impacts negatively on pregnant women (R. J. Chadwick & Foster, 2013; Coxon, Sandall, & Fulop, 2014; Hammer & Inglin, 2014; M. Mitchell & McClean, 2013; Scamell & Stewart, 2014; Stengel, 2014).

Other consequences of the proliferation of risk is the moralisation of pregnancy, as well as the stigmatisation associated with the proliferation of categories of abnormality. Drawing on the idea of the 'risk society' – that we live in a society wherein 'risk' is the predominant way in which we structure our reality and thus has become a force of social change – Alphia Possamai-Inesedy (2006, p. 406) argues that "through the scrutinizing gaze of the public, … the pregnant woman is the least able to escape the consequences of risk society where changed notions of health and responsibility have created a cultural acceptance of medical intervention of childbirth." Elizabeth Armstrong (2003) has continued work on Foetal Alcohol Spectrum Disorder (FASD) and draws the connection between risk discourses on FASD and the criminalisation of pregnant women who drink during pregnancy. She charts the history of research on FASD and questions the "rapid" and "deep" acceptance in medical and popular media of the risk attributed to drinking during pregnancy, a response, she argues, to be "disproportionate to the evidence of risk and maladapted to the actual problem" (E. M. Armstrong, 2003, p. 190). She argues that the medical findings on the topic are influenced by broader societal issues on class, gender and race, as well as existing moral preoccupations. Other writers have also pointed out the connection between risk discourses and the

responsibilisation of the pregnant subject (Bell et al., 2009; Hallgrimsdottir & Benner, 2013; Lupton, 2012b; McNaughton, 2011; G. Parker, 2014; Possamai-Inesedy, 2006; Striley & Field-Springer, 2014; van Mulken, McAllister, & Lowe, 2016; Wetterberg, 2004). These include specific discourses around alcohol and drug use, smoking, eating and exercise. There is also a great deal of research on the ways in which pregnant women negotiate and resist the risk discourses aimed at responsibilising them (Gross & Shuval, 2008; Holland, McCallum, & Walton, 2016; Lupton, 2011; Ross, 2015; Wigginton & Lafrance, 2014; Wigginton & Lee, 2013).

Most of the literature on pregnancy, childbirth and risk has focused on the middle class. Within this literature, whether it utilises a governmentality framework or not, one recognises a particular mechanism that can be categorised as ‘practices of the self’ (Bailey, 1999; Lupton, 2011, 2012b). This is possibly because the way in which risk is deployed as a practice of the self is most evident where it operates in non-state institutions and where it specifically draws on consumptive practices. In this literature, we see that middle and upper-class women can, and sometimes do, negotiate these risk discourses because they have ‘choice’. The conclusion is therefore often made that these practices will have particularly negative effects on poor women (and those in developing countries) exactly because their choices are constrained by a variety of socio-economic, cultural or structural factors (Brubaker, 2007; Brubaker & Dillaway, 2009; R. Chadwick, 1999; Coxon et al., 2013).

Similarly, in South Africa, the focus has been mostly on the middle classes. Chadwick and Foster (2013) and Macleod and Howell (2015) have provided some insight into the way middle-class pregnant women are governed in South Africa. We see that middle-class women’s pregnancy experience is highly medicalised and the use of high tech interventions are normalised through discourses of risk. Even in the discourse of the ‘dissident’ (and choosing) pregnant subject, choice through consumption is evidenced by those women who choose home birth (cf. R. J. Chadwick & Foster, 2013). Macleod and Howell (2015) provide an example of how middle- and upper-class pregnant woman are governed by knowledges relayed to them through online media. The images and discourses about pregnancy found in online media presents women with a particular image of the ‘perfect’ pregnant experience that not only encourages consumption, making these women knowledgeable about risks, and taking responsibility for their foetuses, but also constructs the ideal pregnancy experience along particular heteronormative, gendered and racial lines. Since “internet usage cuts across racial divides” (Macleod & Howell, 2015, p. 2) and also because these images are increasingly being

found in material consumed by South Africans who are not white or middle class, the result is that it "simultaneously regulates the pregnancies of middle-class women, reproduces social and reproductive inequities and informs general social and cultural understandings of what constitutes a 'good' pregnancy" (Macleod & Howell, 2015, p. 11).

4.4. *Risk and pregnancy II: Foucauldian interpretations*

Weir drew on Foucault's concepts and methods to produce a history of what she calls "the threshold of the living subject" (Weir, 2006, p. 1). The birth threshold, Weir argues, was unsettled when the medical reasoning appeared that argued that "the bodies of the fetus late in pregnancy and the newborn were fundamentally alike" (Weir, 2006). Infant mortality rates have been falling in the early twentieth century; however, infant deaths close to birth remained high. If the bodies of the late-pregnancy foetus and the newborn are alike, the argument went, then reducing infant deaths close to birth will require intervention during pregnancy. The 'perinatal' appeared as a new medical term and space of intervention covering the period from late pregnancy to early after birth.

> The concept of the perinatal occupied this ambiguous interval, constituting it as medically actionable: the time of a living subject in some senses distinct from the pregnant woman. (Weir, 2006)

The introduction of risk into epidemiology is, according to Sandra Gifford (1986), due to the reworking of models of causation to adapt to the shift in prominence from infectious to chronic disease. The more complex aetiology of chronic diseases presents a conundrum for epidemiology, and its adaptation to this new challenge is to replace "the causal relationship between an agent and a disease" with that of "the possible association(s) between one or more factors and a disease outcome" (Gifford, 1986, p. 217). *Probability* thus absorbs the uncertainty introduced through multiple-causation. Risk, however, "takes on fundamentally different meanings within epidemiology, clinical medicine and lay experiences of health and illness" (Gifford, 1986, p. 238), and having absorbed uncertainty on a population level, despite not truly being able to apply certainty on an individual level in this way (as clinicians do), has led to the tendency to turn risks back into causes.

This is Weir's point of departure in terms of perinatal practices in Canada.[37] Weir argues that the production of the perinatal subject facilitated the entry of risk techniques into the clinic in

[37] Weir's focus is on the perinatal period and the form of care that is provided from the 28th week of pregnancy until a week after the birth. My focus is more generally on maternity care, or antenatal care, especially the care provided in the lower levels of the district health system (DHS). As such, Weir's focus on the foetus and neonate is not duplicated in this dissertation. Instead the dominant focus of the policies and guidelines in my data concerns

the 1950s by rendering the foetus at the perinatal threshold "medically actionable" and distinct from the pregnant woman. Identified risk factors are "folded into" existing prenatal care techniques. These risk techniques, or "standardised, population-based, routine risk assessment in clinical practice" (Weir, 2006, p. 3) are not insurantial or actuarial in character, rather they are an amalgamation of epidemiological and clinical knowledges. But like insurantial and actuarial risk, epidemiologically-derived clinical risk techniques are also about security. Most importantly, for this dissertation, risk techniques have made its way into patient management. Chapter six describes how, in South Africa, risk embedded itself in the antenatal clinic, and describes in detail how antenatal risk management functions, together with the district management system, to govern pregnant women as liberal, yet developing subjects, in the South African health system.

4.5. Governmentality and the Global South

4.5.1. Governmentality and colonialism

Apart from feminists, scholars of colonialism and postcolonialism have also made an identifiable impact on governmentality studies. Some authors who have taken on Foucault's ideas contend that colonialism equates to Foucault's notion of 'sovereign power' or 'premodern' European practices (D. Scott, 1995). For these authors, the colonial was not biopower, since the colonial period was beset with violence and repression. This argument does not take full cognisance of the fact that biopower is not a 'positive' power in the way it is *not violent*, but rather it is a positive power in the way that it *produces* new forms of being and knowing. Biopower can be very violent in the process of destroying old forms of being and knowing while instituting modern power structures. Not only does this process institute new power structures by delegitimating older structures, it also produces a whole new language – the language of the modern – a language in which any non-modern ideas and possibilities become conceptually unapproachable as operational options within modernity.

> Within the modern world which has come into being, changes have taken place as the effect of dominant political power by which new possibilities are constructed and old ones destroyed. The changes do not reflect a simple expansion of the range of individual choice, but the creation of conditions in which only new (i.e. modern) choices can be made. The reason for this is that the changes involve the re-formation of subjectivities and the re-organization of social spaces in which subjects act and are acted upon. The

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the pregnant woman. This is due to the focus of the writers of the policies and guidelines (since there are organisational divisions between maternal and infant health provision), but also because what is problematised in my data is not the perinatal mortality rate, but rather the maternal mortality rate.

> modern state – imperial, colonial, post-colonial – has been crucial to these processes of construction/deconstruction. (Asad, 1992, p. 337)

This process was systematic, like a game of truths, in which a variety of tactics were utilised such as, for instance, producing what is now the well-studied colonial subject, conceptualised as backward, uncivilised and in need of guidance and civilising. These processes were never straight-forward and all-encompassing, and the persistence, to this day, of 'traditional' practices, is a case in point.

By drawing attention to the changes in Europe's art of government, David Scott (1995, 1999) shows how the colonial project or, as he puts it, the 'colonial career' of modernisation, itself changed. Scott (1995, p. 193) argues that modern power, in the way it aims to displace the 'premodern', is "not merely coincident with colonialism": rather, colonialism is a particular articulation of the modern project as a whole. This statement brings him into conflict with a wide variety of postcolonial thinkers. For instance, Partha Chatterjee counter-positions the modern and the colonial, wishing to allow colonialism its distinctiveness from Europe. His project is to 'forget Europe' in the process of studying the particularities of colonialism which allows the colonial to not merely be an episode in Europe's 'modern' history. Similar to trends among radical feminists outlined in chapter two, many of these scholars have seen their project as "*writing back* at the West" (D. Scott, 1995, p. 192). While there is a certain polemical value to providing colonialism its own distinctiveness and not allowing Europe to continue being the centre of our theoretical knowledge of ourselves, I argue that Scott (1995, p. 192) is ultimately correct in stating that the "Fanonian rhetoric of forgetting Europe"[38] does nothing to resolve the problem of Eurocentrism. But Scott is not simply arguing to 'bring Europe back in', rather he aims to assign a conceptual level to Europe in which it is "understood not merely as a geographical space but as an apparatus of dominant power-effects" (D. Scott, 1995, pp. 191-192).

This conceptual shift assigns a different role to the problem of 'race'. Most work done on colonialism has focused on studying the ways in which the colonised were *excluded*. For instance, Edward Said (1978) showed how particular colonies were represented – were made *Other* – which allowed for the denial of their voice and agency by colonisers. Others (cf. Guha, 1989) illuminated the hollowness of the claim that Europe's colonial project was to introduce liberal political systems based on the rule of law. The easily recognisable fact that these principles were unequally applied based on race have led various writers to argue that the

[38] See for instance Frantz Fanon's *Wretched of the earth* (1967, p. 251).

distinctiveness of colonial power is that it operates according to a "rule of colonial difference" in which "'race' is the defining signifier"[39] (Scott, 1995, p. 196). In a Foucauldian project, race is delegated to being a technology through which people are governed. If one is to take as one's point of departure that power was organised differently during different times, based on shifting rationalities of government then, as Scott shows, the use of 'race' *changed* between the eighteenth and nineteenth centuries. As such there *was* a "colonial rule of difference" which excluded and included people, however, race is not the *raison d'etre* of colonialism; rather it is a technology through which colonialism governed. The question is then, "through what kind of political rationality [race] becomes inserted into *subject-constituting* social practices, into the formation, that is to say, of certain kinds of 'raced' subjectivities" (D. Scott, 1995, pp. 196-197).

To identify the rationality of government Scott asks: "what in each instance is colonial power's *structure* and *project* as it inserts itself into – or more properly, as it *constitutes* – the domain of the colonial?" (D. Scott, 1995, p. 197) The point of this exercise is not to show that our modern postcolonial state is merely derived from Europe's 'original' modernity. Instead, the use of this project would rather be to show that the "structures, projects, and desires" of Europe generated changing ways of impacting the non-Western world, changing ways of imposing and maintaining rule over the colonized, and therefore changing terrains within which to respond" (D. Scott, 1995, p. 198). To understand this, it is important to remember the Enlightenment project:

> the Enlightenment belief in progress rested on an idea of reason which was irreconcilably opposed to forms of understanding and action that depended upon what is called superstition and prejudice. For these, the argument went, disabled individual rational judgment and encouraged timidity and fear, thereby leaving people in blind obedience to the capricious tyranny of despots and priests. However, the emancipation from this moral slavery and the eradication of benighted ignorance could not be carried out by the mere alteration of a few false notions and the superficial tinkering with behaviors. Rather, what was required was, first, their fundamental uprooting by means of a broad attack on the conditions that were understood to produce them, and second, their systematic replacement by the inducement of new conditions based on clear, sound, and rational principles. (D. Scott, 1995, p. 199)

We should rather understand modern power as operating in such a way that it aims not only to replace premodern practices and knowledges, but to produce the conditions in which those practices become nonsensical; to produce the conditions in which people can be governed

[39] This iteration has also been criticised by the fact that historically it was not race but rather religion that framed the way the colonial 'Other' was conceptualised.

according to modern practices. Instead of ‘race’, “the distinctive strategic end of modern power” is the production of conditions that allows for the government of conduct (D. Scott, 1995, p. 200).

Scott applies this formula to the British colony of Ceylon (now Sri Lanka). He shows that the Ceylonese colonial state from 1505 to 1948 consisted of more than one rationality of government. Up until the end of the eighteenth century the colonial regime was to a great extent merely continuations of the prior indigenous regimes (D. Scott, 1995, p. 195). At the start of the nineteenth century Enlightenment reasoning brought its technologies of government to Ceylon to dismantle the premodern and produce the modern. Scott identifies the displacement of a mercantilist rationality with that of governmentality with the introduction of the Colebrooke-Cameron Reforms in the 1830s when the “*spirit* and *target*” (1995, p. 205) of the colonial project underwent fundamental change. The mercantilist project, which we saw revolved around the production and strengthening of the European state, took as its target in the colonies “points of extraction of wealth”, and deployed disciplinary tactics where obedience was needed. It did not care much for the cultural and religious differences of local populations as long as these did not interfere with the extraction project.

This rationality was systematically reformed, and power shifted its focus onto the local population of Ceylon. It was not the first time the British intervened on the Ceylonese, but it was the first time they did so with the aim of ‘improvement’. The technologies were introduced to produce subjects who could be governed according to the principles of liberal governmentality. To do this, the colonisers had to bring their targets into reach by constructing new domains within new fields of operation. The newly-formed judiciary was to systematically draw locals into a framework that would produce them as legal *subjects*. As the Colebrooke-Cameron Commission stated:

> The truth is, the administration of justice to natives is of far more importance than its administration to Europeans, because they are so much less disposed to do justice to each other voluntarily; and I know of no instrument so powerful for gradually inducing upon them habits of honesty and sincerity as a judicial establishment…” (Mendis, 1956, p. 163)

Similarly, with the introduction of education and the free press the new rationality of government sought to produce something liberal society needed: ‘public opinion’. Unlike the mercantilist colonial state, liberal governmentality depended on “the productivity and consumption of an improving public”. As such it had to produce self-interested individuals

which required “a means of inducing an understanding of what those interests were” (D. Scott, 1995, p. 209). In the process, of course, local ‘premodern’ knowledges would be delegitimised and replaced by modern reasoning.

New institutional structures were brought into being to curtail the “absolute and autocratic control exercised by the Governor” (D. Scott, 1995, p. 208). The justification for this was couched in terms of the ‘natural’ rights of the people; some people, however, were still too steeped in prejudice and ignorance to be allowed to express their views in government. It will be quite easy to view this as a rationality based on the gradual progression of democracy. However, it is more illuminating to view it as a technology at work providing an incentive of modernisation as a prerequisite for inclusion: letting go of premodern subjectivities and taking on modern subjectivities such as the rational, legal, productive subject is the criterion that would ultimately lead to the attainment of citizenship. This shift from colonial ‘extraction’ to ‘improvement’, from *raison d'État* to liberal governmentality, is a framework for investigating the rationality of government in any colonial country, including South Africa.

The question of independence was, since the dawn of the twentieth century an important topic of debate world-wide. Independence, from a governmentality point of view, is not something that a liberal rationality of government would necessarily oppose. The general attitude towards independence is perhaps most succinctly put by a British administrator in India, Sir Charles Trevelyan, in the late 1930s,

> The only means at our disposal for preventing [revolution] and securing [reform], is to set the natives on a process of European improvement, to which they are already sufficiently inclined. They will then cease to desire and aim at independence *on the old [Indian] footing*. (quoted in D. Scott, 1995, p. 214)

The modern colonial project was to destroy the *old Indian footing*, and as Scott notes, it is the governmental rationality behind this that we need to map.

There were of course various other instrumentalities and technologies introduced by this commission. What they had in common was that they were about the production of a modern Ceylonese society: a disciplined society inserted into a machinery of power through which their conduct could be governed. It is within this very project that the history of inclusion/exclusion can be identified, not *as* an end in itself, but as technologies that are deployed towards a particular end: *the production of governable subjects*. And it is in understanding this project that one can not only understand why so much structural violence occurred, but also how this

very project, in its desire to create a modern state out of a colonized society, has produced effects that haunt the postcolonial. Of course, it can be argued, this project is not yet complete. This is not to say that local populations have been passive recipients of European power relations. On the contrary, Foucault's formulation of power relations takes as its centrepiece the problematic of resistance.

What is needed is to investigate South Africa's colonial history from the point of view of what the structure and project was of colonial power and what it took as its target. This is, of course, a project that lies beyond the scope of this dissertation. South Africa has a relatively unique history of colonisation and settlement[40]; furthermore, the present has been especially marred by half a century of apartheid rule where 'independence' was ceded by the British not to the local population but to a group of white settlers who, in order to remain in power, sought to dominate the majority of black people living within the new state borders. There is no doubt about the level of authoritarian measures that were deployed in this project. However, that does not mean that biopower was absent; the apartheid state utilised a variety of mechanisms to make the black population governable, both legal and administrative, even if it was not to the extent, or in the same way it did, to govern the white population.

An important aspect of modern governmentality is its interest in gathering knowledge on populations. This process requires the establishment of a variety of institutions and techniques. Various authors have argued that this tendency was absent, particularly in Africa (F. Cooper, 1996, 2002). The connection is often drawn between this lack of concern with putting modern functions in place and the fact that postcolonial countries are 'underdeveloped' (Rodney, 1982). The kind of argument put forth is that in Africa the mercantilist logic that sought to extract resources remained intact throughout the colonial period. The supposed prerequisite of liberal governmentality, being *the preoccupation with improving the well-being of the population,* has confounded many writers wishing to evaluate the possible use of Foucault's ideas for understanding the colonial state. It is quite clear that colonial policies did not aim to improve the well-being of the colonised; sometimes they were left deliberately uncounted (and therefore were not provided any social services), as Breckenridge (2012) argues happened

[40] There is, as Keith Breckenridge (2014, p. x) notes, a tendency among South African historiographers to see South Africa as "completely distinct from any other society". I agree with him here that it would be more useful to first interrogate the links between South African and imperial Europe as a starting point, and then move on to research the peculiarities that unfolded.

during the apartheid era when the state showed more interest in counting black-owned livestock than knowing the exact number of people living in the Bantustans.

Some authors have attempted to address the question of exclusion through the governmentality framework. U Kalpagam (2000) argues that the colonial state operated as a 'parasitic' state which aimed to govern the people in their territory in such a way that it benefitted specific people, particularly the 'alien' rulers. This goes a long way to explain the logic of exclusion more structurally, as Breckenridge himself shows – the general logic of liberal governmentality was not absent in the late colonial and apartheid state in South Africa; in fact the desire to count was there, particularly among the 'progressives'[41]. The Bantustans were conceptualised as the 'natural' geographical space that produced the labouring subjects for the apartheid state, particularly the mines[42]: a technology for reproducing labour as cheaply as possible. *Not counting* (at least not counting in certain ways) ended up being a tactic of the apartheid rulers – exactly because without knowledge there is no ability (or impetus) to govern.

The productivity of racial categories lies in the way they allowed for techniques of discipline to be organised in very particular ways. Anna Selmeczi (2009) goes as far as to argue that this tactic is still present in contemporary society: the 'abandonment' of the 'superfluous' is inscribed in very logic of liberal governmentality. Within an art of government in which the population is categorised into competencies – the competency to work, to contribute to the market, the competency to speak – institutions such as the police play a key role in configuring "a social hierarchy through allocating places and functions to individuals and groups based on their competencies" (Selmeczi, 2009, p. 169). In a country such as South Africa, where a massive group of people are 'superfluous' according to these criteria, the shack dweller's movement Abahlali baseMjondolo's motto "We are the people who do not count" is both literal and figurative.

Various authors have argued that their disciplines should take on the governmentality logic of studying the technologies of power when trying to configure the colonial state (Pels, 1997; Stoler, 1995). There is great descriptive potential in linking up techniques such as registration and identification, and practices of discipline and self-control, such as cleanliness, sanitation,

[41] See for instance the push toward establishing a 'social medicine' during the 1940s.
[42] The apartheid state was concerned about the health of the black population since they were the main form of labour power (McCulloch, 2013). This is not inconsistent with a liberal governmental rationality, although the crudeness with which the project was approached and the lack of civil liberties on the part of the black population was a useful way of reducing spending on a large part of the people in South Africa.

‘civility’, etc. Foucault’s framework, furthermore, gives account of both technologies of power and of the self, and allows for the viewing of colonialism “as a struggle that constantly renegotiates the balance of domination and resistance” (Pels, 1997, p. 164), in other words, it neither denies the agency of the subjected nor vindicate the violent practices of the colonist.

While my project will not be attempting to investigate the South African past according to a governmentality framework, it is nonetheless useful to configure the investigation, knowing that a variety of technologies of government have been at play in the process of governmentalizing the South African state. This project focuses on the democratic present and is specifically looking at the health sector. What will be more immediately useful is to look at the development of institutions of health, how they aimed to govern the South African population and perhaps more importantly, the role of international organisations in putting in place the technologies of power to govern.

4.5.2. Governmentality and development

When the effects of the 1980s structural adjustment policies (that were forced onto Global Southern countries by intergovernmental organisations (IGOs)) became clear, critical scholars started paying attention to international organisations and attempted to theorise the phenomenon which, it seemed, replaced colonialism in the way the West imposed their agenda on the South. The majority of theories that were borne from these endeavours have taken at face value that governments’ scope and ability to rule their own states are being challenged by the proliferation of non-state actors such as IGOs and international funds (Larner & Walters, 2004). They argued that organisations such as the IMF and the WB were reducing state sovereignty and forcing or coaxing states to adopt neoliberal policies – policies that were simply described as reduced state spending on social services and the opening of markets to foreign trade. More all-encompassing, however, the majority of approaches to globalisation claimed that the phenomenon represented “a transformation in the very structure of the world,” i.e. the globalisation of governance (Larner & Walters, 2004, p. 495).

It has been argued that viewing this phenomenon in terms of a *transfer of power* from states to civil society or IGOs, as these theories do, circumscribed critical thinking and side-lined research on the functioning of this process in its practicality (Larner & Walters, 2004). From the early 2000s various scholars, working in international relations and other areas related to the global political sphere, started using Foucault’s notion of governmentality in order to overcome the standstill in critical thinking in relation to the phenomenon of globalisation

(Sending & Neumann, 2006). Governmentality as an analytical tool reoriented the study of globalisation towards its surface aspects – its practices on the ground. A governmentality perspective does not take the position that power is transferred from governments to non-state actors, but focuses rather on practical and discursive changes that result on the level of institutional practices and governance. This perspective also analysed organisations such as the UN and smaller development-focused NGOs. Utilising this analytical tool allowed for the identification of a variety of dimensions of global governance that the current literature omits as well as the challenging of some of its "core claims" (such as that governments are conceding their power to IGOs) (Sending & Neumann, 2006, p. 652). Global governance was instead understood as a rationality of government: one in which NGOs and IGOs could play a more prominent role since their operations concurred with the logic of governing at a distance.

Ole Sending and Iver Neumann (2006) provide a useful starting point to understand the rise of IGOs and their adoption of governmentality functions. They argue that the current governmentality, predicated on governing at a distance, has allowed NGOs and IGOs to take on explicitly governmental functions. Previously, they argue, these institutions functioned more like think tanks: they produced knowledge and aimed to influence policy only. Regardless, these non-state institutions have existed for a long time and have shaped government policy in important ways. For instance, they show how groups of institutions such as the Ford and Rockefeller Foundations, connected to an international network of other institutions, invested heavily in research on reproduction and population dynamics which laid the groundwork for the population policies adopted during the 1960s (Sending, 2003; Sending & Neumann, 2006). These organisations, they argue, operated according to a hierarchical conception of civil society which characterised this era.

> This hierarchical conception implied that whereas individuals were generally seen as endowed with reason and autonomy, consistent with a more general liberal political rationality, a great number of individuals, particularly in the developing world, were specifically not seen as having fully developed the capacity to act freely and autonomously. Consequently, these individuals were defined as objects of government whose behavioral patterns had to be adjusted by identifying and acting upon causal relations. Nonstate actors that could lay claim to authoritative knowledge here assumed a particularly significant role as they rendered this type of governing possible by way of formulating theories about the functioning of "traditional" societies and by identifying how to intervene to act on, shape and speed up the transition to modernity. (Sending & Neumann, 2006, p. 659)

Sending and Neumann argue that this hierarchy that characterises the social engineerist modernisation theory logic served as a block for non-state actors from expressing governmental

functions. The main agenda of population policy in the ‘developing world’ at the time was to reduce population growth since this was, it was argued, what hampered the introduction of liberal principles. Doing so required organisations to produce and lay claim to authoritative knowledge that would resolve the crises of these underdeveloped countries.

The authors identify a moment in which, as they say, a new *governmental rationality* emerged that would reorganise civil society along vertical lines. Focusing specifically on population policy, they argue that the women’s health movement established the individual woman as more than merely an object of policy and reform based on scientific knowledge, instead turning her into a subject with her own perspective and experiences. In other words, she now had autonomy and rights. This new focus on the individual subject, as well as the emerging human rights discourse, reorganised civil society and unblocked its potential to intervene directly by allowing for the production of a civil society that represents people’s rights. Feminist theory and activism “coalesced with other strands of research and with rights-based women's health advocacy to form an integrated epistemic-political platform aimed at advancing ‘reproductive health and rights’” (Sending & Neumann, 2006, p. 661). From the 1980s knowledge on the reproducing woman as both object *and* subject proliferated. Civil society was no longer a passive object, but both an object and subject of government. With this development “civil society and non-state actors do not stand in opposition to the political power of the state, but is a most central feature of how power, understood as government, operates in late modern society” (Sending & Neumann, 2006, p. 651). With the decline in popularity of modernisation theory that produces modern individuals out of traditional ones, ‘development’ instead took on the role of producing an active civil society that would play an important role in being the space through which society is governed.

4.5.3. Theorising inter-governmental and non-governmental organisations

The production of civil society does not just include the formation of NGOs; it is a more encompassing process. Community is a new spatialisation of governance which, contra welfarism, allows for a new sovereignty to be given back to the individual citizen along with a solidarity that is not conceived on a national scale but rather in relation to specific allegiances. The proliferation of smaller NGOs, grassroots movements and advocacy groups is part of this phenomenon. I have also discussed how these types of organisations existed for a long time, but that this new rationality of government operationalises ‘community’ as a *form of government* (Rose, 1996).

Governmentality and NGOs/IGOs have been a prolific area of study. Some authors have focused on large international organisations such as the UN, the IMF and the WB. Francois Debrix (1999) uses Foucault's descriptions of Jeremy Bentham's panopticon to illustrate the ways in which the UN's 'panoptic regime' regulates weapons production. Michael Merlingen (2003) shows how these IGOs use disciplinary and biopolitical techniques to turn post-Cold War communist countries into liberal democracies. Jacqueline Best (2007) argues that recent IMF and WB policy changes are reminiscent of biopolitical tactics rather than disciplinary ones: their focus on transparency, calculability, localised responsibility, the promotion of normative 'best practice' models and global standards, and the technical restructuring of economic, legal and political institutions, all representing, for her, a new global governmentality.

Others have focused on specific discourses of NGOs and IGOs to make visible the close connection between the production of truth discourses and the subsequent practices they allow to be introduced. Laura Zanotti (2005) explores the conditions of emergence of the UN's contemporary political rationale – that of 'good governance' – and argues that good governance is the result of the coming together of the UN's mandate of promoting democracy and that of global security and development. Global security, she argues, was disconnected from the economic at the end of the Cold War and tied to, in the name of development, the quality of institutional structures. Thus, UN strategies were reoriented towards building strong state institutions.

> Good governance doctrines promote visibility, codification, and simplification, both at state and international level. They predicate institutional reforms that foster the reorganization of an array of local practices into administrable varieties in order to make them governable by modern state administrations. (Zanotti, 2005, pp. 466-467)

Shiv Ganesh (2005) similarly interrogates the notion of sustainable development. Focusing on an individual Indian NGO, he argues that the discourse of sustainable development aligns the NGOs practical pursuits with that of transnational capital, and using "shared vocabularies and structures" the NGO produces and reproduces "an ideology of entrepreneurialism" (Ganesh, 2005, p. 2). Ivan Manokha (2011, p. 429) analyses the discourse of human rights and argues that it now "constitute[s] a global norm with reference to which agents are evaluated and increasingly evaluate themselves". Using Foucauldian discourse analysis, Manokha shows that the discourse of human rights is a discursive structure that makes certain forms of intervention possible and acceptable. On the one hand, it consecrates military interventions or sanctions where states do not conform, but mainly it sets the terms to which states behave without any

coercion since human rights have reached a point where they are self-evident and universally accepted.

Aradhana Sharma (2006) bolsters Barry Hindess' (2004) argument that the discourse of 'empowerment' is an aspect of neoliberal governmentality in the way that it establishes a framework of self-government as opposed to more direct forms of rule. Having studied the workings of a women's empowerment state-sponsored NGO in India, she argues that despite its "commitment to radical pedagogy, and feminist goals," the programme nonetheless reproduces the neoliberal agenda by allowing the Indian state to reduce social spending while still governing aspects of social life from a distance.

> The implementation of empowerment programs by semigovernmental bodies perhaps allows for a reconciliation between the developmentalist and neoliberalizing facets of the Indian state, enabling the state to continue to perform its legitimizing development duties by building the capacities of various actors to ensure their own basic needs. (Sharma, 2006, p. 78)

Instead of being, or remaining, alternative voices to state functioning, grassroots movements are effectively governmentalised through these types of NGOs. In the neoliberal age, empowerment has become a technique of government wherein grassroots movements are produced artificially, or existing ones reoriented into professionalised, 'expert intervention' programmes, along with all the trappings of a bureaucratic system with measurable outcomes. The governmentalisation of communities do not always come from the state, however, as Partha Chatterjee shows in *The Politics of the Governed* (2004), wherein marginalised communities' ability to survive often entail engaging with 'the apparatus of governmentality,' and their success, in this age, depends on how successful they are at doing so. Engaging the apparatus of governmentality requires, for Chatterjee, the production of a collective identity – a community – through which the people lobby for government recognition and services. Sometimes these new communities are governmentalised by benevolent outside forces such as NGOs, other times they are governmentalised from the inside by local leaders.

4.5.4. IGOs, NGOs and the new governmental rationality

In terms of knowledge production on childbirth and pregnancy, there is a type of research in the Global South that significantly dwarfs any other tradition. Perhaps the most imposing agenda around pregnancy, but also health in general, is that of IGOs such as the WHO, and other agencies of the UN and individual Western countries' foreign aid agencies such as the United States Agency for International Development (USAID). These organisations' agenda

provides the blueprint for the type of interventions that are implemented and the research that is done in Global Southern countries.[43] They provide support and work with local departments of health or research institutes to gather knowledge on local populations and to identify problems in local forms of provision.

Smaller NGOs also play a part in providing services where states fall short, and advocating, most often with a rights-based focus, for the extension of services to populations. A variety of large organisations situated in the South have also taken up the agenda of promoting rights on their continents such as the AU and the Southern African Development Community. As we shall see in the following chapters various health-focused IGOs, particularly the WHO, play an imposing role in the shaping of policy and interventions in the South African health sector. This section draws together the governmentality framework and the functioning of NGOs and IGOs to make the operational logic of these institutions available for analysis in the following chapters. I will now briefly outline the WHO's history of maternal health research and interventions.

4.5.5. History of the UN and the WHO's focus on women and maternal health

After the first World War the control of disease in newly independent African countries was taken on with vigour by organisations such as the Red Cross, the Rockefeller Foundation and the health committees of the newly formed League of Nations (now the UN) (Malowany, 2000). In terms of women, the League of Nations concerned itself with women's *status*; they were "objects, for whose protection and rights recommendations were made and conventions enacted" (Pietilä & Vickers, 1990, p. vii). The League of Nations worked with, or attempted to influence, governments to provide women with rights and to remove practices that impacted women negatively.

In the early 1970s women were to take up a whole new role in development. As Sending and Neumann (2006) argue, women became both the object and subject of 'development'. Women were no longer merely the recipients of legislative changes on human rights; they were now to be targeted for improvement – the improvement of their education, nutrition, health, or status. Not doing so was argued to be a waste of human resources (Pietilä & Vickers, 1990).

[43] The agendas of these types of organisations can also be set by individual countries. The USA's Republican party's 'Global Gag Rule' (Mexico City Policy) is an imposing example. The policy states that NGOs that receive financial assistance from the USA may not in any way provide, advocate for, or refer clients to abortion services. Each time a republic president has adopted the policy it has had an enormous and detrimental effect on the reproductive health services provided by NGOs in the Global South.

Furthermore, women were to become ‘resources’: integral to, and key players in, the development project.

The UN declared 1975 International Women’s Year (UN, 1975) and throughout the 1970s women’s issues were hotly debated at various conferences organised by the UN. By the mid-1980s the agenda had been established and several major conferences on women were held across the world, organised by the UN or other players in the NGO sector.[44] The vibrant women’s movement in the USA and Europe is often claimed to be part of, or an inspiration to, this new global woman’s project.

Some writers proclaimed that this new UN agenda and focus on women produced a “global sisterhood” that produced “bonds between themselves, connecting them in ways they had never dreamed of” (Pietilä & Vickers, 1990, p. 1). Here we saw at work the very production of a civil society, a community (Rose, 1996) or ‘public opinion’ in Scott’s terms – a group of people who were provided with a new sovereignty with which they were to make demands of their states in their interests. Through their efforts, the UN and other women-centred NGOs produced ‘women’ as a global group, endowing them with characteristics in a process of which they were to be part. These women were then to lobby their governments and produce more development subjects – which was to empower and educate other women to want equality, development and peace (UN, 1984).

The WHO is an agency of the UN and since its founding in 1948 one of its major focuses has been on maternal health. The programme of the Committee on Maternal and Child Health (MCH) covered “the physical, mental and social aspects of maternity care and of the health and medical service for infants, pre-school and school-age children” (WHO, 1949, p. 3). Initially the committee focused on gathering information on the status of maternal and child health-related services and statistics in each member state, and offered support to countries in gathering this information for the WHO. It was soon found that poorer countries, particularly, sought not only support in gathering statistics, but also support and information on providing MCH-related medical and public health services to their populations. This led to calls for “a well-staffed and well-equipped information bureau to provide for the necessary analysis of data and preparation of material, [to] be established, as soon as possible” (WHO, 1949, p. 5).

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[44] There was the NGO Forum in Copenhagen in 1980; the Nairobi Forum ’85 in 1985 with over 14 000 attendees from 150 countries (See *For the Record… Forum ’85* (Pezzullo, 1985)); the 1987 *World Congress of Women* in Moscow; and the 1988 Nordic Women’s *Forum ’88* in Oslo.

The initial interventions proposed by the Expert Committee on MCH were for public health campaigns, most of which aimed to educate parents on how to take care of their children. It was only in the mid-1980s when maternal mortality[45] made it onto the WHO agenda, and along with it, onto the agenda of other international organisations such as the WB. A seminal article on maternal mortality published in 1985 criticised the development community for neglecting the 'M' in MCH, arguing that the health of women has been neglected in favour of the wellbeing of children (Rosenfield & Maine, 1985). This apparent wake-up call was facilitated by alarming statistics – that over 500 000 maternal deaths occur each year globally. These statistics were presented at the Interregional Meeting on the Prevention of Maternal Mortality in Geneva in November 1985. These statistics were mainly from community studies, funded by the WHO, and generalised to the whole population, since national studies were practically non-existent and the protocols of measuring maternal mortality were largely unknown (AbouZahr, 2003; WHO, 1986a). It was the shock factor of the numbers and the shame of the neglect shown up to then by governments and the development community, that initially drove the agenda.

4.5.5.1. Statistics, politics and patriarchy

Since the 1970s, statistical techniques have been continually refined, particularly on the level of the population. The increased accuracy of census data provided, early on, good estimates of infant mortality rates. Maternal mortality was, however, a more complex rate to ascertain, since it required clinical data. It was only when statistical techniques could capture maternal mortality rates when the issue could be brought on the agenda of the development community. This did not, however, explain why maternal health continued to be side-lined in favour of child health. Carla AbouZahr (2003, p. 16) writes that the World Summit for Children, held in 1989 in New York, "was attended by heads of state, executive heads of UN agencies, and senior representatives of countries, NGOs and the international development community," in contrast with the first international Safe Motherhood Conference in Nairobi in 1987 which was not nearly as well attended. The reduction of maternal mortality rates was a target within the larger goal of increasing child survival; as James Grant, the Executive Director of the United Nations Children's Fund (UNICEF) noted, "…the emphasis on goals for maternal mortality is largely a by-product of child survival efforts" (as quoted in AbouZahr, 2003, p. 16).

[45] Maternal death is here defined as "deaths among women who are or have been pregnant during the previous 42 days" (WHO, 1986a, 2014).

The WHO's maternal health initiative also contended with an alternative agenda – of reducing the fertility rate in the Global South. This agenda was also still very powerful and various international aid agencies preferred to fund the distribution of various new types of contraceptives in poor countries. Family planning initiatives, therefore, took precedence over maternal health. This is still the case, to a large extent, particularly with aid from the USA (cf. Rannan-Eliya, Berman, Eltigani, Somanathan, & Sumathiratne, 2000).

4.5.5.2. Ready-made programmes

The tactic of using goals and measurements had the unintended effect of encouraging countries to focus on quick-fix interventions that produced rapid results, rather than addressing the underlying causes of ill health in their societies (AbouZahr, 2003). To counteract this trend, the WHO resorted to emphasising the potential low cost of implementing reforms, or, constructing a health system from scratch. Their primary health care (PHC) model was the grand design, and every subsequent reform were additions to the model (WHO, 1985). The WHO produced ready-made programmes, interventions and systems that could be implemented by countries, as is, at cost-effective rates. For maternal health, the first ready-made programme was the Mother-Baby Package (WHO, 1994). Interested countries could use the Mother-Baby Package Costing Spreadsheet (WHO, 1999) to calculate the exact cost of implementing it in an area and upgrading the existing health system to conform to the necessities of the PHC model.

The politics of aid often mean that donors provide ready-made programmes without any consideration of what the country's government wants to do. In countries that are dependent on the financial aid of big donors such as USAID, their ability to negotiate or change programmes is weak (Whitfield, 2008). This is still the case in many instances; however, the lack of success of development programmes launched in the 1980s and 1990s led to a new kind of thinking around the involvement of local people in the development project. This resulted in the introduction of 'participation' as a form of democracy in development, as well as a way of making countries feel responsibility towards the success of a project. 'Participation' which initially incorporated local policy makers and politicians, has subsequently devolved to the community level. While participation is now considered a 'right,' it is, nonetheless, a bureaucratic process. Various participatory models exist, with frameworks for monitoring and evaluation. There are disagreements within the development community over the various models for ideological and political reasons (Morgan, 2001). While donors often want

participatory models that would make projects more transparent and effective, activists look to participatory models that focus on empowerment.

In a country, such as South Africa, where the bulk of health care finance comes from the national treasury, there is much less coercion in the adoption of international organizations' programmes. Despite a lack of pressure, the South African government has followed the WHO agenda in maternal health care and adopted the developmentalist logic (as will be seen in the analysis). The production of research is a laborious and expensive task, which makes the WHO's already existing evidence-based policy recommendations very attractive. Existing freely-available research and discussions on a topic such as maternal health is often dominated by the large international organizations, which makes them come across as authoritative.

4.6. Conclusion

This chapter was an exposition of governmentality-themed literature and critique related to risk, feminism, colonialism, and development. I discussed risk: in the last few decades risk has come to occupy an important space in the government of pregnancy. Viewed as a technology of government, risk is seen as a means of making something governable. In my analysis of the clinical guidelines for maternity care in South Africa (see chapter six), I discuss how risk is operationalised to make pregnancy governable in the public clinic.

I also gave an overview of feminist critiques and elaborations of Foucault's ideas. I showed how Foucault has been received by feminists, either with open arms, or some apprehension. I then provide a discussion on some of the feminist appropriations of Foucauldian notions and ideas. Most useful to this project is Lorna Weir's use of a governmentality framework to analyse perinatal practices in Canada. Her discussion of how risk entered the maternity clinic was of great use in my own analysis.

Finally, I moved on to a discussion of governmentality as applied to themes beyond the West (in a manner of speaking). The use of governmentality to analyse colonial and post-colonial rationalities of government is a prolific area of study. The argument provided by David Scott and Talal Asad, that claims that modern power creates conditions, and reforms subjectivities, in accordance with its own rationality, and in the process destroying what it considers to be *not modern*, apart from illuminating colonial rationalities, also provides a useful point of departure for understanding what perhaps can be understood as the postcolonial rationality of government, which is, at least in South Africa, based on the discourse of development. Several other authors have made similar connections, drawing on governmentality. The next chapter

analyses South African health policy and practices in the immediate post-1994 period. The aim of the chapter is to lay the groundwork for an analysis of pregnancy-related policies and interventions, as well as shed light on their conditions of possibility. Thus, chapter five (the first analytical chapter) is “a kind of historical fieldwork of problematisations in technologies of health”, as Osborne (1997, p. 181) suggested a Foucauldian health policy analysis should be, along with an “[attempt] to tie such technologies to wider political rationalities of government.”

5. Producing a governable post-apartheid society

5.1. Introduction: Development as a technology of government

South Africa democratised at a pivotal moment in the history of political possibilities. The fall of the Berlin wall and the end of the Soviet Union opened new opportunities for international and non-governmental organizations to assist in democratising and modernising countries that had hitherto been under communist influence. Although South Africa was not communist, the apartheid regime had become internationally reviled for its racist practices – as Julia Hornberger (2011, p. 58) states:

> The South African case offered the perfect occasion for the application of such an agenda [of development and international cooperation]. First, South Africa embodied *par excellence* the global shift in which human rights had become the officially legitimate political global discourse following the demise of the Cold War. South Africa had produced what was described as a miraculous transformation from evil to good.

As a new constitutional democracy in Africa, South Africa was ideal for the deployment of the agenda of development along with its various techniques and practices. The post-1994 South African government made one of its core projects that of 'development' as outlined in its first socio-economic policy framework, *The Reconstruction and Development Programme* (*RDP*) (RSA, 1994). In terms of health, there was an almost wholesale adoption of the WHO's health agenda in 1994, and, at least since 2005 the South African government self-recognises as a 'developmental state' (Kuye & Ajam, 2012). As outlined in chapter three, the framework employed in this project does not approach the subject of power as something that can be transferred; as such, it is not assumed that the new democratic state ceded its power to international organizations or that the WB, IMF or the UN coaxed or forced the new South African government to adopt its policies. Instead, I analyse the practical and discursive changes that resulted on the level of institutional practices and governance (Sending & Neumann, 2006).

From a governmentality point of view, development in the Global South can be conceptualised as a set of practices that aim to governmentalise those spaces within the borders of a state (or, in the context of foreign policy – borders within other states) connecting individuals to relations of power and turning them into subjects of government. What is important in understanding

development in this way, as Michael Watts (2003, p. 13) points out, is to "grasp how 'the possible field of action of others' (see Foucault, 1982, p. 221) is structured through a variety of technics and micropolitics of power (from the map, to the national statistics, to forms of surveillance) to accomplish, or attempt to accomplish, stable rule through certain sorts of governable subjects and governable objects".

In this chapter, I interrogate the various discourses appearing in the initial socio-economic policies of the democratic period insofar as they speak to subjectivities that can be connected to the government of health, and the government of pregnancy. I analyse the role these discourses played (and continue to play), in making South Africans governable, making their health governable, and making pregnancy governable. The techniques and practices adopted in the 1990s have their own histories and conditions of possibility. Some of these histories have been discussed in previous chapters. The focus of this chapter is to analyse the discursive events presented in the initial policy documents, and to discuss how and why the discourses in these documents were appropriated, adapted, and/or reformulated, and how truth and knowledge was put to work in South Africa to produce the desired relations of power**.**

The discourses evident in the initial post-apartheid policy documents draw heavily from international non-governmental organisations. There are various aspects of the *Health Plan* and the *White Paper* that can immediately be traced to international developmentalist influences. The adoption of the district health system (DHS) model and the primary health care (PHC) approach shows the major influence of the WHO (1985, 1988a, 1990). The influence of a variety of international organisations on ANC policy has been extensively covered (cf. Jordaan, 2012), and so has been the phenomenon whereby non-state actors have come to be increasingly powerful in effecting state policies, whether in the Global South or North (cf. Rosenau, 2002). However, what is of interest here is how and why these developmentalist discourses are instrumentalised in the South African context. If governmentalization is the process through which aspects of life are brought into relations of power, then development acts as a technology of government. Development allows for the implementation of a variety of strategies that draw people into relations of power, granting the means to conduct their conduct.

After centuries of colonialism and apartheid, the distribution of modernity in South Africa was distorted. The former Bantustans, granted independence from the 1970s, were poor and incapable of bringing to bear the modern project as it unfolded in the larger cities. A variety of

premodern practices persisted, mingled with modern ones. While the apartheid administrative and bureaucratic apparatus extended its tentacles into the most surprising corners,[46] during the twentieth century and the apartheid years, the vast majority of the South African population languished in more and more neglect in 'undeveloped' townships and Bantustans. In 1994, the democratic government assumed responsibility for a great deal many more people than the apartheid regime cared to consider, and, as such, its principal task was to extend the state into the lives of a suddenly much larger population.

1994 presented a unique moment in which a radically new set of practices could be introduced with little resistance. Of course, these new rationalities had to be justified, and this was done by drawing on a variety of discursive devices (such as being contrasted to that of apartheid). This allowed for, to borrow from Talal Asad (1992, p. 337), "the re-formation of subjectivities and the re-organization of social spaces in which subjects act and are acted upon".

5.1.1. The context of health policy making in 1990s South Africa

The *RDP* (ANC, 1994b), discussed in the introductory chapter, was the social and economic framework and election platform of the ANC, and was accepted as the new framework for South Africa by the Government of National Unity (RSA, 1994). It proposed a wholesale *restructuring*, or *reconstruction* of the entire public sector in line with *development principles*. This fed into the various intersectoral plans, such as the *National Health Plan* (ANC, 1994a). While the *RDP* was replaced by *GEAR* in 1997, the developmentalist principles underlying the social objectives of the *RDP* were retained, and the *Health Plan*, based on the *RDP*, remained as the framework for the restructuring of the health sector.

The apartheid health system was argued to "have created a fragmented health system, which has resulted in inequitable access to health care. The inequities in health are reflected in the health status of the most vulnerable groups" (ANC, 1994a, p. 3). The most pressing concern in the 1990s was that of access. In 1996 a health care facilities audit was completed and according to the *White Paper on the Transformation of the Health System* published in 1997, the aim was to have a clinic density of 1:20 000 by the year 2000 (NDoH, 1997). After considerable expansion of infrastructure which included the building of new clinics, the upgrading of older ones, and the purchase of mobile clinics, by 1999 the Health Department was confident that it

[46] A good example is the elaborate system of registration of cattle in the Bantustans which accorded with strict dipping laws (Breckenridge, 2012).

would soon reach a ratio of 1:13 000 (NDoH, 1999). Due to population growth, by 2010 the ratio was around 1:13 718 (NDoH, 2010d).[47]

Despite linking high maternal mortality rates to low quality and inaccessible health services, and calling for the renewal and building of health infrastructure, the *Health Plan* focused most attention on health promotion practices. 'Health', the *Plan* insisted, was to "be viewed from a development perspective, as an integral part of the socio-economic development plan of South Africa" (ANC, 1994a, p. 2). Ultimately "socio-economic development" would secure the "health of all South Africans" (ANC, 1994a, p. 3), but optimal population health would also realise the aim of reducing population growth.

> International population trends recognise that development strategies which improve the quality of life of the population, contribute to the decline in fertility. Contraception is a necessary, but not sufficient factor in promoting fertility decline. Population programmes must maximise the capacity for individuals to fully develop their potential for social stability and economic growth. The major aims will be improvements in women's legal, educational and employment status. (ANC, 1994a, p. 3)

'Development' is thus presented as the ultimate solution including to that which is foremost on the international community's agenda: population growth in the 'third world'. It is both a individualising and totalising process in which individual capacity and potential is developed alongside social stability and economic growth.

Health viewed from a development perspective meant the institutionalisation of the PHC approach along with its institutional framework, the DHS model. The *Health Plan* introduced an outline of the DHS that was to be instituted. In terms of health, the WHO's policy prescriptions were adopted almost wholesale by the incoming government (cf. ANC, 1994a; RSA, 1994). The inspiration of the WHO (which acted as a consulting body) is evident in the adoption of the PHC and DHS models, along with its emphasis on participation and empowerment, a single comprehensive national health system (NHS), as well as the focus on health promotion and rights, but also in the continued connections emphasised between development and the health of the population.

5.1.2. The Primary Health Care approach

The implementation of the WHO's PHC and DHS options required a complete "reorganization and reorientation" (WHO, 1985, p. 3) of countries' health systems, and this is what the democratic South African government embarked on in 1994, up to 10 years after the first

[47] I have not been able to find more recent figures.

African countries had begun their health reforms.[48] The fundamental restructuring of the health system entailed creating a NHS based on the PHC approach (RSA, 1994). PHC would serve as the "underlying philosophy for restructuring the health system" and "form an integral part, both of the country's health system, and of the overall social and economic development of the community" (ANC, 1994a, p. 3). The *Health Plan* describes the philosophy of PHC as follows:

> It [PHC] embodies the concept of community development, and is based on full community participation in the planning, provision, control and monitoring of services. It aims to reduce inequalities in access to health services, especially in the rural areas and deprived communities. (ANC, 1994a, p. 6)

And quoting the Alma Ata Declaration[49]:

> Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. (ANC, 1994a, p. 7)

The PHC approach was formulated following the Alma Ata Conference in 1978. The WHO slogan driving their comprehensive health system strategy was 'Health for All,' emphasising its focus on equity. Driven by their 'Global Strategy for Health for All by the Year 2000,' (WHO, 1981), the WHO started advocating the adoption of their proposed PHC framework. Along with UNICEF, the WHO offered workshops for policy makers and health professionals in 'developing' countries.

The *Health Plan* emphasised the *participatory* character of the PHC approach, maintaining that it is based on "full community participation in the planning, provision, control and monitoring of services" (ANC, 1994a, p. 3) with representatives being democratically elected. This, it is argued, would make the health system *accountable* to the electorate. This would also increase and produce "local control and responsibility" (ANC, 1994a, p. 7). Community participation, it was noted, cannot be legislated into being. Rather it requires a level of autonomous self-association where communities band around particular health issues that concern them, holding the local level of health provision to account in producing participation. Despite emphasising

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[48] The following African countries had already started implementing (or considering) the PHC approach with the help of international organizations such as the WHO: Ghana, Mozambique, Sudan, Ethiopia, Senegal, Mali, The Gambia, Djibouti, Angola, Tanzania, Zambia, Algeria, Morocco and Zimbabwe. Many of these countries followed the Lagos Plan of Action in 1985. From other parts of the world there are Finland, Portugal, Turkey, Chile, India, Philippines, Sri Lanka, Thailand, Yemen, China, Samoa, Laos, Jamaica, Papua New Guinea, South Korea, Bangladesh, Bhutan, Saudi Arabia, and Yugoslavia, among others (WHO, 1990).

[49] The Alma Ata Declaration was produced at a WHO conference in Alma Ata in 1978. At the conference there was a general consensus that 'health' should be viewed holistically, making the principles of PHC the most useful means of attaining health through the health care system.

this necessary autonomy as a type of local initiative-taking, the *Health Plan* and the *Health White Paper* nonetheless highlighted the importance of *active mobilisation*. The *Health Plan* argues that community health workers would be catalysts for "mobilising people around health issues" (ANC, 1994a, p. 49), which is used synonymously with 'community development'. For the *Health White Paper* 'mobilisation' plays an important role in the future success of the health system and the overall agenda of developing the country.

> All people: women and men, children and adults, the affected and the unaffected, the vulnerable and the non-vulnerable will thus be mobilised to participate. (NDoH, 1997, p. 56)

The project of participation often entailed identifying "high-risk and vulnerable groups" (ANC, 1994a, p. 19), which, it is argued, a PHC system is well-equipped in doing, especially if it is coupled with an effective health information system. Despite this "All people" are required to participate (NDoH, 1997, p. 56). The participatory character of the PHC system means that communities can play their role in this form of surveillance:

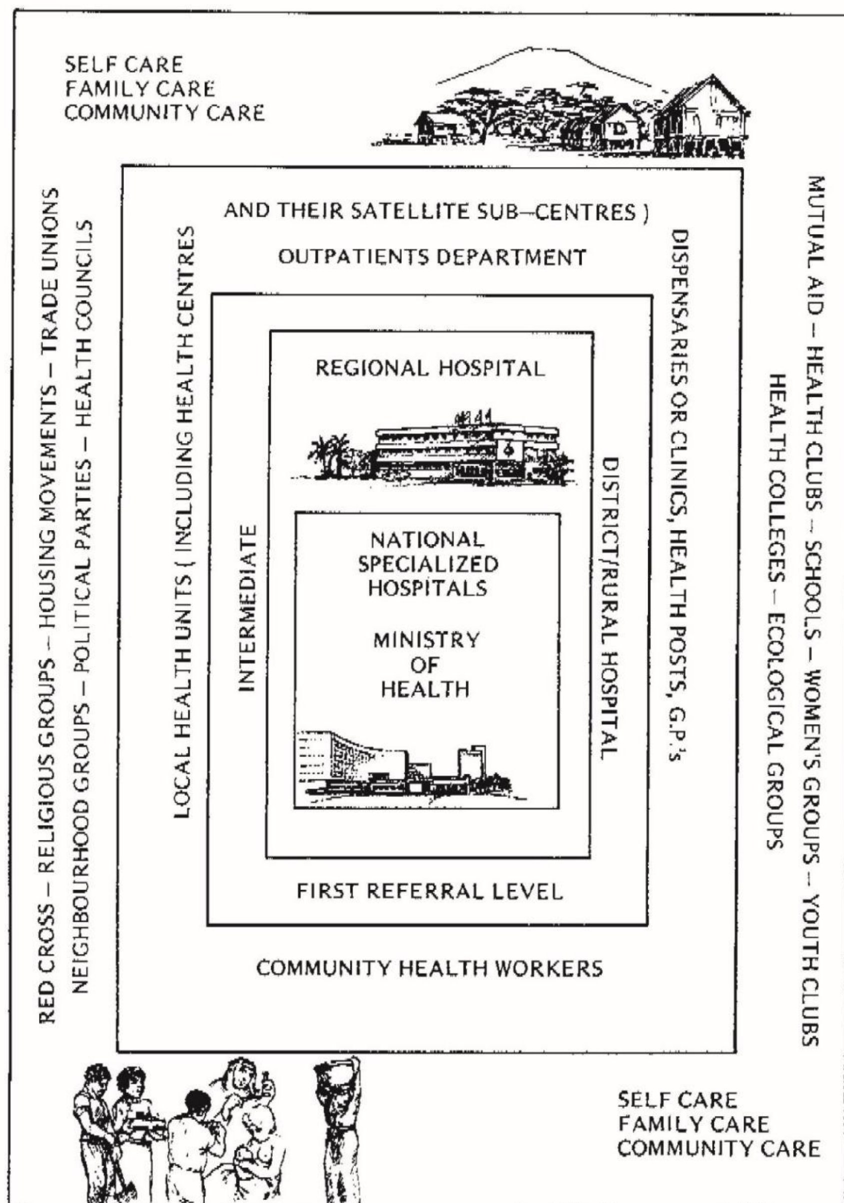
> …community level surveillance will be developed and implemented with the communities' active participation. District health teams will assist the communities to develop the capacity to assess their own problems and identify appropriate remedial actions. (NDoH, 1997, p. 51)
>
> Representatives of the communities should play a pivotal role in identifying underserved groups, and establish strategies to reach them in partnership with the primary health team. (NDoH, 1997, p. 21)

Various other surveillance mechanisms are suggested in identifying vulnerable groups, such as for instance growth monitoring of children through weighing and the introduction of screening tools in the lowest levels of the referral system.

5.1.3. The District Health System

The 'fundamental transformation' of the health system involved introducing a decentralised management and referral system known as the DHS model. The DHS model was borne from the need to provide an institutional framework that would facilitate the delivery of PHC (Segall, 2003; WHO, 1988a). A fundamental aspect of the system is its 'levels of care' structure: a relatively straight-forward referral system (see figure two). Significantly, the levels of care included that of the family, the community, and the individual, as well as all relevant non-state actors – "self-help, alternative care, mutual aid, religious, women's and youth groups" – any group that can be organised around "explicit or implicit health goals," particularly in line with promoting health behaviour (WHO, 1985, p. 1).

Figure 2: "The five boxes of the health system," in Health Systems Based on Primary Health Care *(WHO, 1985, p. 3)*



The *Health Plan* argues that decentralisation would "increase efficiency, local innovation, empowerment and accountability" (ANC, 1994a, p. 35). However, this decentralisation would be accompanied by a parallel centralisation:

> …in order for decentralisation to be effective, there is an absolute need for central coordination within an integrated, unique and comprehensive NHS. Health services in South Africa have been so fragmented and inequitably distributed that it is essential to

> unify them into a single system. Decentralisation without coordination and planning could result in a more fragmented, inequitable system. (ANC, 1994a, p. 35)

The National Health Authority was tasked with these centralised powers over, among other things, planning, budgeting, and human resource allocation. The justification for what the *Health Plan* calls a potentially temporary centralisation of certain aspects of health system functions is due to a lack of management skills as well as a lack of "a culture of coordinated action" (ANC, 1994a, p. 35).

The first level of care in South Africa will be the Community Health Centre (CHC), with those who live in direct proximity to the centre and who would use it as a first port of call being referred to as the 'community'. The community will be "encouraged" to form or democratically elect "Community Development Committees" that will "have advocacy and advisory roles, to help coordinate all aspects of development, and ensure that resources are used to the best advantage of all in the community" (ANC, 1994a, p. 36). The CHCs are to provide a comprehensive service including "promotive, preventive, curative and rehabilitative care" (ANC, 1994a, p. 36). It was envisaged that each CHC would serve around 50 000 people, depending on the context and geography of the area. These facilities are described as a "community resource" (ANC, 1994a, p. 37) similar and preferably situated close to community development and recreation centres.

The clear majority of PHC functions fall on health workers in the CHC. Apart from mobilising community members, they are also required to liaise with the community health committee, other health practitioners, local interest groups, and non-profit organisations (NPO). They are to provide a comprehensive health service including casualty, maternity and family planning services, as well as nutrition rehabilitation and support programmes, and run "outreach education and health promotion and prevention programmes… in schools and work-places" (ANC, 1994a, p. 37). The clinic would also comprise the primary level of care. Clinics were to provide the same comprehensive range of care, but on a more specialised level. While CHCs operate 24/7, clinics would operate normal work-week hours.

The institutionalisation of a DHS required the production of health districts. Provinces were subdivided into health districts based on "functional and geographic coherence" (ANC, 1994a, p. 37) and were, as far as possible, to match other political and administrative boundaries. District Health Authorities were to be set up to provide each district "essential material and logistic support" (ANC, 1994a, p. 37). The District Health Authorities were to represent health interests on the Intersectoral Development Committee, which included ensuring that other

departments played their role in promoting public health concerns. Each district was to have a community or district hospital (secondary), a non-specialist hospital providing general practitioner services and basic surgery and anaesthesia. A District Management Committee was responsible for the operation of all district services including monitoring, evaluation and planning, as well as the coordination and management of health promotion activities, while a District Health Advisory Body, comprising of community representatives and other local stakeholders, was to play an advisory role.

The province was the next level of the network. In terms of care there was to be one tertiary (specialist) hospital per province. These hospitals were not to provide the type of care associated with lower levels, but rather to focus on specialist issues accessed by patients through referral. The Provincial Health Authority was to coordinate provincial service provision and support and supervise the District Health Authorities. On a national level an Intersectoral National Development Committee, consisting of all relevant Ministers including that of Health, Agriculture and Water Affairs, among others, would address general public health issues. The National Health Authority, chaired by the Minister of Health, was the highest health-related body and was to be responsible for the coordination of the entire health system, including policy formation, the production of guidelines, norms and standards, and legislation as well as the distribution of the budget. The National Health Authority is advised by a National Advisory Body that consists of stakeholders on a national level including "statutory bodies, the national associations of health professionals, NPOs involved in health, trade unions and national community structures" (ANC, 1994a, p. 42).

The DHS described in the *Health Plan* has kept this initially outlined structure, at least on paper, although many of the functions have been refined and been provided with elaborate and detailed management and institutional frameworks. The community health workers, whose tasks were described as fundamental to the realisation of the goals of PHC were only completely introduced in 2008 (NDSD & NDoH, 2009). The *Health White Paper* (NDoH, 1997) added another level of care – that of highly specialised tertiary, central or academic hospitals.

5.2. Producing a governable post-apartheid society

In the *RDP* document, the objects of government – the citizenry – are called upon to be subjects in their own development:

> … this programme must become a people-driven process. Our people, with their aspirations and collective determination, are our most important resource. The *RDP* is focused on people's immediate as well as long-term needs and it relies, in turn, on their energies. Irrespective of race or sex or age, or whether they are rural or urban, rich or poor, the people of South Africa must together shape their own future. Development is not about the delivery of goods to a passive citizenry. It is about involvement and growing empowerment. (RSA, 1994, p. 8)
>
> *The Reconstruction and Development Programme (RDP)* is a policy framework for integrated and coherent socio-economic progress. It seeks to mobilise all our people and our country's resources toward the final eradication of the results of apartheid. Its goal is to build a democratic, non-racial and non-sexist future and it represents a vision for the fundamental transformation of South Africa… (RSA, 1994, p. 7)

In these extractsSouth African citizens are produced, not just as objects to be governed, but as subjects facilitating their *own* government: governable subjects produced through development, empowerment and participation. It is the citizenry's capacity for action – their *agency* – that political power wants to harness. There is a "regulated freedom" (Rose, 1993, p. 288) detectible in these governmental tactics. They propose to provide freedom through "the final eradication of the results of apartheid," while demanding a specific type of conduct: the citizens of South Africa should not be passive, but rather bear some responsibility for bringing about the success of the project. In this way there is a careful balancing between state provision and collective responsibility. In the initial policies of the new democratic state, these discourses propose putting in place mechanisms that will allow citizens to play their role as participants; these discourses, along with their mechanisms, do so by producing the new South African citizen-subject. This section discusses the ways in which the new South African subjects were formed drawing on two discursive devices identified in the data: participation and empowerment.

'Participation' has been a core concept in development thinking for decades. The notion of participation has had several appearances with many different associated practices, and at least until the 1970s, participation in civil society and participation in politics were conceived of as distinct. Community participation in projects was neither conceptually nor practically similar to political participation, which involved voting, protest, lobbying, etc. (Cornwall & Gaventa, 2000).

In the face of increasing globalisation, *participatory democracy* was devised as a new form of political participation which saw "citizens not only as users or choosers, but as active participants who engage in making and shaping social policy and social provisioning" (Cornwall & Gaventa, 2000, p. 50). Participatory democracy, a 'citizen-centred' approach to

policy making was also an antidote to state-centred policy making, and "in theory promises to strip the politics away by giving citizens a greater sense of ownership in their own governance" (Grube, 2013, p. 15). From the 1980s onward, the discourse of participatory democracy allowed political power to take on these characteristics associated with civil society. Participatory democracy was put forward as a solution to many problems including a lack of accountability in government, the increasing influence of major international organisations, the crumbling legitimacy of the state, social conflict, and the inclusion of marginalised groups.

Thus, in 1994, the South African government adopted a by then well-known trajectory and proposed the institutionalisation of a new form of governance:

> The human resources objectives underpin the capacity to democratise and renew the society. They are planned to empower the full participation of people on the basis of knowledge, creativity and skill. (RSA, 1994, p. 9)

The ultimate goal of the *RDP*, that of building a "democratic, non-racial and non-sexist future" requires a "fundamental transformation", that includes building strong state institutions, "creating a sustainable and environmentally friendly growth and development path", and finally, "ensuring representivity and participation" (RSA, 1994, p. 7). These objectives are in line with the notion of 'good governance' expounded by the UN. Good governance as a discursive formation (Zanotti, 2005), is a mechanism through which the global is governmentalised, particularly those states that do not have strong state institutions, based on a particular doctrine of rule. Producing strong state institutions in the Global South is a means through which international security can be accomplished. Participation plays an important role in this doctrine of rule, but not because it produces legitimacy for the state. Instead, participation is a technical process: it reorganises "local practices into administrable varieties", it codifies and systematises all governmental systems of "knowing and steering aspects of population life" (Zanotti, 2005, p. 479), and puts in place the techniques for producing data on all levels of society. This process puts in place the necessary techniques and mechanisms for international organisations to monitor and assess states' performance, and reward or punish them accordingly.

In the data, 'participation' is often closely referenced with 'empowerment':

> In developing our human resources, our people will be involved in the decision-making process, and implementation of the programmes of the *RDP*. This will empower them, but can only succeed if there is also an appropriate education and training programme. (RSA, 1994, p. 9)

> Community empowerment is central to the principles of the *RDP*. The primary health care approach to the delivery of community-based services involves the active participation of these communities. This will be done through the dissemination of strategic and appropriate environmental health and hygiene information, education and communication (IEC) to develop the communities' capacity for participation. (NDoH, 1997, p. 82)

Great focus is placed on the empowerment of women and other vulnerable groups, which not only refer to eliminating discrimination and alleviating poverty, but in practice involves education, i.e. "…the empowerment of women through literacy and education programmes" (NDoH, 1997, p. 58). Along with *participation, empowerment* also has a rich history in the non-governmental sector, but its origins lie in psychology, and has also been operationalised by feminists, particularly black feminism in the USA (Calvès, 2009).

Empowerment is rooted in the idea that all people have agency, no matter how oppressed they are. For instance, Hill Collins quotes African-American poet and activist Nikki Giovanni, when she defines what empowerment means for black feminists:

> We've got to live in the real world. If we don't like the world we're living in, change it. And if we can't change it, we change ourselves. We can do something. (Hill Collins, 2000, p. 117)

In psychology, especially community psychology, empowerment is adopted as a means to "transcend the rights/needs dialectic" (Rappaport, 1981, p. 21). Julien Rappaport (1981, p. 10) describes the era preceding the 1960s community mental health movement, as one in which governmental institutions were modelled on the notion of the "caring parent". However, the new rights-based approach was also considered insufficient. The needs model "views people in difficulty as children" (Rappaport, 1981, p. 1); in the rights model, people are citizens with rights. The needs model requires experts to intervene top-down, whilst the rights model tends to ignore the structural issues that the vulnerable face despite their legal status. Empowerment joins the two by requiring that the expert community psychologist views the nonexpert community member as someone with agency, and a creative potential in solving their own problems.

> Co-ordination of programmes alleviating the needs of people living in poverty and marginalised circumstances will be essential to maximise individual potential and minimise the extent of dependency on the State. (RSA, 1994, p. 27)

The goal is to produce subjects who are not dependent on the State. By proxy this means that public health service users are dependent on the State, while private health service users are not. Maximising potential both refers to producing health-conscious individuals who minimise

their need of medical care, as well as produce economically independent individuals who can purchase private health care.

This way of governing people in need represents a paradigm shift that fits the changeover from welfarism to advanced liberalism. On the one hand it allows for a type of intervention that focuses on the 'abnormal' alone, as opposed to the entire population. Those already capable of governing their own lives – i.e. those who have already responsibilised themselves – are left alone, while those who, for whatever reason are unable to do so, are strategically targeted.

On the one hand it enacts a sense of agency among the target population, allowing for a set of techniques to be introduced that depends on subjectivities which can both be shaped, as well as shape themselves. To be empowered means to receive something, but it is also an active process in which the target is required to shape themselves and their behaviour. Empowerment is part of the apparatus of security: it gathers knowledge on the processes that are operating in its 'natural' state, and deploys regulatory tactics in order to return the state to normal where it is found to be deviating from. Empowerment also operationalises 'community' as a space for governing. The 'community' is not only a space, but also a new social bond that replaces the national one, handing back a level of agency and sovereignty to the individual: citizens now make demands of the state in the name of a specific allegiance, whether this allegiance is connected to a geographical location or a particular identity (Rose, 1996).

The regulatory tactics that are deployed in the name of empowerment most often take the form of education. Depending on the desired end-result, empowerment education can produce a variety of subjects, but ultimately it hopes to achieve self-sufficiency among its targets. For instance, the *White Paper on Health* views empowerment as teaching people to take care of their own health, and it utilises rhetoric of agency in doing so.

> Instead of developing predesigned programmes, the Department of Health will provide gender-sensitive, multisectoral support to communities in solving their own nutrition problems. The Department will achieve this through the facilitation of the fundamental processes of assessment, analysis and action cycles in a capacity-building and empowering fashion. It will also be achieved through the multisectoral mobilisation of relevant structures at community level; developing projects that will strengthen household food security; care of children and women-, and providing health services - while promoting a healthy environment. (NDoH, 1997, pp. 55-56)
>
> Empowerment and respect: health promotion activities should be designed to increase and enhance the control that communities and individuals have over their own health – in the process, traditional values and beliefs will be respected. (NDoH, 1997, p. 110)

In supporting communities to solve their own problems, the Department of Health operationalises knowledge in a particular way: communities are assessed and analysed, and development projects are tailored to their specific needs. The aim of these development projects is to produce healthy citizens – not by providing them directly with health, but by providing them with the information they need to shape themselves into healthy subjects. As such, participation and empowerment are put to work to produce active citizen-subjects capable of living healthy lives and taking the necessary steps to remain healthy. These citizens are also mobilised on a community level to serve as a form of surveillance over their fellow citizens, identifying those in need and distributing information. This 'people-centred' approach is put forward as a means of legitimacy, not only on a national-political level, but also because it is assumed that participation would lead individual and group preferences (such as traditions and religious beliefs) to be holistically incorporated into practices.

Participation and empowerment have activist roots, but as we see they have been adopted by governments as useful tactics in governing populations. The adoption, by political power, of functions previously associated with NGOs is discussed by Sending and Neumann (2006; 2010). They argue that this phenomenon signals a change in governmental rationality where civil society is redefined from being a passive object of government to "both an object and subject of government" (Neumann & Sending, 2010, p. 115). The adopted practices, what they call "self-association" and "political will-formation," are mechanisms through which relations of power are produced. These mechanisms were adopted by political power because of their usefulness in governing populations.

Empowerment and participation operate as technologies of agency. According to Mitchell Dean (1998, p. 36), technologies of agency "engage us as active and free citizens, as informed and responsible consumers, as members of self-managing communities and organizations, as actors in democratizing social movements, and as agents capable of taking control of our own risk." These technologies of agency involve practices that produce mobilised, empowered and/or participating subjects: education and training, capacity-building initiatives, community projects, etc. These technologies of agency are able to "convey and mobilize the preferences and concerns of individuals and communities," and they also have regulatory functions (Neumann & Sending, 2010, p. 115).

> Democracy is not confined to periodic elections, but is an active process enabling everyone to contribute to reconstruction and development. (RSA, 1994, p. 9)

> Structured consultation processes at all levels of government will be introduced to ensure participation in policy-making and planning, as well as project implementation. The empowerment of institutions of civil society is a fundamental aim of the Government's approach to building national consensus. Through this process the Government aims to draw on the creative energy of communities. (RSA, 1994, p. 39)

Civil society has become both an object and subject of government. As a subject, the community is positioned as having its own agency or 'creative energy'. As an object, government needs to produce and channel this creative energy through empowerment towards the goal of national consensus. Having been offered "active involvement in action to resolve the kind of issues hitherto held to be the responsibility of authorized government agencies" (Burchell, 1996, p. 29), civil society is produced as its own enterprise: free individuals and groups who actively shape their own futures. This governmental gift, however, involves a "contractual implication" (Burchell, 1996, p. 29, drawing on Donzelot, 1991x) –

> …the price of this involvement is that they must assume active responsibility for these activities, both for carrying them out and, of course, for their outcomes, and in so doing they are required to conduct themselves in accordance with the appropriate (or approved) model of action.

Within this rationality of government, freedom plays a central role. In the production of free subjects, freedom itself is used as a "technical condition" (Burchell, 1996, p. 24). The notion that citizens have the right to participate in the political process frames participation as an instrument that produces freedom. The various mechanisms put in place to apportion participatory conduct also produce the free subject that is required to act out their freedom. Liberal techniques of government "involve governed individuals adopting particular practical relations to themselves in the exercise of their freedom in appropriate ways" (Burchell, 1996, p. 26).

5.3. Institutionalising participation, mobilisation and empowerment

Within this rationality of government, rational governing means arranging things artificially in such a manner that subjects are "free, *entrepreneurial* and *competitive*" (Burchell, 1996, p. 23), or, put in another way, governing involves producing free, entrepreneurial and competitive subjects. Participatory as *democracy* requires an institutional structure that facilitates power:

> Democratic institutions and practices are the cornerstone on which the new society is being built. Proper development is not possible without them. (RSA, 1994, p. 10)

Attached to the state, participation as a discursive formation allows for the complete overhaul of government institutions. For instance, in the *RDP* and the *National Health Plan,*

participation is produced through a variety of techniques including restructuring the institutional and managerial framework of the state governing structures.

The post-apartheid political regime adopted these discursive practices characteristic of civil society and non-state actors because these practices are, within the current rationality of government that aims at a collective security, useful in producing relations of power that allow for the conduct of conduct. The restructuring of the health system provided a good example.

The rhetoric of participation permitted the introduction of the DHS model which, in turn, established a thick web of power relations between citizens and government. The ANCs election platform for health care called for the use of a DHS model and provides a basic outline of its managerial and institutional characteristics.

> The provision of health care will be coordinated among local, district, provincial and national authorities. Authority over, responsibility for, and control over funds will be decentralised to the lowest level possible that is compatible with rational planning, administration, and the maintenance of good quality care. (ANC, 1994a, p. 3)

Developing a DHS means the complete re-orientation of the health system inherited from the apartheid era. It also requires the building of many clinics and community health centres – the first points of contact in a DHS. The DHS model is rationalised as a way of decentralising decision-making processes; "decentralised decision making to the lowest effective level" (ANC, 1994a, p. 57) is understood as a way of fostering participation, which will (in this rationality of government where participation has become a right) be a source of legitimacy.

Another rationale often set forth for the reorganisation of the institutions into a decentralised model is that quality control and efficiency is easier to manage.

> One of the aims of this Plan is to decentralise management of the delivery of services to provinces, districts and institutions in order to increase efficiency, local innovation, empowerment and accountability. (ANC, 1994a, p. 35)

This rationale is predominantly used in Europe to justify dismantling centralised health systems. Decentralisation has been connected to the ideology of neo-liberalism (Lobao, 2007). However, in the South African (and WHO) documents, the rhetoric of decentralisation is accompanied by very visible centralising tactics. While decentralisation is supposed to produce an accountable workforce, myriad standardised management techniques introduced are put forth as means through which to produce efficiency, cost-effectiveness, and quality care.

> The rational and appropriate use of resources is essential… This can be done through the development of therapeutic guidelines, clinical audit, peer and utilisation reviews.

> All health workers in both public and private sectors will be encouraged to follow agreed NHS protocol for the care of common conditions, including appropriate referral of patients. (ANC, 1994a, p. 44)
>
> Norms and standards will be established. Standardised case management protocols for various priority health problems will be developed… (NDoH, 1997, p. 66)

In the *Health Plan*, this apparent contradiction is acknowledged:

> One of the aims of this Plan is to decentralise management of the delivery of services to provinces, districts and institutions in order to increase efficiency, local innovation, empowerment and accountability. However, in order for decentralisation to be effective, there is an absolute need for central coordination within an integrated, unique and comprehensive NHS. Health services in South Africa have been so fragmented and inequitably distributed that it is essential to unify them into a single system. Decentralisation without coordination and planning could result in a more fragmented, inequitable system. (ANC, 1994a, p. 35)

In the *Health Plan,* the need for centralised functions are presented as a means to redress the inequities of the past. During the apartheid era there were 14 health authorities and 14 ministers of health, making the health of the population, particularly the health of the black population, ungovernable. As a local NGO pointed out in 1989:

> …looking at the Northern Transvaal region: there are four or five homeland areas that intermingle – it is completely impossible to separate rationally and geographically. Nevertheless they are "independent" administratively, according to homeland policy. People living in Lebowa can literally walk across the road to a clinic in Gazankulu because it is closer than the Lebowa clinic. This creates a problem for the staff at this and other clinics and hospitals because they cannot do follow-up visits in another "country." (Pietermaritzburg Agency for Christian Social Awareness, 1989, p. 2)

The centrally coordinated NHS and the decentralised district system, while apparently ideologically distinct, both produce useful and needed effects: governmentalising the health of the South African population – bringing all South African citizens into a framework of power in which their conduct can be conducted towards the ends of a collective security, while remaining liberal in theory. These two tactics do not contradict an art of government for which "the rational principle for regulating and limiting governmental activity must be determined by reference to *artificially* arranged or contrived forms of the free, *entrepreneurial* and *competitive* conduct of economic-rational individuals" (Burchell, 1996, pp. 23-24). The centrally produced norms, protocols and management guidelines arrange the conduct of individuals represented as free and participating individuals in a decentralised system. While, in these early documents the extent of enterprising activity promoted by the centrally produced norms is not as apparent as can be seen in Western states, or in other systems such as education, nonetheless a very particular subject of health becomes visible in these policies.

5.4. The production of the community

In the *RDP*, the 'community-based organisation' is referred to as a part of civil society, along with labour and business. While there is direct referral to NGOs, in most cases 'community' refers simply to a group of people, in some way, but predominantly geographically, connected. On the one hand, communities are not wholly autonomous or self-associating groups and must, at least to a certain extent, be *produced*, i.e., have their "political and creative energies" harnessed and unlocked (RSA, 1994, p. 18); be "empowered" and "fostered" (RSA, 1994, p. 27); have their "capacity" "built" through government initiatives (RSA, 1994, p. 39), and where they can show to "contribute" to the developmental agenda put forth in the *RDP*, these community organisations can access government funding (RSA, 1994, p. 40). On the other hand the apparent self-associating and autonomous nature of communities, consisting of participating citizens, are deployed as producers of legitimacy.

> Capacity-building is essential for effective participation of civil society in *RDP* implementation… The Government will co-operate with civic organisations, and other community-based organisations, to develop capacity during the course of an *RDP* campaign to establish local government legitimacy and hence improve both service delivery and user payments. (RSA, 1994, p. 40)[50]

In health, community plays a similar role. The *Health Plan* proclaims that "the most important component of the health system is the community" and the job of government is to ensure "mechanisms are created for effective community participation, involvement and control" (ANC, 1994a, p. 2). The decentralising district health model allows for the provision of health to be reorganised around communities through mechanisms such as the community health centre and the community health worker (CHW).[51]

> Community Health Workers can play a unique role in promoting health and in expanding and improving health services provided they have effective support structures and referral systems and they receive ongoing training. They can also be catalysts for community development, mobilising people around health issues. (ANC, 1994a, p. 49)

As deployed in the health documents, the discourse of 'community' spatialises governance around geographically-defined groups and along with the rationality of PHC, allows for the

[50] The initiatives referred to here were all aspects of the *RDP*.
[51] CHWs are usually volunteers drawn from their local communities. While they are health workers, as I refer to them generally, they are not professionally trained like nurses or doctors. See next chapter for a discussion of the introduction of CHWs.

production of new subjects of government, new subjects of health, as well as new subjects of health provision.

> PHC is not just a cheaper, simpler approach to the delivery of health care, nor is it simply basic health interventions. It is a concept which is changing the medical culture. Previously this was centred around health professionals, where the community - the "patients" - were the passive recipients of health services and the doctors and health professionals alone were the dispensers of health. The change will inevitably bring about some radical transformations, not only of the health services and of the training and research institutions, but also of the attitudes of both health providers and those demanding health care services. (ANC, 1994a, p. 8)

'Community' here, does something important: it displaces the 'social' as a territorialisation of governance. Much has been written on this shift from social to community within the governmentality tradition. It is argued that since the sixteenth century the governmentalisation of the state has required *society*. The process of governmentalisation has had to *produce society* according the problematisation put forth by its rationality. Different rationalities of government have required different forms of society, and have thus relied on different techniques of subjectification: from the production of the population in the eighteenth century in order to strengthen the state (Foucault, 1979), to the production of the 'social' as a 'sector', or 'field' of intervention (Donzelot, 1997; Rose, 1996), allowing for government from a "social point of view" (Rose, 1996, p. 329). More recently a shift away from the social and towards that of community as a sphere of government has been noted.

'Community' is seen as allowing for a new sovereignty to be given back to the individual citizen along with a solidarity that is not conceived on a national scale but rather in relation to specific allegiances. Citizens are therefore to make demands of the state (including health care services as seen in the extract above), not in the name of the 'social', but rather in the name of group identities.

A movement to 'community' as a new target of governmental intervention is evident in a great many societies. In the Global South, particularly, this new territorialisation is imported through models of good governance by international organisations and NGOs that spread the new logic as common-sense principles (cf. Carton & King, 2004; McGrath & Badroodien, 2006). It is not that the theme of society, or social cohesion, has disappeared, but it is "undergoing a mutation" (Rose, 1996, p. 330). While the population is still a form of reference, the ultimate sphere on which governmental practices are directed is the community.

> A population which is poorly nourished, unwell, in pain, requiring treatment, or psychologically stressed is unlikely to be able to make a positive contribution to the wellbeing of the community at large. (ANC, 1994a, p. 8)

Just as economic relations have come to be understood as beyond the national, interconnected with various sectors from individuals, to corporations, to cities beyond the borders of one individual state, so too has the conceptualisation of the national boundedness of the security of the state's population changed, and its reliance on social coherence diminished. To secure the population in the 'post-social' political landscape within the borders of a state's jurisdiction, requires new tactics, new strategies, and new knowledges.

It is useful to see 'community' as a *form of government*. On the one hand it allows the individuals within it the sovereignty to choose their allegiance and articulate their issues through forming communities, something that social solidarity was not particularly good at. On the other hand issues can be identified, groups can be constituted and objectified based on these issues, knowledge can be gathered, and specific techniques can be formulated in order to govern the issue. A good example here is the identification of 'at risk' communities. One of the main prerogatives of the new South African health system – a feature adopted from developmentalist thinking – is giving priority to vulnerable, marginalised groups and high-risk groups, i.e.:

> Health services will be planned and regulated to ensure that resources are rationally and effectively used, to make basic health care available to all South Africans, giving priority to the most vulnerable groups. (ANC, 1994a, p. 6)

The prerogative to focus on the most marginalised groups justifies various types of interventions such as forms of information-gathering which are used to identify, and then to target these 'at-risk' groups, (instead of providing blanket social assistance).

> The most vulnerable individuals and groups will be identified and assessed by comprehensive PHC services. (ANC, 1994a, p. 28)
>
> Good quality data on population needs, on local communities, and particular sub-groups are essential for rational planning and evaluation of services. (ANC, 1994a, p. 11)
>
> Simple community-based information systems should be established by communities with the support of the health staff, to provide the information needed for the identification of priorities, the monitoring of progress made towards locally-established objectives and decisions on actions to be taken. Representatives of the communities should play a pivotal role in identifying underserved groups, and establish strategies to reach them in partnership with the primary health team. (NDoH, 1997, p. 21)

With the help of new statistical methods, problem areas or groups can be identified and interventions can be tailored, utilising specific experts.

In health, such mechanisms entail tailor-made health promotion. For instance, the Integrated Nutrition Strategy is a programme that targets nutritionally vulnerable groups. Identifying these groups requires putting in place systems of monitoring, evaluation and information management, including "a national nutrition surveillance system" which includes "growth monitoring through the universal use of standardised growth cards for all infants and young children" (NDoH, 1997, p. 54). Vulnerable individuals are to be identified by staff in community health centres and by community health care providers and provided with "disease-specific nutritional support and counselling" (NDoH, 1997, p. 54). Women, infants and young children are 'nutritionally vulnerable' by default and are to be provided with nutrition education, including breastfeeding, supplementation and dietary advice. Women, infants and young children, then, make up an at-risk community justifying special intervention. As such, 'community' allows for a flexible approach to governing active individuals – individuals active in their own self-government.

According to Rose (1996), the shift to community changed the ethical character of the relations of power. A totalised collective obligation to the social gives way to that of networks of individuals, whether geographically linked or through affinity. The nature of this new plane of government allows for a type of relationship of power to manifest – the government of the self. A fundamental aspect of governing becomes conferring techniques for the government of the self.

> There is great potential for targeting individuals, households and communities with relevant health information. This will increase their knowledge base and facilitate its application to help prevent or solve common health and health-related problems affecting mothers and children. (NDoH, 1997, p. 65)

The social determinants that shape the individual within the social – determinants such as social class, labour market activity, industrial cycles etc. – are reconfigured on the plane of community. Individuals are still to be compensated for social injustice, but they are to make their demands by creating or joining communities of interest.[52] The mobilisation of communities that the documents speak to serves this function, i.e.:

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[52] It is important to remember that government, in a Foucauldian sense, does not mean the 'Government,' i.e. the State. The state was governmentalised, that is, the state was systematically turned into an apparatus that could bring aspects of life into relations of power. In analysing the policies of the new democratic state, I showed how it is attempting to produce communities that can be governed, and that can govern themselves according to the

> Instead of developing predesigned programmes, the Department of Health will provide gender-sensitive, multisectoral support to communities in solving their own nutrition problems. (NDoH, 1997, p. 55)

> A participatory process will be adopted at the community level to enable communities to set their own objectives. (NDoH, 1997, p. 65)

A variety of strategies are proposed in producing the communities necessary to govern the health of the South African population. These include the technologies of agency discussed: mobilisation, participation and empowerment as noted in the abstract above. The links that bring together communities – whether they be the health communities falling in the jurisdiction of a community health centre, or interest groups such as the gay community, or the landless community – are more direct than the sphere of national society. The affinity to one's community seems more natural than the artificial production of social solidarity on a national scale.

Armed with an understanding of the post-1994 rationality of the South African government (in health and more broadly) that sanctioned the institutional mechanisms that were put in place and that has subsequently shaped the knowledge/power relations that govern pregnancy, this chapter continues this trajectory, focusing on the problematisation of the definition of disease.

5.5. Problematising 'health'

> The South African government, through its apartheid policies, developed a health care system which was sustained through the years by the promulgation of racist legislation and the creation of institutions such as political and statutory bodies for the control of the health care professions and facilities. These institutions and facilities were built and managed with the specific aim of sustaining racial segregation and discrimination in health care. The net result has been a system which is highly fragmented, biased towards curative care and the private sector, inefficient and inequitable. Team work has not been emphasised, and the doctor has played a dominant role within the hierarchy. There has been little or no emphasis on health and its achievement and maintenance, but there has been great emphasis on medical care. (ANC, 1994a, "Foreword," para. 1 and 2)

The 1994 *Health Plan* confronts the segregationist practices within the inherited medical system and makes the connection between curative bias, elitism and racism. The subjects at fault for producing the unequal state of health – apart from the racist policies of the apartheid regime – are identified as both the private medical practitioner and the doctor who focus on

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goals of reconstruction and development. The communities forming outside of the state to advocate their interests or their moral cause, making demands of the state, might not be part of the state apparatus, but are firmly situated within the relations of power that governs conduct.

curative care as opposed to preventative care, as well as the medical statutory bodies. In some cases, the two (racism and the medical system) are conflated, to produce a moral argument for a total reconstruction of the health system. An analysis of the types of health practices proposed in the *Health Plan* and the *White Paper* suggests that it is not just the funding mechanisms that are to be rethought to provide access to all groups of the population – what is fundamentally being problematised is the definition of health and disease employed by medical practice.

In the policy documents, there are two juxtaposed definitions of health provision. 'Medicine' is argued to be curative-orientated and an economic model in which people pay for their medical care. 'Health' includes practices that aim to prevent disease, focus on broader and more holistic means of reducing rates of illness and, at least in the first documents, is associated with universal free health provision. Medicine, in the narrow sense, focuses on treating concrete physical or psychological conditions. 'Health', it is argued, expands the definition of disease and allows for measures to be put in place that aim to prevent diseases before their occurrence. Under a health regime, health is no longer a 'state,' i.e. being sick, getting medical treatment, getting better, being healthy. The new definition of health constructs health as a process without end: disease, or, ill-health, is everywhere, and one is always at risk of one's health deteriorating. The previously distinct states of being healthy and diseased are turned into a continuum.

What is at play here, then, is the definition of health and disease, as the *Health Plan* calls for a complete review of priorities and reorientation to "ensuring that the emphasis is on health and not only on medical care" (ANC, 1994a, "Foreword," para. 4). In the *Health Plan,* health is operationalised as a technology of government and has a significant effect on the type of practices put in place to produce health. Health as a state of being distinct from disease is produced through curative medical practices; as a continuum, the production of health requires vastly different types of interventions. The redefinition of health allows for a variety of mechanisms and strategies to be produced. The new definition makes thinkable the various ways in which external factors can influence the health of the population, and it makes thinkable new ways of intervening on the health of the population. The new definition, which involves the entire life course and takes as its object everything that can possibly be identified as impacting upon 'health,' means that the objects that need to be made governable are infinite. This technology also has a particular relationship with scientific knowledge.

5.6. Discourses of health versus medicine

While the discourse of health is presented in very contextual and moralising terms, the types of arguments made in the *Health Plan* are not new. It was during the mercantilist era that states started taking interest in the health of their population: starting in Germany with the introduction of the *Medizinischepolizei* which, among other things, involved the gathering of information on disease among the population and the standardisation of medical practice and knowledge. Prussia had a form of district health system before the great medico-scientific advances of the nineteenth century (Foucault, 2001), but it was sanitation and other public health measures such as the provision of clean water and the circulation of air in cities based on chemical knowledge that would, according to Foucault, provide the conditions of possibility for scientific medicine.

> The entry of medical practice into a corpus of physico-chemical science was brought about through urbanization. Scientific medicine did not grow out of a private, individualized medicine, nor was it inspired by greater interest in the individual. The introduction of medicine into the general functioning of scientific discourse and knowledge occurred through medicine's socialization, the establishment of a collective, social, urban medicine. (Foucault, 2001, p. 150)

This is what Foucault meant when he said that there is no such thing as an individualised medicine and that medicine has always been social. It was only when medicine detached from a focus on patients and their diseases and looked towards "fields other than ill people" (Foucault, 2004, p. 13) (circa sixteenth century), that it could take on a scientific character. The portrayal, then, of medicine and health as somehow antagonistic, is deceiving. The function of the discourse is to legitimise the practices associated with 'health' *as a responsibility of the state*: "the State in the service of the healthy individual" (Foucault, 2004, p. 6).

If health and medicine are not viewed as antagonistic then what is revealed, as Foucault pointed out, is that the technology of health is quite simply medicine doing what is, it seems, inherent to it which is systematically transforming aspects of life into objects of medical treatment. The twentieth century saw this characteristic of medicine become particularly virulent. Medicine has codified such variable aspects of the body and of life that it is hardly possible to find facets that have not already been medicalised. Medicine has become so dominant that when one aims to resist medicalisation or protest its effects, one is obliged to do so "in the name of a more complete, more refined and widespread medical knowledge" (Foucault, 2004, p. 14).

5.7. Health promotion and disease prevention

Disease prevention has always been a fundamental aspect of public health. So too has been health promotion. However, the *positive affirmation of health* in public health discourse is a more recent phenomenon (Czeresnia, 1999). The technology of health, in producing objects of health, does so using a variety of mechanisms. There have been many transformations in the field of health in the last few centuries. Until around 1850 public health was focused on "geo-climactic" spaces (think quarantine), after which it shifted its focus to "socio-physical" space (Butchart, 1998, p. 129). Public health as sanitation focused on the "body itself" as "the most prominent source of danger" (Butchart, 1998, p. 130). Practices associated with sanitation were concerned with the poor and working classes in the West, and in Africa it would take a particularly noxious form as it produced black bodies as potential distributors of disease and as such a risk to the European, justifying various repressive practices including segregation and forced examination. It was public health that would introduce some of South Africa's most oppressive practices and produce its most racist stereotypes. The 'sanitation syndrome' in South Africa and the various disciplinary practices it spawned has been thoroughly covered by historians (Swanson, 1977; Van Heyningen, 1984).

The many authoritarian practices introduced in the early twentieth century in South Africa focused on the prevention of disease. Disease prevention is organised around 'disease concepts' – on a conceptualisation of disease that is closely linked to medicine. Prevention draws on historical, epidemiological and clinical knowledges and puts in place a set of techniques that would reduce the incidence or potential for a disease to develop. Attached to a racist medical science and in the service of colonial modernisation project, public health practices can take oppressive forms. Alexander Butchart (1998, p. 137 quoting from a 1930 Department of Public Health Report) identifies the introduction of more "tactful methods and friendly persuasion" with the recognition of the failure of harsh preventative practices around the 1930s. A focus on health promotion tends to take less illiberal forms. Health promotion is organised around the concept of 'health,' instead of specific diseases, although some overlapping occurs, depending on the aims of practices. The notion of "personal health" was introduced in South Africa in the 1930s, along with its disciplinary training of the habits and morals of individuals: "Soon to be known as 'social medicine', its attempt[ed] to recruit Africans themselves into the surveillance of anatomical spaces and body-boundaries…" (Butchart, 1998, p. 138). Traditional practices were the first to be tackled. Modern health-oriented individuals were to be produced from an illiterate superstitious people. Some notable

pioneers of social medicine practiced in South Africa. Sidney and Emily Kark were experimenting in 'community-oriented primary care' in the 1940s, merging clinical medicine and public health practices (Geiger, 1993). They also, importantly, connected African's hygienic habits to the economy (cf. Kark, 1934, discussed in Butchart, 1998), justifying increased surveillance (which would take the form of the survey), and the modernisation of African's habits through health education.

Another important discursive shift associated with social medicine was the explosion of causes of illness. It was not just the habits of the individual that would invite infection, but as mechanisms of surveillance expanded so too did the possible causes of ill-health and disease. In the process, the notion of health was reconfigured which allowed for the 'medicalisation of everyday life': "social medicine demanded a technology of seeing that could dissolve the binary division of the population into the ill and the healthy and so induct everyone into its network of visibility" (Butchart, 1998, p. 139). This technology of seeing was very productive as an explosion in surveys followed. The 1940s also presented a moment for progressive health reform exemplified by the Gluckman Report (RSA, 1945). However, as with the community health centres, the reforms were quashed in 1948. This period has been covered extensively by health historians and often serves as an anchor or inspiration for post-apartheid health reform (cf. Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Jeeves, 2000; Yach & Tollman, 1993). Despite the political change in 1948 community health persisted for some time, shifting with new ideas and practices. With the rise in epidemiology, more and more variables were discovered that influenced health, increasing the objects of medicalisation. For instance, in drawing an association between maternal mortality and the wantedness of a pregnancy, researchers allowed for 'unwanted pregnancy' to become a public health issue. This shift introduced the *lifestyle* of individuals and communities which itself was tempered through external factors into objects of intervention.

> The lifestyle of a community and of its individual members is a product of the environment and the reactions of the community or individual to it. There is every reason to believe that the patterns of health and disease is [*sic*] determined to a great extent by the prevailing lifestyle. (Butchart, 1998, p. 150)

This produced a shift of focus from present illness to future illness, a shift facilitated by the epidemiological notion of risk and its futuristic character.

For several decades, while the South African apartheid government disenfranchised large swathes of the black population, and in the process neglected their public health needs, the

WHO steadily continued identifying more and more causes of ill health, mastering the survey and producing a massive centralised apparatus of data collection for the health of the whole world. The *Health Plan* was to bring South Africa in line with these developments. Increasing 'health and well-being' as opposed to preventing disease opened a whole array of possibilities for intervening in the process of attaining 'optimal health'.

> Every person has the right to achieve optimal health, and it is the responsibility of the state to provide the conditions to achieve this. (ANC, 1994a, p. 6)

This discursive change within medicine also opened a field of inquiry that was practically infinite. The determinants of disease were limited, but the determinants of health – already itself an inexhaustible concept – were boundless. The 1986 Ottawa Conference on Health Promotion put health promotion on the agenda of the WHO and other development agencies and provided the following guidelines as to what could be the prerequisites for health: "peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity" (WHO, 1986b). Attached to a rights discourse, this opened a broad area in which the state could intervene and insert surveillance mechanisms, and in which populations and groups could make demands of the state for intervention. These discursive changes allowed for a variety of injustices to be made visible. International norms linked to global goals such as the MDGs meant that 'social determinants of health' be taken seriously by governments to reduce mortality or morbidity rates. However, this shift presented several new challenges. On the one hand in the Global South the capacity of the state to provide these rights to its population was constrained. On the other, increased intervention in the name of optimum health could be perceived as illiberal interference. The democratic South African government argued that increased intervention in the form of preventative measures was a prerogative of government.

5.8. A new morality of the body

Contemporary public health practices pushed by the WHO represent attempts at producing liberal mechanisms for promoting optimum health in populations. While most mechanisms are aimed at reducing diseases, they draw on the concept of health because this concept provides the conditions of possibility for a particularly useful form of liberal government. The government of the health of populations through mechanisms of health promotion attaches social, existential and ethical dimensions to the new project of 'achieving health.'

'Empowerment' in all its vagueness is a technique of health promotion (among other things). It opens the field of intervention to new knowledges and mechanisms (Czeresnia, 1999). In

health promotion the 'vulnerable,' or 'at risk', are identified epidemiologically and 'targeted' for empowerment, as discussed in the previous section. Epidemics and disease are now being prevented by identifying the at-risk population and proactively teaching them the necessary habits (read *empowering*) in order for them to avoid being infected. The multiple determinants of diseases act as categories of identification for potential interventions. While intervention on behaviour is perhaps the most prominent mechanism of health promotion, it consists of various techniques that are not simply 'educating'. Health promotion opens new areas for medicalisation, and it opens these new areas for management in a particular way: linking the body to new knowledges and techniques and binding the individual to new contractual obligations.

> The aim will be to empower women through improved knowledge about their bodies and their health. (ANC, 1994a, p. 34)

The subject of health will *know about her body* and *know about her health*, providing her with the ability to self-manage her own health, most likely through healthy behaviour. The basis of health promotion, the framework on which the PHC approach is constructed, is the promotion of individual self-management of health by promoting a *will to know*. In its most tidy version, health promotion produces *knowing subjects,* capable of a self-regulating freedom through a knowledge of their own bodies. Health promotion is a technique through which active, enterprising subjects are produced. This fits into a broader rationality that aims to produce *autonomous* subjects. The relationship that is promoted through these health promotive techniques is between the individual and her own body. Nineteenth century hygienic practices established a relationship between individuals and those around them – the survival of themselves and their children, "ensur[ing] labour and production in their turn" (Foucault, 2004, p. 6). The twentieth century sees a discursive shift that produced a new morality of the body, a "somatocracy," that is "a regime that sees the care of the body, corporal health, the relation between illness and health, etc. as appropriate areas of State interventions" (Foucault, 2004, p. 7).

5.9. Conclusion

After introducing the trends in health and maternal policy making in international development, specifically the WHO, this chapter discussed the developmental and health policies produced in South Africa following the 1994 transition to democracy. Drawing heavily on discourses taken from international developmentalist thinking, the democratic government proposed a

complete restructuring of the health system and the implementation of a PHC system based on a DHS model. This chapter discussed how these systems acted as conduits for the governmentalisation of health. I identified the primary role of the community as a new spatialisation of governance. Community has become an "*imagined territory*" for the current governmentality to administer collective and individual existence (Rose, 1996, p. 331).

Community allows for political culture, whether on the left or the right, to problematise issues in a specific way. Within this *imagined territory* individuals are defined as active agents in their own fate and connected to governmentality through their personal allegiances with others. In this way, 'community' allows for a new organisation principle for government and is a new formulation for bringing together the social and the individual. A description of the conditions of possibility of this shift away from the social towards that of community is beyond the scope of this project, but there is no doubt that it was not a simple process with a single cause; if, as Rose (1996, pp. 331-332) points out, "[t]he social formed as a complex plane of interconnection among diverse minor lines of force, shifts in knowledge, in devices for charting populations and their vicissitudes, in practices of regulation and the pathways of action and calculation they traced out, contingent problematisations and ethical and political reformulations," then the story of community becoming and taking over the social as a technical space of government is equally complicated.

Community here acts as a technology of agency, producing governable subjects – according to the contemporary governmental rationality that requires active subjects, capable of governing themselves. Self-association, or the ability to assemble autonomously around particular agendas, is central to the post-apartheid society envisaged in the *RDP*. Of course, the assembling is not as autonomous as would be supposed, the type of society that the *RDP* requires is produced through techniques of empowerment, mobilisation and participation. Similarly, with political will-formation (the production of commitment and support for initiatives or projects among citizens): restructuring, development and growth requires, according to the rationality of the *RDP*, collective support for the *RDP*. The *RDP* requires autonomous individuals who enact the role of the developing self: through developing themselves, they participate in producing a secure collective future for the whole of South Africa.

6. Governing pregnancy in the public health system

The analysis conducted in chapter five lays the groundwork for the analysis of pregnancy-related policies and interventions as well as uncovers some of the conditions of possibility of the current shape of maternal health policies, interventions and practices. It does so by providing an understanding of the post-1994 rationality of the South African government – in health and more broadly – that sanctioned the institutional mechanisms that were put in place and that had subsequently shaped the knowledge/power relations which govern pregnancy. This chapter focuses on the specific techniques and mechanisms deployed to make pregnancy and childbirth governable in South Africa.

This chapter will first describe and discuss the expansion of surveillance mechanisms in health in South Africa. The gathering of information on the population is a fundamental part of the reconstruction of government, as argued by the *RDP*:

> An efficient information management system is the key to the maximum utilisation of scarce resources. It is crucial that we develop an information management system that allows Government to effectively communicate and avoid duplication of effort between different Departments and Provinces. This is also a prerequisite for proper governance and performance assessment. (RSA, 1994, p. 17)

The gathering of information functions to achieve several goals. On the one hand, information on the population allows the government to target specific groups for intervention since resources are scarce. On the other, it allows for performance assessment. As such, surveillance is an apparatus of government, one of several apparatuses which allow government to analyse, reflect and calculate the tactics which permits the exercise of power. Since state apparatuses only penetrate the lives of citizens if they have been governmentalised, I therefore see the massive project initiated in 1994 as that of governmentalising those aspects of South African society that had not yet been governmentalised. While some of the goals align with the reasons for installing pregnancy-related surveillance mechanisms, these mechanisms are nonetheless shaped by the specific pregnancy-related issues encountered in South Africa.

The techniques and practices introduced as a result of the gathering of knowledge on pregnancy and childbirth in the public sector in South Africa are tackled next. A variety of techniques were introduced over the last 24 years. This chapter is not an exhaustive discussion of all of

them, but rather one "version", or "reading" (Wetherell, 2005, p. 384) that is contingent on the question: how is pregnancy governed in South Africa? I identified two specific objects of government in the government of pregnancy: pregnant women and health workers (including nurses, midwives, auxiliary health workers, community health workers, and doctors, but mainly nurses and midwives – the workers with the closest connection to the pregnant woman in the antenatal clinic). Sections two and three focuses on how pregnant women and health workers are produced as subjects. The connection is drawn between the knowledge production discussed in the first section of this chapter, and the subsequent practices employed, discussed in the second and third sections.

6.1. Governmentalising pregnancy

The *RDP* (ANC, 1994b) called for the production of a maternal and child health programme which was to include free medical care to pregnant women and children under the age of six years. The *Health Plan*, derived from the principles set forth in the *RDP*, identified maternal and child health as one of the five main priorities of the new health system, alongside nutrition, the control of communicable diseases, and violence, with a specific focus on "vulnerable groups" (ANC, 1994a, pp. 4-5). It was in maternal and child health where it was envisaged that the community could intervene the most. Health workers were to play an important role in educating parents on how to identify health problems, that is, to play their role in the PHC system.

While the need for accessible and quality antenatal care was acknowledged in the *RDP*, in the *Health Plan*, and the *White Paper*, the primary preoccupation was on the possibilities that were provided by health promotion. A comprehensive system was to be established that would provide support and information of everything health related for mothers-to-be and families (ANC, 1994a). Great focus was placed on the empowerment of women and other vulnerable groups, which was occasionally referred to as the elimination of discrimination and alleviation of poverty, but not as redistribution since "Development is not about the delivery of goods to a passive citizenry. It is about involvement and growing empowerment" (RSA, 1994, p. 7). In terms of practical recommendations for implementation, empowerment meant being educated, i.e. "the empowerment of women through literacy and education programmes" (NDoH, 1997, p. 58). It was closely referenced with participation and teaching people to take charge of their own health. These notions were often used interchangeably and ultimately to be empowered was synonymous with being developed; participation was produced by teaching people how to

take care of themselves. From 1998 onwards this rhetoric would somewhat abate as the real state of antenatal services in the country became apparent. This was facilitated by statistical and clinical data.

6.1.1. Institutionalising maternal health improvement

The Maternal and Child Health Directorate called for in the *Health Plan* was established. The group, which came to be called the National Maternal Child and Women's Health (MCWH) Committee, published a framework for the implementation of a maternal and child health system in 1998 (MCWH, 1998). Most importantly, the committee identified the major causes of maternal death. These included "hypertensive disease/disorders in pregnancy, bleeding, prolonged labour, anaemia, infections and ruptured uterus" (MCWH, 1998, pp. vi-vii). The report also highlighted high levels of perinatal death rates and pointed to the fact that "newborn babies suffer the effects of maternal disorders, therefore hypertension, sepsis, infections, abruptio placentae, haemorrhage, pre-term labour and unexplained still births are the most frequent causes of perinatal deaths" (MCWH, 1998, p. viii). The solution they proposed was the improvement of the quality of antenatal services.

The committee did not have access to comprehensive data and drew their figures from various bodies, including the Department of Health, national antenatal surveys, but mostly existing academic research. The information available was not adequate to provide a maternal or perinatal mortality rate for South Africa, and the major causes of disease were most likely generalised from the whole African or sub-Saharan region. Considering that almost half the contributors to the report consisted of the United Nations Educational, Scientific and Cultural Organization (UNESCO) and World Health Organization (WHO) consultants, these figures, and the constant references to international treaties and global goals, are likely due to their influence. The committee consistently pointed to the need for a comprehensive health information system, including clinical audit of maternal and perinatal deaths, "a prerequisite for proper planning, monitoring and evaluation" (MCWH, 1998, p. vii). Ultimately, they concluded that the greatest cause of maternal and perinatal mortality was the lack of access and low quality of health services. "There is an ample record available", they argued "to show that health services are often inappropriate, inadequate or inaccessible for mothers, women and children" (MCWH, 1998, pp. vii-ix).

As was their task, the committee outlined a MCWH programme and located it within the broader health system, providing a detailed framework for MCWH-related practices at every

level of care. The referral system discussed in the previous chapter was integral to the provision of antenatal care: "A clear and rapid pathway of referral and feedback along a hierarchy skills and levels of service is implicit" (MCWH, 1998, p. xii). The National Department of Health was made responsible for "rare or complex disorders and problems in need of super-speciality (quaternary) services" (MCWH, 1998, p. 60). Tertiary, or provincial, hospitals were to provide sub-specialist care as well as primary and secondary care for the immediate community. Level two hospitals would provide secondary care, and level one hospitals would provide services to high-risk pregnant women. Community Health Centres (CHC) and clinics were to provide comprehensive obstetric care "for low risk mothers" (MCWH, 1998, p. 62) as well as emergency services. CHCs would also provide screening services and be the hub for "health surveillance and data collection" (MCWH, 1998, p. 63) as well as perform MCWH-relevant health promotion and disease prevention activities. The committee included another level they termed 'home' which "involves the individual child or women herself, the parents, other family members, caregivers, teachers and other community members" (MCWH, 1998, p. 64). Like the WHO's lowest level of the DHS, the report described this level as a space in which individuals were identified for either living unhealthy lifestyles or because they were showing signs of illness, complication, or health problems. The community members themselves were to play the role of identifying these individuals with the help and education of health workers through health promotion activities.

6.1.2. Introducing surveillance mechanisms

The unit also produced a framework for the establishing of a national MCWH unit and a national MCWH advisory committee. The MCWH unit would have sub-units for maternal health, child health, women's health, etc. Each sub-unit would have more sub-units concerned with specific issues such as antenatal care, intrapartum care, postpartum care, perinatal care, auditing etc. The National MNCW unit was tasked with acquiring the data for planning, developing a standardised audit programme, and performing regular audits of services to inform allocation of resources, to define the standards of service management, to design a system for implementation of service audit and quality assurance, monitoring, producing management protocols, designing a patient-carried card that included antenatal care and labour information, designing standardised in-patient maternity and neonatal documentation, and designing a computerised maternal and neonatal audit programme which included information on perinatal and maternal deaths including avoidable factors, caesarean section rates and community assessments of services rendered (through community health committees). The

information system set up was not only to make planning possible: there were also many references to making progress *measurable***.** The production of clearly measurable goals, aims, objectives and targets were emphasised along with the fact that "the attainment of these aims and objectives has to be formalised into a set of achievable targets reached within realistic time periods (say by 3 years and by 5 years) and monitored by specific indicators" (MCWH, 1998, p. xi). The initial measurable goals were to reduce mortality and morbidity rates for which clinical data were needed, to improve nutritional status, and to ensure health care coverage through improving and building infrastructure. Auditing was to play a particularly important role.

The National Health Information System for South Africa (NHISSA) was only one of many health-related information systems put in place, and there were also many non-health-related mechanisms implemented since 1994. The functions of these surveillance mechanisms were to make liberal governing possible by allowing government to analyse, reflect and calculate their tactics. Without information on their population, liberal governing was impossible. A system auditing maternal deaths was established in 1998 and placed in the hands of the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD), who were able to do these audits since, in 1997, maternal deaths had become notifiable by law. The procedure of notifying deaths and the NCCEMD process is quoted in full:

> After each maternal death in a facility, a defined process is followed. First, the facility completes a Maternal Death Notification Form (MDNF) which is sent to the provincial office within 7 days of the maternal death. The Province forwards all documentation to a Provincial Assessor, who in turn informs the NCCEMD that a death has occurred. The NCCEMD issues a unique file number for the case. The Provincial Assessor is responsible for completion of the MDNF. The assessor must provide information on the primary, final and contributory causes of death and must also establish whether there were avoidable factors, missed opportunities or any other aspects of substandard care present in the maternal death. The Assessor must complete and return all documentation to the Province within 30 days. All documentation is then forwarded to the NCCEMD for collations and analysis. The NCCEMD uses this data [sic] to compile reports on maternal deaths in South Africa. Once the report is accepted, all data is [sic] destroyed, and work begins on the next report. (NCCEMD, 1999, p. 7)

Maternal death is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (NCCEMD, 2012, p. viii). The NCCEMD divides all deaths reported to them into three categories: direct, indirect and fortuitous/coincidental. Direct deaths are defined as "Deaths resulting from obstetric complications of the pregnancy state (pregnancy, labour and puerperium), from interventions,

omissions, incorrect treatment or from a chain of events resulting from any of the above." Indirect deaths are defined as "Deaths resulting from previous existing disease, or disease that developed during pregnancy and which were not due to direct obstetric causes, but which were aggravated by the physiological effects of pregnancy", and fortuitous deaths are "Deaths from unrelated causes which happen to occur in pregnancy or the puerperium" (NCCEMD, 1999, pp. 6-7). Fortuitous deaths, despite not technically being maternal deaths, were nonetheless included by the NCCEMD to measure the level of violence against women as well as the suicide rate.

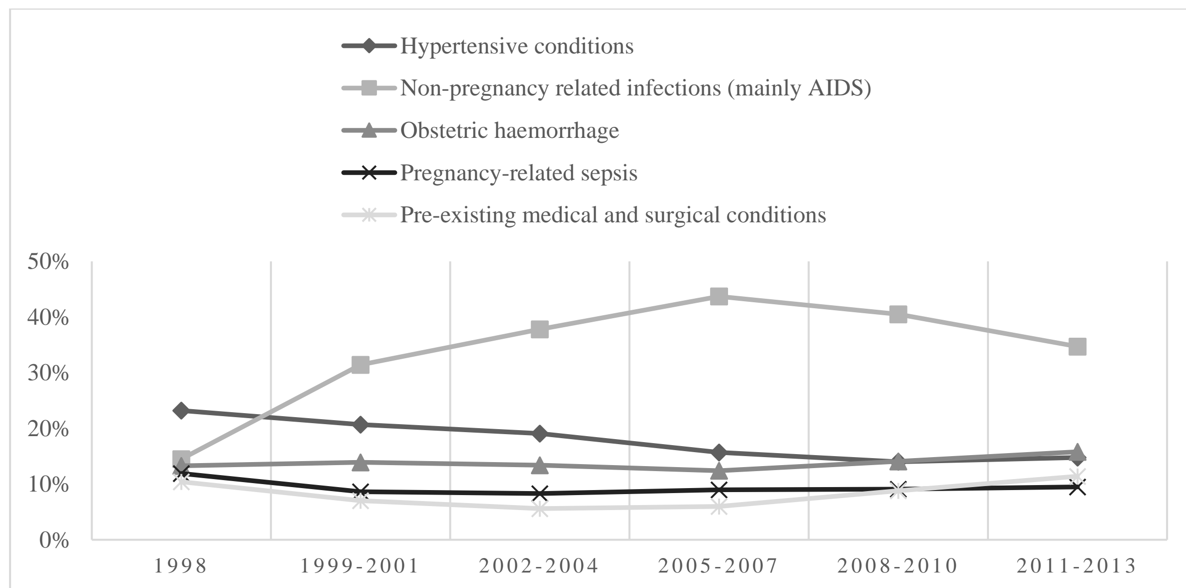
The maternal mortality rate (MMR) is reached by calculating the annual number of maternal deaths per 100 000 live births. The first NCCEMD report had to rely on a system of maternal death reporting that was still finding its feet, especially in some provinces, and the annual live birth rate was not available. This made the calculation of a MMR for the whole country impossible, but the NCCEMD agreed that the *Demographic and Health Survey Report* estimate of around 150/100 000 live births was most likely accurate.

The international target for developing countries was to reduce the MMR rate to 124/100 000 live births by 2015. The MMR, however, increased drastically over the next decade due to both better reporting as well as increased deaths in health facilities mainly due to the HIV/AIDS epidemic. The "realistic estimate" for 1999-2001 was "between 170 and 200/100 000 live births" (Moodley, 2003, p. 364). The 2001 census estimated the MMR rate at 578/100 000 live births. By 2008 the estimated MMR for South Africa was between 181-382/100 000 live births while the UN estimated it between 240-400/100 000 (NCCEMD, 2008). The fifth report provided an institutional MMR of 176.22/100000 live births which excluded all births outside the health system (NCCEMD, 2012), while the national MMR was estimated at 310/100 000 live births (Health Data Advisory and Co-ordination Committee, 2012). The sixth report reported an institutional MMR to 154.06/100000 live births, a first and significant decrease which they credited to the success of the HIV programme (NCCEMD, 2014).

Five major causes of death dominated during this time: complications of hypertension, non-pregnancy-related infections, obstetric haemorrhage (postpartum and antepartum), pregnancy-related sepsis, and pre-existing medical and surgical conditions. Non-pregnancy-related infections and pre-existing medical conditions were categorised as indirect deaths. The first report included only 585 cases in their report. The functioning of the reporting system increased consistently with 2 445 cases included in the second report, 3 406 in the third, and 4 077, 4 867

and 4 452 in the fourth, fifth and sixth report respectively. Accuracy in identifying the leading causes of death was increased by the growing performance of the reporting system, but remained dogged by a fundamental aspect of the identification of the most prominent cause of death, at least since 2000: that of HIV testing. Figure three provides a visual of the five leading causes, as percentage of overall maternal deaths, as reported over the six reports.

Figure 3: The leading causes of maternal death 1998-2013 according to the NCCEMD (data taken from Moodley, 2003; NCCEMD, 1999, 2002, 2006, 2008, 2012, 2014)



In 1998 the leading cause of maternal death was complications due to hypertension, including eclampsia, pre-eclampsia, chronic hypertension and intracranial haemorrhage. From 1999 onwards, the leading cause of death was non-pregnancy-related infections, driven by the HIV/AIDS epidemic. Already in 1998 HIV/AIDS was the most common non-pregnancy-related infection despite the HIV status only being known in 24.2% of cases. Other infections included pneumonia, tuberculosis and meningitis, most of which would likely have been reclassified as AIDS if the status of the woman was known, since these infections are opportunistic to AIDS (Moodley, 2003).

HIV testing has become increasingly widespread over the years. The HIV status was known in 36.4% of maternal deaths occurring between 1999 and 2001, 46.3% between 2002 and 2004, 59% between 2005 and 2007, 79% between 2008 and 2010, and 87% between 2011 and 2013. The sixth report stated that, of the women whose status was known, 65% were HIV-positive. This report showed the first reduction in infection rates since 1999 (during 2008 and 2010 70.3% of women who tested were HIV-positive).

55% of the HIV-positive women who died between 2011 and 2013 had been receiving highly active antiretroviral therapy (HAART). HAART consists of multiple antiretroviral (ART) drugs customised to protect the body from various opportunistic infections and to shield the immune system, turning the otherwise lethal infection into a manageable chronic disease. Initially only certain prophylactic antibiotics were available to HIV-positive pregnant women and the NCCEMD recommended that all HIV-positive pregnant women should receive them (NCCEMD, 1999). Guidelines for the use of ART therapy in pregnancy appeared in 2004 (NCCEMD, 2004) and a comprehensive treatment plan was rolled out. The policy was that all pregnant women with a CD4< 200 cell/mm^3 or with an AIDS defining illness were to be started on ARTs after the first trimester. In 2014 the conditions were dropped and all HIV-positive women regardless of CD4 count or clinical staging were to begin receiving ARTs (Motsoaledi, 2014). HIV-positive women were considered high risk and needed to be referred to a regional facility. Invasive procedures such as amniocentesis were to be avoided to protect the unborn foetus from infection. This was part of a set of practices called the ‘prevention of mother to child transmission’ that included a set of similar safety practices as well as increased surveillance and counselling (NDoH, 2015c).

Despite the shortcomings of the data they collected (especially in early reports), the NCCEMD were nonetheless able to draw some specific conclusions. Their mandate was to identify the main causes of maternal mortality and make remedial recommendations. Through a thorough examination of the documents accompanying each death, the NCCEMD identified the most frequent issue to be that of poor quality care provision. Obstetric haemorrhage, “a good indicator of the quality of maternal care” (NCCEMD, 1999, p. 46), remained one of the top three causes of death across the six reports. The NCCEMD presented their analysis with reference to ‘avoidable factors’, ‘missed opportunities’ and ‘substandard care’. These factors were identified in relation to patient conduct, the administrative process, and medical personnel-orientated problems with regards to emergency events and resuscitation.

The most common patient-related issues were that of non-attendance, delayed or infrequent attendance and self-induced abortion. Attendance issues were factors in deaths due to obstetric haemorrhage and played a role in 41% of all maternal deaths in 1998 (NCCEMD, 1999). There was no available information on why these women did not attend antenatal care. During 1999-2001, 23.6% of the deaths reported to the NCCEMD contained no indication of antenatal care being provided and with another 19.1% attendance being uncertain (Moodley, 2003). The third report calculated the risk factor involved with non-attendance, drawing on the 1998 South

African Demographic and Health Survey: “non-attendance for antenatal care carried an approximately four times increased risk of maternal death compared with the general pregnant population” (NCCEMD, 2006, p. 6). The report called for health messages to be focused on the importance of attendance. Between 2005 and 2007, 20.1% of women who died did not attend antenatal care with the attendance of 16.1% cases being unknown. These figures would increase, with delayed attendance presenting as a factor in 31% of deaths between 2011 and 2013 and non-attendance in 16% of deaths (NCCEMD, 2014).

Administrative factors included transport issues, whether personal or facility-related, delay in admission, or lack of beds, laboratory or intensive care facilities, and blood transfusion, as well as a lack of appropriately trained medical personnel and the lack of communication between health workers. A fundamental aspect of a successful referral network depends on transportation. Women who were referred often died waiting for the ambulance to arrive (NCCEMD, 1999). The ‘delay in seeking help’ factor, which played a role in 32.6% of deaths between 1999 and 2002 was also speculated to be due to a lack of transport (Moodley, 2003). The delay of referral and the treatment of patients at the wrong institutional level was also potentially due to a lack of transport. According to the latest figures inter-institutional transport issues contributed to 12.2% of deaths between 2011 and 2013 (NCCEMD, 2014) which means the problem had not been solved (in 1998 the figure was 13.6% (NCCEMD, 1999)). A severe lack of the necessary infrastructure and technology also played a role in many deaths.

While lack of referral was possibly connected to the insufficient transportation system, the most important factors impacting on the maternal death rate were directly connected to health workers.

> Problems in the care of women occurred in more than half the cases of maternal deaths, the majority occurring at the primary level of care. Poor initial assessment and diagnosis of cases especially at secondary level of care, failure to follow standard protocols at primary and secondary levels and poor monitoring of patients at all levels of care were the common health worker related problems. (NCCEMD, 1999, p. 9)

In assessing the care provided, and scrutinising the decisions, interventions, and management by the health workers of the women who died, the NCCEMD managed to identify a variety of health worker-related issues in their first report. The data from 1998 showed that patient assessment was very poor, especially at clinics and CHCs. Diagnosis and problem identification were also very poor. 22 patients were wrongly diagnosed at level one facilities, 38 at level two and eight at level three (from a total of 585), leading to their deaths. The data also showed that health care workers failed to manage emergency events properly in more than

half of the cases. Lack of observation, and a lack of action following some observation, plagued many cases as well.

As a result of this level of lack of skill (along with standard protocols not being observed, and referral routes not being utilised), the report at times took on an exasperated tone. The process of analysis involved a case by case examination of the documented process following admission until death. Some cases were described in the first report along with problem identification and recommendations. A few examples are included:

> [Hypertension] Case 4: A P1, G2 at 36 weeks gestation was admitted because of a blood pressure of 200/120mmHg and proteinuria to a level 1 hospital. There was no evidence of any decision-making or intensive monitoring or observations. The patient was found to be comatose during the night, and the nursing staff could not get a doctor on call until the following morning.
>
> Comment: This case illustrates administrative and management problems. It is the responsibility of the superintendent of a hospital to ensure doctors are on call and available. In situations where no doctors can be contacted, the nurses should have the authority to transfer patients. However, the initial management of this patient was totally inadequate. Was this due to ignorance or laziness? A severe proteinuric hypertensive at 36 weeks should have had her high blood pressure lowered and baby delivered as a matter urgency. (NCCEMD, 1999, p. 37)
>
> [Early Pregnancy Death] Case 5: Patient presented with an inevitable abortion. The haemoglobin was measured as 5g% and 2 units of blood were ordered and given the following day. Ampicillin prophylaxis was given. A fever developed the next day. The haemoglobin after transfusion was recorded at 7.5g%. No blood was ordered, but penicillin G and metronidazole was started for sepsis. Patient was not seen the next day and died the day after that.
>
> Comment: What can one say! (NCCEMD, 1999, p. 55)
>
> [Acute collapse and embolism] Case 7: Post-caesarean section patient who complained of pain and nausea 18 hours after surgery. Pethedine was administered and the patient died. According to her documentation she had been shocked for 6 hours prior to death, but the staff had not identified the problem.
>
> Comment: Unprofessional conduct regarding management of intrapartum and postpartum events are apparent here. A patient who was shocked and probably hypoxic was given a sedative, which suppressed respiration and caused death. The shock was not recognised and no appropriate treatment was given. (NCCEMD, 1999, p. 74)

Apart from upgrading the skill level of nurses, midwives and doctors, the NCCEMD recommended, as a solution, the production of management protocols for the treatment of various diseases, reassessing staffing norms, and expanding termination of pregnancy services. The NCCEMD pointed out several times that the reasons for the provision of unsatisfactory care and noncompliance to protocol standards were unclear, and could be due to either

ignorance or laziness. Protocols were to ensure that "ignorance should no longer be a factor" (NCCEMD, 1999, p. 15).

6.1.3. Initiating interventions

Most of the health worker-related problems persisted across the six reports and a whole set of guidelines were produced to reduce these problems. The first guidelines produced by the Collaborative Guidelines Group outlined a systematic approach to examining an ill pregnant woman: "a simple easy to remember examination method", which comprised a symptom-driven clinical diagnostic tool that aimed to identify the presence of organ system dysfunction (NDoH, 2001b, p. 6). A management framework was then produced based on the observation of signs of organ system dysfunction. The Collaborative Guidelines Group chose this method because the first NCCEMD report showed that most deaths involved multi-organ disease. The first edition was published in 2001 and there have been subsequent editions in 2002, 2007 and 2016. Despite this, not following protocols, along with poor clinical assessment, delays in referrals and not responding to abnormalities in the monitoring of patients remained a high contributor to maternal deaths. The second NCCEMD report documented that over half of cases involved some level of preventable health worker-related issue (Moodley, 2003). Health worker-related factors decreased slightly from 2008 in the management of some factors (NCCEMD, 2012, 2014). The decrease is tentatively credited to the roll-out of training to interns known as Essential Steps in the Management of Obstetric Emergencies (ESMOE). ESMOE training was eventually extended to doctors, nurses and medical schools, and included fire drills (NCCEMD, 2008).

Health worker-related problems had been on the WHO's agenda as well. Their solution was the introduction of the Focused Antenatal Care Approach (FANC) in 2002 since researchers suggested that the traditional antenatal care approach was at fault (Federal Democratic Republic of Ethiopia Ministry of Health [FDREMH] & UNICEF, 2001). The traditional approach, developed in the 1990s, it was argued, was based on a risk assessment model, categorising women into high, low or risk-free categories. This was deemed problematic, since lower-risk women were therefore not provided with counselling on danger symptoms, but more importantly, health workers were simply not able to recognise all the risk signs, allowing many at-risk women to slip through their fingers. Furthermore, traditional antenatal care required women to attend clinics often, between 16 to 18 times, and researchers found that frequent attendance did not improve pregnancy outcomes (FDREMH & UNICEF, 2001). Traditional

antenatal care was considered a burden on health resources, while FANC was supposed to be more fitting for low resource countries. FANC employs the rhetoric of client-centred care: evidence-based, individualised care that takes the client's input into consideration. While FANC is argued to move away from the risk categorisation model, it did not necessarily do so. The rhetoric did change; for instance, those women considered 'low risk' were now to be categorised as "eligible to receive routine antenatal care" or the basic ANC component, while 'high risk' women were to receive the specialised component of ANC (FDREMH & UNICEF, 2001, section 13.3). Quite explicitly, there was no longer to be a 'risk-free' category. Risk was therefore merely incorporated into the referral system. This FANC approach was advocated across the African continent (WHO, 2006a).

The 2005 maternity guidelines introduced the FANC approach to South Africa, although it was modified and renamed Basic Antenatal Care (BANC) (Pattinson, 2005). The Medical Research Council (MRC) developed a BANC quality improvement training package that formed part of a new policy that required all primary care health workers to have basic BANC skills (NDoH, 2008). BANC consists of an elaborate set of checklists and screening tests that are to be performed at every antenatal visit to position pregnant women within a grid of epidemiological risks which have been statistically calculated over populations. The first antenatal visit involves the taking of a full history including socio-economic and behavioural factors such as alcohol, tobacco and drug use, a physical examination ranging from blood pressure to dental checks as well as the newly instituted 'mid-upper arm circumference' (MUAC) test. This test not only provides "useful information on nutritional status and pregnancy risk," but is also valuable data for further risk assessment and is, as such, also a requirement on every Maternal Death Notification Form (NDoH, 2007b, p. 21). This very basic measurement of the mid-upper arm can categorise women into risk groups according to weight. Whilst there is a set of routine screens, the more technical and expensive ones are reserved for high risk groups. Some other important aspects of antenatal visits are the provision of self-care information and education on danger signs during pregnancy. A woman with a history of alcohol use will be counselled on the risk involved in drinking during her pregnancy and enjoined to regulate her alcohol intake.

The NCCEMD data were clinical in nature, but they did use epidemiological techniques. This allowed them to identify risk factors. One risk factor was parity: "women in their first pregnancy or with 5 or more were also at greater risk" (NCCEMD, 1999, p. 9). This factor persisted throughout the six reports. Another factor identified was maternal age: "women 30

and older were at greater risk of dying than younger women" (NCCEMD, 1999, p. 9). The age of risk was subsequently increased to 35 (Moodley, 2003). These risks were again refined and supplemented: "Women less than 20 years of age were at greater risk of dying due to complications of hypertension whereas women 35 years and older were at greater risk of dying of obstetric haemorrhage, ectopic pregnancies, embolism, acute collapse and pre-existing medical disease" (NCCEMD, 2008, p. 3). These were two main epidemiological findings and the NCCEMDs initial recommendations were to educate women on these factors and to promote contraceptives for at-risk women. This was connected to a broader belief that 'unplanned' pregnancies tend to have a more negative outcome than 'planned' pregnancies (NCCEMD, 2008).

Reference to risk factors would become more prominent as new reports were published. Age and parity would be joined by various other factors, both behavioural and clinical. Statistics on attendance of antenatal care allowed the writers of the 2006 report to draw the conclusion that women who do not attend antenatal care in early pregnancy were four times more at risk of dying that those who do (NCCEMD, 2006). They argued that antenatal care in early pregnancy can contribute to the identification of risk facts which would facilitate the clinical management of problems arising during pregnancy and called for the production of risk classification guidelines. Subsequent guidelines would arguably provide even simpler methods for managing pregnant women as the focus shifted towards identifying risk factors. Some epidemiological and clinical risk factors were mentioned in the first guidelines document; they were always mentioned in relation to the referral system and with reference to maternal age, parity and caesarean section history. Both epidemiological and clinical risk factors would multiply considerably, and the latest guidelines provide a detailed risk management framework which involves meticulous note taking and observation. At any point at which a woman shows a potential risk for complication, they are immediately to be referred to a higher level of care.

Another aspect the NCCEMD data could illuminate is whether the referral network was functioning properly, and on which levels the system was breaking down. The main indication of the referral network is to see in which facilities women are dying from what. Ideally most deaths would occur at level three hospitals since it is there that serious complications arising during pregnancy can be treated. Throughout the six reports, it is lamented that an excess of deaths still occurred at level one and two institutions. In fact, the number of deaths in these institutions increased while those in level three hospitals decreased (NCCEMD, 2008). The reasons for the breakdown of the referral network were broadly determined to be either due to

a lack of transport, or a lack of or delay in problem identification among level one and two staff, or a mixture of both. The large number of women found to have died in ambulances on their way to higher level hospitals corroborated this finding (NCCEMD, 2014). In order to help staff identify problems quicker so that women developing complications are already at the correct facility that can help them, it was suggested that more attention be given to the importance of following protocols, providing additional training to health staff, and to identify and closely monitor women who are at higher risk of developing complications.

A similar audit system was put in place to measure and analyse child and perinatal deaths – the Perinatal Care Survey run by the Perinatal Problem Identification Programme (PPIP). Despite insufficient data collection, perinatal deaths far exceeded maternal deaths, hampering the PPIP's ability to perform a proper audit of all the deaths (MRC, PPIP, & NDoH, 2001). The most common cause of perinatal death was patient related, mainly non-attendance or late attendance, although low quality care also played an important role. While I will not analyse child-related policies in this dissertation, it is important to note that the identification of such a vast number of non-maternal deaths associated with pregnancy had a significant impact on the subsequent policies that appeared, especially after the National Perinatal and Neonatal Morbidity and Mortality Committee (NaPeMMCo) was established in 2008. NaPeMMCo drew on PPIP data, as well as other child health-related audit research, and the District Health Information System which was by then working well. They also drew data from the Department of Home Affairs and Statistics South Africa. NaPeMMCo has produced two reports (NaPeMMCo, 2011, 2014).

6.1.4. Re-engineering PHC: Community health workers and outreach teams

An integral aspect of the WHO's PHC framework involves the work of community health workers (CHWs). These locally sourced and informally trained workers function as extensions of the health system – into the homes of citizens and patients – and are meant to be core facilitators of the processes of participation, mobilisation, and empowerment. CHWs were not initially incorporated into the South African health system, and existing CHWs worked only in the NGO sector. An audit of CHWs published in 2011 showed that 2 800 NPOs with 72 839 CHWs were operating in South Africa (Aantjes, Quinlan, & Bunders, 2014; NDoH, 2011). Following a national conference on CHWs, a National Community Health Worker Policy Framework was drafted and finally published in 2009 (NDSD & NDoH, 2009).

The focus of nutrition policy had mainly been on children through the community Integrated Management of Childhood Illness (C-IMCI) project. The *Framework for Accelerating Community-based Maternal, Neonatal, Child and Women's Health and Nutrition Interventions* (NDoH, 2010b) proposed the use of CHWs to meet the needs of both children *and* women, especially in rural areas since, they argued, "significant proportions of maternal and child deaths occur[red] at home" (NDoH, 2010b, p. 5). The introduction of CHWs was to fill the final gaps in access to health services. CHWs were also put forward as a means of negating the effect that poverty and a lack of education have on mortality rates.

The document was inspired by the WHO's refocus on CHW and the initial MNCW framework was extended as the *community-based* maternal, neonatal, child and women's health and nutrition framework. 'Service delivery modes' would be extended to include "regular home visits… community-based support groups, joint outreach preventive and curative services by professional nurses and CHWs, twice-yearly child health days and monthly visits to the ECD [Early Childhood Development] centres, all of them supported by an effective community mobilisation strategy" (NDoH, 2010b, p. 4). The volunteers were to be hired and managed through NGOs, with technical and financial support provided by government. NGO nurse supervisors were to work closely with PHC facilitators at CHCs and hospitals. The programme would be subject to several oversight and monitoring levels, had to produce progress reports, and had to meet several core progress indicators.

CHWs, drawn from their own communities, were to function as a surveillance mechanism, identifying women who were pregnant and making sure they attended their antenatal visits. They were also responsible for "educating women and assisting them on birth preparedness" (NDoH, 2010b, p. 9). They also had to distribute supplements and antibiotics and ensure that women and children ate nutritious food. An estimated 40 000 child deaths were identified as being preventable through CHW interventions. Interventions for mothers and pregnant women were argued to reduce the risk of maternal morbidity and mortality which, as they stated, would decrease the risk of child death in turn since the death of a mother increased the risk of child death between three and 10 times.

The *Framework for Accelerating Community-based Maternal, Neonatal, Child and Women's Health and Nutrition Interventions* (NDoH, 2010b) was the first to refocus attention to maternal health-related health promotion practices, arguing that community engagement had been inadequate and that related interventions aiming to change the behaviour of individuals and

communities were not successful. Health-seeking behaviour especially was singled out, as were breastfeeding practices. CHW projects were argued to be cost-effective, since only simple training was needed to deliver an uncomplex package of interventions. Participation was emphasised as something that would create a feeling of community ownership, while empowerment would produce responsible families.

> Better health for women and children requires that families take personal responsibility to improve and share health knowledge and to adopt health and nutrition behaviours that will enhance the key family care practices and health seeking behaviours. (NDoH, 2010b, p. 12)

Emphasised as fundamental to the success of the programme was the requirement of "leadership, commitment and active engagement", as well as "knowledge, skills, competencies and motivation" from service providers, 'stakeholders' and political figures (NDoH, 2010b, p. 14). This was a common emphasis and was extended to the targets of interventions. Communities and individuals were required to engage with the programme, as they had to engage with CHC services: mobilising, forming committees, advocating for services they deemed necessary, raising awareness, working with social partners, and, of course, taking on the responsibility of their own health by gathering knowledge on, and practicing good health behaviour. Ultimately CHW interventions were about identifying and targeting specific groups of people, and then informing them about and motivating them to "bring about desired changes in knowledge, attitudes, and behaviours" (NDoH, 2010b, p. 14).

Another important aspect of CHWs jobs was to collect data on the families living in their communities which were then fed into the District Health Information System. These data were deemed essential since the NCCEMD and PPIP only had access to deaths occurring in health institutions. The Community Maternal, Newborn, Child, and Women Mortality Audit Form (NDoH, 2010b, p. 30) were highly simplified clinical audit forms that non-professional health workers could fill in. CHWs therefore extended the reach of the health information system into the homes of women.

The CHWs' functions were that of 'experts of conduct' (see Rose, 1996), data worker, and manager of risk through the identification and targeting of at-risk individuals. Their targets – pregnant women – were considered to be active and as such, their government entailed direct targeting, the production of new norms of conduct, and education, which included a variety of techniques of self-management.

The *Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Afric*a (NDoH, 2012b) shifted the focus from CHWs to ward-based PHC outreach teams. These teams were to provide "community-based services" (NDoH, 2012b, p. 9). Drawing on the 2010 *Framework for Accelerating Community-based Maternal, Neonatal, Child and Women's Health and Nutrition Interventions,* the 2012 *Strategic Plan* incorporated the suggested community services into that of the outreach teams. These services included home visits, recruiting and organising mothers into support groups, and organising health promotive outreach work. The focus on access had not abated, but it took on a new form. While previously health messages were supposed to encourage women to go to clinics, health workers now had to meet women at their homes, at least to provide these women with health promotive services and information.

Several similar interventions appeared over the next decade that would increase the level of surveillance as a way of reducing the MMR. The NDoH introduced a 'mHealth' programme that would draw on mobile technology to provide health information to the population. Its flagship initiative was MomConnect, an SMS service for which pregnant women could register for to receive "appropriate advice throughout their stages of pregnancy" as well as be "active participants in monitoring the quality of health service they received at healthcare facilities" (NDoH, 2015b, p. 6 'Foreword by the Minister of Health'). In 2017 the department also increased the number of recommended antenatal care visits from four to at least eight.

The increased use of CHWs is also in line with what is generally deemed a 'neoliberalisation' of public services through the introduction of New Public Management (NPM)/New Public Administration (NPA) principles. The introduction of CHWs through NGOs serves as a type of privatisation where NGOs bid, or tender, for specific tasks. They are then audited and assessed, and if they do not meet their targets, they can be replaced by different organisations. In the case where CHWs are transferred to being employees of the health system, they are nonetheless 'volunteers' – cheap ad hoc labour, working on the margins of, or "outside of the traditional boundary of the profession" (Ward, 2011, p. 209). NPM principles have been around for almost half a century, and while some of these principles such as decentralisation were adopted along with other WHO ideas, it was in the mid-2000s that NPM seriously came on the agenda of the WHO as well as the South African government.

6.1.5. Re-engineering PHC: Measuring and managing performance

By the mid-2010s, the rhetoric of 'outputs', 'outcomes' and 'targets' as a means of measurement had become commonplace in the health sector, and along with this the introduction of practices that would make health governable according to such outputs. These practices included mechanisms that made all events measurable, enabling the calculation of the performance of a clinic. When the ANC President Thabo Mbeki was replaced by Jacob Zuma, Mbeki's economic plan, *Growth, Employment and Redistribution* (*GEAR*) was also replaced by that of Zuma's *New Growth Path*. The 'outcomes-based approach' was introduced with the *New Growth Path* (Department Economic Development [DED], 2010) and adopted by the Department of Planning, Monitoring and Evaluation (DPME) that systematically introduced this rhetoric into the various departments through the *National Development Plan* (NPC, 2012), medium-term strategic frameworks and service delivery agreements (DPME, 2017). The *New Growth Path* justified the introduction of an outcomes-based performance, and monitoring and evaluation system on the grounds that it allowed for good government – good government being the ability to identify challenges and to develop solutions to these challenges.

> A developmental state is not simply hostage to market forces and vested interests. Through careful alliances, clear purpose and by leveraging its resource and regulatory capacity, it can align market outcomes with development needs. Achieving this aim, however, requires that it identifies economic challenges clearly and develops innovative solutions and then generates broad public support for these efforts. A key challenge in this light is to improve the state's efficiency, effectiveness and responsiveness in the face of new opportunities and risks. The new outcomes-based performance monitoring and evaluation system provides a major new platform to achieve these aims. (DED, 2010, p. 28).

As President Zuma himself stated:

> The defining feature of this administration will be that it knows where people live, understands their needs, and responds faster. (Zuma, 2010)

The process of producing the outcomes-based performance and monitoring and evaluation system included the identification of measurable outputs that were connected to activities. Each government department's minister was required to sign off on a performance agreement connected to these required outputs. A negotiation on the outputs with each department resulted in the *Negotiated Service Delivery Agreement* (NSDA). The NSDA provided targets, or outputs, that had to be met by 2014. Outcome Two was focused on the health system entitled "A long and healthy life for all South Africans" (NDoH, 2010c). The Minister of Health's wholesale 're-engineering' of the South African health system followed the signing of the NSDA.

One of the four outputs the health department agreed on was to reduce the MMR to "100 (or less) per 100 000 live births" (NDoH, 2010c, p. 4). According to the document the MDG country report estimated the MMR to have been at 625 per 100 000 live births at the time. The renewed shift of emphasis to promotive and preventive care was to "underlie all interventions needed to achieve the outputs" (NDoH, 2010c, p. 5). The other foci were increasing the effectiveness of the health system and rendering all aspects of the system measurable to be able to show progress towards the goals. Increasing the effectiveness of the system would entail overhauling various aspects of the health system and implementing national health insurance. Re-engineering South Africa's PHC system meant introducing a variety of private sector management practices which would render services assessable and outcomes measurable to meet the goals set by the *National Development Plan*.

Various other developments mark this time. A bill was introduced to create an Office of Health Standards Compliance and the European Union joined the Department of Health in developing a Primary Health Care Sector Policy Support Programme. The programme had a R1.2 billion backing. The programme specifically focused on CHWs, particularly those working through NGOs, and creating formal partnerships between the health system and the NGOs. The introduction of specialist teams was also part of this programme. Specialist teams were meant to invigorate the DHS model by deploying a team to each district which included, among others, a principal obstetrician and an advanced midwife. This team would be directly responsible for doing clinical audits of deaths and holding mortality meetings for every incident, "to deal with the cause at hospital level immediately rather than waiting for research studies and results later" (Motsoaledi, 2011).

Further goals, objectives, targets and indicators were provided by the African Union (AU) as part of their *Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa* (CARMMA). These goals were connected to the extended MDG deadline of 2015 and attempted to invigorate the Maputo Plan of Action, a continental sexual and reproductive health rights policy. The goal was to reduce maternal mortality and morbidity; the targets being that of the extended MDGs, and their objectives were in line with several trends in global health thinking such as the idea that each health issues needed a prominent 'national champion' that would mobilise support by keeping the issue in the public's minds and adopting best-practice methods and approaches (NDoH, 2012a).

The various developments discussed in this chapter regarding the mentality of governing health, and maternal health specifically, and the changes that have taken place are merely some of the discursive events available for interpretation. They nonetheless provided a great deal of detail for understanding the changes in maternal health policies in South Africa. The need to tackle the high maternal mortality and morbidity rates, alongside a developmentalist discourse in health meant the government of health in South Africa required first the expansion of surveillance systems in order to bring the entire population into relations of power. At first this was to take the form of an expansion of access through the building of infrastructure. The WHO district model contained an element of community-level surveillance in which community members were drawn into the practice of policing their community's health. However, only since the mid-2000s did the South African government refocused their attention to this level with the installation of community health workers, ward-based PHC outreach teams, district specialist teams, and mHealth interventions. These practices were meant to increase access by going to women themselves.

Another means of drawing the population into relations of power was through the creation and expansion of information gathering systems and auditing bodies such as NHISSA, the NCCEMD, NaPeMMCo and the PPIP. The major influence of risk thinking in statistics and epidemiology, as well as global trends in maternal health thinking, introduced risk into maternal health practices in South Africa since it was bodies such as the NCCEMD that were responsible for producing clinic and hospital guidelines. However, risk was not just utilised to govern the conduct of pregnant women (governing her as an individual enterprise in her pursuit towards optimum health), it was also utilised to govern health workers. As information and auditing systems began to produce data, incompetence and lack of training among health workers, both nurses and doctors, were illuminated as a major cause of maternal mortality and morbidity in South Africa. A variety of practices were introduced to govern health care workers. Sections two and three of this chapter is an analysis of risk management of pregnant women and health workers in the South African clinic.

Surveillance is a prominent theme in Foucault's work. It is exemplified by his theorising around the Panopticon (Foucault, 1995). Constant observation produces obedient subjects. Part of this surveillance entails detailed reporting – documenting anything that can be observed and producing extensive tables of information. Discipline acts on individual bodies. What the discovery of the 'population' allowed, was for biopolitical techniques to embed itself in the disciplinary tactics and to modify it towards the need of biopolitical security. Since the

eighteenth century, birth-rates, mortality-rates and the various measurements of population health have been used to produce security. The only variable has been in the way, among other things, *health,* and *security* have been problematised and conceptualised, which have, in turn, affected the types of mechanisms and techniques that had been deployed. Osborne (1997), for instance, argues that the debate around curative and preventative medicine has to do with the prevailing conceptualisation of the notion of *security*. Thus, while some may consider preventative interventions too direct a technique for a liberal government, others may argue that prevention in terms of health should count as part of security. Liberal techniques consider the population a natural domain, which means direct intervention is not what is required, but rather "delicate sustenance", as Osborne (1997, p. 183) puts it. This form of sustenance can be extended to the point of a 'socialised' medicine where the government takes a great deal of responsibility for the health of its citizens. Nonetheless, techniques remain indirect, and based on a notion of the population as a natural entity, aiming to produce absolute 'health'.

There is, however, a noticeable movement away from this type of liberal government of health. The technologies of health described in the previous section are not as indirect as a liberal governmentality would prefer, i.e. it is not based on the idea that the population is a natural entity which can be delicately nourished towards optimum health. Instead, the techniques take on a more direct character: they are strategic, aiming to interfere in concrete health values. These values are put forward as goals, outcomes, and measurable targets such as the four targets of the NSDA, or the 20 deliverables of the NDoHs 2010 *Strategic Plan*, the priority areas of the *MNCWH Strategic Plan*, or the AU's CARMMA targets. These measurable goals require a whole set of techniques to render them calculable. For instance, without a detailed health information and maternal death audit system, the CARMMA target of reducing "by three quarters, between 1990 and 2015, the maternal mortality ratio", would not have been operable. These values are also often de-limited, requiring a specific focus on a specific population group, or a specific practice.

I have discussed the way in which health has been problematised in democratic South Africa, and, as a result, the types of mechanism and techniques applied to make health governable in South Africa. The rationality according to which surveillance is deployed has this same function: drawing South Africans into relations of power, making them governable. But surveillance is also deployed according to a rationality that makes the specific conceptualisation of health function properly. In the first health documents of the democratic government, health was conceptualised in a particular way. Ill health was conceptualised as a

result of the way the racist apartheid health system operated. As such, ill health was caused by a lack of access to health facilities, the curative-oriented nature of the medical system, as well as the effects of institutionalised inequality. To remedy this required an expansion of facilities and a reorientation of the health system towards a more preventative model, but also social development.

In terms of the health system, the model chosen was that of the WHO's PHC. This type of model required the introduction of a specific set of mechanisms and practices, including the DHS, which allows for governing the health of the population through mechanisms that govern through community. Since 'health' concerns a much broader sphere than 'disease', a whole set of preventative measures are justified in order to achieve a healthy population status. The government of the health of populations through mechanisms of health promotion attaches social, existential and ethical dimensions to the project of achieving 'health'. This project requires that individual bodies are instilled with a truth on behaviour and lifestyle and its connection to health, but also by attaching a moral character to healthy behaviour.

> Health workers at all levels will promote general health and encourage healthy lifestyles. (ANC, 1994a, p. 7)
>
> The aim will be to empower women through improved knowledge about their bodies and their health. (ANC, 1994a, p. 34)

Health promotion is a technique through which healthy subjects are produced at a distance from the state. As such it is an essential technique for liberal government.

From the 2010s onward, there was a change in the way that 'health' was conceptualised in the South African health policies: introduced with an 'outcomes-based' approach, the more abstract idea of 'health' was divided into a set of 'surrogate variables'; the first of which were introduced through the *National Development Plan*, and its various agreements and frameworks:

> The Negotiated Service Delivery Agreement (NSDA) is a charter that reflects the commitment of key sectoral and intersectoral partners linked to the delivery of identified outputs as they relate to a particular sector of government. The Government has agreed on 12 key outcomes as the key indicators for its programme of action for the period 2010 – 2014. Each outcome area is linked to a number of outputs that inform the priority implementation activities that will have to be undertaken over the given timeframe to achieve the outcomes associated with a particular output. (NDoH, 2010c, p. 3)

The National Health Department were provided with four outputs: to increase life expectancy, to decrease maternal and child mortality, to combat HIV and AIDS as well as Tuberculosis,

and to increase the effectiveness of the health system. These outputs had quantifiable targets that needed to be met:

[1] Life expectancy must increase from the current 53.9 years for males and 57.2 years for females (Statistics SA 2009) to 58 years for males and 60 years for females by 2014.
[2] South Africa's Maternal Mortality Ratio (MMR) must decrease to 100 (or less) per 100,000 live births by 2014. The Millennium Development Goals (MDG) country report estimates MMR at 625 per 100,000.
[3] The child mortality rate must decrease to 20 deaths (or less) per 1,000 live births by 2014. The MDG country report estimates child mortality rates at 104 per 100,000.
[4] The TB cure rate must improve from 64% in 2007 to 85% by 2014.
[5] 80% of eligible people living with HIV and AIDS must access antiretroviral treatment.
[6] New HIV infections must be reduced by 50% by 2014. (NDoH, 2010c, p. 4)

While there have always been goals attached to policies, these surrogate values became a means through which the health system itself was governed, either by external bodies such as the WHO, AU or the Presidency, or the way the National Department of Health governed provincial and local departments.

Apart from a health information system that draws on statistics to set goals, and view progress in achieving them, a whole set of new techniques and technologies were introduced to govern the health system according to these new concrete health values, and output categories. As a result, a new type of 'management' emerged that could functionalise the government of concrete health values such as measurable outputs. Within this type of management framework, monitoring and evaluation were foregrounded, along with performance and risk management. This new type of management framework, where it was imported into public systems, has become generally known as New Public Management (NPM).

Management has been an integral part of the production of the modern state, particularly since the mid-nineteenth century, as it replaced the old patronage-based system, which it called 'traditional public administration', that helped produce the massive centralised bureaucratic public systems we see in most countries today (Chipkin & Lipietz, 2012). Along with this new system, management also produced a new class of professional state administrators similar to Karl Marx's *supervisor*, situated between the capitalists and the workers: the "special form of wage labor" for whom "the work of supervision becomes their established and exclusive function" (Marx, 1963, p. 314). Many authors have argued that these changes, of which management has been integral, are what enabled modern politics (Fukuyama, 2010; Weber, 1947).

The global mainstreaming of NPM was made possible by critiques of aspects of traditional public administration associated particularly with welfarism, including its centralised character, the lack of accountability, and the perceived corruption occurring in the massive bureaucratic system inhabited by 'faceless' public servants. The argument against traditional public administration was also bolstered in South Africa by the connection drawn between apartheid and traditional public administrative techniques, as well as the idea that it was insufficient for producing development in the 'developing' world (Chipkin & Lipietz, 2012).

Because of these critiques, an overhaul of public management systems was suggested along the lines of what is now called NPM. NPM techniques are based on a regime of truth that is closely connected to what Rose (1993) calls advanced liberalism, which sought to, in particular, replace the set hierarchies of the traditional model with a sense of entrepreneurialism among managers. NPM techniques also sought to make entrepreneurs of workers, in this case health workers such as nurses and doctors. The way it proposes to do so is through decentralisation of decision-making – introducing a notion of entrepreneurialism among civil servants, reorganising hiring practices to be closer to those of the private sector and replacing the traditional bureaucratic system with a new system of management. The new management structure would be made accountable and honest through transparent budgeting processes, local participation, the introduction of competitive service provision, and performance management enabled through a shift of focus to outputs made assessable through quantitative performance indicators.

Some of these techniques have been discussed already. Decentralisation functions as an important technique of organisational devolution that provides more responsibility to local administrators and health workers. Instead of being governed in the traditional top-down sense, health workers and local administrators are governed through techniques of accountability. These techniques include various auditing mechanisms as well as performance agreements that are made measurable against set targets.

Decentralisation, a feature of the DHS, is an aspect of NPM which was already deeply entrenched in the PHC model. Along with decentralisation, accountability, participation, rationalisation, and performance management were introduced with the PHC and DHS. In 2008 the WHO introduced other aspects of NPM which had thereto been absent, and focused renewed attention on those that were already present – this time the rationale put forth was in line with that of NPM reformers:

> Doing better in the next 30 years means that we need to invest now in our ability to bring actual performance in line with our aspirations, expectations and the rapidly changing realities of our interdependent health world. (WHO, 2008, p. ix)
>
> Globalization is putting the social cohesion of many countries under stress, and health systems, as key constituents of the architecture of contemporary societies, are clearly not performing as well as they could and as they should. (WHO, 2008, p. xi)

With a new focus on performance, the introduction of an entrepreneurialism among health workers, development met a new management style based on a new regime of truth. As a regime of truth, management is “a set of ideas and practices”, not just “the application of particular managerial practices in organizations”, but also of ideas such as that workers cannot perform or will not be efficient if they are not being managed, and they need to be managed by professionally trained managers (Ward, 2011, pp. 205-206). Decision-making, it is argued, should be centralised and not left to workers. Even though bureaucracy is under attack under the reign of NPM, this does not mean that productivity and decision-making is left to workers; rather, it entails the introduction of a variety of techniques that aim to govern workers, and even managers.

The analysis in the next section is of the management of the pregnant woman, after which I will show how the language of managerialism was introduced into the South African maternity clinic.

6.2. Risk managing the pregnant woman

Evident in the *Guidelines for Maternity Care in South Africa* (NDoH, 2015a) is a patient management framework based on risk. Preconception care mainly consists of informing women of the various risks that pregnancy poses to both her and her potential offspring. Possible risks to be made aware of include or are connected to: previous or current medical conditions, history of, and current medication being taken, obstetric history, nutritional state, family medical and genetic history, lifestyle choices, exposure to occupational or environmental elements, mental state and social and economic circumstances.

When a pregnant woman arrives at a South African antenatal clinic she is provided with a *Maternity Case Record*, a 33 page, pre-printed booklet that includes space for personal information, antenatal visit information, medical history, an antenatal graph, checklists for the various screening tests, checklists and observation charts for labour, problems, assessments, forceps delivery, caesarean section, anaesthesia, and more checklists and note taking space for detailed observation, summaries of assessments and procedure notes during pregnancy and

labour, before and after delivery, and of the neonate. There are also general guidelines for health workers about procedures and warnings dotted in between the charts, checklists and note space.

Once the gestational age of the foetus is determined the pregnancy management framework is set up based on the developmental stage of the foetus. Next is standardised risk assessment, which involves the taking of a medical history, including obstetric history, current pregnancy, and general and familial medical history. Her family and social circumstances are also noted. History taking also includes recording the lifestyle habits of the pregnant woman, in particular her use of alcohol, tobacco and other substances.

What follows is a physical examination of the entire body, the pregnant uterus, and the vagina. Apart from the general examination (noting her weight, height, heart rate, colour of the mucous membranes, blood pressure, checking for oedema and palpation of lymph nodes, examination of teeth and gums, breasts, thyroid and heart and lungs), the woman's body mass index is determined and the MUAC test is also administered. The MUAC test is quite simply the measurement of the width of the mid-upper arm with a soft tape measure. Measurements around the arm, such as the MUAC test, is used generally as a rough indicator of body fat, and thus nutritional status. The *Guidelines* identify a 'normal' arm circumference as between 23 cm and 33 cm. The results of this test are stated to be not diagnostic in nature, but rather supposed to "raise vigilance" for potential risks such as, in the case of a circumference less than 23 cm, the risk of under-nutrition or chronic illness. And in the case of an MUAC greater than 33 cm, the risk of hypertension and gestational diabetes. The MUAC test is a risk technique, categorising women in risk groups: being categorised 'at risk' for either under-nutrition or obesity, requires the performance of extra screening tests such as an increased use of SFH measurement and uterine palpation (to screen for foetal growth restriction or foetal macrosomia), or testing for diabetes and hypertension.

There is also a list of essential screening tests to be performed at the first antenatal visit. These include syphilis serology, Rhesus (D) blood group, haemoglobin (Hb) levels, human immunodeficiency virus (HIV) serology, and a urine dipstick test for testing protein and glucose. These tests are all rapid tests. Rapid screening tests are not diagnostic tests; only if the rapid test shows a positive result will the woman be asked to do a diagnostic test. These investigative tests also function to ascertain a woman's risk level, which in turn requires further tests; for instance, a MUAC greater than 33 cm requires the administration of a blood glucose

screening test. Other non-routine screening tests that are done only if the assessment points to risk include: ABO blood group, screening for Down's Syndrome, Rubella Serology, Cervical smear, urine culture, and ultrasound.

Another aspect of the first antenatal visit is the provision of information to the pregnant woman. Apart from discussing 'self-care' practices, which include diet, exercise, hygiene, breast care, medication and the use of alcohol, tobacco and recreational drugs, and of discussing a birth plan and basic infant care, the woman is also made aware of the danger signs during pregnancy that require her to return to the clinic.

Finally, a 'BANC clinic checklist' (see appendix two) for the first antenatal visit is filled in. This is a quick tick sheet that categorises basic risk factors, indicating the need for referral or hospital delivery. 21 questions are provided with a 'yes' and 'no' column, and at the bottom it is indicated that "A yes to any ONE of the above questions (i.e. ONE shaded box marked with a cross) means that the woman is not eligible for the basic component of antenatal care, and she is to be referred to higher-tier health centre" (see NDoH, 2015a, p. 24). This is how the referral system functions in practice. A woman with no risk factors is eligible for 'basic antenatal care' and will be required to perform four follow-up visits (eight, since 2017). At each of these visits the physical examination and screening tests will be redone, and the pregnant woman will have another opportunity to be educated on the danger signs in pregnancy. An at-risk woman is referred to a higher tier hospital where further screening and diagnostic tests are performed. Only women eligible for BANC should be giving birth at a MOU or CHC; every other pregnant woman will have the rest of her antenatal visits, as well as her labour at a district hospital, unless she is referred to a regional or specialist hospital at provincial level or academic hospital at national level. Pregnant women over the age of 35 will be referred to a regional hospital which is where genetic amniocentesis is performed, since her foetus is automatically at-risk for Down's Syndrome due to her age, while a diabetic or pregnant woman with heart problems will be referred to a tertiary hospital.

The clinic is no longer simply a space governed by biomedical knowledge i.e. taking patient history is a clinical practice and clinical practice has historically relied on biomedical knowledge. Here the technique of patient history taking is combined with epidemiological categories of risk. These clinical risk techniques function alongside the referral system: a system of identification and classification within a larger apparatus of security wherein women are categorised according to risk. Diagnosis of problems during pregnancy is constructed as a

course of action triggered by a risk factor. O'Malley (2008, p. 57) argues that as a technology of government, risk embodies "a particular way in which problems are viewed or 'imagined' and dealt with". This is because risk is calculable: it defines the whole whilst being able to provide individualised proposals for intervention. It is these characteristics which governmentality can utilise since it is "intensely practical". The world exists in a state that can be governed – "problems are construed in ways that make them subject to practicable solutions" (O'Malley, 2008, p. 56). Thus, risk functions here as a technology of government – it produces the ability to govern something. Risk enables the government of pregnancy in a clinical setting.

There are various characteristic traits worth pointing out which the risk techniques discussed present. Firstly, clinical risk management relies on epidemiological knowledge as its main form of diagnosis. Risks, determined on population level, are applied to the individual.

> Clinical risk conjoins two conceptually distinct forms of health judgment: the judgement of risk (from epidemiological reasoning) and the judgment of the normal and the pathological (diagnostics)… clinical risk aggregates heterogeneous and incommensurable forms of health reasoning. It is thus analytically incoherent and intrinsically unstable. (Weir, 2006, p. 65)

Population level generated risk probabilities cannot predict disease outcomes on an individual level; clinical risk thus presents something incalculable as calculable. Despite these critiques, which are often voiced by health professionals, risk has only proliferated in the health sector. This is because risk is a useful alternative to governing liberally in a situation where a reliance on the individual patient to reduce their own risks is not wholly feasible due to the fact that, as the NCCEMD shows, the vast majority of conditions contributing towards problems during pregnancy cannot be prevented through individual responsibility.

This brings me to the second prominent characteristic of these risk techniques: they do not presuppose the self-governance of the subject. Apart from specific information around the use of alcohol, tobacco and other substances, the health promotion aspect of routine BANC involves educating women on danger signs that can only be confirmed and dealt with by health professionals. Furthermore, the types of risk management expected from middle-class or Western women often involve financial spending. As a patient at a public health facility in South Africa, the pregnant woman is automatically considered to be financially needy. This does not mean that they are not construed as active subjects; however, in a country that is considered 'developing', subjects are not regarded completely modern (yet), and thus capable

of governing themselves. Instead they are constructed as still in the process of learning how to be free subjects; i.e., they are ‘developing’ subjects: developing into modern subjects. Being free means not being reliant on the state for health needs. Health promotion thus plays an developmentalist-educative role, producing healthy subjects. Risk management, such as found in the South African antenatal clinic, at least in theory, aims to manage the risks that developing subjects are not able to manage themselves, either due to lack of financial ability or due to lack of personal ability.

Writers in risk and health have argued that the prominence of the diagnosis of the pathological by the expert is systematically being replaced by a form of self-diagnosis through self-knowledge (see Greco, 1993). The government of risk has become the self-government of the neoliberal subject. The government of risk has come to be, and still is, I think, conflated with neoliberal self-management. But the risk factors found in health promotion, as Weir also argues, are much more prominently focused on self-management than those found in clinical care, as well as the antenatal clinic. Because many of these risk factors, such as genetic risks, are not modifiable through behaviour change, the risk techniques attached to them are different and have different effects. Instead they place the bodies of pregnant women under continuing surveillance. Unlike insurantial risk, clinical risk breaches the distinction between disciplinary governance that acts on individual bodies and security governance that acts on populations.

Another reason clinical risk management techniques have become popular, especially within the WHO, is because they are argued to be cost effective. Risk assessment disqualifies a great many pregnant women from undergoing costly and potentially invasive procedures. Invasive procedures during childbirth have long been critiqued by some groups, while others have argued that they bring about many benefits. Risk management follows the middle path by letting risk determine what will otherwise be a choice. Here the expert is the checklist. This is not merely a way of governing pregnant women, but also of governing the health care worker.

6.3. Risk managing the health care worker

Viewing the current managerialism introduced systematically since the early 2010s *as a regime of truth*, illuminates an analysis of the government of maternal health care workers since proposed practices are formulated based on specific problematisations, and problematisations are formulated based on the dominant regime of truth. Managerialism aims to govern health workers and is one of a number of new technologies that are being deployed to link experts to relations of power (Rose, 1996). It is about efficiency, productivity, effectiveness, but it is also

about ordering their conduct to reduce maternal mortality rates since health workers, and in particular their decision-making and unprofessional conduct, were identified as the main reasons the maternal mortality rate was so high.

One of the objectives of the Maternal, Child, and Women's Health Unit (MCWH) is to use the vast tracts of information gathered to produce guidelines and protocols for clinics and hospitals. This section is a discussion on how the information gathered by surveillance mechanisms have been introduced into guidelines and how it has shaped the government of pregnancy. The guidelines document sets out a detailed framework for health personnel, in particular midwives and nurses, for the management of pregnant women from arrival at the clinic, until birth. The document includes a short section on preconception care as well as routine postnatal care. The framework is advanced as a means through which to reduce the maternal and perinatal death rate, which, according to the statistics gathered by the information system, is, as it has been since the beginning, mainly due to "challenges of the health care system" (NDoH, 2015a, p. 13). These challenges include "inadequacy of services and substandard care related to knowledge and skill of the health care provider" as well as a failure, on the part of pregnant women, to use the facilities. It is worth noting that the only connection drawn between the death rate and maternal conduct, that is: the failure to utilise public health facilities, is in line with the general structuralist approach to causes of illness within the health department considered to be due to a failure on the part of the health system and not directly connected to individual conduct of the pregnant woman. The lack of attendance is therefore considered to be an issue of *access*.

The guidelines contain two concrete reactions to the specific way in which maternal and perinatal death is problematised and which involves the governance of two distinct groups. The immediate subject of governance through the framework provided in the guidelines, is that of the pregnant woman. However, there is another subject of government identifiable in the guidelines. The guidelines themselves are part of a framework that governs the conduct of health care staff towards the aim of increased quality of service. It is the lack of skill and knowledge of the staff that has been identified as underlying the main causes of pregnancy-related death and thus the introduction of 'clinical management protocols' are posited as fundamental to reducing these death rates (NDoH, 2015a, p. 13). In this section I focus on how the guidelines aim to govern clinic staff, what techniques are deployed in doing so, and what logics and systems of truth are drawn from in the government of antenatal care providers.

The latest *Guidelines for Maternity Care* (NDoH, 2015a) drew on the 2011-2013 *Saving Mothers* report (NCCEMD, 2014) which is the latest report. The *Guidelines* document took as its point of departure the fact that the majority of preventable deaths, which include deaths due to non-pregnancy-related infections, obstetric haemorrhage and complications of hypertension, have in common the fact that their contributing factors are "mostly related to the knowledge and skills of the health care providers and the challenges within the health care system" (NDoH, 2015a, p. 14). The *Guidelines* are for non-specialist health workers, mainly in the lower levels of the health system, and specifically do not provide aetiological and pathogenetic information – only specific and practical steps in identifying, diagnosing and managing problems that occur during pregnancy and birth.

It is suggested that the *Guidelines* are used as a framework for each clinic and hospital to "dr[a]w up their own protocols based on the contents, adjusted to their own particular circumstances" (NDoH, 2015a, p. 17). This is in line with the centralising/decentralising tendency inherent in the regime of truth connected to NPM discussed in the previous chapter. On the one hand, it apparently limits the state and draws on the truth regime that posits that efficiency is produced by allowing "economic-rational individuals" (Burchell, 1996, p. 24) to draw on their own entrepreneurial spirit. On the other hand, artificially arranging the conduct of individuals in line with centralised notions of conduct does not contradict the current art of government. This slight move away from the orthodox liberal governmentality that prefers complete indirect government – providing experts and professionals the space to govern their own conduct completely – becomes more prominent, not only in the provision of guidelines, and the insistence of producing protocols, but also in the introduction of various technologies of performance.

While there is no specific mention of the introduction of clinical risk management practices in the health department documents (apart from a broad discussion on risk management in the *2015/16-2019/20 Strategic Plan* (NDoH, 2015d)), characteristic practices are systematically introduced over the post-1994 period, intensifying in both implementation and rhetoric from around 2008. Clinical risk management is adapted from risk management, a framework that is popular in business and industry (and more recently government) and which involves the identification, assessment, evaluation and treatment of risks. Risk here is generally defined by the International Organization for Standardisation as the "effect of uncertainty on objectives" (ISO 31000). Clinical risk management is an approach to improving the quality and safety of healthcare by identifying what places patients at risk of harm and acting to prevent or control

these risks. Information and audit systems such as the NCCEMD provide the means for identifying risks, and risk management practices are considered to be the solution. A variety of these practices have been introduced.

The BANC framework is itself a risk management framework, not because it identifies risks during pregnancy, but because it is aimed at reducing the risks health workers pose to pregnant women. Apart from its mere presence, the specific ways in which it aims to govern the conduct of health workers to reduce maternal death and morbidity is by simplifying the entire process of managing the pregnant woman. The process of diagnosis is taken away from the health worker and given to the screening checklist, as Rose (1996, p. 349) notes, "Experts are thus increasingly required to undertake not so much an identification of a condition but a calculation of the riskiness of an individual or an event". The health worker's conduct is steered by these checklists. After taking a full obstetric history, a physical examination, and screening for basic diseases (and noting down in its correct space the information given), the health worker does not make a clinical or professional judgment, but consults the clinic checklist that insists that "A yes to any ONE of the above question (i.e. ONE shaded box marked with a cross) means that the woman is not eligible for the basic component of antenatal care" (NDoH, 2015a, p. 42). Eliminating subjective judgments on the part of the health care worker is an inevitable outcome, and where the subjective judgments of health care workers are problematised as being a potential cause of maternal death, subjective judgment becomes a dangerous practice for the health worker, especially in a society where mistakes are met with litigation.

Experts are thus increasingly required to undertake not so much an identification of a condition but a calculation of the riskiness of an individual or an event, with the obligation to take (legal, moral, professional, financial) responsibility for the calculations that they make, the advice that they give and the success of the strategies that they put into place to monitor and manage that risk.

Rigorous data work such as this is argued to strengthen the referral system. Risk is reduced by moving the at-risk pregnant women away from the least trained health workers towards more specialised and experienced health workers. This framework is also perceived to be cost-effective. The operating costs of the various facilities work on a sliding scale, MOUs and CHCs only have basic equipment and staff with basic training. The BANC framework and the referral system sift out the individuals that require more specialised (and more expensive) technologies. The various risk assessment techniques discussed in the previous section are recognisably

cheap. The rapid test, the determination of body mass index, palpation of the uterus, and the measurement of the symphysis-fundal height and mid-upper arm all require minimal and inexpensive appliances.

Auditing is another risk managing technique that not only identifies risks, but renders visible the daily decisions that health professionals make. On the national level auditing bodies such as the NCCEMD can identify the risks to pregnant women through detailed information gathering and auditing of those women who died. This provides information for the manuals. A more focused and personalised auditing mechanism than the NCCEMD is that of the district specialist team, a group of experts and professionals responsible for doing clinical audits for every incident of maternal and perinatal death, dealing "with the cause at hospital level" (Motsoaledi, 2011). Audits have become a new form of trust (Rose, 1996), displacing the trust that used to be embedded in the professional autonomy that medical experts held.

These technologies of performance management, along with the focus on outputs, are reshaping the ways in which professionals govern themselves. Their actions and decisions are rendered calculable through the documentation they are required to fill in, and the auditing of these documents by the NCCEMD and district specialist teams, the hospital and clinic management. Output requirements and service delivery agreements shape their individual decision making in new ways and new norms are produced that shape professional conduct.

6.4. Conclusion

The health promotion rhetoric of the 1990s abated somewhat with the realisation of the state of the public health services provided to pregnant women. This realisation was facilitated by statistical and clinical data provided through audit. The NCCEMD system was comprehensive and as it established itself it allowed for an 'avalanche of printed numbers', like Ian Hacking's (1982) figurative description of biopolitics' curiosity meeting statistical techniques. Literally, it was the counting of pregnant and birthing women's dead bodies. The auditing system provided the conditions of possibility for a wide set of new practices to be introduced into the health system. It allowed for rational planning, including introducing and measuring performance. It allowed for the identification of the drivers of death and morbidity in the system. The greatest issue auditors identified was poor quality care connected to the actions of health workers. The solution put forth was the production of protocols and guidelines.

Some of the most prominent features identified in the guidelines produced for the South African public sector was that it drew increasingly on a risk management framework which

was put forth as a means to counter ignorance and poor training among health workers. The guidelines are produced to be as uncomplicated as possible. As I showed in this chapter, this essentially turns health workers into data workers as much of their professional autonomy is reduced to ticking boxes. Another emphasis, often stated by the WHO, is that of cost-effectiveness. The system put in place, along with the techniques that are used, is geared towards reducing the overall costs of implementing and running a PHC system. The DHS, along with the risk management framework, sifts those who need more expensive tests out and the initial tests are all very basic and cheap. Finally, the entire system is geared towards making everything measurable, even beyond maternal death and morbidity. The conduct of health workers is made measurable and thus auditable.

Within such a system, health promotion also takes on new forms. Health promotion techniques produce new connections between institutions and citizens and provide new meaning to mobilisation and empowerment. In many cases, this type of work is delegated to non-state actors such as NGOs or volunteers. While this might mean ‘less state’, it does not mean less government. Most of the techniques implemented in the name of health promotions, such as CHWs, bring the health system closer to the nonconforming pregnant woman, who, for whatever reason, is not attending the clinic itself. These techniques also facilitate the collection of data.

The clinical risk management framework implemented in the clinic not only governs the conduct of health workers – turning them into data workers and managers of risk on behalf of the pregnant woman – it also makes the health workers’ conduct *measurable*. Performance assessment can only function properly with specific types of subjects. If their conduct is not measurable, and modifiable based on these measures, they will not respond to performance management techniques. The movement away from regarding health as a natural entity requiring delicate sustenance, towards a definition of health that is direct, strategic, and able to be governed as a set of concrete values (such as a maternal mortality rate that can be reduced) was necessary for the implementation of NPM principles such as outcomes-based performance management. Goals, objectives, targets and indicators: these have all become part of the way health is understood to function.

Clinical risk management is not just a framework for managing pregnant women in a public clinic cheaply or a means of managing the conduct of health workers, reducing the risk they pose to pregnant women and conducting their conduct, the introduction of risk into the clinic

also allows for something ultimately unquantifiable (such as individual probability of disease) to be quantifiable. As ‘unstable’ (Weir, 2006) as this conjoining of two forms health judgment is, it nonetheless functions to make the maternal health clinic *manageable*.

7. Conclusion

The aim of this dissertation is to uncover how the government of childbirth and pregnancy in the South African public health system is connected to knowledge and power. Through this I hoped to introduce a 'new perspectivism': "introducing a critical attitude towards those things that are given to our present experience as if they were timeless, natural, unquestionable" (Rose, 1999b, p. 20). Governmentality provides *a way in* by focussing on knowledge production, and power relations produced by practices, and subjectivities. It allows for an analysis of the ways in which people's conduct is conducted by institutions. It also shows how technologies are put in place in institutions, and society at large, to govern us according to a specific rationality. By "de-institutionalising and de-functionalising" the state (Foucault, 2007, p. 165), it can be seen that the state is not, and never has been, the only force through which our conduct is governed.

Furthermore, since vast swathes of the spaces and population of South Africa had been largely deprived of essential antenatal services until the democratic period means that studying the slew of documents that appeared post-1994 provides a unique opportunity to understand how the government of pregnancy is set up in a post-colonial context. There is no denying that South Africa's history has impacted the current state of health of the population as well as the shape of its health institutions and policies. And it continues to do so. The colonial and apartheid eras animate this dissertation as much as it still animates life in South Africa. Furthermore, by focusing on how an area such as maternal health was governmentalised within a *post-colonial context* have brought to our attention the manner in which 'development' operates as a truth regime. The art of governing health in South Africa can thus be described as developmentalist as was shown in chapter five. Mechanisms such as the district health system (DHS) were discussed; mechanisms which functionalised 'community' as a space of government which in turn shapes the way in which issues are problematised. As a technology of agency, community produces subjects that are governed as individuals within communities. I discussed how, within the context of health, these communities had to be produced through empowerment, mobilisation and participation. Communities of health formed the lowest level of the DHS, and as individuals they are also the clients of the health system.

Development functions here as a technology of government: bringing individuals, groups and spaces into relations of power so that they can be governed liberally. The aim of a developmentalist art of government is to systematically produce liberal self-governing individuals from a previously ungovernmentalised space. Developmentalism is also completely compatible with an advanced liberal mentality of government, as is evident in the various management techniques introduced in the 2010s.

Drawing on the governmentality approach and utilising Foucauldian discourse analysis I analysed all relevant health and maternal health policy and procedural documents, audit reports, clinic guidelines, handbooks and protocols that has been produced for use in the South African public health sector. Current pregnancy practices consist of an intricate web woven over time with a multitude of threads. Starting with the distinctly liberal freedom function and the way it initiates debates and critiques about pregnancy and childbirth practices, I now provide an overview of the main conclusions drawn from this dissertation.

7.1. Contributions of the research

This dissertation is an engagement with the post-apartheid formation of the South African programme of health governance with a focus on governing pregnancy. It is analytically situated at the conjunction of Foucauldian governmentality studies, including the scholarship on neoliberal governmentality, and feminist social science. Empirical and analytical contributions are made to governmentality studies as well as feminist thought.

This dissertation contributes to the discipline of governmentality studies through the application of the governmental analytic in an original way to provide an account of how pregnancy was made governable in South Africa with the advent of democracy. The governmental analytic applied represents a fusion of the work of the Anglo-Foucauldian governmentality scholars, feminist contributions to governmentality studies, scholars who have interrogated the possibilities of approaching colonialism as a particular art of government in European history, and governmentality scholars working in the area of international relations, specifically those who have written on the concept of development and looked at the operation of non-state organisations. These scholarly writings are all reviewed in chapters three and four.

This synthesis of different thought on the possibilities of the governmentality analytic was of importance because the topic discussed is very contextual: it concerns a particularly woman-specific health topic in a post-colonial country. By extending the governmentality analytic, this dissertation contributes towards Foucauldian feminist scholarship, specifically in its

application in the Global South. Feminist scholarship has investigated pregnancy and the swarming of governance around pregnancy, but not maternal death in pregnancy and childbirth. In the Global North, as Northern feminist scholarship has shown, the neoliberal governance of pregnancy historically postdates the reduction of maternal and infant mortality to what were regarded the irreducible lows of the mid-twentieth century. This dissertation contributes to feminist scholarship by demonstrating the existence of a program of neoliberal governance focused on maternal mortality rather than perinatal mortality. This insight comes forth from a feminism fashioned in the global South.

Chapter five provides an empirical contribution to governmentality studies and feminist thought through a close reading of the national policy documents showing how health was rendered governable in post-apartheid South Africa through a primary health care approach implemented through district health care practices. It also demonstrates the gradual fusion of primary health care with neoliberal governmental techniques in health promotion which govern the subject in freedom through community, lifestyle and empowerment.

Chapter six focuses on the governance of pregnancy in the public health system of democratic South Africa, showing its central problematisation has been the reduction of maternal mortality. The statistical systems implemented in the late 1990s to produce health systems data documented extremely high rates of maternal mortality which were principally due to poor health care, unattended pregnancies and births, and lack of transport. Chapter six elucidates maternal mortality as a target of contemporary advanced liberal health governance. Other scholarly sources focus on the pregnant woman as a subject of governance, not health care workers. In this dissertation the pregnant woman is constituted as a subject of risk governance, but of secondary importance to the governance of health care workers.

7.2. The polymorphism of liberalism: The case of biomedicine and feminism

My first consideration of the contingency of pregnancy practices involved a discussion of two of the most important shapers of pregnancy and childbirth practices: feminism and biomedicine. Foucault argued that the current governmentality is polymorphic because it is characterised by a "persistent self-critique" or "perpetual self-problematization" (Bratich, 2003, p. 77). Liberal governmentality is wrapped up in a project of trying to free itself from practices that can be defined as 'unfree', because it "constitutes… a tool for the criticism of reality" (Foucault, 2008, p. 320). The acquisition of knowledge is determined by what is defined as freedom, and the agenda of what is defined as freedom is shaped by various actors.

However, in a liberal governmentality freedom always means actors can make their own decisions, conduct their own conduct, and not be directly governed, whether by state administrators, medical personnel, or strangers on the street. Thus, tension is immediately produced whenever liberal governmentality faces conduct that needs to be changed. It is at that point where it encounters behaviour that counteracts the security of the population where it is most vulnerable against resistance and counter conduct, and yet, this resistance and counter conduct help shape its very relations of power.

This polymorphism is evident in the transformation of clinical practices associated with pregnancy and childbirth. Clinical practice is not inherently ‘liberal’ or committed to producing freedoms to its patients (Osborne, 1992); rather, transformations in the practices of pregnancy in clinical settings, as well as without, can be better explained with reference to the polymorphism of liberal governance: “its capacity for auto-critique and renewal, [and] its ability to incorporate external and internal critique through changes in its discursive practices” (Weir, 1996, p. 385). Pregnancy and childbirth practices have been heavily influenced by external critics. As was shown in chapter two, feminism in particular has provided a steady flow of external criticism, so much so that Weir (1996, p. 185) has called it biomedicine’s “dialogical partner.”

Counter discourses such as feminism have focused their critique on medicine’s practices being “directive and sovereign with respect to the members of certain social groups, e.g. indigenous peoples, racialized groups and women” (Weir, 1996, p. 385). Feminists have generally approached the contemporary government of pregnancy from the point of view that biomedicine has produced practices which conflict with the autonomy, or liberal government, of pregnant women. Feminists have, at least since the 1970s, produced a vast array of subjectivities for pregnant women to draw on. They have studied the impact of medicine on the pregnancy process, they have critiqued the epistemological basis of obstetrics, they have salvaged the history of midwifery and traditional woman-centred pregnancy and childbirth practices, they have critiqued the intentions of medical men, and they have questioned the ontological paradigm of pregnancy and childbirth itself. Feminist contributions to understanding and experiencing pregnancy and childbirth are vast.

According to feminists’ historical conceptualisations, the medicalisation of pregnancy is a direct result of the patriarchal ambitions that are rooted in the medical establishment. This is similar to the Marxist version of the critique of medicine. As another counter discourse, the

Marxist version states that the transformation in medicine around the eighteenth century is determined by class – specifically transformations within the division of labour that allow for the emergence of professional hierarchies (Jewson, 1976). In other words, the doctor-patient relationship underwent fundamental changes during the eighteenth century and allowed for medicine to take a specific route in its development.

In *The Birth of the Clinic* (2003b), Foucault described the emergence of the clinical gaze. While on the surface the Foucauldian, feminist and Marxist formulations seem to be describing the same process some important differences. What is similar within these critiques is that they show that medical knowledge is not simply *discovered* (D. Armstrong, 1994). Medical knowledge is a social product: in the case of Marxists, of a society transforming to the needs of capitalism; in the case of feminists, patriarchal interests of men wanting to dominate women and their unique reproductive functions. On the face of it Foucault made a similar argument, arguing that it is not medical discovery that transforms medicine, but rather the emergence of the clinical gaze that produces these medical discoveries. These new medical discoveries are ultimately also a social product – that of the new power mechanisms, and their unquenchable will to knowledge and the continuous extension of a pervasive disciplinary power that produces docile bodies. But it is beyond these surface aspects where Foucault parts ways with these critical humanist traditions.

These critical humanist traditions allow for a critique of the medical establishment that, in turn, allows for the further transformation of an institution that promises more freedom. According to Foucault this freedom function is fundamental to the entire Enlightenment project.

> For the last two centuries there has been in Western culture a fundamental belief in the ethical autonomy of the individual: this belief is manifest in the humanist values and civil and political rights that pervade Western culture. This means that these values can morally be peddled to, imposed on, or used to judge, non-Western culture, and, more significantly for the present argument, be used to interpret the past. Within such a framework, which dominates liberal and Marxist thinking alike, individual ethical inviolability is a universal feature of the human condition: this means that the process of objectification is a fundamental assault on this state of grace. (D. Armstrong, 1994, p. 21)

In other words, the very production of critique of modern medicine is the product of the Enlightenment humanist values, but so, also, is the diseased subject of modern medicine. The individual with ethical inviolability is a product of the medical gaze, among other power mechanisms, and now Marxists and feminists are using this very principle to critique the medical gaze for robbing the individual of its autonomy. In other words, the function that

produces the object and subject of modern medicine – the individual – is also interpreting its own history in such a way that allows for the transformation of the object and subject of modern medicine – in the name of freedom based on humanist values.

In other words, “the process of corporal objectification,” as David Armstrong (1994, p. 22) calls it, is not an assault on an already existing (i.e. universal) human individuality, rather it is “the very practice through which that individuality is given a literally solid foundation and manifestation.” Ultimately what feminists do is to add another dimension by adding new techniques for making the body speak. While the body speaks through the stethoscopes and gazing eyes of physicians, through statistics, surveys and enquiries following the women’s movement, the body can now speak for itself. These bodies initially spoke of the oppression they endured at the hands of obstetricians and physicians who made these female bodies feel like they could not know their own bodies. Then these bodies spoke of the oppression they endured at the hands of the various techniques and technologies of the medical establishment. Of course, not all women felt these practices as oppressions, and very soon they too were given a voice. A change in the medical model – from medicine to health – allows women to speak about more than merely oppression by the medical establishment. Feminists argue that there are numerous other ways in which social aspects of life can oppress the pregnant woman. Feminists carved out a completely new area where the pregnant body could be studied; producing new techniques, or taking over older ones, marking out new types of bodies – no longer a passive biological patient. The pregnant body becomes an active and sentient one. In this way, as a dialogic partner to biomedicine, feminists have had a fundamental effect on the shape of pregnancy practices.

In the South African context critical feminist scholarship is quiet compared to its international counterpart. In the face of a systemic failure of the health system generally, the focus of critical scholars has been less ontological and more pragmatic. This does not mean that South African feminist scholarship has not influenced local practices, but rather that global feminist discussions have often been imported along with global health practices, sidestepping local debates. Most of the South African scholarship focused on childbirth and pregnancy is written in the public health tradition and tackles policy and implementation issues from a rights perspective. Particularly, a variety of research institutes, some connected to universities, exist in South Africa. These institutes contribute towards the production and analysis of epidemiological knowledge concerning childbirth and pregnancy in South Africa, as well as

the production of handbooks, guidelines, policies, reviews and audits, much of which forms part of my data. The data, in turn, was subjected to a rigorous Foucauldian Discourse Analysis.

7.3. The South African subject of development

After a detailed reading of my data, I identified a regularity in the initial health documents of the South African government. This regularity, or discursive formation, adheres to an identifiable knowledge regime. Firstly, it is structuralist: social issues are problematised within a framework of a larger system, and the effects this system has on these issues. 'Health,' thus, as a structuralist approach to viewing illness, comes to replace 'medicine', which in turn affects the type of interventions introduced into the health system, i.e., the PHC system. Secondly, in these documents, 'development' operates as a truth regime. The specific reality presented by development is akin to modernisation: there is an 'evolutionary' scale and individuals, groups, and countries can all be situated at some point on this scale. However, instead of referring to race, culture, or religion, the scale refers to some or another form of 'deprivation' such as education or socio-economic level. Another aspect of this reality is that people on this scale can be uplifted with the application of technical knowledge and practices, what has generally come to be called simply 'development.'

The subjects of development are not passive, nor are they directly governed. The South African government merely puts in place the structural requirements for individual development, which the subject of development needs to take up, as the *RDP* (RSA, 1994, p. 8) states: "the people of South Africa must together shape their own future." This is emphasised in the documents through technologies of agency such as participation, mobilisation and empowerment.

Participation, which is considered synonymous with democracy, is described as a prerequisite for development. This is because development is predicated on active citizenship. However, participation is technically instituted, in the case of the health system, through the reconstruction of the health system based on the primary health care (PHC) model and an institutional framework such as the district health system (DHS). Health staff within a DHS are required to mobilise citizens to participate. PHC, with its structural approach towards illness means that instead of focusing on the manifestation of illness alone, the health system can now focus on the many determinants of illness, and thus provide new forms of intervention that target the 'structural requirements for individual development', in terms of health. This is a form of governing at a distance which is seen both to be able to alleviate real causes of illness such as in the provision of nutritional supplements or ARV treatment, and also to provide

preventative education which is meant to systematically produce subjects that can govern themselves.

As chapter five showed, empowerment, or capacity-building, is to a great extent synonymous with educating. Again, DHS health workers are required to empower people through health promotion. The subject of health is empowered with "improved knowledge about their bodies and their health" (ANC, 1994a, p. 34). Subjects of health promotion are not passive. It is argued that medical culture used to revolve around the professional, who provided care to a passive patient. Within PHC both health providers and patients are requested to change their attitudes since patients are now active players in their own health (ANC, 1994a).

The new spatialisation of government – away from the social towards community – also plays an important role in activating citizens. Citizens are now to make demands of the state, not in the name of the 'social', but rather in the name of group identities. People living within health districts are required to mobilise around the specific health issues they are facing. The mutation from the social to the community, which is still ongoing and incomplete, is extremely useful for governing at a distance since communities are self-associating, and where they are not self-associating, development can step in with its mobilisation discourse to produce them.

The forms of knowledge that make up the discourse of development and from which it constantly draws, are statistical, and in terms of the government of health, epidemiological: the distribution of illness across the population. One of the techniques of power frequently distinguished in the data is the identification of 'at risk' groups. This technique has, as its condition of possibility, statistical knowledge. Without an elaborate system of information gathering, such as NHISSA, NaPeMMCo, the PPIP and the NCCEMD, this technique, which has come to play a very important role in the government of health, cannot function. And in turn, this information bolsters this technique of power. Focused intervention also has an *economic* function. By targeting the 'at-risk', resources are not wasted on those individuals who are not considered to be needing them; which is why the government can claim that "An efficient information management system is the key to the maximum utilisation of scarce resources" (RSA, 1994, p. 17). A focus on the marginalised confers both legitimacy in the eyes of the international community and reduces state spending.

Development ultimately functions to governmentalise South African citizens and spaces. It is uniquely capable, through its various technologies, to produce liberal citizens out of previously 'underdeveloped'/'undeveloped' people. Chapter five is a discussion of how development

operationalised in the South African health sector, and the technologies and mechanisms through which it aimed to 'develop' subjects of health.

7.4. Modernisation in a neoliberal era: 'Developing' the Global South

I used David Scott's writings on colonialism as a model for thinking through the operation of governmentality in the Global South. He calls colonialism the 'colonial career' of modernisation. He argues that colonialism is a specific articulation of the modern project – rather than a wholly different type of project. The modern project involves the delegitimation of all non-modern practices and thinking. Race and religion are technologies through which the colonised were governed, i.e., produced as modern subjects. Perhaps one can argue that, in the Global South, governmentality has entered its 'development career' in the mid-twentieth century. While development is merely a reiteration of the modernisation project, it nonetheless takes inspiration from the most contemporary thinking in the West, and its practices are heavily influenced by the advanced liberal mentality of government.

As Sending and Neumann (2006) show, various discursive shifts have enabled the current global mentality of government to take on the characteristics it has today. The example they use to show how IGOs have been able to adopt governmental functions is that of the women's movement, who 'released' the agency of women (in particular) for governmentality, turning her from object to subject of government. This unblocked a new rationality of governing people in the Global South that is not as horizontal as it used to be. The individual that was merely an object of policy, reform and modernisation was turned into a subject with her own perspectives and experiences. This is how IGOs and NGOs came to adopt governmental functions (Sending and Neumann, 2006). The production of communities representing shared interests and advocating for their own rights has been identified as part of a governmentality that seeks to govern at a distance (Rose, 1996; Sending & Neumann, 2006). In this sense, civil society is not in opposition to governmental functions, but rather a central feature to it. Civil society is fashioned either through the production of artificial communities, or the reorientation of existing ones by experts or through bureaucratisation.

While the WHO played an important role in shaping South African health policy, it was, however, the government itself that had taken on and applied the discourse of development. The South African government utilised the development discourse because it was the dominant regime of truth at the time, and because it provided useful techniques and practices for turning the apartheid state into a democracy, at least according to the most contemporary meanings

that democracy held, i.e. participatory democracy (Grube, 2013). Participatory democracy allowed political power to take on characteristics associated with civil society, characteristics which were put forth as potential antidotes to the types of issues Global Southern states were facing such as accountability problems, crumbling legitimacy, social conflict, and the exclusion of marginalised groups. The type of governing principles that accompanied participatory democracy included the introduction of basic governmentalising practices such as putting in place vast surveillance systems to gather data from all section of society, and instituting good governance techniques, which implied putting in place the necessary techniques and mechanisms for international organisations to monitor and assess states' performance, and reward or punish them accordingly (Zanotti, 2005).

7.5. Management in the South African antenatal clinic

I identified a systematic shift away from the holistic notion of health introduced in the *RDP* and *Health Plan* in the last two decades. Health was fragmented into surrogate values. In terms of pregnancy, the main surrogate values for health became the maternal mortality and morbidity rates. These surrogate values turned an otherwise unbounded state of being into a measurable object. The move towards health targets such as those put forth in the Negotiated Service Delivery Agreement (NSDA) was part of the logic of the outcomes-based approach adopted in the late 2000s. This approach required the introduction of a set of mechanisms which would make these outcomes measurable – thus the shift towards performance, monitoring and evaluation. Effectiveness, which incorporated both principles of reducing waste of resources and increasing efficiency of services, was the dominant mode of thinking about public services within this new regime of truth.

Part of re-engineering the PHC system in the 2010s involved introducing this new regime of truth into the health system. The first move was to introduce a new management style in line with New Public Management (NPM) principles. NPM was based on a regime of truth that aimed towards effectiveness through managing employees as if they were autonomous agents. Employees are now individual enterprises and should be governed as such. Management techniques are updated to enable employees to be entrepreneurs and provide only "delicate sustenance" (Osborne 1997, p. 183). Employees are made accountable and honest through transparent budgeting processes, local participation, the introduction of competitive service provision, and performance management, enabled through a shift of focus to outputs, made assessable through quantitative performance indicators.

These aspects are all visible in the antenatal clinic. New management techniques are drawing health workers into relations of power that govern them at a distance, hoping to increase efficiency, productivity and effectiveness. It is ordering their conduct that reduced maternal mortality rates, since it were health workers, and particularly their decision-making and unprofessional conduct, that were identified as the main reasons why the maternal mortality rate was so high.

In chapter six I discussed the clinical management protocols that functioned to govern the conduct of health staff. The management guidelines are modes for artificially arranging the conduct of the health staff within the clinic according to a risk management model. The risk the clinic staff pose to the pregnant woman is reduced by removing from them, as far as possible, the need to make a diagnosis. Instead the risk assessment model ultimately sifts the risky patients out of the hands of the lower level workers of the PHC and directs them to more expensive expert technologies.

The elaborate checklists and note taking required by health staff also functions to render visible the daily decisions that the staff make. These decisions are audited regularly by the district health specialist teams, and, in case of a maternal death, audited on a national level.

7.6. Governing pregnancy in South Africa

Development and its technologies put in place the conditions of possibility for the current regime of governing pregnancy in South Africa. The technology of health promotion, technologies of agency (instituted through the DHS), and the various surveillance mechanisms laid the groundwork for an analysis of antenatal practices in the South African health system.

I have discussed in detail how the NCCEMD was instituted. I have also shown how risk became predominant once the NCCEMD was able to provide accurate information. The present is suffused with 'risk'. In showing how these technologies of risk are operating according to a specific rationality of government I am not aiming to deny the reality of these risks, but merely to show how they are operationalised. If anything, this shows that the continuing expansion of risk and the centrality it takes in contemporary forms of governing is itself contingent on the very acceptance of this form of government. Its expansion is not inevitable and "new possibilities are always opening up" (O'Malley, 2008, p. 62).

In 1996 Rose writes that there is a "strategic shift occurring in the politics of security".

> Individuals are, once again, being urged by politicians and others to *take upon themselves* the responsibility for their own security and that of their families: to insure against the costs of ill health through private medical insurance, to make provisions for their future through private pensions, to take an active role in securing themselves against all that could possibly threaten the security of their chosen style of life. (Rose, 1996, pp. 341-342)

The technology of risk plays an important role in this new politics of security since responsibilisation functions as a form of personalised risk management. This logic aims to produce entrepreneurial subjects – entrepreneurs of their own lives. While this logic is not completely absent in the functioning of the South African public health system – one can simply consider the way in which technologies of health promotion function to educate (read 'empower') individuals to take charge of their own health – in a country such as South Africa, where the burden of disease is so high, and the social landscape has been persistently corroded by centuries of inequality, discrimination, and high levels of poverty, these advanced liberal techniques of self-government, which are very dependent on purchase power, are quite likely to have a minimal success rate among patients who utilise the public health system.

While technologies of responsibilisation and entrepreneurialism have been the most popular foci among those researching the dynamics of risk and contemporary pregnancy practices (particularly among feminist scholars), a sole focus on these technologies would render a study of practices in a Global Southern country such as South Africa inadequate. The vast majority of these studies have focused on Western contexts, and while they have been at pains to point out the negative consequences these practices might have on those women who cannot afford this new consumerist-based prudential lifestyle, few of them have considered the technologies that govern poor Global Southern pregnant women, and the contradictory ways in which they operate.

Despite being socially funded, the logic underlying the public health system is no longer welfarist. Perhaps it can be called 'developmental'. The point of the health system is to produce active and responsible citizens who contribute towards their community by, at first, being empowered, and then empowering others. A developmental rationality of government accesses individuals through technologies that are meant to produce modern individuals, but where people are obviously not capable of purchasing their own freedom, autonomy and lifestyles through market mechanisms, they are 'developed' towards such a state through public funded institutions operating according to developmentalist logics.

A useful point of reference to understand liberalism's functioning in this way may be that of Rose's (1996) reference to the government of the margins. In the Western context those living on the margins of society are both fewer, and perhaps more vilified by their politicians, than in the Global South – the welfare mothers, the drug addicts and the chronically unemployed. They are, nonetheless, according to Rose's definition, quite simply those who are not governing themselves as modern individuals should: "unable to enterprise their lives or manage their own risk" (Rose, 1996, p. 347). This could either be because they are refusing to, or because they "have not been given the skills, capacities and means" (Rose, 1996, p. 347).

Rose describes the new practices emerging in the government of the marginalised minorities living in council estates in the West which can be argued to operate on a similar logic as the government of the marginalised *majorities,* populating the vast townships of South Africa. Firstly, there is the production of communities, since these large swathes of the population are somewhat dislocated through urbanisation, without affiliations, neither part of the greater social, nor really capable of connecting to their fellow community members without some help. Secondly, the "high-risk and vulnerable groups" (ANC, 1994a, p. 19) are to be identified for receiving targeted intervention, something the PHC system is argued to be particularly good at. The DHS is supposed to operate in this way on the micro level. Community Health Centre (CHC) staff and semi-volunteer Community Health Workers (CHW) are required to connect with patients living in their district. They are all supposed to be educated or "mobilised to participate" (NDoH, 1997, p. 56). Communities are not described as without autonomy, but their autonomy is inscribed with their responsibility to participate in governmental objectives.

Risk is operationalised through the DHS to 'sift' risky individuals for referral to experts. The PHC system allows risk to function like this on a mass scale. I showed how antenatal risk management functions to manage risk on behalf of the pregnant woman through standardised risk assessment, a basic and very economical non-diagnostic physical examination which also functions as a means of assessing risks, and the performance of essential screening tests which are also non-diagnostic. Connected to the referral system, antenatal care in South Africa becomes an elaborate risk management system.

7.7. Limitations and future research

It is important to bear in mind that I did not research *how* the techniques were implemented on the level of the institution. I did not do interviews or study the clinic setting in person. As such the meaning of the analysis is limited to a description of intentions. Whether the proposed

practices and guidelines are properly implemented, whether they are resisted or whether they succeed or fail in their intentions was not the focus of this dissertation. This project is thus a study of the government of pregnancy in the South African public health setting in terms of the "intended consequences of action" rather than the "unintended consequences of action" (Osborne, 1997, p. 176). A study of how these techniques and mechanisms are taken up by health care professionals would complement this research.

A more systematic comparison of health governance in the apartheid and democratic periods would have strengthened the dissertation. A coherent account of health governance during the apartheid period would have helped elaborate the political form of the apartheid state. The tendency therefore is the assumption that the political is reducible to governmentality. The rupture between the apartheid regime and the beginning of democratic South Africa did not amount to a failure of one governmental program and the gradual fashioning of another. This had occurred in the Global North with the historical transformation from governing through the social to advanced liberalism. In SA the profound changes in governing through health which took place from 1994 were made possible at a political level anterior to governmentality.

Governmentality is an empirical know-how that flows from an empirical political imaginary. The 1994 National Health Plan is framed by the non-racial, social democratic vision of popular sovereignty; it articulates popular sovereignty to governmental know-how. As Chapter five establishes, the subsequent governmental practices revised popular sovereignty as neoliberal agency.

Appendices

Appendix 1: List of documents that comprises the data

Documents produced by and for the Republic of South Africa

Republic of South Africa. (1994). *White paper on reconstruction and development: Government's strategy for fundamental transformation*. Cape Town, South Africa: Government Gazette.

Documents produced by and for the African National Congress

African National Congress. (1994a). *A national health plan for South Africa*. Johannesburg, South Africa: African National Congress. Retrieved from http://www.anc.org.za/content/national-health-plan-south-africa.

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Appendix 2: Basic antenatal care clinic checklist

Clinic Checklist - Classifying (first) visit

Name of patient ______________________ Clinic record number | | | | | | | |

Address ______________________ Telephone ______________________

______________________ Cell ______________________

INSTRUCTIONS: Answer all the following questions by placing a cross mark in the corresponding box

Obstetric History	No	Yes
1. Previous stillbirth or neonatal loss?		
2. History of 3 or more consecutive spontaneous abortions		
3. History of a congenital abnormality in previous pregnancy		
4. Birth weight of last baby < 2500g?		
5. Birth weight of last baby > 4000g?		
6. Last pregnancy: hospital admission for hypertention or pre-eclampsia/eclampsia?		
7. Previous surgery on reproductive tract (Caesarean section, myomectomy, cone biopsy,cervical cerclage)		

Current pregnancy		
7. Diagnosed or suspected mulitple pregnancy		
8. Age < 16 years		
9. Age 37 years or older (at conception)		
10. Isoimmunisation Rh (-) with antibodies in current or previous pregnancy		
11. Vaginal bleeding		
12. Pelvic mass		
13. Diastolic blood pressure 90mmHg or more at booking		

General medical		
14. Diabetes mellitus on insulin or oral hypoglycaemic treatment		
15. Cardiac disease		
16. Renal disease		
17. Epilepsy		
18. Asthmatic on medication		
19. Tuberculosis		
20. Known 'substance' abuse (including heavy alcohol drinking)		
21. Any other severe medical disease or condition		

Please specify ______________________

A yes to any ONE of the above questions (i.e. ONE shaded box marked with a cross means that the woman is not eligible for the basic component of antenatal care

Is the woman eligible (circle) No Yes

If NO, she is referred to ______________________

Date ____________ Name ______________________ Signature ____________

(staff responsible for antenatal care)

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