

DISCOURSES OF EXPERIENCE OF PREGNANCY IN LOW INCOME  
WOMEN ATTENDING KATUTURA AND CENTRAL HOSPITALS'  
ANTENATAL CLINICS IN WINDHOEK

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MAIKA EYSSELEIN

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Main Supervisor: Prof. Servaas van Deventer

Co-supervisors: Ms. Heidi Burmeister-Nel

Ms. Lea Haidula

### **Abstract**

This thesis explores and discusses the discourses drawn on by pregnant women in their construction of their 'selves' in pregnancy. The study was qualitative in nature, in order to understand the women's experience from their context and to allow for their individual constructions to come forth. The aim of the study was to explore firstly, which discourses the pregnant women draw on during their pregnancy and secondly, how the women construct themselves as pregnant beings. The sample included eighteen women, who are from a low-income background attending Katutura and Central Hospital's antenatal clinics. Transcripts of tape-recorded interviews, comprised of open ended questions, were analyzed using discourse analysis. Discourse analysis is a method of deconstructive reading and interpretation of a text, which brings to the fore marginalized views. Five dominant discourses were identified, namely the Medical Discourse, the Discourse of Dependence, the Discourse of Embodiment, the Discourse of Ownership of Pregnancy and the Discourse of Motherhood. Participants draw on these discourses in order to construct themselves as pregnant beings. Furthermore, the positioning of the women within each of these discourses is traced with ambivalence. The task of navigating the experience of pregnancy and constructing the 'self' as pregnant is mapped out in differing positions. This is further obscured by the shifting of agency between the women and their environments. Participants' constructions shed light on the complex interplay of positioning and agency in constructions of 'self'-as-pregnant. It is concluded that the ability to position the self on a continuum within a Discourse, as opposed to rigidly positioning the self, allows women a less stressful experience of pregnancy.

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## **Dedication**

To those who are marginalized. May you recognise and question the Discourses that restrict your lives and challenge them accordingly.



**Declarations**

I, Maika Eysselein, declare hereby that this study is a true reflection of my own research, and that this work, or part thereof has not been submitted for a degree in any other institution of higher education.

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## CHAPTER 1: INTRODUCTION

Women remain marginalized in numerous areas of society as well as with regard to various experiences. Literature portrays those who are marginalized and who bear the brunt of the problems as mostly women. “Women and girls may be disadvantaged in the intersections of customary law, customs and practices, religion and socio-economic conditions” (Stewart, 2008, p. 148). Also, women are marginalized by their economic background (Liamputtong, 2005) and culture (Yen & Wilbraham, 2003). Saris and Johnston-Robledo (2000) are concerned that “poor women are still “shut up” and “shut out” of” (p. 234) the discourses of psychology.

In pregnancy, marginalization is manifested in the construction of pregnancy by others as well as the women themselves (Marshall & Woollett, 2000). Furthermore, there is a change in the way society views and reacts to pregnant women – a transition into a culture different to that which the women are used to – a culture where a pregnant woman will often be regarded as a “passive object” (Cheetham, 1977, p. 43) and her individuality and privacy are disregarded (Cheetham, 1977). In the literature on pregnancy pregnant women, specifically, from low income background are marginalized (Youngleson, 2006).

Women are thus marginalized in various domains as a result of society’s efforts to position them within these domains (McDowell & Pringle, 1992). Power relations are influential in causing marginalization and are evident in language, culture, and ideology (Rogers, Malancharuvil-Berkes, Mosley, Hui, & O’Garro Joseph, 2005). Through beliefs that are held by dominant groups, discourses are shaped. These

discourses get expressed through language, which in turn functions constructively (Van Dijk (2006). Thus, discourse is the social practice of using language (Fairclough, 1995). Discourses can be used to convey power and knowledge and are evident in the expression of meaning through the use of words (McGregor, n.d.). Meaning is thus made through relations between multiple discourses (Starks & Brown Trinidad, 2007). Van Dijk (2006) presents a fitting analogy for discourse: "...discourse meanings are like icebergs of which only part of the non-presupposed meanings are explicitly expressed" (p. 122). Thus, through their role in 'meaning-making' and 'truth-making', discourses can be both dominant as well as subordinate. Subordinate discourses are marginalized and are also mostly associated with those marginalized within a society (Hare-Mustin, 1997).

People take on the role of agents as well as subjects in discursive systems (Allen & Hardin, 2001). Where the speaker or 'agent' addresses the 'other', a discourse is being drawn on (Parker, 2005). When we access Discourses we draw on our previous interactions and understandings. As result of having internalised these, they now influence and shape how we experience (Allen & Hardin, 2001). Thus, "discourse systematically constructs versions of the social world" (Rogers et al., 2005, p. 371).

Discourse analysis, which is the research method used in this thesis, is an academic movement focusing on the theoretical concepts of and the manifestation of relationships of power, ideology and domination, discrimination, and control in language (Baker et al., 2008). It aims to understand how language is utilized by persons in order "to accomplish their objectives and position themselves in relation to

others” (Starks & Brown Trinidad, 2007, p. 1375). A more detailed clarification of discourse and discourse analysis follows, in chapters 2 and 7 respectively.

Kruger (2003) argues that even a story that is told in a most individual manner, is shaped by dominant ideologies, which in turn are influenced by political, social and economic circumstances. This has important implications for research. Firstly, analysis of stories should not merely be a retelling of these but should also find out about underlying ideologies. Secondly, since stories are positioned in contexts, any analysis of these stories must include material, cultural and socio-economic influences that shape the women’s lives and thus their stories (Kruger, 2003).

This study aims to explore the individual experiences of pregnant women from a low income background. A detailed explication of the literature relevant for this topic follows below: In Chapter 2, the theoretical background is considered, namely postmodernism, social constructionism, and feminism. In Chapter 3, pregnancy is introduced, focussing on the literature on African women and women of low income groups. Chapter 4 contains a discussion of the medical model. The impact of the medical model on pregnancy, antenatal care and birthing is examined. In Chapter 5 a review of the literature on constructions of pregnancy, namely those of embodiment, dependence, ownership of pregnancy, and motherhood is presented. Chapter 6 comprises a summary of all literature reviewed. In Chapter 7 an explanation of the methodology used for this research is given. The findings of this study are presented in Chapter 8, followed by a discussion of these findings in Chapter 9. Finally, Chapter 10 concludes this thesis.

## **1.1 Objectives and research questions**

This study was designed to investigate discourses drawn on during pregnancy by a group of women attending two specific antenatal clinics. The objective was to expose the discourses that underlie the experience of pregnancy in women from a low income background. To accomplish this objective, the following research questions were addressed:

- Which discourses do these pregnant women draw on during their pregnancy?
- How do these women construct themselves as pregnant beings?
- How do these women construct themselves as pregnant beings from a specific culture?
- How do these women construct themselves as pregnant beings from a low income background?

## **CHAPTER 2: THEORETICAL CONCEPTUALIZATION OF THE STUDY**

### **2.1. Introduction**

The theoretical background to this study is based on postmodern, social constructionist and feminist thinking. Below follows a brief explication of these theories as well as a detailed explanation of discourse. Furthermore, language involvement in the shaping of as well as the drawing on discourse is elaborated on. Lastly, the construction of women's identity relating to these theoretical constructs is considered.

### **2.2. Postmodernism and social constructionism**

Postmodernism advocates that no objective truth exists and that the knowledge possessed by a person is dependent upon the person's perspective (Agger, 2007). "Postmodernist thinkers regard knowledge as partial and ambiguous, and they challenge dominant discourses by calling attention to marginalized and subjugated discourses" (Hare-Mustin, 1997, p. 570). Reality, to postmodernist thinkers is constituted by texts. Gilbert (2008) elaborates on Foucault's view: "Texts are not merely written documents, but are any meaningful events, processes or objects that can be interpreted" (p. 449). Agger (2007) points out that texts are always obscure because of the nature of meaning. A text is always approached through language and the interpretation then rests on the production of new meaning. The meaning of a text will thus never be fully grasped (Agger, 2007). Therefore, our experiences and the meaning we make are based on our perspectives and the discourses we draw on.

Social constructionism views psychological theories not as a reflection of the world but as an active construction of the world (Brinkmann, 2006). It may seem as though knowledge exist as fixed objects (Hammersley, 2008b), however it exists out of social relationships which are situated culturally and contextually. Meaning is produced via the use of language in social relationships. Thus, meaning is never the possession of the individual (Gergen & Gergen, 2007). Claims made, then, are only true inside a certain construction (Hammersley, 2008a). They are thus discursively constructed (Hammersley, 2008b). Social construction relates to tracing the origin of knowledge, meaning, and understanding of human relationships. It has its origins in the critique of authoritative explanations of the world (Gergen & Gergen, 2007).

“Constructionists tend to view “the social” as a space in which we try to increase our rights, a place where we are engaged in a competition for redescription” (Brinkmann, 2006, p. 107). Constructionism, thus, emphasizes that we have the power to change anything just by changing its description (Brinkmann, 2006). This process of constructing can hence bring about changes (Brinkmann, 2006).

Yardley (1997a) elaborates on the implications this has on our understanding of things:

It is simply impossible for humans to transcend their own capabilities and context; ultimately, we can *only* perceive the world around us by means of human senses ... and in relation to human desires and activities, and we *must* explain it to ourselves and others using human cultural concepts and language.

If it is meaningless to conceptualise an ‘objective’ reality which is somehow

independent of our activities and understanding, this means that the neutral perspective to which science claims to aspire can never be attained. (Yardley, 1997a, p. 1)

The theory of discourse analysis is embedded within the social constructionist view (Brinkmann, 2006).

In summary, postmodernism states that no truth exists. Social constructionism puts forth that we are actively constructing the meaning of our experiences, using culturally and contextually situated discourses. With this theoretical background it becomes obvious that the understanding gained through this study, can never be viewed as a precise account of the women's experiences. This study will merely yield insight into the women's constructions of pregnancy as well as the dominant discourses of pregnancy the women draw on.

### **2.3. Feminism**

Feminism has been concerned with women, their identity and their roles for decades, and has thus raised important questions about power, oppression and marginalization regarding women. Feminist perspectives allow for different views of understanding women's experience of oppression (Mama, 1995).

Women's roles and how they are defined by society are of interest to feminists. McDowell and Pringle (1992) emphasize that women are defined in terms of their roles within the family, namely as nurturers and carers. Women are also defined in relation to men, being the subordinate ones in a binary opposition. Thus they always



are the 'other' to men (McDowell & Pringle, 1992, p. 3). Hence, a woman's status is constructed around various binary oppositions, like work and home, rationality and emotionality. Social reality is interpreted through these opposites. Women are thus marginalized in various domains through society's categorization of their positions within these domains (McDowell & Pringle, 1992).

One of the concerns raised by feminists is the exclusion of women from social research. Thiele (1992) calls attention to the exclusion of women firstly, in an overt way, where they are left out of theories and discourses altogether. The second is a subtle form of exclusion. Here, women are dropped from the relevant discourse, entirely. Therefore, although they might be mentioned, they bear no relevance to the theory (Thiele, 1992). Pseudo-inclusion, on the other hand, includes women in the theory but marginalizes them. In these theories, women become the exception to the rule (Thiele, 1992). Another manner, in which women are not part of social theory, is through alienation. Although women are included in the theory here, their lives are discussed in a distorted manner as the theorists' discussion happens from the position of their maleness (Thiele, 1992). There is thus a need for research about, and for, women – research which does not exclude the women.

Power, and especially those who are marginalized by it, is of interest to feminists. Power can be uncovered by addressing and questioning decisions made as well as issues obscured by dominant groups or individuals. However, it is when power is exercised in such a way that we do not realize that we are being controlled, that it is at

its strongest. Thus, by gaining knowledge of the manner in which power works, we attempt to challenge it (Maguire, 1992).

Discourse analysis is argued to fit well with feminist perspectives, as it reflects feminists' opinion that "the personal is political" (Miller, 2000, p. 325). Thus, that which is obscured becomes the focus. In keeping with feminist views, the present study, thus, aims at giving marginalized voices the opportunity to come forth. Shedding light on potential marginalization as well as exposing the dominant discourses that contribute to the marginalization of these women, is thus of importance.

#### **2.4. Discourse**

Where, on one hand, 'discourse' refers to "a system of statements, practices, and institutional structures that share common values" (Hare-Mustin, 1997, p. 554), it on the other hand refers to language used as a form of social practice (Fairclough, 1995). In coming into existence, thus, human experiences are socially as well as linguistically influenced (Yardley, 1997a). McDowell and Pringle (1992) define discourse, from a feministic viewpoint, as the statements and beliefs that classify women.

Discourses with a capital 'D' refer to systems of knowledge that are based on a specific principle, for example race. However, discourses with a lower case 'd' are communicative in nature and emerge in a social situation. Thus, through analyzing discourses, dominant Discourses will become apparent. Also, how meaning is

produced as well as regulated is evident in Discourses (Smith & Pangsapa, 2007). In this research the discourses, in the interviews with pregnant women from a low income background will be studied, in order to make visible the Discourses they draw on to construct themselves.

Discourses are utilized for expressing meaning and knowledge through the use of words (Fairclough, 1995; Starks & Brown Trinidad, 2007). People draw on discourses while speaking and through that have an influence on the power dynamic of the communication (Miller, 2000). The concept of a discourse is constituted by certain arguments, the relationships between statements, and how dominant groups or individuals organise information into systems of ideas (Grbich, 2007). Hence, “discourses do not arise from thin air” (Allen & Hardin, 2001, p. 172). Furthermore, discourses are forever changing, as they are part of the social (Smith & Pangsapa, 2007).

Cultural frameworks, whose powerful influence is often disregarded, influence that which we say and believe. It is this influence which serves specific power relations and which thus needs to be questioned (Hare-Mustin, 1997). Fairclough (1995) and Miller (2000) explain discourse as being produced through social and historical influences and practices. Actors employ “cultural resources that are publicly available” in “contextually variable ways” (Hammersley, 2008b, p. 102). Furthermore, a discourse takes on a specific position regarding cultural and historical data, either reproducing it or altering it (Fairclough, 1995).

According to Baker and associates (2008) it is not only the linguistic aspects of a text that are of interest in discourse analysis but also that which is influenced by the production of the text. Van Dijk (2006) stresses the need for studying the influence of context on discourse. Attention needs to be paid to the context in which talk is happening. The context has implications for the meanings of the talk (Smith & Pangaspa, 2007). Grasping the context in which discursive elements are situated is, thus, of importance (Lynch, 2007).

Thought is influenced by power relations that have been created historically. “Facts are never neutral and are always embedded in contexts” (Rogers et al., 2005, p. 368). It is a consequence to these influences of culture, context and history on the power relations within discourse that groups in society differ with respect to their access to services, commodities and products (Rogers et al., 2005). Central to the existence of humans, thus, are descriptions of them as well as “social discursive contexts” (Brinkmann, 2005, p. 786).

Analysis is not only a methodological aspect; it is also inherent in discursive exchanges. The manner, in which an utterance is analysed and responded upon, is dependant on how it was analysed by the person at whom this utterance was directed, initially. How this utterance is understood and analysed, depends on the context within which the person is situated (Lynch, 2007).

Discourses are used in a selective manner as well as when they serve a specific purpose. Hence, discourses do not “drive talk” (Miller, 2000, p. 326) but are drawn on

when there seems an advantage to doing so. They do however influence our social interactions through supplying us with positions and roles (Gilbert, 2008). Discourse is, thus, active (Hammersley, 2008b).

A dominant Discourse thus supports a manner of understanding that is supportive of specific groups (Gilbert, 2008). It would seem that as a subject we can place ourselves within these discourses and take on a position. However, not always is there freedom in such positioning. For some, positions are imposed upon them and they, thus, become objects of control (Smith & Pangsapa, 2007). Kober (1997) is concerned that as result of the rarity of critical views on discourses, the reproduction of power relations through discourses is all too common. Competent participation in a discourse requires that one be familiar with and knowledgeable with the discourse. It is without this knowledge and familiarity that one becomes marginalized. Thus, the awareness and understanding of a specific discourse is instrumental in whether it will empower or marginalize. Through discourse analysis, the manner in which people take up the role of agents and subjects, in discursive systems, thus, becomes obvious (Allen & Hardin, 2001).

Allen and Hardin (2001) point out that social structure is the effect of practices being taken up and then being reproduced and modified. Individuals therefore are constructed through being recruited into discursive practices as well as through reproducing these (Allen & Hardin, 2001). Discursive and linguistic data, hence, is viewed as a social practice and is influential in the reflection and creation of ideologies in society (Baker et al., 2008). Mama (1995) states that movement is

critical in the creation of new discourses. Movement refers to intrapsychic changes as well as to social movements and cultural changes. The creation of new discourses, thus, is pre-empted by a collective experience of similar change. Discourses become powerful through the numbers of people positioning themselves within them. In summary, discourses are active on various levels: Discourses construct individuals; discourses construct ideologies; and in turn are constructed by movement.

According to Brinkmann (2005) people are ‘made up’ through certain discursive processes. “The central point in Foucault’s view of the human subject is that individual human beings are constituted as subjects (subjects to be known and controlled, and subjects who know and control) by practical technologies, infused in power relations” (Brinkmann, 2005, p. 778). Brinkmann (2005) argues that humans interact with what they are classified as and also have the ability to influence the classification themselves.

Thus, the existence of a certain human description is dependant of the availability of that description within a certain social setting. So, although humans experience out of what seems like free choice, the action is always subject to the existence of a description of that action (Brinkmann, 2005). Through the description of the action, the action can be located within a discursive context.

Importantly though, humans are interested in these categories of descriptions because, to them, values are attached to these descriptions. Brinkmann (2005) emphasizes that psychology is very active in creating categories, in determining a psychological truth

about identity; thus psychology is a powerful actor. “We imagine life in psychological terms” (Brinkmann, 2005, p. 787).

In summary, discourse is language in use as well as the systematisation of knowledge and power relations based in culture, history, context and social practices. Our experiences are thus greatly influenced by how these discourses construct them. Discourse is fluid in that there is constant change. People are influenced by discourse as well as influence it. In communicating we are surrounded by culture, context, history and the social. Thus we use these influences to navigate discourses, thereby changing them in our movement through them. When there is no awareness of this, however, discourses remain to be shaped in such a way that they further marginalize some groups and empower other groups. Yet, when awareness exists, discourses are used with certain aims. A critical awareness of discourses is thus imperative.

## **2.5. The role and function of language**

Language and talk have various functions. Allen and Hardin (2001) explain that we use language to enact our roles and relationships. We learn how to repeat words and discourses. These repetitions enable the production of social structures. People also make use of interpretive repertoires, which are recurring terms or sets of terms that are used to define realities, for example, how women call upon the identity of motherhood (Silverman, 2006).

Although the terms we use seem value-free, they act as social control through the way in which they portray that which they refer to. Our vocabularies are laden with

expectations and restrictions (Gilbert, 2008). According to Smith and Pangsapa (2007) meaning comes into being through the relationship between words. Yet, it is not only the relationships between words that are important, but also the relationship between words and context. Language is also a social construction. It has dialectic properties, meaning that it can influence and be influenced by context (Rogers et al., 2005).

Furthermore, meaning-making is not only related to context but is a culturally as well as historically situated process (Rogers et al., 2005). Discourse is active in two ways: It reflects the social world and constructs the social world. Therefore it is not impartial. Rather it is influenced by culture, religion, racial beliefs, politics, society and the economy (Rogers et al., 2005).

The language which is used to frame the experience of the self is not viewed as having mere descriptive qualities but as playing an important role in the construction of said experiences (Wilkinson & Kitzinger, 1995). People firstly select and then use linguistic resources, in constructing versions of the social. The use and selection of linguistic resources, however, is not necessarily a conscious process (Smith & Pangsapa, 2007). The way in which we talk, make excuses and give justification, for example, are not automatic actions. They reflect skills which we possess and through which we present ourselves as agents (Harré & Stearns, 1995). It is assumed that “actors” (p. 325) are actively doing things with their talk (Miller, 2000). “Speaking and hearing, conversing, is something we do. It is not something that happens to us.”



(Harré & Stearns, 1995, p. 136). A discourse, thus, has agency because it is actively involved in 'making-up' objects (Gilbert, 2008).

Repositioning takes place when we act as agents and move within different discursive possibilities (Allen & Hardin, 2001). A person thus is neither purely shaped through that which she/he experiences nor is her reality controlled purely by society (Allen & Hardin, 2001). Thus, the manner in which language is employed in people's narratives is a reflection of the constant interplay of power, and a repositioning of the self (Allen & Hardin, 2001).

Language becomes powerful through the manner in which it is used (Baker et al., 2008). The fact that language can be used to generalize about a number of different events, allows us to interpret things in such a way, as to reflect our own interests. As consequence of this, language allows us to hold power (Fairclough, 2008). People construct events as 'scripted' and thus as part of a pattern. Thus by using scripts, that which is said, is referred back to a pattern that has been either approved or disapproved by society. Through this, matters like appropriateness, responsibility and blame are touched on and that which is said, hence, also describes the personality of the actor (Silverman, 2006).

Language also becomes powerful through the exclusion it creates. According to Thiele (1992) this exclusion can happen in various ways. It can occur through decontextualization, where theorists depart from 'real people' and 'real events', to make generalizations about for example 'Man' or 'Society' (Thiele, 1992). A second

manner of achieving exclusion is through universalisms, which are prominent in language. This happens when language arranges phenomena under one term and disregards the differential treatment of men and women. An example is 'mankind'. Binary oppositions are also used to exclude women. Binary oppositions contain an underlying judgement, where the one is deemed positive and the other negative (Thiele, 1992), for example 'natural' and 'unnatural'. Where 'natural' has a positive connotation and is often linked to health, 'unnatural' is negatively depicted and linked to pathology.

Furthermore, binary oppositions result in the polarisation of agency in language. It is through the process of contrasting something to its polar opposite, that meaning is attributed (Harré & Stearns, 1995; Grbich, 2007). Meaning, thus, relies on the opposition of ideas in language. For example, 'illness' implies 'health'. The meaning of the one, thus, depends on the other (Yardley, 1997a). Language is inundated with dualities, which act to hide hierarchies. One polarity, one 'other', will always be superior to the other. An example of this is the opposition of the terms 'male' and 'female' (Agger, 2007). "Construction of meaning, representation of reality and privileging of binary opposites" (Grbich, 2007, p. 172), becomes visible within texts.

In summary, the discourse perspective then links language and signifying practices to a critical view of social structure (Allen & Hardin, 2001). We use language for navigating relationships and describing our reality, in that we learn to use specific discourses. Thus we shape social structure through choosing only specific discourses, which then act as a control. Context, history, religion, politics and economics all

influence language and thus influence this process of social control. This control is accomplished through the opposition of realities into binary oppositions. This process leaves these realities bare of their contexts. Furthermore, our own experiences are shaped by the discourses we draw on through a somewhat unconscious process. Hence, we as speakers have agency, but so do the discourses we draw on.

## **2.6. Construction of identity**

Pregnancy brings with it a change in identity (Kruger & Van der Spuy, 2007). In being pregnant, women “are giving birth to a new identity of motherhood” (Peterson, 1996, p. 35). Thus, in pregnancy, it seems that women’s identity and the changes therein are of importance. Modern societies are focussing more and more on the ‘self’. In focussing more on our ‘self’ we also reflect on this ‘self’ more, comparing our ‘self’ to that which we understand to be the norm (Allen & Hardin, 2001). In other words, subjects are both self-defining as well as constructed by dominant others (Mama, 1995). Thus, subjects come to be through the social conditions existing at that time. Subjective processes are those processes “during which people take up and move through different positions that are discursively and psychodynamically generated in the course of collective and individual social relations” (Mama, 1995, p. 146). According to Mama (1995) our subjectivity consists of all the discursive positions that are available to us.

The positioning of the self, hence the structuring of identity is also based on internalizing symbolic order, which then allows for social participation (Weir, 1996). Social interaction is the product of self-identity and is made possible through

language. Thus, language is the dialectic between practice and structure. This means that human practice, informed by identity, produces and changes structure (Weir, 1996).

Various discourses interact to create cultural narratives, which shape identities. It is these identities which influence the choices we make (Hare-Mustin, 1997). These choices cannot, though, be without a political stance, as identity and subjectivity are comprised of a person's position in different discourses. Hence, this implies that there will always be a politicising of this position (Widdicombe, 1995). "The discursive location of the individual frames his/her 'personal' experience of self and subjectivity" (Wilkinson & Kitzinger, 1995, p. 3).

The complexity of identity becomes evident in its repressiveness (Weir, 1996). The term 'différance' implies that there exists a regular exchange between meaning and non-meaning, which never can be integrated into one identity. Identity is thus subject to power systems, oppression and exploitation (Weir, 1996). Conflicts in identity and role arise when uncertainty is created through competing discourses and expectations of the participants of a conversation (Starks & Brown Trinidad, 2007).

Thus, it becomes evident that the place of the greatest struggles of power is the self-identity (Weir, 1996), and it is there that the issue of domination has to be addressed. Power and domination are not purely 'done' to people but to an extent are also self-imposed as dominant discourses become part of the identity (Agger, 2007). It is through talk that resistance against this domination is fostered (Widdicombe, 1995).

In summary, identity is central to participation in society, yet also it is shaped by social influences. Discourses and the positioning within them either allow for resolution of the identity or create ambivalence. Identity is thus the fulcrum on which social participation as well as social change rest. Ideally, the formation of identity should rely on “an acceptance of internal differentiation – an acceptance of the otherness within the self” (Weir, 1996, p. 150). Identity should be viewed as inclusive, where it allows us to be actors with the ability to change ourselves and our world (Weir, 1996).

## **2.7. Summary**

Departing from the view that no truth exists, postmodernism allows us to grasp what social constructionism advocates: No meaning is fully understood or possessed by an individual. Also, knowledge is constructed socially and contextually. Discourses are drawn on, in order to construct others and ourselves as well as to communicate power and knowledge. Language is not removed from the mind; rather it is active in making up experiences. Language allows people to take on agency and to move within social structure and context. In light of this, feminism notes that women are constructed by society. In this construction they become the ‘other’, thus being marginalized. Women’s identities are thus gendered and become repressed through that. Thus, it is within the construction of women’s identities that power needs to be addressed foremost.

## **CHAPTER 3: PREGNANCY**

### **3.1. Introduction**

Inadequate knowledge exists about all women's experiences of pregnancy, according to Kruger and Van der Spuy (2000):

Perhaps because pregnancy is regarded by society at large as a condition that it would rather not know about, the discourse on pregnancy is one that omits subjectivity: we know very little about the meaning of pregnancy for the subject – the pregnant woman herself. (Kruger & Van der Spuy, 2000, p. 11)

Within the literature it, however, appears as if more inquiry has been made into western, middle- and high-income women's experience of pregnancy. It seems to be that the discourses drawn on by and influencing women from a low income, non-western background have been marginalized in the literature, in that they have not been considered. "Research on low-income pregnant women is severely limited, is typically situated within the biomedical model, and focuses largely on perinatal outcomes" (Burmeister-Nel, 2005, p. 43). Furthermore, this research overlooks the emotional experience of these women (Burmeister-Nel, 2005). It is thus of importance to research these marginalized areas and to allow women's constructions to come forth. Below follows an explication of pregnancy, the implications of a low income background and culture as well as an overview of southern Africa with regard to health, illness and reproduction.

### **3.2. An overview of health, illness and reproduction in southern Africa**

Reproductive views are influenced by the values of a society. In Namibia, a woman's fertility is of importance in many of the different Namibian cultures. Much of a

woman's value to society is thus based on her ability to bear children (Waters Lumpkin, 1996).

The inclusion of statistics from Namibia's neighbour country, South Africa, gives context to the Namibian statistics. In their study of South African women, Spjeldnaes, Sam, Moland and Peltzer (2007) reflect on the changes that the South African society has undergone in the last decades. This has also influenced the conditions for reproductive health and reproduction. South Africa has experienced a fertility drop in its population (Spjeldnaes et al., 2007). In their sample of teenage women, their mothers and their paternal grandmothers, Spjeldnaes and associates (2007) found some differences regarding reproductive views. The young women in the study expressed decreasing fertility ambitions. The authors relate this to the changing economic and educational opportunities for young women (Spjeldnaes et al., 2007). Furthermore, Spjeldnaes and associates (2007) assume that the HIV/AIDS crisis in South Africa has also contributed to these changes: "Their reproductive attitudes, however, have been shaped in the midst of the HIV/AIDS crisis where the ABC slogan (abstinence, be faithful, condomise) of the HIV prevention campaign is the order of the day" (Spjeldnaes et al., 2007, p. 858).

In viewing statistics about Namibia, here too a change in reproductive trends becomes visible. The prevalence of contraceptive usage among Namibian women aged between fifteen and forty-nine years, in 1992 in Namibia was a mere 28.9%. In 2000 contraceptive use had increased to 43.7%. For our neighbours, South Africa, the contraceptive prevalence trend was 56.3% in 1998 and 60.3% in 2003 (International

Bank for Reconstruction and Development / The World Bank, 2007). The infant mortality rate in Namibia, as measured by the World Bank was recorded at sixty deaths per 1000 live births in 1990. In 2000 it dropped to fifty per 1000 live births, and in 2005 to forty-six deaths per 1000 live births. When compared to other African countries including South Africa, Namibian infant mortality seems less severe than in those other countries. However, the maternal mortality rate as measured in 2000 is worse than that of South Africa, with Namibia having a maternal mortality of 300 per 100 000 live births. In 1992, Namibia had sixty-eight percent of births attended by skilled health staff. In 2000 this rose to seventy-six percent (International Bank for Reconstruction and Development / The World Bank, 2007).

The biggest underlying cause of maternal mortality in Namibia is still obstetric in nature, compared to death as a result of HIV, abortion and malaria (Ministry of Health and Social Services, 2000). However, the sample of Namibians in the study of Frank (1997) attributed maternal mortality to heavy work during pregnancy, lack of sufficient help at home, ill health, smoking or alcohol abuse, lack of food, young age of the woman, the wearing of dresses with belts, having intercourse with too many different men, witchcraft, and lack of hot water treatment. Unicef Namibia (2008), however, views the problems underlying maternal mortality, as social in nature: “The root cause for the decline in maternal deaths may therefore lie in women’s disadvantaged position in many countries and cultures, and in lack of attention to, and accountability for, women’s rights” (Unicef Namibia, 2008, p. 3).



It appears that constructions of health and illness in Namibia have an impact on both beliefs as well as behaviours. LeBeau (1999) suggests that the perceived aetiology of an illness determines whether people seek out western or traditional health care. For example, if the aetiology of mental illness is perceived to be social or spiritual, people are likely to seek out a traditional healer for help. Namibian traditional healers perceive mental illness from a holistic perspective, noting the physical, social and spiritual aspects of mental illness. She emphasizes that in Katutura mental illness is primarily treated by traditional healers, who are perceived as experts with regard to mental illness (Waters Lumpkin, 1996).

Waters Lumpkin (1996) states that one of the causes of mental illness, as explained by traditional healers in Katutura, is childbirth. The traditional healers describe that after having given birth, the woman “became very cold and hungry within her own body” (p. 167). The aetiology of tuberculosis, too, is related to child bearing. If a man has tuberculosis, it is portrayed as having been transmitted to him by his wife, who has had a miscarriage. As result of neglecting to consult a traditional healer after her miscarriage, she contaminates her husband’s food through handling it. Waters Lumpkin (1996) concludes that after miscarrying, the woman had thus broken a sexual taboo. According to Waters Lumpkin (1996) many women do not attend antenatal clinics because in their culture, they are believed to be more susceptible to sorcery, when pregnant.

Traditional midwives or traditional birth assistants are still very much active in Katutura, which is a suburb of Windhoek (LeBeau, 1999). It seems that most

traditional healers do some of the work of traditional birth assistants, namely massage. Thus, this service is widely available to women (Waters Lumpkin, 1996). The traditional birth assistants specialize in giving abdominal massages to women, to correct the position of the foetus before birth as well as for relief of backache and for preparation of the womb for labour (Waters Lumpkin, 1996). Traditional birth assistants in Waters Lumpkin's (1996) sample used herbal remedies to, firstly, decrease pain during delivery and labour, and secondly, to strengthen women after delivery.

In summary, although the reproductive trends are changing in, both, South Africa and Namibia, these statistics seem to portray trends that are worrying. The values of a society are said to play a role in shaping these trends. Where, on the one hand, fecundity is of importance, childbirth is constructed as a potential cause for mental illness. These constructions of health and illness, thus, also influence pregnancy experiences.

### **3.3. Pregnancy in women of low income**

The experience of pregnancy is greatly shaped by the women's social and educational status (Liamputtong, 2005). Research shows that as a result of poverty, women with a lower socioeconomic background are more at risk for mental illness (Todd & Worell, 2000). Furthermore, studies have found that a woman's low income background has negative outcomes for her pregnancy (Ahrari, et al., 2002; Kruger & Smit, 2002; Liamputtong, 2004; Liamputtong, 2005).

Ahrari, and associates (2002) conducted a study in Egypt to determine the factors that resulted in some women having fewer problems during pregnancy than others. They took as indicator for a good pregnancy outcome, regarding the women, an increase in weight during pregnancy, and regarding the newborn, good weight at birth (Ahrari et al., 2002). The main distinguishing factors between the women who had a good pregnancy outcome and those who did not, were the following: more visits to antenatal clinics, more rest (at night as well as during the day), higher economic status, and schooling received by the women, with less schooling implying greater risk. The authors highlight that a woman's environment, while she is pregnant, is one of the greatest factors influencing the newborn's weight (Ahrari et al., 2002).

Liamputtong (2005) found that women from a poor, rural background have less choice in doctors and hospital settings, than middle class women. She links poor women's voicelessness to their lack of empowerment. In another study the findings of Liamputtong (2004) showed that educated middle-class women were able to make choices more easily and had more power than rural poor women. Liamputtong (2005) found that middle class women had more power over childbirth procedures than rural poor women had. Also, the choice of caesarean section was linked to financial resources, since rural women were unable to pay for it. Middle class women viewed caesarean sections as allowing them more power over the birthing process (Liamputtong, 2005).

Kruger and Smit (2002) note that in the South African context, many women's experiences of pregnancy are influenced greatly by the effects of being poor and a

single mother. In Namibia, poverty is widespread. According to Schmidt (2009) many Namibians live in deprivation and poverty. Namibia's high Gini-coefficient (0,63) is an indication that inequality regarding the spread of income is still a reality (Central Bureau of Statistics, 2008). The Khomas region, although better off than many of the rural areas, still has many households falling below the "severely poor" poverty line (Central Bureau of Statistics, 2008). Even though we know that many women in Namibia are poor, we do not know whether and how this affects their experience of pregnancy.

Inadequate knowledge exists about the experience of pregnancy of women with a low income background (Youngleson, 2006). "Currently, knowledge concerning the experience of low-income black mothers is inadequate" (Youngleson, 2006, p. 12). Furthermore, "literature documenting the experience of low-income black mothers is scarce and has in the past been marginalized" (Youngleson, 2006, p. 12). Researching the experience of pregnancy in low income women in Windhoek, thus has merit.

#### **3.4. The influence of cultural background**

Similarities and differences among populations are often defined with regard to culture, race and ethnicity. Ethnicity implies shared cultural, linguistic, religious and cultural resources. Culture refers to the manner of thinking and living in a group, where knowledge, values and skills are shared (Fisher & Anushko, 2008). These definitions of ethnicity and culture are in turn constantly transformed by changing economic, social and political influences (Fisher & Anushko, 2008).

Society and culture are influential in how our experiences are constructed. The discourse of the 'African culture' has a marginalizing effect (Yen & Wilbraham, 2003). "These constructions of 'culture' – usually applied to African patients or indigenous healers – function powerfully in legitimating or disqualifying diagnosis, treatment and patient-management decisions" (Yen & Wilbraham, 2003, p. 563). Yen and Wilbraham (2003) argue that "constructions used within mental healthcare discourse about indigenous healing, and the corresponding 'African culture' and 'African mind' it supposedly addresses, produce problematic effects" (p. 581). Cultural constructions position 'African' as the 'other' thus constructing these belief systems as primitive and illogical (Yen & Wilbraham, 2003).

The 'African' way is opposed to the 'Western' way, as the 'African' way implies principles of humanity – ubuntu – and communalism, and the 'Western' way is depicted as modern, yet selfish. In the field of psychology, African communalism is then constructed as compelling people to have a psychological need to conform to the group, and that the group places cultural demands on the individual, causing great amounts of distress (Yen & Wilbraham, 2003).

It seems that not much literature exists about the influence of culture on specifically, pregnancy. However, one can assume that culture does influence the discourse and through that the experience of pregnancy. Literature was available though, on the effect of culture on parenting: Cultural demands are visible in the gendering of practices. Society is very specific about the gendering of parenthood, for example, often to the extent of exclusiveness of motherhood (Bell, 2003). These constructions

reflect the binary nature of the subject positions related to maleness and femaleness (Nentwich, 2008).

In summary, culture influences experiences in that it creates binary oppositions. The 'African' is constructed as the 'other'. Thus, the 'African' experience is constructed as the 'communal' experience. Culture also contributes to the gendering of experiences. The absence of literature on the influence of culture on pregnancy further emphasise the need for such a study.

### **3.5. Feminist views on pregnancy**

Feminist theorists like Beckett (2005) and Kitzinger (1993) have considered the issue of pregnancy, the process of giving birth and all related issues of women's mental health, in detail over the past decades. Beckett (2005) states that over the years, feminism has taken on different stances towards pregnancy, parturition and all its related practices.

A great amount of literature examines, specifically, birthing. The issue of the male-dominated medical world has been the catalyst for many debates about women's right of choice (be it to choose a caesarean section, to choose the help of a midwife over a medical doctor, or to choose pain-relieving medication during parturition) (Beckett, 2005). Medical propaganda has influenced women into making decisions that perhaps they would not have made, had it not been for this dominant discourse. This comes as result of this discourse rendering them useless in the area of childbirth, in which before, they had been experts. This way of thinking and believing has left the process

of birth as a condition of “medical emergency” and not one of a “family event”, as feminists argue it should be (Beckett, 2005, p. 254).

Discourses serve to justify practices that have considerable consequences (Beckett, 2005). Women make choices regarding their pregnancies and the birthing process based on biased information from the discourses of the medical world. Often this advice plays on the notion that women who intend to be “good mothers” (Beckett, 2005, p. 266) are the ones who will risk surgical delivery.

Women are expected to opt for caesarean section rather than vaginal birth, based on the fact that there is less risk for the baby. Rising levels of caesarean sections have been linked to a number of reasons. Beckett (2005) points out that firstly, use of the Electronic Foetal Monitor continues to overestimate foetal distress, resulting in caesarean sections. Secondly, doctors seem to be more comfortable with caesarean sections than with vaginal birth. This is cause for concern as these decisions to intervene reduce the women’s power to make important decisions regarding the birthing process. Furthermore, there is a great loss of intimacy between the woman and the medical caregiver due to this modernization of birth (Beckett, 2005). The author critically notes that often the reasons behind a woman’s choice of caesarean section are based in patriarchal values. For example, the loss of vaginal tone is one of the concerns that lead to the decision for elective caesarean section (Beckett, 2005).

In discussing postnatal depression, Kruger and Smit (2002) are concerned about the idea that a woman is portrayed as more prone to mental illness, than a man, due to the

fact that she can fall pregnant. Psychological explanations are offered for women's experiences and they are constructed as inability to cope, and failure to adjust (Kitzinger, 1993). Hence, the perception is that, of a woman's biological features resulting in her vulnerability (Kruger & Smit, 2002).

Kitzinger (1993) emphasises the need to protect women of this domination:

But it also means that we have to protest against the violence that is done to women, often as a matter of routine, and the abuse of medical power, especially with those women who are most vulnerable: the poor, the educationally disadvantaged, women of ethnic minorities, women categorized as high risk, those who cannot articulate their wishes and anxieties, and any woman who fears for her baby and is therefore easily persuaded to submit. We have a responsibility to resist institutionally sanctioned sexual abuse in the form of the rushed second stage, with barked commands to push, and routine incision of the woman's sexual organs. (Kitzinger, 1993, p. 216)

Just as many other developmental milestones of female development are not spoken about overtly in society, so is pregnancy and childbirth (Peterson, 1996). This too contributes to the ongoing domination of women by discourses that construct their pregnancy and motherhood experiences for them, placing them in a passive, vulnerable position (Peterson, 1996). Kruger (2003) calls attention to feminist theory's suggestion that seeing a mother as a subject as well as a person with needs and feelings, is of importance in the struggle to free women from ideological frameworks through which their experiences are re-defined by the greater society.



Kitzinger (1993) concludes that merely protesting will not have the desired effects. She urges that “we have to go beyond this. We need to be able to redefine her problems in political terms” (p. 216).

In summary, feminism is critical of the patriarchal values, evident in the medical arena as well as in society. Feminists question and object to these discourses and constructions, and advocate for a re-defining and re-construction of pregnancy, birthing and motherhood.

### **3.6. The pregnant ‘self’**

A woman’s self-esteem is very important for her health both prior to and after having given birth. It is thus essential that a woman’s self-esteem be supported during her pregnancy (Peterson, 1996). However, Peterson (1996) feels that because pregnancy and the transition to motherhood are not viewed by society as deserving this attention, it is difficult for women to obtain this support. Pregnancy is, after all, deemed a very common occurrence; therefore it seems not warranting special attention. According to Peterson (1996) the factors contributing to a woman’s perception of self, as positive, during the birthing process: Women need to feel that they have sufficient coping skills for birth, that they are allowed chances to explore as well as convey all their feelings about becoming or being a mother.

Darvill, Skirton and Farrand (2008) report many changes in the self-concept of first time mothers. Initially, there was a time of joy at the news of being pregnant (Darvill et al., 2008) and the change of self was positive. The women experienced more

confidence as well as feeling more grown up, and feeling more comfortable in being alone (Seibold, 2004). Shortly thereafter, their self-concept weakened and only strengthened again at the time of the birth. After giving birth, however, there was again a time, when the women felt drained and their self-concept was low. The decline in self-concept seemed related to the unfamiliarity of experiences (Darvill et al., 2008). This was related to the shift in focus onto the child. Equilibrium only returned once the women had regained some sense of control. This sense of control was induced by the feeling of having gained experience in caring for the baby as well as a decrease in physical stress (Darvill et al., 2008).

Also, the women's self-concept is affected by the change in the structure of the family. Darvill and associates (2008) found that changes in a woman's self-concept during first-time pregnancy were affected by her notion of forming a family. The women came to realize that a transformation was taking place, in the sense of becoming a new family.

Not only does a woman have to revise her self-concept to her pregnancy, she also has to integrate her pregnancy into her identity. Pregnancy and the transition to motherhood are both seen as empowering and constricting. Peterson (1996) believes that it is the addressing of all the changes, by the women herself, which makes the experience empowering. "Their sense of empowerment lies in their exploration of themselves. After all, they are giving birth to a new identity of motherhood!" (Peterson, 1996, p. 35).

Whether or not women hold agency has implications for their experience of pregnancy in terms of that experience being positive or negative (Rúðólfsdóttir, 2000). Agency refers to what Allen and Hardin (2001) call “‘free will’ to act”, as opposed to being “discursive marionettes” (p. 169). Rúðólfsdóttir (2000) points out that the experience of pregnancy is affected by the construction of body and self through medical and healthcare discourses. She argues that in pregnancy literature, pregnancy is normalized and that this prevents women from having agency (Rúðólfsdóttir, 2000). “When women become pregnant, they are confronted with and inserted into the ideological and discursive practices surrounding motherhood” (Rúðólfsdóttir, 2000, p. 338).

The discourses of pregnancy that women draw on create an experience of pregnancy, which is often far removed from its actual context. The various discourses of pregnancy do not allow women their own experience of pregnancy but rather dictate to the women how, when and why they should be having certain experiences. In the literature on pregnancy, it is implied that women should have an ability to be pregnant successfully, they should be “fit to reproduce” (Marshall & Woollett, 2000, p. 363). This construction of having to deal with pregnancy effectively is a strong way of regulating women.

Being “fit to reproduce” (Marshall & Woollett, 2000, p. 363) means having knowledge about what is normal and what is abnormal during a pregnancy. This then isolates certain emotions and experiences as abnormal, leading to decontextualisation

of the women's experiences of their pregnancies as well as creating a central identity of pregnancy, toward which pregnant women should strive.

Decontextualisation refers to constructions of pregnancy which "render it separate from women's other relationships, identities and knowledges, with little regard for the specific circumstances in which women become/are pregnant" (Marshall & Woollett, 2000, p. 351). This leads to marginalization of those women, who do not draw on this discourse and who do not position themselves in this construction of pregnancy. The women from a low income background in Youngleson's (2006) study were caught in a double-bind, which also removed them from their actual experience of pregnancy. These women were expected to fulfil mothering roles of utmost intensity, yet they were kept from doing this by the struggles they faced as result of poverty.

Woollett and Marshall (1997) note further areas where pregnancy is decontextualised. They argue that pregnancy is constructed through drawing on the concepts of 'health' and 'illness'. Information provided to pregnant women often highlights that "normal delivery" is associated with many risks, whereas the risk associated with "medicalised childbirth" are either not mentioned or are minimized as "disadvantages" (Woollett & Marshall, 1997, p. 180). The authors note how nausea during pregnancy is constructed as healthy and is placed at the centre of a woman's experience of specifically the first trimester. They further note how often medical treatment is not considered, irrespective of the impact of nausea on the women's functioning (Woollett & Marshall, 1997).

Furthermore, the construction of pain is linked to the construction of health and illness. Where childbirth is positioned as healthy, pain is constructed as a “normal accompaniment” (Woollett & Marshall, 1997, p. 181), while if childbirth is positioned as an illness, pain is constructed as something that needs to be dealt with medically. Lastly, the message of self-discipline over the body, together with the construction of pregnancy as being a ‘risk’, decontextualises pregnancy and removes it from the other arenas of a woman’s life. It further ignores the woman’s unique experience of becoming and being pregnant (Marshall & Woollett, 2000).

In summary, a woman’s self-esteem, self-concept and identity are all integral to shaping her self as she is pregnant. This process of redefinition of the self is further influenced by the amount of agency she holds, the discourses drawn on to construct herself-as-pregnant, and thus whether or not her pregnancy becomes a decontextualised experience.

### **3.7. Summary**

Today, the experience of pregnancy, especially for certain women, still seems to be not fully explored. Especially women, who are marginalized through culture and level of income, appear to become even more marginalized during pregnancy. The absence of knowledge about these women marginalizes them even further. In southern Africa, this marginalization is evident in the constructions of pregnancy as they are influenced by culture. The southern African woman’s marginal experience is reflected in the statistics on reproduction and childbirth. Thus, feminism is exceptionally critical of all factors maintaining this marginalization, for example binary

constructions of experiences of pregnancy, normalisation of pregnancy and the construction of pregnancy as a time of risk. Feminist views therefore challenge the constructions and discourses underlying pregnancy, as these result in her experience becoming removed from the context she moves in.

## **CHAPTER 4: THE MEDICAL MODEL**

### **4.1. Introduction**

From the literature review, which follows, it will become evident that constructions of pregnancy can be categorized into two polarities, or binary oppositions, namely pregnancy as a construction of health and, alternatively, pregnancy as pathology construction. Furthermore, the effect of this binary opposition is explored in the literature on antenatal care and birth.

### **4.2. Health and pathology**

Strong discourses are active in the area of health care, especially discourses constructing pregnancy as pathology. Redwood (1999) explains that discourse analysis offers an ideal position from which to look at and analyse the “oppression and inequality of power relations” (p. 914), prominent in most health care practices. Discourses of medicine and biology dictate behaviour and opinions in this arena. According to Starks and Brown Trinidad (2007) the discourse of medicine “suggests that physicians should be expert diagnosticians, scientists practicing evidence-based medicine, and advisors to their patients. Within the profession particular respect is accorded to those who know” (p. 1378).

The biomedical discourse leads to the objectification of the woman. “The obstetric gaze fixes the childbearing woman within a biomedical framework that constitutes her as an obstetric subject” (Davis & Walker, 2009, p. 4). The body is scrutinised and thus objectified (Davis & Walker, 2009). The biomedical discourse positions the

pregnant and birthing woman in a position of passivity, one of being “done to” (Davis & Walker, 2009, p. 4).

Also, the foetus is perceived as the “second patient” (Beckett, 2005, p. 266). This implies that the principal threat to a foetus is the pregnant woman. Various phenomena of pregnancy have been associated with a discourse of foetal impairment and therefore prenatal impairment (Tremain, 2006). Uken (1976) notes the foetus’ vulnerability and the connection between this and the mother’s mental health. Uken (1976) suggests that the anxiety in a mother might have an effect on her pregnancy, her delivery as well as the foetus itself.

In another study, Arck and associates (2008) found that pregnant women in their first trimester, who had high levels of perceived stress, had a higher risk of miscarriage. According to these authors, hormones released as a counter balancing response to stress can account for decreased levels of progesterone during pregnancy, which subsequently leads to miscarriage (Arck et al., 2008). This discourse of the foetus being ‘at risk’ is taken further in allocating the responsibility as well as the blame when something goes wrong, to the mother (Marshall & Woollett, 2000; Peterson, 1996).

Uken (1976) suggests that both the state of the infant as well as the mother-infant relationship depend on the mother’s state during her pregnancy. Thus, this discourse places all responsibility on the women and therefore allows for the controlling of the women (Marshall & Woollett, 2000).



Davis and Walker (2009), on a similar note, state that the practices of screening and testing for abnormalities during the antenatal period pose a big challenge to the midwifery view of birth as a natural ability (Davis & Walker, 2009).

Even though many herald obstetric procedures as allowing women more choice in birthing matters, Tremain (2006) strongly believes that these procedures actually further constrict women in their responses to pregnancy. She likens this to a modern form of government over women. Tremain (2006) draws on Foucault, in arguing that the subject which is represented by power relations is also formed by these. Thus, she argues that the idea of disability brings on that of impairment, and that these then allow for a greater regulatory control. It is through this process of viewing impairments (in utero impairments, for example) as 'natural', that the power relations become hidden (Tremain, 2006). Tremain (2006) concludes that "the government of impairment in utero is inextricably intertwined with the government of the maternal body. Through the government of their own bodies, pregnant women are enlisted to facilitate the normalization of the fetal body" (p. 37).

Discourses of pathology can be instrumental in constructing pregnant women as physically and psychologically vulnerable and thus as needing protection. Furthermore, this view warrants the controlling of pregnancy as a process, in order to diagnose potential problems at an early stage.

According to Andersson and associates (2003), psychiatric disorders are common in pregnant women and often go undiagnosed and untreated. The disorders bring with

them more somatic problems than usual for pregnancy and they are concurrent with an increased fear of childbirth. Somatic symptoms were more prevalent in those pregnant women in the sample who had a psychiatric diagnosis, compared to the women who did not have a diagnosis (Andersson, 2003). Most of the women in the sample, who were diagnosed with a psychiatric disorder, had not been previously treated. This implies that their illnesses had not been acknowledged before. Andersson and associates (2003) argue that this could possibly be because, firstly, women tend to present with atypical symptoms of depression, secondly, they present with unspecified somatic complaints as symptoms of psychiatric illnesses, and thirdly, somatic symptoms are to be expected from a pregnant women, thus, they are often overlooked. Furthermore they emphasize that since major depression is associated with substantial patient suffering, disability, lost productivity as well as increasing mortality, there is a great need for treatment.

Ahrari and associates (2002) suggest that a woman's environment while she is pregnant is one of the greatest factors influencing the newborn's weight. Various factors affect the woman in such a way that could inhibit circulation across the placenta and as a result of this, the foetus is supplied with insufficient nutrients and oxygen. This medical discourse, hence, which advocates for both the controlling of the woman as well as her environment, leaves her without agency. This results in pregnancy being constructed as something that happens to women and as something which places them in danger. Pregnancy is a 'risk' (Marshall & Woollett, 2000).

Midwives are concerned with what Davis and Walker (2009) call the “biomedical gaze” (p. 6). They see themselves as and take on the role of advocates for the women. This term (biomedical gaze) stems from Foucault and implies that a form of power is being held and acted upon by the medical profession. Midwives are interested in understanding each woman’s manner of constructing childbirth and how they have situated themselves in that space. This construction confronts obstetric constructions of childbirth (Davis & Walker, 2009). Midwifery challenges the construction of the woman’s body as faulty and the women as passive, preferring the construction of the woman as “engaged with” (p. 4) the processes she is undergoing (Davis & Walker, 2009).

The literature shows that resistance by women to the medical discourse of pregnancy was often subtle but present. Complaining about the treatment by medical staff and challenging the views of medical staff were ways in which the women in the sample of Rúdólfsdóttir (2000) resisted the medical discourse. However, women who resist the medical discourse are construed negatively. This makes the management of women’s resistance easy (Marshall & Woollett, 2000). Thus, although women do try and resist the biomedical discourse, fact remains that women still make choices, regarding their pregnancies based on biased information from the medical world (Beckett, 2005).

It is not only within the medical arena where these discourses are so prominent. Information, presented in pregnancy guides and booklets, positions optimum information sources as those linked to the medical discourse. By discrediting family

and friends as information sources it thrusts women towards the medical conception of pregnancy (Marshall & Woollett, 2000). Ironically, the literature on pregnancy advocates for women's choices during their pregnancies. Yet, these choices are set up against the safety and needs of the child and mother (Marshall & Woollett, 2000).

The literature also points to the other polarity in this discourse, namely the construction of pregnancy as natural and healthy: Midwives actively construct the discourse of childbirth as a natural process (Davis & Walker, 2009). They also construct the mother's body as a capable body. Furthermore, they construct women as active and partaking in the experience of pregnancy and birthing (Davis & Walker, 2009). The midwifery discourse places the woman as the main decision maker with the aim of helping the woman to experience birth and pregnancy to her own liking. Thus, empowering the woman through allowing her to be in control of processes is of importance to those drawing on this discourse (Davis & Walker, 2009).

It seems that this binary construction of pregnancy and childbirth might complicate the experience thereof. It is thus suggested by Darvill and associates (2008) that "identifying the childbearing process as one transitional state along with factors that might influence the quality of the transition may help to extend our understanding of women's different reactions to the maternal transition" (Darvill et al., 2008, p. 8).

It would be unjust though, to portray women as mere victims here. Beckett (2005) explains that it is in fact these discourses which give pregnancy and childbirth their meaning. Thus, to argue that the 'medicalisation' takes away meaning from

pregnancy and childbirth, is to presume that meaning is inherent in pregnancy and childbirth. This, however, is not the case. Discourses create meaning. Hence, by choosing to be assisted by medical technology, women are not subjecting themselves to a male-dominated arena but are creating a new discourse of their choice. She argues that it is superfluous to deliberate on whether the natural, or medical, aspect of pregnancy and birthing, is a better reality for women, since both are merely abstract and cannot truly be measured. However, discourses have consequences for those drawing on them, and it is those, which may not be ignored (Beckett, 2005).

Furthermore, it needs to be noted that the romanticizing of vaginal birth presupposes a reality that is not true for many women (Beckett, 2005). According to Rúdólfsdóttir (2000) “women’s experiences do not mirror the images of pregnancy and childbirth with which they are presented. Because we as subjects have different life stories and move through different discourses of knowledge in life, our reactions to normative ideas can never be fixed” (p. 338). The lack of agency that women have, when pregnant, is the result of the binary opposition between mind and body, where the one excludes the other. It is this, which makes controlling of pregnant women so effortless. Righard (2008) and Rúdólfsdóttir (2000) believe in the importance of women approaching birth with trust in their own abilities.

In summary, the challenge for pregnant women lies in the reading of their own bodies within the dominant biological-medical discourses (Woollett & Marshall, 1997). In light of these seemingly extreme polar opposite constructions, it will be of interest to gain insight into the constructions of the women in the chosen sample.

### **4.3. Antenatal care**

Having noted the impact of the medical model and the binary construction of health and pathology, it seems prudent, to consider antenatal care, because of the role it plays during pregnancy. Various views and constructions of antenatal care exist. The review of the literature, below, categorises these views and constructions into, firstly, that of antenatal care as screening, monitoring, preventing and pathologising. Secondly, the reasons for women's avoidance of antenatal care are examined and, thirdly, suggestions about changes in this system are considered.

There are various constructions of antenatal care and its usefulness. The construction of antenatal care as preventative function focuses on early diagnosis and the avoidance of potential problems. Chung, McCollum, Elo, Lee and Culhane (2004) emphasize the importance of early and increased screening, detection and treatment of depression, in pregnant women. "A healthy baby and a healthy mother are valued hopes and dreams of families of all cultural heritages" (Atrash, Johnson, Adams, Cordero, & Howse, 2006, p. 3).

In light of this, it is suggested that women be diagnosed earlier and treated sooner. Arck and associates (2008) suggest the development of a measuring tool to measure the perceived stress of, specifically, pregnant women. Andersson and associates (2003) explain that specifically for women who suffer from fear of childbirth, specialised treatment is of importance.

Risk factors contributed by the women's background as well as the women's mental health should be monitored. Bilszta and associates (2008) emphasize that it is of importance to identify psychosocial and socioeconomic risk factors. Through this, early interventions for pregnant women's distress can be created and postnatal mood disorders could be averted. The psychosocial risk factors that should be addressed, include the context of whether a pregnancy was planned or not, as well the importance of awareness of perceived stress, depression and demographic variables (Bouchard, 2005). "Because of the known impact of poor antenatal mental health on parenting efficacy and infant attachment postnatally, identification of psychosocial and socioeconomic risk factors, including the quality of partner support, is strongly advocated" (Bilszta et al., 2008, p. 63).

Buist and associates (2008) suggest that it is important for maternity services to be able to identify and manage the emotional health needs of women. They recommend that assessment of mental health should be ongoing in the postnatal period. An integration of mental health services into prenatal care is thus ideal (Bastani, Hidarnia, Kazemnejad, Vafaei, & Kashanian, 2005). Yet, Woollett and Marshall (1997) argue that during pregnancy, medical intervention mostly implies no more than monitoring and thus the argument for medical involvement in pregnancy is not validated.

A further construction of antenatal care focuses on the anticipation of potential problems for the infant. Early diagnosis and intervention is important for preventing potential future complications, as far as possible. Chung and associates (2004) argue that it is difficult for a woman, who is suffering from depressive symptoms, to focus

on the health and wellbeing of her child. The authors found that those women, who were at any point during the prepartum to the postpartum phase suffering from depressive symptoms, were more likely than those women without symptoms of depression, to have their infants hospitalized as well as use corporal punishment.

Atrash and associates (2006) suggest that maternal health is still lacking in many ways and complications of pregnancy are still common occurrences, despite an existence of detailed knowledge on the health of mothers as well as on preventing negative pregnancy outcomes. Delayed antenatal care is indicative of poor birth outcome (Mayer, 1997). However, the increase in antenatal testing and screening procedures, with the aim of antenatal diagnosis, has contributed to the construction of prenatal impairment (Tremain, 2006). Even though antenatal care is constructed as monitoring health and normality, it is still monitoring. Women are compared against what the medical profession believes is the “right way in pregnancy” (Woollett & Marshall, 1997, p. 179). Hence, the women in the sample of Woollett and Marshall (1997) explained that the emphasis on diagnosis and the lack of reassurance during antenatal care became a stressful experience to them.

Thus, by portraying the motherly body as a risk to the foetus, the biomedical discourse, thus, advocates for the monitoring of pregnancy and birth. The woman’s body is constructed as faulty (Davis & Walker, 2009). “Therefore, the focus of the antenatal visit becomes pathology rather than physiology” (Davis & Walker, 2009, p. 3). Andersson and associates, (2003) suggest that antenatal clinics are the ideal place



to diagnose and treat because pregnant women are expected to regularly attend these clinics. However, women do not always attend antenatal clinics regularly.

Various researchers have raised concerns about the lack of attendance of antenatal care. A number of reasons, for this behaviour, have been suggested. Reasons for not attending are related to social circumstances as well as individual decision making. In Edin and Högberg's (2002) study, midwives made sense of the non-attendance of antenatal care, as the result of various psychosocial reasons. They mentioned that fear about the future delivery may keep women from coming to the antenatal clinic. Furthermore, fear of gynaecological examination could play a role (Edin & Högberg, 2002). It is also possible that the women's previous experience of antenatal care had been (Edin & Högberg, 2002; Mayer, 1997).

However, the experience of care is also influenced by the women's mental health. Britton (2006) found that the satisfaction with hospital care was inversely related to the degree of maternal anxiety and depression. Thus in assessing the satisfaction with perinatal care, the effect of depression and anxiety should be noted and controlled for.

According to Mayer (1997) non-attendance might be related to the belief that antenatal care is insignificant. Also, women might have believed antenatal care to be useless, or believed self-care to be more effective. Furthermore, women might have believed their pregnancies to be normal and thus not needing care. He is critical of the women's conclusion that a 'normal' pregnancy does not require antenatal care. Mayer (1997) also suggests that women, who have unintended pregnancies, might delay

antenatal care, either because of denial of the pregnancy or indecisiveness about keeping the foetus. Delayed prenatal care is more common among low income women, and Mayer (1997) concluded that for these women, life stressors might have kept them from viewing antenatal care as important.

Brown, Hofmeyr, Nikodem, Smith and Garner (2007) suggest that the quality of maternity care in South African state hospitals is lacking and that women are often treated cruelly. However, although women were treated very badly, on the women's rating of the care received, only 5% reported the care to be poor. This low expectation of decent care, by the women, is of concern. It could potentially contribute to underutilization of antenatal services.

Myer and Harrison (2003) emphasize that the paradox constructions of antenatal care are problematic for use thereof, specifically in Southern African. Women construct antenatal care as merely providing a passport to the hospital for the time when it becomes crucial, namely when labour sets in. Thus, birthing is constructed as needing medical intervention, and pregnancy as not needing this. The authors elaborate:

Inherent in this framework for antenatal health-seeking behaviour is a dichotomy in which women are poorly informed about the risks of pregnancy and the importance of antenatal care, while being coerced by the structure of the health care system into using facility-based services for labour and delivery. This contrast, heightened by poor communication between lay women and providers, sharply influences pregnant women's perceptions of antenatal care services and helps to shape their service utilization, reinforcing

views of antenatal care as a nuisance and of labour and delivery as requiring facility-based care. While these approaches to antenatal care provision and utilization may help contribute to safer childbearing through facility-based delivery, they also serve to limit women's understandings of health and health risks during pregnancy. (Myer & Harrison, 2003, p. 271-272)

Research on the barriers to accessing health care, in Namibia, shows that these are direct barriers as well as social barriers. Social barriers include gender inequality, poverty and stigma. Direct barriers are the distance to a clinic or hospital and the service and treatment fees. Furthermore, there are barriers impacting on the quality of health services, for example, the lack of correct information, attitude and lack of support of the health staff, language barriers, delays and long waiting times, breaches of confidentiality, and lack of understanding of the context the women live their lives in (Parliamentarians for women's health, 2007).

In light of these various constructions, the question that many women will likely ask themselves is: Is it really worth attending antenatal care? Beckett (2005) notes the irony of not delivering adequate antenatal care to women, in comparison to spending huge resources on saving premature, under-weight babies, who are directly affected by the absence of antenatal care (Beckett, 2005).

Various researchers (Brown et al., 2007; Darvill et al., 2008; DiMatteo, Kahn, & Berry, 1993; Kitzinger, 1993; Kruger & Smit, 2002; Liamputtong, Yimyam, Parisunyakulb, Baosoung, & Sansiriphun, 2004; Peterson, 1996; Seibold, 2004) have

made suggestions on how to better cater for women's needs during the antenatal period. Ideal antenatal care should consider and allow for the understanding of each woman's unique experience.

Interventions should target mothers in the antenatal period already (Kruger & Smit, 2002). Women should be educated about pregnancy. Darvill and associates (2008) suggest that more information should be made available to women on the topic of pregnancy before they fall pregnant. This would help women with the shaping of realistic expectations about pregnancy. The expectations that women have about giving birth, at the start of their pregnancy, are different to the actual outcome. Furthermore, the authors state that information for women should be according to the different stages of pregnancy. Through informing pregnant women about pregnancy, women could be supported into managing the transition through their first pregnancy with fewer complications. DiMatteo and associates (1993) also suggest that women should be educated about birthing. They explain that women should be educated about which factors they can control personally, like breathing and pain management, and those that are beyond their control, like the hospital regulations. This will allow women some sense of autonomy (DiMatteo et al., 1993).

Peterson (1996) suggests that women should receive counselling during their pregnancy in order to work through all the changes occurring. Also, Peterson (1996) feels that women need to receive attention for the enormity of their experience. "Identifying the childbearing process as one transitional state along with factors that might influence the quality of the transition may help to extend our understanding of

women's different reactions to the maternal transition" (Darvill et al., 2008, p.8). Peterson (1996) expresses the need to treat the childbearing process as a process of creating a family and to give women support in this changing of roles during antenatal care. Addressing aspects like the taking on of new roles, the woman's expectations as well as her own childhood experiences with women during their pregnancy, allows women to adjust better (Peterson, 1996). DiMatteo and associates (1993) further suggest that women take part in support groups during their pregnancies, to allow them to share their experiences and to help them overcome the view that they need to perform up to a certain standard.

Prenatal care, as it is now, is lacking in the empowerment of women in their emotional changes, thereby not giving women the chance to integrate their experiences (Peterson, 1996). Liamputtong and associates (2004) elaborate:

Women are different in their meanings and experiences of motherhood. These differences must be recognised so that a clearer understanding of motherhood can be achieved. Only then can health services and care be made more meaningful to many women who have decided to become a mother. (Liamputtong et al., 2004, p. 589)

Brown and associates (2007) suggest that an improvement in the care received at maternity clinics might increase utilisation of maternity care. Research has shown that the availability of compassionate health care professionals was instrumental in women's experience of pregnancy (Seibold, 2004).

Finally, where necessary, the dominant discourses on pregnancy and motherhood need to be challenged.

The challenge is to develop strategies that will improve the environment of birth for women everywhere, to give women a voice, and to link them powerfully together to ensure that the changes for which they are striving find practical expression. If that is “rocking the boat,” it is an essential part of our task. (Kitzinger, 1993, p. 216)

In summary, it is evident that the different constructions of antenatal care either praise its merits or reject its sentencing to the pathologising and marginalizing of pregnant women.

#### **4.4. Birth**

A further aspect of pregnancy that seems to be greatly influenced by the medical model is the construction of the birth. Women, during their pregnancies, already construct this experience for themselves. Birth, and the anticipation thereof, therefore, plays a significant role in the women’s experience of pregnancy.

The medical model’s influence on birthing becomes apparent in the creation of binary oppositions: vaginal birth vs. caesarean section. Where vaginal birth is constructed as unsafe, unpredictable, and painful, caesarean section is constructed as safe and convenient. Childbirth is thus medicalized (Davis & Walker, 2009; Liamputtong, 2004). “Childbirth within this medicalised framework is seen as a medical problem

that can be handled only by medical professionals such as doctors and nurses in a hospital setting” (Liamputtong, 2004, p. 470).

Redwood (1999) points out that a discourse of ‘caring control’ is used by those in positions of authority over those who have no authority (Redwood, 1999). Interestingly, it seems that this is not only the case for women with a lower socioeconomic background, but for all women. Even though many middle class women had sufficient knowledge about birthing, they preferred the expert, the doctor, to take control (Liamputtong, 2005).

The discourse of risk constructs vaginal birth as risky for baby and mother. Caesarean section, on the other hand, is constructed as safe (Liamputtong, 2005). One of the major influences on this reframing was the medical discourse, which encouraged women to opt for a caesarean section for safety reasons (Fenwick, Gamble, & Hauck, 2006).

According to Fenwick and associates (2006) medical practitioners seemed to intensify women’s fears, thus convincing the women to consent to a caesarean section because of a decrease in their belief, in being able to have a vaginal birth. Also, when too much emphasis was placed on safety, the women’s anxiety would increase (Fenwick et al., 2006). In the constructions of birth, safety, thus, seems a big determinant. In Liamputtong’s (2004) study, Thai women chose to deliver in hospitals. However, previously, home birth was a widespread practice in Thailand. Yet, regardless of women’s background, they viewed giving birth at the hospital as the safer option.

This was because they believed they would have doctors assist them, should complications arise.

The women in the study of Fenwick and associates (2006) were reinforced in the belief that vaginal birth is not safe, by acquaintances and family members. Also, the women's experiences with prior births, was influential on the choice between vaginal birth and caesarean section. Many described negative experiences with a prior vaginal birth, which led to anxiety and the seeking of a safer option, namely caesarean section (Fenwick et al., 2006).

The medical discourse encouraging caesarean section, thus, influences women in two ways. Firstly, women regarded caesarean sections as safer than vaginal birth (Fenwick et al., 2006). Secondly, there seems to a perception that there would be an advantage to the baby in choosing caesarean section, in that there would be a decrease in trauma experience as well as no use of instruments on the baby (Fenwick et al., 2006). The discourse of "delivery of healthy babies" thus ties in with the biomedical discourse (Woollett & Marshall, 1997, p. 183). Women are, thus, expected to opt for surgical delivery rather than vaginal delivery based on the fact that there is less risk for the baby. However, in surgical delivery the mother faces more risk. Ironically, maternal death is thus not considered a "birthing disaster" (Beckett, 2005, p. 267).

A further construction of the mother as threat to her child refers to the time after the birth. Women's experience of postpartum Depression is seen as influential on their attitudes towards their babies, for example showing disinterest, fearfulness of being



alone with the infant, or overintrusiveness (American Psychiatric Association, 2000). The politics of choice of birthing procedure evidently, are very complex. The playing off of mother against child leaves the one more vulnerable than the other (Fenwick et al., 2006).

Vaginal birth is also constructed as unpredictable, in contrast to caesarean section, which is constructed as planned and convenient. In the sample of Fenwick and associates (2006) women found vaginal birth to be unpredictable. The researchers suggest that as result of some women's first birthing experience being negative, they "reconstruct vaginal birth as uncertain, unpredictable, unsafe and potentially unachievable" (Fenwick et al., 2006, p. 127). The women thus reconstructed caesarean section as a more convenient option (Fenwick et al., 2006). Caesarean section was more popular with the women in the sample because women felt it to be are more pragmatic approach to birth.

Opting for caesarean section was thus informed by two advantages for the women. Firstly, perceived control made the women feel less anxious. Secondly, through being able to plan the birth, women had more information under their control (Fenwick et al., 2006). The women thus reconstructed caesarean section as allowing them to be more ready for the birth (Fenwick et al., 2006).

Also, it seems women perceived to be gaining more control from choosing a caesarean section because the caesarean section was turning birth into something planned, which before was unexpected (Fenwick et al., 2006). DiMatteo and

associates (1993) concur that many women experience the time around giving birth as a time, when they lose control as well as personal autonomy. The women relate these feelings, of loss of control, to the fact that the experience of pregnancy is never spoken about in terms of the pain experienced during birthing (DiMatteo et al., 1993). The women experienced the hospital as an environment where others yield control over them and they are thus left feeling vulnerable and powerless (DiMatteo et al., 1993). Also, women were expecting to have needs met by the hospital. Both physical as well as emotional support was found to be lacking (DiMatteo et al., 1993).

On the other hand, women are also controlled by the medical arena's use of this construction. One of the ways in which the obstetric discourse exerts control is by putting time frames on specific instances of the birthing process. For example, time deemed appropriate for the second stage of labour is not more than two hours (Davis & Walker, 2009). The biomedical discourse of childbirth constructs the doctor as the "authoritative decision-maker and director of care" (Davis & Walker, 2009, p. 3). Righard (2008), a senior paediatrician, reflects on the factor of control as well as his role as a doctor:

Consider the factor of control. We doctors want to have everything under perfect control, knowing exactly what to do and what is scientifically correct. What could be more convenient for us than to have the woman in labour in a bed with an intravenous drip going and with an electronic monitor checking the contractions and the infant's heartbeats? In vaginal birth the woman is moving around in upright positions trying to find the most comfortable position and turning to herself to find her own inner strength. Such a woman is

not so easy to control! She follows her own impulses and intuitions and her own body's signals. She relies on nature. (Righard, 2008, p. 2)

Lastly, although history documents fear of childbirth as having always been present, medical propaganda has contributed greatly towards the current perceptions of childbirth and thus potentially to the lack of control over as well as fear of pregnancy and childbirth (Beckett, 2005). In the sample of Fenwick and associates (2006), after they had to undergo a caesarean section, women reconstructed vaginal birth as painful and likely to result in complications. Yet, women's perceptions vary. The women in the sample of Rúdólfsdóttir (2000) perceived the medicalization of birth ambivalently. Although they appreciated, for example, the control of pain with medication, they were apprehensive about the medicalization of pregnancy when this left them without power over their own bodies.

It seems that women automatically draw on the medical discourse in order to construct birthing. Kitzinger and Shaw (2007) analysed calls to a helpline about homebirths, in order to explore to what extent the medicalised view of childbirth was dominant in this talk. In the calls to the helpline, women automatically position their questions within a "medicalized culture of birth" (Kitzinger & Shaw, 2007, p. 205).

There are, however, those who are concerned with this influence of the medical model.

Over the last 30 years there has been a major shift in the care given to women around the time of birth. Particularly in developed countries, despite the

excellent health of most childbearing women, the rate of childbirth intervention is at an all time high. (Fenwick et al., 2006, p. 121)

The rising levels of caesarean sections are cause for concern, as these decisions to intervene, reduces the women's power to make important decisions regarding the birthing process. Furthermore, there is a great loss of intimacy due to this modernization of birth (Beckett, 2005).

Women adapt their expectations and needs to the dominant discourses. "Childbirth expectations became fluid to 'fit' a system that increasingly cannot offer many women anything other than a technocratic childbirth experience" (Fenwick et al., 2006, p.128). Beckett (2005) critically notes that often, the reasons behind a woman's choice of caesarean section are based in patriarchal values. For example, the loss of vaginal tone is one of the concerns that lead to the decision for elective caesarean section. One final worry, which Fenwick and associates (2006) mention, is that caesarean sections are surgical procedures and thus remain a risk to women.

When the discourse of safety informs decision making, the meaning of giving birth is lost (Fenwick et al., 2006). Righard (2008) is concerned that "we obviously do not look upon natural birth as the norm" (p. 1). Also, because birth is constructed as a "critical life event", women have to "hand over control of their situation to health care providers" (Liamputtong, 2004, p. 471).

In summary, birthing, as many other experiences of pregnancy, is greatly influenced by the medical discourse. In polarising the constructions of birthing into either unsafe

or safe, or then unpredictable or convenient, the construction of this experience as well as the preparation is thus removed from the women.

#### **4.5. Summary**

The prominent influence of the medical model, as well as the impact of constructing pregnancy in binary oppositions, becomes evident from the literature reviewed above. On the one hand, pregnancy is constructed as something to be monitored, in order to prevent pathology for both mother and child, with the woman becoming objectified in this construction. On the other side of the continuum, pregnancy is constructed as the woman being in control of her own experiences. Antenatal care is influenced greatly by these constructions of pregnancy. Thus, women's attendance of and belief in the merits of antenatal care are greatly shaped by this too. The same applies for birthing. It too, is influenced greatly by the medical discourse. The implications for women, who buy into this, are experiences of choosing between binary oppositions, which allow no individualization of the experience. It is thus these discourses that need to be challenged and understood in order to allow women to create antenatal as well as birthing experiences for themselves, which are unrestricted by binary oppositions and discourses.

## **CHAPTER 5: CONSTRUCTIONS OF PREGNANCY**

### **5.1. Introduction**

In order to gain an understanding of that which other researchers have found, a comprehensive literature search was conducted, using the research objective and questions as guideline. A review of this literature illustrates that pregnancy can be constructed in various manners. Below follows a detailed explication of constructions of pregnancy as embodiment, constructions of dependence in pregnancy, constructions of ownership of pregnancy as well as constructions of motherhood.

### **5.2. Constructions of embodiment of pregnancy**

Bakare-Yusuf (2003) argues that there is interaction between the body and its surroundings. Therefore, a woman, through being alive, is constantly constructing her “lived experience” (Bakare-Yusuf, 2003, para. 31). She elaborates:

Of course, the kinds of experiences I have and how I make sense of these, depend on my specific form of embodiment. At a simple physical level, the kind of body I have shapes how I inhabit, engage with and interpret the world. The way I receive and negotiate the world will vary according to whether, for example, my body bleeds every month; I become pregnant or sick; I am black or white; old or young. (Bakare-Yusuf, 2003, para. 24)

Rice (2009) concurs by explaining that subjective experience is always embodied. Thus, ontologically speaking, our body becomes the basis for our psychological experiences and interactions (Bakare-Yusuf, 2003). The body is not understood as an object but as embodied and alive (Davis & Walker, 2008).

Glynos (2000) argues that it is our embodiedness which complicates discursive positioning:

We could say that there is something missing from discourse, the final word or signifier that would close it up so as to fix our identities for ever. This lacking signifier thus makes a hole in discourse. And it is the rim of the hole circumscribing the limits of discourse which becomes contingently entangled with the rims of our body. (Glynos, 2000, p. 95)

Glynos (2000) concludes that “the rims of our body *qua* organism come to *embody* the rims of discourse” (p. 95). This raises questions about whether pregnancy further complicates this positioning or rather facilitates it?

Construction of pregnancy as embodied experience is evident in both women’s discomfort with their embodied experience as well as in the need to exert control over the embodied experience. Physical changes are prominent during pregnancy. Seibold (2004) notes the discourse of needing to have a trim and taught body in the bigger society. However, the young women, in her sample, responded, not with bitterness about their changing bodies, but rather focus the changes in their identity on the role of motherhood, which they were embracing.

Uhlmann and Uhlmann (2005) found that amongst the women in their sample, some objectified the female body. Pregnancy was construed as the time when women could ignore the strong views of society on body control. Some women in their sample celebrated pregnancy as “the demise of the waistline and liberation from many bodily restrictions” (Uhlmann & Uhlmann, 2005, p. 98). Especially during the second

trimester, the women enjoyed the physical changes their bodies were undergoing. They interpreted this as their babies' growth process (Seibold, 2004).

For some women, however, the change in physique creates apprehension. Earle (2003) describes three areas which the women in her sample worried about. Firstly, they were concerned about when they would begin to look pregnant. Secondly, they worried, where on their bodies the changes would be noticeable. Thirdly, they were concerned about the possible challenges of returning to their pre-pregnancy body. Earle (2003) found that women, throughout their pregnancy, were apprehensive about their appearance. However, many accepted this change in their bodies, as only temporary.

Women mention the problem of being mistaken as being fat, early in their pregnancy. Especially during the first months of pregnancy the participants showed fear of their pregnancy being mistaken as weight gain. Earle (2003) links this fear of being thought of as gaining weight, to self-discipline and control. Discourses of health are closely linked to those of self-control. Where before, strict measuring and monitoring procedures were 'done to' women, now women 'do' these to themselves. Self-monitoring has allowed public health to become a concern, not of state institutions, but of the public (Willig, 2000). The play of power over pregnant women is manifested in the discourse of discipline. Women are advised to be disciplined about themselves as well as their pregnant bodies (Marshall & Woollett, 2000). Marshall and Woollett (2000) emphasize that the information presented to pregnant women in pregnancy guides, for example, is aimed at motivating women to rearrange their lives



into self-disciplining actions for their bodies and themselves. The experience of pregnancy as embodiment is thus constricting.

Pregnant women's body images are regulated by the norms cast upon them by contemporary society (Earle, 2003). Earle (2003) links this apprehension women have about their appearance, to "a form of oppression" (p. 250). She explains that women are still adhering to the norm that they should "conform to the contemporary ideal of slenderness" (Earle, 2003, p. 250). Alternatively, the author suggests that women's worries about their bodies could be related to the fact that they want to avoid being cast into the stereotype of motherliness. In other words, she proposes that through worrying about their bodies during pregnancy, women are worrying about the possible loss of their sexuality during this time (Earle, 2003).

Yet, it is not only the control exerted by discourses in society that shape the embodied pregnancy, but also the woman's construction of her self is shaped by this embodiment. "The embodied pregnancy is more than merely a biological event in this situation. In pregnancy, the boundaries between self and other are already troubled as the woman's body nurtures another human being within" (Davis & Walker, 2008, p. 5).

In summary, bodily and psychological experiences are interconnected in the construction of our reality. Thus, for some women, society's views on the female body result in objectification of the body. The valuing of the trim body hence, results in oppression, for some women. The woman self, therefore joins in on the monitoring

of her own body. This construction of her body is further complicated by the sharing of one body by two individuals, making the positioning of the self a complex task.

### **5.3. Constructions of dependence in pregnancy**

Dependence during pregnancy is briefly referred to in the literature as occurring as result of society and the medical arenas influence. Women are constructed as 'passive'.

Cheetham (1977) notes a change in the way society sees and reacts to pregnant women – a transition into a culture different to that which she is used to – where a pregnant woman will often be regarded as a “passive object”, and where there is a “lack of privacy and respect for a woman’s individuality” (p.43). Dawid (2003) noted that the women in her sample were concerned about loss of independence, as result of having fallen pregnant.

Uhlmann and Uhlmann (2005) found that women felt disciplined during pregnancy, especially within the medical arena. Women were denied choice in this arena (Fenwick et al., 2006). For example, women did not expect to have a vaginal birth if they knew that their doctors leaned more toward caesarean section. It seems, thus, that women are concerned about being turned “into passive and dependent patients” (Kyomuhendo, 2003, p.21).

Women, in pregnancy, are at times rendered dependent, in that they receive advice about how to be pregnant (Cheetham, 1977). Interestingly, the women in the study of

Uhlmann and Uhlmann (2005) felt more disciplined and pushed into roles of motherhood by other women and not men.

Grossmann-Kendall, Filippi, De Koninck and Kanhonou (2001) found that for women in Benin, pregnancy resulted in even greater dependence on their husbands, as they had to rely on their husbands to finance antenatal care for them.

However, women were not only negative about dependence. In the sample of Darvill and associates (2008), women mentioned needing someone to take on a mentoring role during pregnancy. This need was often not met, leaving the women feeling vulnerable. Also, in Liamputtong's (2004) study women expressed need for a companion, specifically for birthing. In Thai hospitals it was not allowed, however, to have a birthing companion. Of the women, many expressed the need to have their mothers as birthing companions. However, these women did not feel empowered enough to ask permission from their doctors, to have a birthing companion (Liamputtong, 2004).

In summary, women experience loss of independence during pregnancy, when they are rendered dependent by society or the medical arena. However, they do not necessarily portray this experience of dependence as negative. The differing experiences of dependence highlight the need to further explore this area.

#### **5.4. Constructions of ownership of pregnancy**

Below, follows a review of the literature on the acceptance and, thus, ownership of pregnancy. Falling pregnant necessitates a negotiating of the self-as-pregnant, resulting in ownership of pregnancy. Plotkin (2008) explains ownership as “something in one’s possession” (p. 1599). She reasons that this implies a form of dependence.

For some women, their pregnancies are ‘unplanned’ (Seibold, 2004) and/or ‘unwanted’ (Cheetham, 1977). Yet, defining ‘unwanted pregnancy’ is not an easy task – different meanings can be attached to the word ‘unwanted’ (Cheetham, 1977). Often ‘wanting’ a pregnancy is likened to pleasure – a positive construction; whereas an ‘unwanted’ pregnancy is often expected to have accompanying negative feelings of apprehension, depression and panic. However, in most pregnancies there is a continuum of emotions along which a woman feels, depending on factors, such as the stage of the pregnancy she is in. (Cheetham, 1977).

According to Cheetham (1977) there is no rigid manner in which a pregnancy will be experienced – an ‘unwanted pregnancy’ can turn into a ‘wanted child’ (Cheetham, 1977). Understanding ‘unwanted’ pregnancies can only be successful if there is an understanding of the context this unwanted pregnancy is in. The definition and understanding of ‘unwanted’ can only be shaped by viewing it in relation to the shifts in female and male roles (Cheetham, 1977). In Seibold’s (2004) sample, for example, the women did not construct their pregnancies as unwanted; rather they constructed them as initiating phases of change (Seibold, 2004).

In their study of women with a low income background, Kruger and Van der Spuy (2000) found that during pregnancy women conceal aspects of the self, in an attempt towards a unified self. As result of their disempowered state, women are denied a self that allows for multiplicity. They thus deny a part of themselves – their pregnancy – in order to fit into society’s view of them. This is an integration of wider discourses of pregnancy that the women yield to, where the maternal, pregnant body is seen as a threat to the rational patriarchal society (Kruger & Van der Spuy, 2000). Thus, pregnancy provokes a split-subjectivity in the woman between herself and her body (Kruger & Van der Spuy, 2000). This leads to a process that is deemed ‘life-giving’, becoming a process of restriction and denial.

To not acknowledge pregnancy was found to be quite common in this population of female farm workers in the Winelands Region of South Africa (Kruger & Van der Spuy, 2007). Kruger and Van der Spuy (2007) describe the disavowal of pregnancy to be a complex process, one that is not necessarily conscious but motivated unawareness to the extent of being a dissociative process. The “wishing away of the pregnant body” was an “attempt to re-connect with a non-pregnant self who was lean, active, and strong” (Kruger & Van der Spuy, 2007, p. 14). This motivated unawareness of pregnancy is one manner of dealing with the change in identity which pregnancy brings with it (Kruger & Van der Spuy, 2007).

Kruger and Van der Spuy (2007) elaborate:

For many pregnant women, the obscuring of the pregnant body is a personal strategy to regain control, a strategy that might ... constitute the assimilation of wider strategies of social control. In the service of a project of the unified

self, some women cannot acknowledge their pregnant bodies, their identities as pregnant women. It is also important to note that it is a specific kind of knowledge that these women ‘choose’ to obscure. It is not knowledge that is publicly verifiable, provable, or objective; it is the knowledge of the body, the knowledge of the womb. (Kruger & Van der Spuy, 2007, p. 16-17)

Lundquist (2008) argues for compassion for those women who face this split in their subjectivity. It is as result of internalized social norms that women have to split their subjectivities. This seems to be an unconscious process (Lundquist, 2008).

Furthermore, when women are labelled as denying their pregnancies, their truths are being constructed far from their own reality: “The term *denied pregnancy* is further problematic since denial, by definition, presupposes an initial acknowledgment, while women who deny their pregnancies seem to lack all subjective awareness of the biological facticity of their pregnancies” (Lundquist, 2008, p. 148).

Kruger and Van der Spuy (2007) conclude that it is especially those who are marginalized who suffer the most:

The participants, like so many people who are socially and politically disempowered, were forced to make use of defense mechanisms such as denial and dissociation in their efforts to reclaim a unified disembodied subjectivity, the kind of subjectivity that felt safe to them as female farm workers. (Kruger & Van der Spuy, 2007, p. 18)

The obscuring or denial, or rather the motivated unawareness, of pregnancy has implications for health care. The pregnant women only received antenatal care very late in their pregnancies or not at all, as their actual realization of their pregnancies only occurred late in their pregnancies and they, hence, visited antenatal clinics quite late in their pregnancy (Kruger & Van der Spuy, 2007).

Women experience unplanned pregnancies in different ways as can be seen by the following discussion. Seibold (2004) reports that on finding out about the unplanned pregnancy, the women in her sample were initially very focused on accepting the pregnancy and committing to the pregnancy. Adjustment to being pregnant was, thus, a continuing process of creating acceptance. Contrary to these findings, Lundquist (2008) suggests that for some women, it seems, pregnancy is first positioned as “symptomatic of an illness, or food poisoning” (p. 148), before the women positions her self-as-pregnant, thereby owning her pregnancy.

Pregnancy, in the sample of Woollett and Marshall (1997), was constructed as defining relations with the baby. Balbernie (2003) found the mothers in her sample, to create a mental space for their infant in their minds. Whether these mental images of their child, comprehended the child’s inner world, had a bearing on the mother-child relationship. The women’s own histories of attachment also had a bearing on the attachment they formed with their children (Balbernie, 2003). Priel and Besser (2001) found that the manner in which pregnant women form attachments to their unborn babies, is influenced by the way in which pregnant women represent their own

mothers. All these factors influenced the extent to which the mothers perceived their infants to need them (Balbernie, 2003).

In summary, it becomes evident that during pregnancy, women draw on a discourse of ownership in the process of constructing themselves as pregnant beings. For those women who are not able to construct themselves as owning their pregnancy, the experience is filled with ambivalence. Acknowledging and owning a pregnancy is often difficult in light of absence of certain experiences, such as... It seems, that women who cannot position themselves in the discourse of ownership, are thus not able to integrate their pregnancies into their 'selves'. However, this construction of owning the pregnancy is not a concrete process; rather, it is frequently a process of 'coming to terms with' and 'accepting' the pregnancy.

### **5.5. Constructions of motherhood**

Society places high value on pregnant women, as they embody the "generative aspect of society" (Bakare-Yusuf, 2003, para. 13). The discourse of motherhood is made up of various constructions about ideal motherhood, womanhood, female gender identity, and the needs of children (Walker, 1995). However, Bell (2003) feels that certain constructions of motherhood force women to have to meet idealistic standards.

Uken (1976) describes motherliness as a love for all living things, not only love for a child. "Motherliness is a concept connoting deep caring not only between mother and child but between persons as well" (Uken, 1976, p.136). The state of well-being, warmth and giving, are, thus, an essential part of motherliness. Motherliness develops



during the course of pregnancy (Uken, 1976). It is therefore, important to understand more about how women construct themselves as mothers or mothers-to-be during their experience of pregnancy.

Motherhood is constructed through cultural, ideological and contextual influences. Women construct their mothering role from within a cultural framework that brings with it norms and expectations about motherhood (Bell, 2003). It is because of this that Walker (1995) doubts whether motherhood can be empowering for any woman, when it is regulated, so strictly, by patriarchy. In her study, Kruger (2003) notices that although her participants see themselves as liberated, they still reinforce the “dominant mothering ideology” (Kruger, 2003, p. 202). Yet, that which women expect and need from motherhood is dependant on the context they move within (Youngleson, 2006). Thus, women aspire towards ideals of motherhood that are neither achievable nor realistic, as result of the socio-economic circumstances the women find themselves in (Youngleson, 2006). The women are thus subjected to the discourse of the ‘perfect mother’, yet they inevitably fail to reach their goal.

Liamputtong and associates (2004) found that for Thai women, there was no dissatisfaction with motherhood, unlike in many western cultures. They attribute this to the expectations of mothers, within the Thai society. Thai women drew on the discourse of motherhood making them happy and proud, because it allowed them to fulfil the role, which society expected of them.

Cultural demands are visible in the gendering of practices. Parenting is a binary opposition, where roles are often mutually exclusive (Bell, 2003; Nentwich, 2008). Society is very specific about the gendering of parenthood, often to the extent of exclusiveness of motherhood (Bell, 2003). “The gendered division of child care is so ingrained in our culture that ‘to father a child’ encapsulates quite a different meaning than ‘to mother a child’” (Bell, 2003, p. 130).

In the western world the construction of parenthood faces the dilemma of the parenting role versus earning income (Nentwich, 2008). Fathers marginalized in the binary opposition of parenting (Sunderland, 2006). They are not characterized in this role, which is more easily given to women (Sunderland, 2006). Western societies construct the father role through acknowledging his role as income generator. Woman’s role on the other hand is constructed through a dilemma. It implies a decision between the children and employment. In their sample, Sims-Schouten, Riley and Willig (2007) show how women draw on financial discourses in order to support specific constructions of motherhood. The women use the discourse of financial needs to justify their wanting to return to work after having given birth. Thus it seems that, in order to justify to themselves their need for autonomy and individuality, they need to reconstruct their financial needs in such a way, as to justify their rejection of the ‘caring’ construction of motherhood (Sims-Schouten et al., 2007).

Chopra (2001) is concerned about ‘exclusive mothering’, during which the mother’s role, according to feminist discourse on motherhood, is restricted to mothering. This division of labour in the family reproduces gender identities that suit the industrial

western society. Opposed to the 'exclusive mother', is its 'other', the 'absent father' (Chopra, 2001). Bell (2004) describes a discourse of 'intensive mothering', which the women in her sample drew on. This discourse is normative in nature and mothers' practices are evaluated against it. Bell (2004) describes the discourse of intensive mothering as "a historically specific and embodied practice" (p. 67).

The 'mother/child' narrative portrays a relationship between mother and child, which is closed off. The father does not feature in this narrative (Jordan, Capdevila, & Johnson, 2005). Women are seen to have closer bonds to their children. Also women are opposed to men in that they are believed to be able to develop instinctual motherhood (Bell, 2003).

In Bell's (2003) sample, women defined motherhood as implying selflessness. This was related to being committed to their children. This selflessness is expected of mothers: "Putting children first is expected of mothers, in fact being a good mother is conditional upon this" (Bell, 2003, p. 133). After delivery of a child, the mother takes on a background role. Her needs are neglected (Peterson, 1996). The Thai women in the sample of Liamputtong and associates (2004) felt that children would have to be put first. To the Thai women, becoming a mother implied more responsibilities, which in turn implied more self-sacrifice. The women also drew on the discourse of enduring things to come, for the sake of their children. Also, as a mother the women felt they had to be more mature in terms of controlling their emotions and behaviour (Liamputtong et al., 2004). Thus, women construct motherhood as self-sacrificial (Bell, 2004; Liamputtong et al., 2004).

Motherhood seems to be portrayed as integral to female identity. Established constructions of mothering are continuously shaping the individual stories of women. Furthermore, women use these constructions and replicate them in their own, personal stories (Kruger, 2003). Through these discourses, which construct women according to the views of the greater society, women tend to feel that being a woman is solely defined through motherhood (Kruger, 2003). Furthermore, stigmatization of women happens, based on whether they fit this ideal of the 'true'-woman-as-a-mother (Todorova & Kotzeva, 2003). Todorova and Kotzeva (2003) explain that women's identity, self-formed as well as imposed by society, is based on this 'mothering mandate'. The women in the sample of Todorova and Kotzeva (2003) drew on and accommodated the discourse of motherhood 'fulfilling' them as woman. Furthermore, motherhood is viewed as a 'duty to society' in this sample (Todorova & Kotzeva, 2003). Identifying themselves as mothers gives some women a perception of being respected (Harrington, 2002).

Walker (1995) on the other hand, is concerned that there is no distinction between 'mothers' and 'women'. She criticizes the view that motherhood is a natural role to a woman, rather suggesting that a woman's identity is made up of, not only motherhood, but also of being a woman. Walker (1995) is concerned about society's notion that although a woman fulfils more than one role once she becomes a mother; she will have to fail at one of these roles. Furthermore, a woman's role becomes limited: "The responsibilities of motherhood: to nurture, preserve and protect" (Walker, 1995, p. 419). Walker (1995) doubts that the action of defining and creating a concept of motherhood, which should refer to all women, is justified (Walker,

1995). However, the women in the sample of Harrington (2002) placed emphasis on the fact that they were not ‘only mothers’ but that there were other important areas in their lives that they needed to engage in. Similarly, the participants in Seibold’s (2004) sample did not perceive motherhood as their only role, maintaining other roles in their lives as well.

Importantly, society categorizes every mother into a ‘good’ or a ‘bad’ mother (Peterson, 1996). Woollett and Boyle (2000) explain:

Motherhood is constituted as compulsory, normal and natural for women, for their adult identities and personal development, and is regulated through binary oppositions in which the warm, caring and ‘good’ mother is contrasted with ‘bad’ mothers, selfish, childless and career women, and empty and deficient infertile women. (Woollett and Boyle, 2000, p. 309)

To the women in Youngleson’s (2006) study, the ‘good’ and the ‘bad’ mother were binary oppositions, which did not allow for the definition of the one to extend towards the other. “This polarity of good and bad creates the sense that being a good mother may be an impossible and overwhelming task; making it feel almost unattainable” (Youngleson, 2006, p. 28).

The women in Harrington’s (2002) sample, described the ‘good’ mother as showing emotional control and consistent mothering. Furthermore, she is seen as consistently patient and always available and loving. Further qualities of a good mother include putting the child’s priorities ahead of her own priorities as well as taking care of her

child herself and not leaving that up to someone else. These qualities imply a self-sacrificial view of mothering (Youngleson, 2006).

Women strive towards 'good' motherhood, yet also acknowledge the impossibility of ideal motherhood. The women in the sample of Harrington (2002) pushed themselves quite hard towards this ideal of motherhood, in order to master it. The sense of mastery could only be attained, however, when the women drew on the discourse of the impossibility of ideal motherhood (Harrington, 2002). As result of the women measuring themselves constantly against the inaccessible norm of 'the good mother', they had constant feelings of guilt (Harrington, 2002). In the sample of Liamputtong and associates (2004), Thai women experienced some conflict, related to whether their husbands and mothers-in-law believed them to be good-enough mothers (Liamputtong et al., 2004). Self-surveillance led to feelings of guilt and the women struggled to deal with these feelings of guilt. Harrington (2002) is concerned that the feelings of guilt lead to distancing from the identity.

However, some women also construct new discourses of the 'good' mother. The Pakeha women from New Zealand, to some extent, drew on a discourse of the 'good' mother but also actively constructed this discourse. For example, the women suggested that a good mother needs time for herself. Also, good mothering means sharing the parenting role between husband and wife (Harrington, 2002). Women also question whether this perceived necessity of caring, is purely a female domain (Harrington, 2002). Furthermore, the women in the sample placed emphasis on the

fact that they were not 'only mothers' but that there were other important areas in their lives, which they needed to engage in (Harrington, 2002).

Importantly, the factors determining good mothering practices are related to the context in which mothering takes place. This ideal context for motherhood, according to the women in Youngleson's (2006) sample, lies within the nuclear family, where the partner plays a supportive role. Furthermore, it is a context in which the mother has some financial freedom, thus allowing her time to spend with her child (Youngleson, 2006).

Although it was easier for the women in Youngleson's (2006) sample to define 'bad' mothers than 'good' mothers, the women could not believe that truly 'bad' mothers existed. Youngleson (2006) suggests that it was necessary for the women to believe in 'good' mothering and to deny 'bad' mothering. The women described a 'bad' mother as someone who does not take responsibility of childrearing (Youngleson, 2006). 'Bad' mothers were seen to be egotistical and selfish and often smoked and consumed alcohol as well as neglected their children (Youngleson, 2006). In discussing 'bad' mothering, the women however did not acknowledge the influence of context and society, but squarely placed the blame for any of the 'bad' mothering practices on the woman (Youngleson, 2006).

Women weigh themselves as mothers, against the opinions of those they deem experts of them (Bell, 2004). Harrington (2002), on the other hand, notes that the women in her sample did not mention feeling judged, about their way of mothering. She

believes, however, that the women are judged by others but that the discourse of judgement was a taboo because of the very strong discourse of 'the impossibility of ideal motherhood'. Also, surveillance from women of the same generation, who had already had children, was noticed (Harrington, 2002).

For some women, constructions of motherhood involve more emotionality, than for others. The women in Bell's (2004) sample describe mothering as emotionally involving. Youngleson (2006), on the other hand, notices that the perceptions of motherhood, as portrayed by the women in her sample, were lacking of emotionality. She speculates that the women are disempowered in their community, and that this keeps them from allowing their emotions about motherhood to come forth.

Discourses of motherhood in Thailand included happiness with, as well as, pride of motherhood (Liamputtong et al., 2004). Furthermore, pride stemmed from the feeling of bringing a life into the world. Also, the women viewed becoming a mother as positive because becoming a mother ensured care in old age. Furthermore, children were perceived as supportive during hard times (Liamputtong et al., 2004). The women in the sample of Jordan and associates (2005) also referred to themselves as 'happy mothers'. The women portray themselves as overall positive about becoming or being a mother.

For other women, motherhood is constructed as tiring (Bell, 2004), difficult to define as well as overwhelming (Youngleson, 2006). Youngleson's (2006) concludes: "Many of these women feel inadequate to mother and are overwhelmed by the



responsibility of mothering and trying to cope under stressful economic and social circumstances” (Youngleson, 2006, p. 59).

Pregnant women’s mothers seem to be a great source of support, which often takes on the form of reassurance and information about pregnancy and birth. Women expressed a need for closeness to their own mothers during this time (Seibold, 2004). Thai women also mentioned that becoming a mother made them become more aware of what their mothers had done for them (Liamputtong et al., 2004). These women appreciated the love they had received from their mothers and were also able to grasp this love better, now that they themselves were mothers (Liamputtong et al., 2004).

It is evident that the construction of motherhood is not a static construction. “Motherhood as an institution is changing, socially and discursively” (Sunderland, 2006, p. 524). The literature reviewed, above, points out that culture, society, context and the women self, all contribute towards this construction. Furthermore, the construction of motherhood into binary oppositions – the mothering vs. the fathering role; the good vs. the bad mother – as well as the distinct discourses of how motherhood should be – bonded to the child and integral to womanhood – certainly influence each woman’s experience of and her own construction of motherhood.

It is thus no wonder that the road to motherhood is one that is ‘under construction’ for quite some time. Darvill and associates (2008) argue that the transition to motherhood starts very early during pregnancy and is only complete, once the woman feels that she has regained some control. This is likely to occur some time after birth. Seibold

(2004), in her sample, found the realization of motherhood to be a slow process. Hence, the construction of motherhood is likely to be a slow transitional process, which begins during pregnancy.

## **5.6. Summary**

Women's experiences of pregnancy are greatly shaped by the discourses drawn on to construct these. Their meaning-making of their pregnancies is thus often not a subjective experience; rather it is situated in contextual, societal, and structural positions. The task of pregnancy is thus to navigate these constructions. Constructions of embodiment of pregnancy result in the female body becoming something that needs to be monitored as well as complicating the discursive positioning for the woman-as-pregnant. Constructions of dependence during pregnancy construct the woman as left dependent on especially the medical arena as well as others. Constructions of ownership of pregnancy allow for the integration of the pregnancy into the 'self', thus, allowing for acceptance of the pregnancy. Motherhood is constructed as a fluid process that consists of various binary oppositions, which the women have to navigate in order to finally position themselves in the discourse of motherhood.

In summary, a revisit of the objectives and research questions reminds us that exposing the discourses that women from a low income background draw on during pregnancy, is the objective of this study. In the literature review, discourses of pregnancy are reported as constructions of pregnancy. The answers to the research questions of understanding how women construct themselves as pregnant beings as

well as from a specific background, thus lies in the various discourses they draw on, in their constructions of self-as-pregnant. To study these discourses, is of importance, in order to make known the discourses that those women who remain marginalized, draw on. “Future research should actively focus on eliciting the discourses of coloured and black women who have previously been ignored as the minority” (Youngleson, 2006, p. 59).

## **CHAPTER 6: SUMMARY OF LITERATURE REVIEWED**

The literature reviewed provides a comprehensive view of a range of factors influencing the experience of pregnancy and various constructions of pregnancy. It seems that women are marginalised in a number of ways. Firstly, they are disadvantaged through cultural constructions of womanhood and motherhood. Secondly, they are disadvantaged as result of their economic status. Thirdly, women are disadvantaged as result of pregnancy.

The disadvantage and subsequent marginalisation of these women is linked to the discursive positioning of women, which is subject to dominant Discourses that are contextually bound. Thus their marginalisation is understood from a theoretical framework which is based on postmodernism, social constructionism and feminism. Postmodern understanding of these women's experience implies that there is no one truth for all women. Social constructionism describes these women's reality as constructed through discourses. Feminist theory advocates for new ways of understanding women's experiences and is critical of the understanding of women as the 'other' to men.

Discourse is understood to be both language and construction based on beliefs, experiences and dominant views. The fact that discourses can be dominant is instrumental in the marginalisation of women. Thus awareness of discourses is of importance.

Language is the tool used to maintain social structure through its repetitive function. Also, language creates meaning through the interplay between words and context. Language is active in constructing experience. Thus, with language we can reposition ourselves. Furthermore, we can actively use language to reflect our own interest, thus giving us power. It is the ability of language to exclude, decontextualise and create binary oppositions, which allows for marginalisation.

Identity is the result of positioning in discourse. Thus, the position we take on determines our experience of self. These positions are however subject to power thus can be repressive. The positioning in discourse is necessary for a steady sense of self. Inability to navigate discourses and positioning therein, results in ambivalence and conflict within identity. The challenging of dominant discourses thus facilitates positioning in discourses.

It seems as though the literature thus sees a pregnant woman's experience of pregnancy as dependent on her truth, which in turn is constructed by both her and society around her. Her construction of self is important to her sense of self. How she constructs herself is influenced by the culture she is based in, her economic background, the dominant discourses in her environment, her own use of language, and her positioning in different discourses.

Factors like economic background and cultural influence vary for different regions. Southern Africa's reproductive views have changed in that they are no longer deemed as valuable as they used to. Furthermore a drop in the fertility rate is linked to the

context of HIV/Aids and the need for abstinence and contraception. Statistics show us that maternal and infant mortality are a reality pregnant women in Namibia are faced with. The belief systems about health and illness in southern Africa greatly influence pregnancy birth and the experience thereof. Where the aetiology of an illness is understood to be spiritual, for example with mental illness, treatment is preferred by traditional healers as opposed to the westernised medical system. As mental illness is related to childbirth in this context, these constructions influence women's experience of their pregnancies.

Economic background is linked to vulnerability to mental illness. A low income background is also said to negatively influence the experience of pregnancy. Women from a low income background seem to have fewer choices. It can be shown that poverty is great in Namibia. However, research on the effect of poverty on the experience of pregnancy is lacking. Cultural background is influential on women's experience of self since the 'African' culture is constructed in opposition to the 'Western' culture and thus made the 'other'.

Feminists are concerned about the experience of pregnancy in the context of the male dominated medical arena. They feel that women are marginalised and disempowered in their pregnancies. The construction of pregnancy as causing vulnerability for mental illness and society's tendencies to not speak about pregnancy is of concern to feminists. Power is taken from women in that their expertise in pregnancy and child bearing is taken from them. They are constructed as being in a medical emergency. The influence of the medical arena is also visible in birthing. Vaginal birth is opposed

to caesarean section. The modernisation of birth is linked to loss of control for women.

The self-as-pregnant seems a fluid concept that needs navigation and integration to avoid it from further disempowering women. In order to do so, women need agency in their pregnancy. However, when discourses about pregnancy are removed from a woman's reality the integration of a pregnancy into the self becomes difficult. Health and illness are decontextualised and the woman's experience is thus skewed towards dominant discourses. Her experience of nausea, for example, is constructed as natural thus restricting her from experiencing it as bothersome. The experience becomes dictated to women.

A very influential model on the experience is the medical model and its construction of health and illness. Differing views understand pregnancy to be either pathological or a healthy experience. Medical discourses objectify women and construct the woman and her foetus as 'at risk'. The woman thus is held responsible for the health of the foetus; however she is not given responsibility. Rather the discourses of pathology permit the controlling of the woman. Midwifery advocates for a healthy construction of pregnancy, namely women as competent agents of their own bodies. However, the romanticising of vaginal birth is also criticised.

The medical model is influential in two areas, namely antenatal care and birth. Antenatal care is constructed as screening, monitoring and preventing. It thus, again, pathologises. Avoidance of antenatal care seems common among women from a low

income background. Reasons seem to be poverty, mental illness, unsupportive health staff, denial of pregnancy and beliefs about antenatal care, for example, that it is not necessary. It seems that until women are empowered and educated, antenatal care attendance will not increase.

Birth is constructed in a discourse of caring control, where safety is emphasised. This influences a woman's anxiety and disempowerment. Caesarean sections are constructed as safe and convenient as opposed to vaginal birth, which is constructed as unsafe and unpredictable.

A woman's body and the construction thereof are also influential in her experience of pregnancy. The embodiment of pregnancy needs to be negotiated as the body is viewed as basis for psychological experience. Thus, inability to construct one's embodiedness makes discursive positioning difficult.

The construction of dependence during pregnancy is important for the experience of pregnancy. Society and the medical arena seem to construct women as passive and thus dependent. This dependence is constructed as financial and as disregard for women's individuality and privacy. The disciplining of women is one the one hand rejected yet on the other hand women seem to seek out mentors during their pregnancies.

Ownership of pregnancy is important in the negotiating of the self-as-pregnant. At different times, for different women, pregnancy can be unwanted, wanted, unplanned,



or planned. The concealing, denial and motivated unawareness of pregnancy seems to happen when women find it difficult to construct themselves as owning their pregnancies. They thus become removed from their reality, which seems to further marginalise them. Ownership of pregnancy thus allows for acceptance of pregnancy.

Motherliness is seen as fluid concept that develops during pregnancy. Motherhood is constructed in terms of society's expectations of the ideal mother. This construction presupposes women's selflessness and their rejection of other roles in favour of motherhood. The good mother is opposed to the bad mother. However, ideal motherhood is neither realistic nor achievable, it seems. Womanhood is constructed as being dependent on motherhood. A true woman is depicted as one who has experienced motherhood.

The literature reviewed is thus clear on the variety of experiences of pregnancy, as well as the variety of influences on these experiences. No pregnancy experience is the same. Rather is based on the influence of the woman's economic and cultural background, the manner in which she uses language to construct herself, the discourses that are prominent and available in her surrounding, as well as the discourses she draws on, her construction of self, as well as her construction of self-as-pregnant, the influence of the medical arena, her construction of her body, dependence, ownership of pregnancy and motherhood.

## CHAPTER 7: METHODOLOGY

The methodology of this research is informed by the theoretical background to this study, namely social constructionism and feminism. According to Mathole, Lindmark, Majoko and Ahlberg (2004) constructionism views the world as “constituted by multiple and competing versions of truth and realities” (p. 124). Feminism is concerned with the meaning-making and construction of women’s realities and truths (Mama, 1995). A qualitative research methodology was chosen in order to yield data that would be congruent with constructionist and feminist theory. Harris (2006) points out that constructionist research is informed by constructionism. Thus, it should not be assumed that phenomena, like inequality or power, for example, are an objective fact. Hence, phenomena would be experienced in different ways, by different people (Harris, 2006). The aim of constructionist research is not to ‘find’ the cause and effects of, or the ultimate truth about phenomena but to study how people create the meaning of these phenomena (Harris, 2006).

In constructionist research, terms like inequality, power, or class, should not be defined prior to the research. How the participants define these terms is of importance (Harris, 2006). Also, the constructionist researcher would not make claims about her own beliefs about the reality of phenomena, like inequality, for example (Harris, 2006). In constructionist research no claims about who the victims and the perpetrators are, will be made. Rather, researchers would look at the manner in which the labels ‘victim’ and ‘perpetrator’ are used. Constructionist researchers also try to set aside their assumptions about a text or a participant (Harris, 2006).

The feminists stance of this research emanate from three concerns: Firstly, women's lives have been absent from social research (Doucet & Mauthner, 2008). Feminists have long argued that the experiences of women have been invisible in the social sciences disciplines, as the scientific discourse had not (and to some extent still does not) conceptualized women. As a result of knowledge being created through discourses, scientific knowledge was based solely in discourses of science. Feminism objected to the basis of social sciences in masculinist values, which were reflected in the discourses (Hekman, 2007). Secondly, women of colour were absent form feminist research. Thirdly, the mainstream positivistic and quantitative research methods were not suited to researching the complex nature of women's experiences (Doucet & Mauthner, 2008). "Many of the spheres of social life important to women's lives are not susceptible to quantification and are, thus, invisible" (Hekman, 2007, p. 539).

Thus, feminist research is carried out when the position of women in society is what is of interest to the researcher. "Pervading almost all feminist research is a focus on the distinctive experiences of women" (Hekman, 2007, p. 539). Furthermore, it is informed by attention to women's needs and empowerment (Grbich, 2007).

Feminism, thus, is rooted in social constructionism. "Feminist methodology has its roots in the critique of positivism, a critique grounded in the insight that knowledge is socially constructed" (Hekman, 2007, p. 545). It is important that feminist research should not imply a universal woman. Any research on women needs to situate them

with regard to their history, and the society, the ethnic group as well as the culture they are a part of (Hekman, 2007).

In summary, feminist research is informed by, amongst others, the following ideas: Firstly, feminist research implies a self-reflexive understanding of the researcher's role in the research (Naples, 2007). Reflexivity should thus be practiced. Secondly, participants play an essential role in steering the research. They, too, have power and can thus influence the process just as much as the researcher does (Naples, 2007). Discourse analysis views the role of both interviewer and participant as using language in an effort to present themselves in a certain way (Starks & Brown Trinidad, 2007). Thirdly, data is not presented as 'truth', rather, the readers are invited to make their own decisions about what is presented to them. Fourthly, as part of the research, there are recommendations as to how women's' lives can be improved (Grbich, 2007). Discourse analysis is, thus, one of the methods of analysis utilized by feminist researchers (Naples, 2007), as it focuses on how inequalities of a social nature are evident in as well as reproduced by discourse. It also focuses on how these inequalities are reflected in linguistic features (Gilbert, 2008). Discourse analysis, thus, allows us to understand which discourses are drawn on and how "they shape identities, activities, and relationships" (Starks & Brown Trinidad, 2007, p. 1373).

The research objective and research questions informed the choice of qualitative paradigm. As these are grounded in social constructionism as well as feminism, a qualitative stance for this research is ideal. This choice is also supported by an interest in allowing the participants of this study to share things from their frameworks as well

as to have the researcher and reader understand the manner in which the women construct their experiences. The strength of qualitative research lies therein, that phenomena can be studied, that are not evident through other methods of study. Qualitative methods, thus, allow for a “deeper understanding of social phenomena” (p. 56), than a quantitative methodology would allow for (Silverman, 2006). Also, qualitative methodology allows the researcher “to delve into questions of meaning” (Starks & Brown Trinidad, 2007, p. 1372). Therefore, the nature of qualitative analysis is subjective because of the involvement of the researcher in the research process, for example in “decontextualizing and then recontextualizing the data” (Starks & Brown Trinidad, 2007, p. 1372). ‘Decontextualizing’ and ‘recontextualizing’ imply the researcher examines “how understanding is produced through a close look at the words” (Starks & Brown Trinidad, 2007, p. 1373). The researcher is thus “interested in *how* the story is told, what identities, activities, relationships and shared meaning are created through language” (Starks & Brown Trinidad, 2007, p. 1373).

As Kruger and Smit (2002) point out, the qualitative approach to such a study is motivated by the need to understand the women’s experiences from their contexts and through that allowing for their lay constructions to come forth.

### **7.1. Sample / participants**

The sample consisted of women who attended two antenatal clinics in Windhoek, namely the Central Hospital’s and the Katutura Hospital’s antenatal clinics.

It should be noted that the aim in discursive research is not to have a sample that has representativeness for the greater population. Rather, discourse analysts are interested in the inconsistency in discourse (Yardley, 1997b).

The sampling method employed, was purposive sampling until saturation. According to Cohen and Crabtree (2006) saturation implies informational redundancy. Saturation is reached when no new subject matter is yielded by the data. Elliott, Holland and Thomson (2008) define purposive sampling as sampling where “cases are chosen because they illustrate some feature or process in which the researcher is interested” (p. 235). Eighteen women were interviewed at the two antenatal clinics. Twenty-two interviews were conducted in total. However, only sixteen interviews were included in the study. The exclusion of certain interviews was based on their unsuitability: one interview was done for practice purposes and, thus, the woman’s profile did not suit the study. The other interviews were excluded due to poor language expression.

## **7.2. Data collection**

### **7.2.1. The interview**

An interview drawing on constructionist theory will have the aim of “documenting the way in which accounts are part of the world they describe” (Silverman, 2006, p. 129). Thus, in interviewing participants we are interested in how they create meaning (Silverman, 2006). Starks and Brown Trinidad (2007) emphasize that data yielded by a semi-structured interview, suits the purposes of discourse analysis.

In interviewing with the aim of using discourse analysis, the purpose is to capture the participants' language. However, the meaning conveyed through language can differ for the researcher and the participant (Starks & Brown Trinidad, 2007). Interviewing yields "researcher-provoked data" (Silverman, 2006, p. 201). This means that the researcher is involved in creating data that would not have existed without her intervention, as she too draws on discourses, which are reflected in her language use.

The interview guidelines, used in this study, were obtained from Prof. L.-M. Kruger, at the University of Stellenbosch. The same interview guidelines were used for a research project, the Women's Mental Health Research Project, run by Prof. Kruger. This project focused on the "psychological distress and resilience of low-income women of colour residing in the Winelands region of the Western Cape" (Youngleson, 2006, p. 19).

The interview consisted of various open ended questions (the unstructured interview guidelines are included under Appendix B). Once a question was posed to a participant, the researcher would further probe for information. Probing implies that the interviewer asks a follow-up question to obtain a fuller response. Through this the researcher encourages participants to give a full answer (Gilbert, 2008).

All interviews were audio-recorded. The choice of recording talk on audio tapes has clear benefits. They are a way of holding on to the talk as well as allowing for repeated listening and transcribing of the talk (Silverman, 2006).

### **7.2.2. Procedure of data collection**

Data collection occurred at two hospitals' antenatal clinics in Windhoek, namely, the Katutura Hospital and the Central Hospital. Prior to the recruitment of participants, permission was obtained from the Ministry of Health and Social Services (see Appendix F). Recruitment of participants took place on those days on which women checked into the clinic for the first time, to have their first check-up, regardless of trimester. Contact was made with the head nurse of each clinic, who was duly informed of the research. Contact with the nurses was exceptionally important, as the researcher had to rely on their help in recruiting participants. The nurses were presented with short information sheets, which they used for screening candidates for interest in partaking in the research as well as fluency in either Afrikaans or English.

Once a potential participant had completed her medical check-up, the researcher made contact with her. A quiet, private room in the antenatal clinic was used for further contact between researcher and participant. All correspondence with the participants was available in English and Afrikaans. An information sheet, including the participant's name, address, home language as well as her due date for delivery, was completed. The demographic details questionnaire (see Appendix C) was completed next, including a question on the woman's as well as her household's income level. Thereafter, the unstructured interview was held.

At the Central Hospital's antenatal clinic ten women were interviewed. Some women were interviewed more than once, during different trimesters. Altogether, one first trimester interview, three second trimester interviews, and eight third trimester



interviews were obtained at the Central Hospital's antenatal clinic. Thus in sum, twelve interviews were obtained from this clinic. At Katutura Hospital's antenatal clinic eight women were interviewed. Altogether, two first trimester interviews, two second trimester interviews, and six third trimester interviews were conducted at Katutura Hospital's antenatal clinic. Thus, in total, ten interviews were obtained from that clinic.

The original aim was to interview the same women across trimesters of pregnancy. However, this was not possible. Firstly, most women only made contact with the clinic after the first trimester, and at times after the second trimester. Secondly, some women did not return for scheduled follow-ups, in later trimesters of their pregnancies. Thus, with some of the participants only one interview was held, whereas with others two or three interviews were held. This was influenced by the fact that not all women came to the clinic for the first check-up during their first trimester of pregnancy. A first interview would thus, for some women, only happen during her third trimester. The motivation behind interviewing women more than once lay in the need to build trust as well as establish circumstances under which their constructions could possibly, repeatedly, come forth. Also, the researcher was interested in monitoring possible changes in the women's constructions over the course of their pregnancy.

### **7.2.3. Transcription of interviews**

The transcription of texts is necessary for data analysis. Yet, it raises some concerns. Buchholtz (2007) explains:

The entextualization and recontextualization of speech via transcription is a fundamental methodology of discourse analysis. However, particularly for researchers concerned with sociopolitical issues in discourse, transcription is not a straightforward tool but a highly problematic yet necessary form of linguistic representation. (Buchholtz, 2007, p. 784)

One way of ensuring reliability in transcription, thus, is to avoid overlooking important facets of the text, for example pauses and overlaps. Also, the method of transcription should be a standardized one (Silverman, 2006). The interviews in this study were transcribed according to Jefferson's transcription notation system (Atkinson & Heritage, 2006), which is described in Appendix D. Transcriptions were prepared by the researcher as well as a second person contracted for transcriptions.

### **7.3. Data analysis**

The choice of discourse analysis is based on the researcher's approach to this analysis, namely a postmodern approach informed by feminism and social constructionism. Postmodernists and feminists argue that conservative social science replicates dominant perspectives and thus contributes to the marginalization of some individuals and groups. Social science should rather play a role in challenging the dominant powers to enable marginalized discourses to be heard (Hammersley, 2008a).

Baker and associates (2008) describe discourse analysis as not one specific method. Rather, it has the aim of analysing the social, political, historical and intertextual contexts, while employing different strategies for different purposes (Baker et al., 2008). Through discourse analysis, the effects of employing language, the things

sustained as well as undermined by it, and the relationships between talk and social repertoires, become apparent (Chouliaraki & Fairclough, 1999). Parker (1994) points out that discourse analysis provides a framework for that which has been reproduced through language.

Discourse analysis is based on the following foundations: Text occurs naturally (interviews are included in this). Understanding of the words is gained through acknowledging their co-text and context. Words have non-literal meanings. Analysis is aimed at revealing the social actions of the words (Antaki, 2008).

Discourse analysis is based on a three of principles, namely that there is no truth, that discourse is fluid and that language has varying functions. This is explained in more detail: Firstly, there is no truth. Furthermore, discourse analysis is not aimed at uncovering a certain truth (Gerbich, 2007). Discourse analysis works with conflicts of different explanations, rather than choosing an explanation above others (Parker, 1994). Importantly then, discourse analysis is not aimed at finding that which is consistent but rather it searches for “contradiction in communication” (Parker, 1994, p. 530). Miller (2000) elaborates on this:

Discourse analysis is concerned not with the Truth – about women, difference, or any other social reality – but rather with the politics of representation. It enquires to the ways ordinary actors enact power by representing the world in this way rather than that, how some accounts of the world work to influence other accounts. (Miller, 2000, p. 345)

Secondly, discourses are not static but involve texts, institutions and the sociocultural. Thus, discourse needs to be studied in its complexity (Slembrouck, 2001).

Thirdly, discourse analysis is based on the principle that language has varying functions, namely that it is influential on discourse, political, not constant and allows for positioning. Language is active in discourses. Language influences identities, knowledge and meaning. Discourse analysis, thus, explores “how knowledge, meaning, identities, and social goods are negotiated and constructed through language-in-use” (Starks & Brown Trinidad, 2007, p. 1374) as well as focuses on understanding how language is used to shape identities and action (Starks & Brown Trinidad, 2007).

Language, also, is not constant, nor abstract. Rogers and associates (2005) suggest that since language is a social practice, it will not be produced and treated equally. This then implies that all analyses will be critical. Discourse analysts begin with an interest in understanding, uncovering, and transforming conditions of inequality. Discourse analysis challenges the view that language is abstract (McGregor, n.d.). Rather then, it views language and the words we use as being based in a historical, social, and political order.

Furthermore, language constructs through positioning. Language is effective in constructing because it positions subjects, according to Parker (2005). Positioning cannot happen through discourses alone but has to be facilitated by language use (Parker, 2005). “It is this that makes every act of speaking into an act woven into

discourse, with performative effects on others and effects on the speaker” (Parker, 2005, p. 175). According to Starks and Brown Trinidad (2007) in discourse analysis the researcher observes how the participants’ language is utilized to further own objectives. Thus, in analysing text, we look at the words and their function in the organization of texts (Smith & Pangsapa, 2007).

Finally, language is political. Everything which is spoken, even that which might seem non-political, everyday-like talk has a political character, which is laid bare through reading it with a discursive approach (Miller, 2000). Language gives those speaking various options in which to convey that which is said. Language is thus political. This political nature of discourse then warrants discourse analysis, “...rather than purely descriptive, data-driven approaches which are epistemologically inadequate in accounting for the complex linguistic choices made during the processes of text production” (Baker et al., 2008, p. 281).

A further aim of discourse analysis is to investigate the social construction of reality, intertextuality, the political nature of discourse and to reveal and make visible certain processes. Firstly, it investigates the social construction of reality. Discourse analysts see reality as well as social phenomena as being constructed. These constructions are viewed as having social consequences (Hammersley, 2008b). Discourse analysis is, thus, not a simple reading of a text (Hare-Mustin, 1997). In doing discourse analysis, the researcher focuses on the detail (Smith & Pangsapa, 2007).

Secondly, discourse analysis investigates intertextuality. In utilizing discourse analysis, we perform an intertextual analysis. McGregor (n.d.) suggests that a text acts as description of what is happening in a larger social context. Within that context are sets of power relations and these influence how readers and listeners interpret the text according to their mental models, and the rules and norms they follow. “Texts are social spaces in which two fundamental social processes simultaneously occur: cognition and representation of the world, and social interaction” (Fairclough, 1995, p. 6). Texts have both an ideational function as well as an interpersonal function. The ideational function of a text is composed of knowledge and belief systems. The interpersonal function of a text is made up of identities and social relations between subjects (Fairclough, 1995).

Fairclough (1995) describes intertextual analysis as showing “how texts selectively draw upon linguistic systems” (p. 188). Thus it can make visible “how texts selectively draw upon *orders of discourse* – the particular configurations of conventionalized practices (genres, discourses, narratives, etc.) which are available to text producers and interpreters in particular social circumstances” (Fairclough, 1995, p. 188). Hence, by means of intertextual analysis, attention is being drawn to the manner in which texts depend on society and history (Fairclough, 1995). “Thus, discourse analysis is not, and cannot, be limited to the text produced by the research subjects. It requires reading between the language of personal narratives and the social, cultural and historical discourses that those narratives drew from” (Allen & Hardin, 2001, p. 172). Thus, it would defeat the aim of discourse analysis to merely look at the text itself. Buchholtz (2001) warns that discourse analysis needs to be

motivated by an awareness of power, context, history and agency. Fairclough (1995), on a similar note, explains “analysis of texts should not be artificially isolated from analysis of institutional and discursive practices within which texts are embedded” (p. 9).

Thirdly, discourse analysis investigates the political nature of discourse. Texts are political in nature and phenomena like dominance, power, ideology and inequality are addressed (Antaki, 2008). Parker (2005) equals the subject’s relation to discourse to the subject’s relation to knowledge. Through tracing the points in a text where knowledge is believed to lie, power and authority can be traced. Where the speaker or ‘agent’ addresses the ‘other’, a discourse is being drawn on.

Fourthly, discourse analysis reveals certain occurrences. It reveals the manner in which discourses, power and subjectivity are entwined. Also, it makes visible the manner in which societal discourses are drawn on in personal communications (Parker, 1994). Thus, discourse analysis aims at making evident how discourse is influenced by relationships of power and to show the effect of discourses on knowledge systems, social identity and relations (Burck, 2005). In other words, the aim is to make obvious how “discourse systematically constructs versions of the social world” (Rogers et al., 2005, p. 370-371).

Discourse analysis allows us to become aware of the origins of mainstream views (Grbich, 2007). “Although general properties of language and discourse are not, as such, ideologically marked, systematic discourse analysis offers powerful methods to

study the structures and functions of ‘underlying’ ideologies” (Van Dijk, 2006, p. 115). Furthermore, Widdicombe (1995) points out that analysis of talk allows the emergence of power and resistance as they are played out. Thus, it allows us to challenge these ideas as well as to highlight marginalized views (Grbich, 2007).

Discourse Analysts locate power in the arena of language as a social practice (Rogers et al., 2005). Analysis, thus, reveals the manner in which language obscures these power relations. Dominance can be made visible and thus oppression, repression, and marginalization can be challenged (Fallon, 2006; McGregor, n.d.).

The aim of discourse analysis is thus the following. Firstly, there is a need to uncover the rules defining the discourse and holding together certain patterns of discourse (Grbich, 2007). The second aim is to ascertain the individual’s role, her agency, in positioning herself and being positioned through language (Burck, 2005). Thirdly, discourse analysis permits resistance. “This allows resistance to prejudice, injustice and inequality, which might otherwise appear as societal conventions” (Fallon, 2006, p. 187).

Importantly, discourse analysis allows for new discourses to come forth. Widdicombe (1995) notes that the motivation behind using discourse analysis is, for it to provide alternative discourses, which are less politically connected. “Feminist and anti-imperialist theorists have therefore insisted that subordinated groups be empowered to articulate their realities and become subjects rather than objects in knowledge-



production processes” (Mama, 1995, p. 14). Importantly, discourse analysis, itself, is a process of construction and exposing (Grbich, 2007).

In summary, Rogers and associates (2005) define the goals of discourse analysis as needing “to disrupt discourses, challenge restrictive pedagogies, challenge passive acceptance of the status quo, and reveal how texts operate in the construction of social practices” (p. 376). Discourse analysis is used, hence, to describe, interpret and explain the manners in which discourse constructs, becomes constructed by, represents, and becomes represented by the social world. It aids thus in making clearer the relationship between language and society (Rogers et al., 2005).

Finally, at this point, a brief consideration of that, which does not constitute discourse analysis, follows. In light of various authors’ wariness about what is being used and done under the name of discourse analysis, a good deal of literature has emerged on this topic. It is quite helpful then to become aware of potential pitfalls in attempting discourse analysis.

Firstly, a potential shortcoming is a lack of depth in analysis, through the process of summarizing or commenting on themes (Antaki, Billig, Edwards, & Potter, 2003; Fairclough, 1995). Rather, discourse analysis should cover a textual analysis. In studying texts, it is of importance to look beyond themes in a text, since only then the historical and institutional grounding and the manner in which social order is produced as well as reproduced, becomes obvious. Therefore, neglecting to take a deeper view at a text strips it of its context (Allen & Hardin, 2001).

Secondly, a mere pointing out of what was said is, also, short of analysis (Antaki et al., 2003; Burman, 2003). The effect of summarizing is that the analyst's own words become decontextualized, thereby making it more positivist in nature. The political stance of the analyst would, thus, be hidden (Burman, 2003).

A third shortcoming happens through positioning – when the author takes sides. This happens when the analyst starts to offer her own moral and political opinion of that which was said by the participants. It is then, that the participant is not given a voice but rather the author wants to elicit sympathy from the reader for the 'victim'. Also an overly critical stance from the analyst influences the portrayal of that, which is said by the participant (Antaki et al., 2003). Burman (2003) warns, though, that assuming to be able to avoid the taking of sides might be problematic in itself. "Objectivity is not the absence of subjectivity but a particular form of it. Put simply, there is no way of avoiding adopting some kind of position. The question therefore is rather which, and on what grounds this is evaluated" (Burman, 2003, para. 5).

A fourth shortcoming happens when the interpretation of discourses is based on the assumption that underlying the discourses, are specific ideas, thoughts and opinions which are reproduced in talk. Discourse analysis does not view talk as reproducing specific ideas, rather the focus in discourse analysis then remains on the psychological use of language (Antaki et al., 2003).

Fifthly, Burman (2003) mentions that under-analysis, also, happens through uncontested readings. Avoidance of this shortcoming implies noting the interaction of different discourses and the manner in which that deflects certain other discourses. These contests between discourses have functions and it is those which need to be uncovered.

A sixth shortcoming is decontextualisation. Burman (2003) elaborates:

While it is clearly logically impossible (as well as probably undesirable) to claim to identify the ‘whole context’ of the text, the issue is to provide both a rationale for it as a meaningful text to analyse (how it has come about, why it is important, who has which kinds of stake in it, and why and how), and to indicate the stance from which the analysis is conducted. (Burman, 2003, para. 12)

Thus, in summary “the interpretation of a text would not explore the ‘horizon of meaning’ of the text, still less the internal world of speakers viewed as responsible for producing it” (Parker, 2005, p. 177). Rather, “the task of an analyst is to work on ‘the line of the Symbolic’ (working within the domain of the text), and to open up the text by disrupting and disorganizing it so that its functions become clearer, including its functions for us” (Parker, 2005, p. 177).

#### **7.4. Ethical considerations**

The Economic and Social Research Council (n.d.) suggests the following guidelines for ethical qualitative research: Research should ensure integrity and quality

throughout the research process. Participants must be fully informed of the research and its potential risks. Confidentiality must be maintained. Anonymity of participants must be respected. Participants should not be coerced into parttaking; rather they should do so voluntarily. Harm to participants should be avoided. Conflict of interest of the research should be avoided.

“The principle of respect reflects a moral concern for the autonomy and privacy rights of those recruited for research participation” (Fisher & Anushko, 2008, p. 99). Thus consent has to be obtained and participants need to be provided with all information pertaining to the study. “The right to be informed means that potential research subjects should be given a detailed but non-technical account (in a format they can understand) of the nature and aims of your research” (Silverman, 2006, p. 324). This information should include the purpose, duration and procedures of the study as well as the right to decline information or withdraw from the study, possible risks or distress, possible benefits to participant or society, and incentives. Also, the contact details of the researcher should be made available to the participants and they should be allowed to ask questions (Fisher & Anushko, 2008). Participants should be allowed to withdraw from the research at any point. Ethical research also has implication for the analysis. Researching marginalized groups could lead to a romanticized description. It is essential to show that the data was dealt with fairly (Silverman, 2006).

Participants in the study were presented with an elaborate explanation of the study. The women were asked to sign a consent form (see Appendix E) regarding their

voluntary participation in this study, after it had been explained to them that they would remain unidentified. Consent for undertaking the research at Katutura and Central hospitals' antenatal clinics, was obtained from the Ministry of Health and Social Services (see Appendix F). Furthermore, those participants expressing need for counselling, were referred to the PEACE (People's Education, Assistance, and Counselling through Empowerment) Centre for support. The PEACE Centre delivers therapeutic services to those who cannot afford to pay for such services.

#### **7.5. The challenges of methodology and maintaining validity**

Billig (2008) emphasizes that discourse analysis, through the theories informing it, implies quite some impossibility. As investigators of language, discourse analysts still have to make use of language. Through that we risk doing precisely that which we want to uncover, that is the exposure of ideology and power within the language. Thus, a separation of that which is studied from the manner in which it is analyzed is not possible (Billig, 2008). The reflexivity of language then is evident in the manner in which discourse surfaces from and responds to the manner in which it is used (Lynch, 2007). "In other words, discourse is action, even when frozen in texts (or other immutable mobiles) – it is active, reactive, and inter-active. Discourse analysis itself is discourse, reflexively bound to what it studies" (Lynch, 2007, p. 512). Thus, the creation of new text in the process of analyzing another text can be critical in reproducing ideology (Billig, 2008). "Written discourse is mediated discourse, in the sense that a technical medium is used to increase time-space distantiation" (Chouliaraki & Fairclough, 1999, p. 42).

The problem of discourse analysis then is the fact that by its design it replicates its own agenda through the “entextualization” and “recontextualization” of discourse (Buchholtz, 2001, p. 179). Discourse analysis thus makes into text, ‘entextualizes’ that which it attempts to analyse, and in producing data ‘recontextualizes’ it by ‘entextualizing’ it from within the context of the researcher. Recontextualization of discourse is a constant social process and therefore, it is the motivation behind the need for awareness of the researcher’s role in transforming discourse into text (Buchholtz, 2001). Discourses thus become both the topic of research as well as the means for research (Smith & Pangsapa, 2007).

Billig (2008) emphasizes that in using discourse analysis, the analyst has to be very aware of her language use. This does not imply the style of writing but warns of the fact that language is central in the creation of ideology, inequality and power. Rogers and associates (2005) remind us that that no matter what techniques applied, “any discourse analysis is a process of constructing meaning” (p. 382). Through writing, researchers themselves are involved in constructing the social world (Hammersley, 2008b). Furthermore, Foucault viewed the social sciences as sources of authority (Gergen & Gergen, 2007). Van Dijk (2008) thus suggests that because academic language carries with it academic discourses, these need to be reflected upon, self-critically.

The researcher invests her identity in the research process. When she/he has a shared identity with the research subjects, it seems, the research is likely to be more ethical. Similarity between researcher and researched also implies better understanding of one

another. However, being an outsider or insider as a researcher, is not linked to fixed points. Rather this investing of the identity influences our insider or outsider status as researchers. That of our identity, which we choose to make available in the research process, emphasise the dynamics between researcher and researched (Doucet & Mauthner, 2008).

To feminists an interview is not a manner of collecting data only. Rather it is a place where data is co-constructed and the process of making meaning is started. Also, the interview is a place where the researcher's own identity is further constructed (Doucet & Mauthner, 2008). Burck (2005) suggests that note should be taken of the interactional processes throughout the interview. Through this, awareness can be raised about "researcher effects, themes neglected, and areas opened up and closed down" (Burck, 2005, p. 256). Awareness of countertransference is also essential throughout the process of analysis. However, research participant also have power and can thus influence the process just as much as the researcher can (Doucet & Mauthner, 2008; Naples, 2007). This can lead to a back and forth of power relations during the interview. Parker (1994) therefore suggests reflecting on how certain data came to be focussed on.

Lastly then, the constructionist approach to research poses the following problem: "If there is no means of correctly matching word to world, the warrant for scientific validity is lost, and researchers are left to question the very role of methodology and how it might be evaluated" (Gergen & Gergen, 2007, p. 466). "The fact that discourse analysis is a reflexive property of discourse production has profound methodological

implications” (Lynch, 2007, p. 501). The methodology of discourse analysis is thus enmeshed with that to be analysed. Reflexivity is one manner with which to address the above dilemma (Gergen & Gergen, 2007). In summary, concerns of identity and power are apparent throughout the whole research process, not only during interviewing but also in analysis (Doucet & Mauthner, 2008); and awareness of this is thus critical at all times.

Wilkinson and Kitzinger (1995) note that a certain “fuzziness” (p. 7) remains about the methodology of discourse analysis. As part of any research, researchers have to show how they maintained validity throughout their research. However, in the context of postmodern, qualitative research, this becomes difficult, since validity implies the existence of a truth. Furthermore, postmodern, qualitative researchers believe that they are very involved in their research (Wilkinson & Kitzinger, 1995).

There are however means towards maintaining validity. Nixon and Power (2007) suggest a framework for establishing rigour in discourse analytic research: Firstly, they suggest that a clear research question be asked, which is appropriate for discourse analysis. Secondly, they advise that a clear definition of discourse analysis be given. Thirdly, Nixon and Power (2007) recommend that a clear and explicit theoretical framework be used, which specifies the epistemological as well as ontological positioning of the research. Fourthly, the authors suggest transparency in the method of analysis and in the theory of analysis. As fifth point, they propose clarity in the selection of texts. Lastly, Nixon and Power (2007) recommend using clear strategies to guide the analysis.



“The question of validity can be summarized as a question of whether the researchers see what they think they see” (Flick, 2006, p. 371). One aspect of validity in qualitative research is whether the interview was conducted in an authentic manner for all participants. Thus, it needs to be established whether the interviewer intervened differently for different participants or intervened more for some, than for other participants? (Flick, 2006). In summary, validity also is ensured through the argument made by the researcher: “Analytic credibility depends on the coherence of the argument” (Starks & Brown Trinidad, 2007, p. 1376).

In this research, validity was maintained through relying on a clear objective and specifically formulated research questions. Also, the theoretical background and the methodology were clearly defined. Finally, validity was also addressed through the researcher’s awareness of her own language and her working reflexively. A more detailed explanation, of the researcher’s role in maintaining validity through working reflexively, follows below.

#### **7.6. Reflexivity of the researcher**

Chouliaraki and Fairclough (1999) suggest that as consequence of the involvement of the researcher, reflexivity of the position from which the analysis is performed, should form part of the analysis. “Feminist researchers stress that if researchers fail to explore how their personal, professional and structural positions frame social scientific investigations, researchers inevitably reproduce dominant gender, race and class biases” (Naples, 2007, p. 552). According to Yardley (1997b) transparency can be achieved by working reflexively and divulging assumptions that could have

influenced the process. Hence, through being reflexive, the researcher aims at revealing their own situatedness and their personal undertaking in the research (Gergen & Gergen, 2007). In doing discourse analysis, the researcher should thus become aware of what her role and position is, in the discourses she is describing (Starks & Brown Trinidad, 2007). Rogers and associates (2005) point out that reflexivity, thus, implies “turning the analytic frame back on the researcher” (p. 381).

Miller (2000) emphasizes the relationship between the analyst’s values and her analysis:

Where critical inquiry is understood as Truth-seeking, the theorist’s commitments are expressed in her ability to tell social truths from ‘ideologies’ (...). But by invoking Truth as the grounds for that decision, the theorist inevitably masks her moral-political agenda. (Miller, 2000, p. 328)

The analysis should thus not be presented as the truth but rather as a reading of the texts. Through that the researcher will be able to reflect back to that which informed the reading (Miller, 2000).

The intention of reflexivity relates to what assumptions and procedures the researcher used (Rogers et al., 2005). Reflexivity is applied throughout the research process. Maintaining sensitivity towards others is one application of reflexivity. Reflexivity allows for exposure of inequalities and domination (Naples, 2007).

Discourse analysis should “turn inward as well as outward” (Buchholtz, 2001, p. 181).

This means that as a discourse analyst, one needs to employ a heightened self-

consciousness and that one should become aware of one's relationship to research. Thus, reflexivity as an attempt to distance ourselves from our subjectivity is essential. In other words, through reflexivity we are trying to become aware of the feelings invoked in us, by our research (Buchholtz, 2001). "We don't just think things about our research, we don't just believe them – we feel them, and we need to explore the profound consequences of that fact" (Buchholtz, 2001, p. 181). Thus, as an analyst, before we critically start looking at that which is to be analyzed, we should critically look at ourselves (Buchholtz, 2001).

Allen and Hardin (2001) warn that it is essential to identify and note the power plays between the researcher and the participants. Logically, just as the participants have motives behind that which they say, so do researchers (Smith & Pangsapa, 2007). Structural differences between researcher and participant also have an effect on the interviewing process. These structural differences, besides gender, are present in class, ethnicity, age, language of the interview, and sexuality (Doucet & Mauthner, 2008). Reflexive self-awareness is thus essential (Smith & Pangsapa, 2007).

Fallon (2006), as well as Allen and Harding (2001), give reasons behind the need for reflexivity: Researcher transparency is no more guaranteed than participant transparency. Researchers need to uncover their own hidden ideologies (Allen & Hardin, 2001). Rogers and associates (2005) note that the analyst is involved in the relationships between texts and social practices. Widdicombe (1995) warns of the fact that researchers tend to elevate their own political agendas and use those as a framework for their analyses. They therefore end up undermining the analyses

themselves. The reader of a text is seen as active – as using her own rules in interpreting and acting on the text. It is because of this that marginalization might then remain unseen (Fallon, 2006).

Yet, reflexivity, by no means, should be the avenue for the researcher's narcissistic tendencies, nor should it function to justify suspicious research practices (Yardley, 1997b). Allen and Hardin (2001) warn that being self-reflective does not guarantee understanding of the researcher's influence on the text she/he is studying. Parker (1994) casts doubt on whether reflexivity alone can be the solution:

Reflexivity is a necessary but not a sufficient condition for an understanding of relationships and how they are reproduced in discourse, and it is not necessarily a step in the right direction when it is taken on its own. If it is employed as if it were the solution on its own, it may be worse than no help at all in so far as it fails to problematize power relations. (Parker, 1994, p. 544)

Yet, the identification of discourses relies mainly on the analyst's capability at being reflexive (Parker, 1994).

Parker (1994) notes that humanity's complexity implies that reflexivity alone is not enough and that reflexivity might obscure power relations. Reflexivity will always imply positioning. Although perhaps the primary position is reflectively challenged, through this a new position towards a text is formed (Chouliaraki & Fairclough, 1999). Thus, the significance behind self-reflexivity of the researcher lies in the taking of responsibility for one's own positioning (Burck, 2005).

In summary, it should be kept in mind that the process of doing a reflexive analysis, of how a document was discursively constructed by the author, can never be completely explanative of all constructive processes. This process could carry on forever (Hammersley, 2008b). Thus, the onus lies with the reader to make deductions from what is being analysed as well as what is personally reflected on.

At this point, I would like to reflect on the research process, my potential influence on and my experience of this process. At the beginning of the interviewing process I was quite uncomfortable with asking women about something that I could not relate to in the same experiential manner as the women I interviewed. I had never been pregnant. I wondered firstly, whether they would confide in me and secondly, whether I would grasp what was being said or have the insight to probe at the right moments. Earle (2003), who did similar research also grappled with this issue. Yet, she argues that by never having been pregnant before, she was allowed more insight into the constructions of her participants. She believes her participants to have explained in more detail than they would have to someone who had experience of pregnancy. It is thus not clear whether my 'inexperience' with this topic was to the benefit or detriment of the research process.

A further aspect I had to consider was whether my being female influenced what the women said. Would they have shared different information with a male interviewer? I also wondered about the position of power I was in when interviewing the women. I came to the interviews bearing letters with the insignias of a university as well as the Ministry of Health and Social Services. I invited the women to talk to me in an

environment that was part of the institution of the antenatal clinic in a hospital, which in turn is controlled by the Ministry of Health and Social Services.

Also, I am from a middle-class background interviewing women who come from a marginalized group. Did they feel free to share their constructions with me? I was very aware of arriving at the antenatal clinic in my car as opposed to a taxi, carrying with me recording devices.

This all leads me to the question of how the women were constructing themselves in relation to me and how they were constructing what we were doing. I wonder about this especially, in the context of HIV, which is so dominant in these antenatal clinics. Did they perhaps think they were coming for HIV counselling? There is an HIV counselling station at every antenatal clinic. Although they were told by the nurses about the study when they were recruited, I will never know what exactly the nurses said to them. Furthermore, if the nurses too are in a position of power, how did what they said affect the women and influence their decision to come see me?

Importantly, I also had to consider how I as 'never-before-pregnant' approached these texts. How has my subjectivity influenced the meaning-making in this research? Was I perhaps only aware of those discourses, which I too drew on and neglected to focus on others? How did I contribute to the construction of knowledge during the interviews? Which discourses do I draw on to construct pregnancy and the experience thereof? In an effort to find out about my own constructions, I interviewed 'myself-as-pregnant'. How would I be likely to construct my experience of pregnancy? Which

discourses would I draw on? Interestingly, I expected more differences in the discourses drawn on by myself and the women in this study. There were similarities between us, in that I drew on the same discourses the women drew on. Differences were visible in my positioning in these discourses. It seemed like I could position myself more firmly in the Discourse of Ownership of Pregnancy, than many of the women. Could this ease in positioning be the result of my assumption that I would not have an unplanned pregnancy? Also, I would draw on the Discourse of Embodiment in more positive terms than the women, using it to construct my 'uniqueness'.

Furthermore, the Discourse of Embodiment would allow me to construct my dependence on my body. My positioning in the Discourse of Dependence would seem very different from that of the women. It seems that I would seek out solitude, rather than being dependent on a group of people. Also, probably as result of my education, I would very much position myself as independent and in control of myself. On the other hand, in drawing on both the Medical Discourse as well as the Discourse of Dependence my construction of doctors and antenatal check-ups would be similar to that of the women in that I would find peace of mind in being checked on. The most dominant discourse I would draw on would be the Discourse of Motherhood. I already draw on this discourse now that I am neither pregnant, nor a mother. However, it seems that my positioning in this discourse would be somewhat different to that of the women in that I would be able to position myself as both 'mother' and 'woman' in this discourse.

It becomes obvious thus that my own constructing of self and my positioning within certain discourses could have influenced which discourses I became aware of during analysis. Yet, this does not mean that the women in this research do not draw on these discourses, rather it means that I might have chosen to work with something that another researcher might not have taken note of.

Furthermore, if we depart from the view that in constructing reality and creating texts the researcher cannot fully remove herself, we can conclude that I as researcher will have played a contributing role in the construction of these women's pregnancies and their experience thereof.

### **7.7. Analytical methodology**

The methodology followed for analysis was, unlike those suggested by Parker (1992) or McGregor (n.d.), a more unstructured approach. Below follows an explanation of the methodology used.

Burck (2005) suggests a general outline of less structured steps to be followed in doing discourse analysis: Firstly, the analyst needs to select those parts of the text which relate to the research questions (Burck, 2005). In this analysis, the transcriptions were read through and data was grouped according to various themes relating to the research questions.

Burck (2005) suggests that once the relevant sections of the text have been selected, the analyst observes the text in order to ascertain the manner in which language was



used to construct the information. As part of this analysis, the themes were analyzed according to the discourses they drew on, where after the five most prominent discourses were picked out. The data was then allocated to the discourses it drew on.

Thereafter, Burck (2005) suggests that the analyst looks for variability within the data. This means that note should be taken of inconsistencies in meaning in the constructions (Burck, 2005). Parker (1994) calls these “counter-themes” (p.541), and explains that they are hidden in discourse. Parker (1994) argues that it is part of human thought to communicate contradictions. Deconstruction then happens when the analyst seeks out the inconsistencies or binary oppositions. Grbich (2007) draws on Derrida’s explanation of deconstruction, in calling it “a natural unravelling which the text invites by presenting this opportunity within its own structure” (p. 175). The aim of deconstruction is then to expose the use of polar opposites, of binary oppositions, which Weir (1996) calls the “logic of repression” (p.25) in texts. However, there is no set method of ‘doing’ deconstruction. Derrida suggested that “deconstruction isn’t done to the work, from the outside, but is the tendency of the work to dissolve when prodded and probed” (Agger, 2007, p. 446). Some guidelines as to how deconstruction is done do exist however:

“Take the position of accepting nothing and rejecting nothing in a critical and sceptical reading, the overall outcome of which should be the production of an understanding of the text’s structure, its content and its omissions” (Grbich, 2007, p. 177). Also, the text should be examined for marginalized voices and information that has been concealed.

“Making decisions about what we choose to decentre, or re-centre is one of the most political acts researchers and scholars make” (Allen & Hardin, 2001, p. 173). The decision of what to focus on then also has implications for what will be deconstructed in the process of analysis. During this analysis, the data, as it was analyzed for discourses, was also analyzed for ambivalence and contradictions.

Thereafter, according to Burck (2005), the aim is to bring forth that which the discourse achieves (Burck, 2005). Each of the five discourses were, thus, analyzed in detail as to how the women drew on them, how they positioned themselves within them, and also at times how others drew on these discourses.

Hence, through deconstructing the data and making obvious the discourses drawn on, the researcher reveals that which before was hidden and which preserves social circumstances. Thereby, an opportunity is created to challenge conventions which are held in place by such discourses (Youngleson, 2006).

## **CHAPTER 8: RESULTS**

### **8.1. Introduction**

The objective of this study had been to create awareness of the discourses that underlie the experience of pregnancy in women from a low income background. Specifically, the research was aimed at answering questions about which discourses the pregnant women drew on during their pregnancy, how the women construct themselves as pregnant beings, as well as about how the women construct themselves as pregnant beings from a specific culture and how the women construct themselves as pregnant beings from a low income background.

The eighteen women interviewed were not a homogenous group. They varied with regard to age (with the range falling between 16 and 29 years) and educational level attained (with the lowest educational level attained being Grade 8 and the highest being tertiary education). All of the women were literate. The home languages of the women included English, Afrikaans, Oshiwambo, Otjiherero, Nama, Damara, Silozi and Rukwangali.

For nine women it was their first pregnancy, for eight women their second or third pregnancy, and for one woman her fourth pregnancy. Two of the participants lived with their husbands and one woman mentioned living with her partner. The remaining fifteen women lived with other family members. Two women were married and only three women were not involved in a romantic relationship. Twelve of the women were unemployed. Of the employed women, the majority were domestic workers. For most women their total household income was unknown. For those who were aware of it,

the total monthly household income ranged from N\$ 835 to N\$ 5000. A table with all the demographic information obtained, has been included as Appendix A.

During analysis of data the discourse generated – the text that came into being through the interviews held with the women – was analyzed with the aim of becoming aware of the Discourses the women drew on. Discourse with a capital ‘D’ represents a system of knowledge and discourse with a lower case ‘d’ refers to communication (Smith & Pangsapa, 2007). Below follows an analysis of the discourse produced through the interviews with the women. The data is represented according to five dominant Discourses. Naturally, there would be more than five Discourses evident in such discourse. However, for the purpose of this study, only five Discourses were focussed on. The choice of these five Discourses was influenced by the literature reviewed on women’s constructions of their pregnancies. During analysis, attention was thus paid to texts reflecting these Discourses. These Discourses were labelled the Medical Discourse, the Discourse of Dependence, the Discourse of Embodiment, the Discourse of Ownership of Pregnancy and the Discourse of Motherhood.

The results are supported with examples of the discourse generated through the interviews. These examples are presented in text boxes and include a brief description of whether the woman interviewed was pregnant with a first child or did not fall pregnant before, as well as whether it was the first, second or third time that she was interviewed and which trimester of her pregnancy she was in. For example, ‘*1<sup>st</sup> pregnancy; 2<sup>nd</sup> trimester; 1<sup>st</sup> interview*’ means that the women was pregnant for the first time, that she was in her second trimester at the time of the interview and that the

text originates from the first interview that was held with her. The names indicated in the text boxes are pseudo-names chosen by the participants.

Furthermore, as interviews were held in both English and Afrikaans, a translation was provided for the Afrikaans text examples. However, it is important to note that analysis was not done using these translated texts; rather the original text in its original language was used for analysis. For navigation of the text below, Appendix D can be used for understanding the method of transcription and Appendix A introduces the women and their demographic information.

## **8.2. The Medical Discourse**

In the women's effort to construct themselves as pregnant, they draw on the Medical Discourse in four ways. Firstly, they draw on the Medical Discourse in order to construct their experience of pregnancy as symptomatic or as an illness. Secondly, the women draw on the Medical Discourse to construct falling pregnant as 'risky' as well as to construct the visit to the antenatal clinic as finding out their HIV status. Thirdly, the women construct caesarean sections using the Medical Discourse. Fourthly, in navigating their experience of pregnancy the women draw on the Medical Discourse in making sense of their traditional belief system.

The women draw on the Medical Discourse in constructing their experience after having fallen pregnant. They construct their experience as symptomatic, as one of illness. Questions of the women's awareness of their pregnancy are raised at this point. Do the women know that they are pregnant when they construct themselves as ill? Or is it perhaps that the women construct their experience as an illness experience before

they can construct it as an experience of pregnancy? Thus, are they at this point already positioning themselves in pregnancy? For some women, there is an understanding of the experience as being part of an illness and not pregnancy. Michelle constructs her experience of pregnancy as illness symptoms.

<i>1st pregnancy; 1st trimester; 1st interview</i>	
Michelle:	Toe ek nou, agh, toe ek nou op die plaas kom, toe kom hy – hy was mos – hy was ook bekommerd.
Interviewer:	Het hy ook iets verwag?
Michelle:	Nee, hy het geweet ek is siek. Toe sê ek mos, ek kom Windhoek toe en - om te kyk wat is dit.
Michelle:	When I now, agh, when I came to the farm, then he came – he was – he was also worried.
Interviewer:	Did he also expect something?
Michelle:	No, he knew I am ill. Then I said, I'm coming to Windhoek and – to see what it is.

For Born symptoms are interpreted as an illness rather than pregnancy. In light of so many complications and symptoms it is difficult for Born to construct her experience as pregnancy. Rather, she constructs the experience as an illness. One wonders if Born would have constructed this experience differently had she known from the beginning that she was pregnant. Yet, why did she not consider constructing this experience as pregnancy?

*Not 1st pregnancy; 1st twin pregnancy; 3rd trimester; 1st interview*

Interviewer: Tell me about the day that you found out that you were pregnant.

Born: {laughter} The day I found out I was pregnant?

Interviewer: Hmm

Born: Wow, {laughter} I was very (bad) really.

Interviewer: Why?

Born: Because I didn't know that I was pregnant, so I used to sleep every day, feeling weak, like I am ill; because I was having hmm, problems before, so I thought maybe it's that disease that I was having before; then I find out that I am pregnant but I find it very difficult, really. Because at the beginning of the pregnancy it was like I am having an infection hmm, hmm, (...) an infection. So they didn't find it at the beginning because they used to say that: 'You are affected by those (blood pressure)'. So, I find it difficult (.2) to see that I am pregnant.

Furthermore, the Medical Discourse is not only drawn on by the women but also by the clinic. When Serious goes to the clinic, concerned about the nausea she is experiencing, the clinic constructs the experience Serious is undergoing as illness symptoms and prescribes medication. The clinic thus takes on agency in constructing Serious' reality.

*Not 1st pregnancy; 2nd trimester; 1st interview*

Interviewer: Hmm. (.3) Sjoe. (.3) Kan jy nog onthou, kan jy die dag onthou waar jy swanger geraak het?

*Continued:*

Serious: (.3) Toe het ek siek geraak. As ek pille drink het ek gekots, en as ek drink of iets eet moet ek dit uitkots. Toe voel ek nie lekker nie. Toe gaan ek kliniek toe, ek het een nie geweet nie, ek het pyne hier gehad.[

Interviewer: [Hmm]

Serious: Toe gaan ek kliniek toe, toe sê hulle: 'Nee, jy is swanger'. Toe kom ek terug (.3) ah, ah, hulle het nie gesê ek is swanger nie, hulle het net my pille gegee wat ek moet drink, maar ek het die pille weer uitgekots.

Interviewer: Vir wat was die pille?

Serious: Dit was antibiotikas, my bloed was 'n bietjie hoog gewees.

Interviewer: Hmm

Interviewer: Hmm. (.3) Gee. (.3) Can you still remember, can you remember the day where you fell pregnant?

Serious: (.3) Then I became ill. When I took pills I threw up, and when I drink or I eat something I must throw it up. Then I did not feel well. Then I came to the clinic, I did not even know, I had pain here[

Interviewer: [Hmm]

Serious: Then I went to the clinic, then they told me: 'No, you are pregnant. Then I went back (.3) ah, ah, they did not say I was pregnant, they just gave me pills, which I was supposed to drink, but I just threw the pills up again.

Interviewer: What were the pills for?

Serious: They were antibiotics, my blood pressure was a little high.



In Serious' narrative there is quite some ambiguity: With her words, "nee, jy is swanger", she is both denying and affirming pregnancy. Furthermore, she then says "ah, ah, hulle het nie gesê ek is swanger nie", changing the narrative yet again. The experience of pregnancy – especially finding out that one is pregnant, it seems – is experienced as confusing and ambiguous when the Medical Discourse is drawn on. Furthermore, through positioning herself in the Medical Discourse the resulting ambivalence makes it difficult for her to position herself in the Discourse of Ownership of Pregnancy, which will be discussed later.

The Medical Discourse is also drawn on when the circumstances around a pregnancy are unfavourable. It is not only drawn on by the women but also their partners who need to construct this reality for themselves. The experience of pregnancy is then rather constructed as illness symptoms, for example an ulcer or food poisoning.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Katryn: Toe het ek nie kliniek geloop nie, altans, ek het nie dokters toe gegaan nie, want daar was ook nie 'n (...) nie. Toe het ek net een aand baie siek geraak – voor oggend – dit was hier in, in – toe gaan ek ook na 'n dokter toe. Toe is dit mos nou die storie dat die ou nie werk het nie, verstaan jy? En ons het nou Windhoek toe gekom en ons bly nou nog by sy mense en verstaan jy? Dis 'n baie lekker storie. Toe het hy my so stres gegee. Toe sê hy vir my, ja hmm – maar ek het nou eintlik gedink dit is miskien die vorige aand se kos – die vark wat ons geëet het – vark vlees – toe sê hy vir my, ja ek het 'n maagsweer ontwikkel.

Interviewer: Ok, wow

Katryn: En ek het toe (...) wil nie jok nie. En die goed wat hulle gee is amper soos sie sooi-brand pille, so 'n wit vloeistof.

Katryn: Then I did not go to the clinic, rather, I did not go to the doctors, because there also was no (...). Then I just got very ill one evening – before morning – it was here in, in – then I also went to a doctor. Then it was that story of the guy not having work, you understand? And we came to Windhoek now and we are staying with his people, you understand? It's a very nice story. Then he gave me such stress. Then he said to me, yes hmm – but I actually thought it was the previous evening's food – the pork which we ate – pork meat – then he said to me, yes, I developed a stomach ulcer.

Interviewer: Ok, wow

Katryn: And I then did (...) don't want to lie. And that stuff they give is almost like the acid reflux pills, this white liquid.

Katryn constructs her experience as resulting from food poisoning, whereas her boyfriend constructs the experience as resulting from a stomach ulcer. One wonders whether Katryn had previously constructed pregnancy as 'symptom-free', thus resulting in her construction of her nausea as illness?

Pregnancy, especially falling pregnant, is constructed as a risk in the context of potential HIV infection. Going to the antenatal clinic for a check-up during pregnancy thus becomes more than just that. It also is constructed as a time when one's HIV status could potentially be revealed. Pregnancy is thus constructed as a risk and the women are constructed as undergoing risk.

Tangi relates how the first comments she received were related to the risk of HIV as related to falling pregnant. Thus, when pregnancy is acknowledged, the sexual encounter, which resulted in the pregnancy, is constructed as having been an ‘unprotected’ sexual encounter. Thus, pregnancy is not constructed as ‘miracle of life’ but rather as ‘a brush with death’.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Tell me about the people, the people in your life – your family, your friends. What did they say when they heard that you were pregnant?

Tangi: Oh, they quarrel about – but it’s part of life.

Interviewer: What did they say? How did they quarrel?

Tangi: They say that you – in this for nowadays there is a risk of HIV.

Interviewer: Hmm

Tangi: and hmm (...)

Interviewer: Ok, so there was[

Tangi: [because people – many people, they are dying]

Interviewer: Ok

Tangi: They say you must try to use condom.

Tangi and the people who commented on her pregnancy thus construct pregnancy as risky.

For Grace, the experience of having her pregnancy check-up at the antenatal clinic is constructed prominently, using the Medical Discourse. In constructing the experience as receiving an HIV diagnosis, her pregnancy becomes inferior.

*1st pregnancy; 3rd trimester; 1st interview*

Grace: Then she also know - then it was so – she was in such a hurry – she speak so fast. Ja: ‘Did you ever come to take your blood? Did you ever get sex with your boyfriend?’, and I say: ‘No, I didn’t.’ ‘When you go have sex with a boyfriend, you must use condom.’ But sometimes you go to the test the blood. You get positive or negative. It’s not there really - answer. You must maybe get three month, then you go again. Hmm, hmm, ok, you test for HIV. I didn’t maybe understand it what he say. Ah, they said that maybe the blood doesn’t work. And I thought she said I must go again to test.

Interviewer: And so you were very worried.

Grace: Yeah, I got HIV

Interviewer: Ah, shame!

Grace: When I walk, walk and I take out the card. I look again {laughter} I look again, ok. Then I come to – when I told my mother. Oh, my mother is very shocked. {laughter}

Interviewer: Did you say to her that maybe – you were worried that you had HIV?

Grace: I told her, my mother: ‘I’m having HIV.’ ‘Eh?!?’ She’s very shocked!

Interviewer: Oh.

*Continued:*

Grace: Then she told me, ah, there is another paper you must check but ha-ah there is one other place written. Ok, fine, we are going to wait for my sister, she is the one who knows. Ja, my sister she is looking here, at that paper. She: 'the answer is negative! It's negative!' 'Ha-ah, that nurse told me I must go again – the blood doesn't – didn't done well. If the answer doesn't come I must go again but I thought (this writing) doesn't mean something. The answer is on this one. Ah, they told me nicely, what they explain nice. Ok. {laughter}

Interviewer: Sjoe

Grace: Oh, my mother say: 'Ah-ah.' Worried. She was very worried, worried, because she was sure that I was told that because that decision, né. People are suffering, what, what.

Interviewer: Hmm (.2) Do you find that you often don't understand the nurses and the doctors?

Grace: What?

Interviewer: Does it happen a lot that the doctors and the nurses, they talk too quick and you don't understand?

Grace: You don't understand! Also, that one was very quickly. Then I went and asked again: 'Did you say here?' I just written (at the back). Also, she was having another person for counselling and I leave then. I going to hear from my home.

Grace constructs her visit to the antenatal clinic as a HIV scare. Furthermore, everyone who she consults buys into that same construction.

It seems that women construct the experience of visiting the antenatal clinic as going for a diagnosis. Thus, the process of making meaning of their reality of pregnancy is constructed partly with the Medical Discourse as diagnosing illness. The medical discourse of illness is so strong that Baby thinks she might have been infected with HIV, although she has been tested.

*1st pregnancy; 2nd trimester; 1st interview*

Interviewer: Ok. Tell me about those first months of being pregnant. What changed, what was different?

Baby: The first part of being pregnant - especially if it comes to vomiting - you won't like it, because I really vomit, even if I drink water, [

Interviewer: [really]

Baby: I should vomit, if I eat a sweet, I shall vomit, nothing had gone to my (heart)[

Interviewer: [Hmm]

Baby: And you know, I started losing weight[

Interviewer: [Hmm]

Baby: And I was wondering now, I heard people, when a person is pregnant, you get more weight and everything[

Interviewer: [Ja]

Baby: now how come my weight is losing? [

Interviewer: [Exactly]

Baby: then I was thinking of this HIV, whatever, whatever[

Interviewer: [Ja, ok]

Baby: Maybe I might be HIV and everything like that. (.2) And my boyfriend knows that, no, she - 'cause we used to be tested and everything[

Interviewer: [Ok]

Baby had, before falling pregnant, constructed pregnancy as an experience of a certain kind. She had constructed her reality in anticipation. When her experience is different to that which she has constructed it to be like, her construction changes to that of an illness or 'abnormality'. This construction of hers leaves her fearful and uncertain. Experiences during pregnancy are thus constructed as illness symptoms. Baby draws on the Medical Discourse to construct those experiences that are not congruent with her expectations and constructions of pregnancy. In light of the HIV pandemic, Baby constructs and makes sense of the 'abnormal' experiences as possibly being related to HIV.

Sofia also uses the medical discourse to construct that which does not fit her previous construction of pregnancy.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Hoe vergelyk hierdie swangerskap met jou ander twee swangerskappe?

Sofia: Hmm, dis baie verskillend.

Interviewer: Is dit?

Sofia: My ander twee swangerskappe was net normaal. Ek het nie probleme gehad nie.

Interviewer: How does this pregnancy compare to your other two pregnancies?

Sofia: Hmm, it's very different.

Interviewer: It is?

Sofia: My other two pregnancies were just normal. I did not have any problems.

When the experience of pregnancy does not align with her previous construction, Sofia needs to make sense of her reality drawing on a different discourse, the Medical Discourse.

In constructing themselves as women who give birth, the women draw on the Medical Discourse in order to construct caesarean sections. The women construct themselves as women who give birth ‘naturally’, thus giving birth vaginally rather than undergoing a caesarean section. They construct vaginal birth as the normal way of giving birth – the embodied experience of birthing – and caesarean sections as abnormal. It seems that a woman constructs herself as having more agency in vaginal birth than in birth through caesarean section. Hence, although the Medical Discourse advocates for caesarean sections, the women draw on this discourse differently in constructing caesarean sections not as the ideal, but rather as the abnormal way of birthing.

*Not 1st pregnancy; 2nd trimester; 2nd interview*

Interviewer: Wat vertel hulle van die operasie?

Maria: (.4) As die baba groot is?

Interviewer: Hmm

Maria: (Dan) gaan jy operasie kry.

Interviewer: (.2) Ok, (.2) want dan pas hy nie?

Maria: Hmm

Interviewer: Ok. Ja.

Maria: (die baba klein is) (...) normaal kry.

Interviewer: Ja. Ja. (.3) Ok. (.3) Wat dink jy gaan met jou gebeur?

Maria: {laughter}

Interviewer: {laughter}

Maria: Ek sal (...) (self baba kry) {laughter}



Interviewer:	What do they tell you about the operation?
Maria:	(.4) When the baby is big?
Interviewer:	Hmm
Maria:	(Then) you will get an operation.
Interviewer:	(.2) Ok, (.2) because then he does not fit?
Maria:	Hmm
Interviewer:	Ok. Yes.
Maria:	(the baby is small) (...) have it normally.
Interviewer:	Yes. Yes. (.3) Ok. (.3) What do you think will happen with you?
Maria:	{laughter}
Interviewer:	{laughter}
Maria:	I will (...) (have baby myself) {laughter}

To Maria there is a normal way of giving birth. Normal birth means doing it yourself thus having agency in birthing. Maria draws on the Discourse of Embodiment in constructing vaginal birth as the ideal. However, there is ambiguity in Maria's narrative. In previous parts of the dialogue, she repeatedly expresses the need to give birth to a "big" baby, attributing size to the baby's health. However, this stands in conflict with her construction of the ideal way of giving birth. It thus becomes difficult for Maria to position herself in the Medical Discourse.

The women either buy into the Medical Discourse and go to the antenatal clinic which represents the westernized construction of birthing and pregnancy, or experience difficulty in positioning themselves in this Medical Discourse in relation to their

traditional belief system and the construction of birthing and pregnancy as based on this system.

Baby describes how she needs information and feels she is not getting this. When she receives information from older women, it is based on the traditional belief system with which Baby does not agree.

*1st pregnancy; 3rd trimester; 2nd interview*

Interviewer: Hmm. Sjoe. Did your mother talk – do you talk to your mother or to other older women, maybe?

Baby: I talk to mom. My mom gave birth in 1985

Interviewer: Hmm

Baby: twenty-two years back. (...) So I also think she (...) some of the things.

Interviewer: Hmm

Baby: That what she is telling me is just about their old traditional beliefs and I don't believe in any traditional beliefs.

Interviewer: What are the traditional beliefs?

Baby: I shouldn't drink too much water.

Interviewer: Is it?

Baby: Ja, shouldn't drink too much water. I should put like sand in the water. I shouldn't make yellow things, like eating oranges and drinking yellow juices[

Interviewer: [Oros and all those things]

Baby: Ja, but here at the clinic then they used to tell us that we should eat more Vitamin C

*Continued:*

Interviewer: Hmm

Baby: but is[

Interviewer: [in all the orange fruit] {laughter}

Baby: Ja, in all the orange fruit. So you used to wonder, now which one should I use?

Interviewer: Hmm. I can imagine that being difficult – you know your (.1) mother and the older people that you usually listen to, whose advice you usually take, then clashes[

Baby: [hmm]

Interviewer: with this.

Baby: I don't listen to them.

Interviewer: Ja

Baby: I just read the books. I used to buy this pregnancy books. Just run through them.

Interviewer: Ok, is that helping you a bit?

Baby: Ja, you get some information there. Then you use it.

There is ambiguity in Baby's narrative. Although she at one point states that she does not buy into the construction of pregnancy from the traditional belief system, she also constructs herself as torn between these two constructions. She wonders about which one she should use.

In conclusion, the women draw on the Medical Discourse in a number of ways. Firstly, the Medical Discourse is used in constructing their experience of their pregnancies as an experience of illness. They construct themselves as ill and suffering from symptoms. The women construct the visit to the clinic as going for a diagnosis and thus construct pregnancy as a diagnosis of illness. Furthermore, they construct themselves as in danger of falling ill as result of falling pregnant. They thus construct falling pregnant as 'risky'. Together with constructing the visit to the clinic as receiving a diagnosis, the women also construct this experience as that of finding out their HIV status. Lastly, the women draw on the Medical Discourse in order to navigate their position in this Medical Discourse with regard to their traditional belief system.

The Medical Discourse is also connected to the use of other Discourses. The women draw on the Medical Discourse, in order to construct birthing practices. However, vaginal birth is constructed using the Discourse of Embodiment, which will be shown in that section, as opposed to caesarean sections, which are constructed using the Medical Discourse. Thus, when the women position themselves in the Discourse of Embodiment, the changes in their bodies are constructed as 'normal'. On the other hand, if they position themselves in the Medical Discourse, their changing bodies are constructed as 'ill'.

It seems that there might also be a relationship between the Medical Discourse and the Discourse of Ownership of Pregnancy. Furthermore, it seems that the positioning of their experience of pregnancy in the Medical Discourse is significant for later

positioning in the Discourse of Ownership of Pregnancy. The construction of self-as-pregnant is complicated and delayed by the women's drawing on the Medical Discourse. Only once they can leave behind their construction of self-as-ill, can they begin their construction of self-as-pregnant. It is in this navigation of the Medical Discourse that the women feel ambiguous about the reality of their pregnancies, which makes positioning in the Discourse of Ownership of Pregnancy difficult.

The Medical Discourse which the women draw on in order to construct themselves as ill and suffering from symptoms is also underlying the Discourse of Dependence. The Medical Discourse results in a construction of pregnancy as something that renders women vulnerable and thus needs to be monitored. The women buy into the Medical Discourse in constructing themselves as needing to be checked on during their pregnancy, thus dependent on the medical arena.

### **8.3. The Discourse of Dependence**

The Discourse of Dependence is drawn on in five different ways. Firstly, the women draw on it in order to construct themselves as dependent and to give agency to older women or their own mothers. Secondly, the women draw on it in order to construct themselves as dependent and to give agency to the antenatal clinic, hence the medical arena. Thirdly, the women construct themselves as dependent without shifting agency to any specific person or institution, though. Hence, in this instance they construct themselves as 'not independent'. Fourthly, the women draw on the Discourse of Dependence in order to construct their unborn children as dependent on them, the

women. Lastly, the women draw on the Discourse of Dependence in navigating the dependence on either the medical system or their traditional belief system.

The women construct themselves as dependent on an older, more experienced person's guidance during their pregnancy. The construction of dependence on older persons carries more weight than the construction of dependence on the clinic, it seems. Thus, the women are shifting agency onto older persons in constructing themselves as dependent.

Ansie shifts agency to older persons. She explains that ever since she has fallen pregnant, she has avoided persons her own age and rather spends time with those who are older, thus constructing herself as dependent on, specifically, older persons.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Klink vir my jy wil bietjie vir jouself beskerm?

Ansie: Is (...), ja. Meer - bietjie met die ouerige persoon deurmekaar raak, as wat jy met jou ouderdom mense (moet akkomodeer) of so.

Interviewer: Jy, jy het nogal 'n sterk behoefte om met ouer mense te, te praat en te wees, né? Hoekom dink jy is dit so?

Ansie: Dis vir my 'n goeie lewe, of 'n goeie ding om met groterige persone te kommunikeer, as jong mense, want ek dink deestyds het jong mense – ons is nie van mense wat sê: 'Dit wat jy doen is verkeerd. Maak so. Hou jou weg van daardie!' Ons is nie so nie. Ons wil net vir ons in verkeerde rigtinge inlê en so. Maar 'n ouerige persoon sal vir jou sê: 'My kind, dit wat jy doen is verkeerd. Maak so, maak so.' Ek is eintlik van my ma so groot gemaak.

Interviewer: Sounds a bit to me like you want to protect yourself?

Ansie: Is (...), yes. More – a bit of interaction with the older person, rather than that you (must accommodate) your age group people, or so.

Interviewer: You, you have quite a strong need to, to speak to and to be with older people, right? Why do you think it is like that?

Ansie: For me it is a good life, or a good thing to communicate with bigger persons, than young people, because I think that in the past young people – we are not the kind of people who say: ‘That what you are doing is wrong. Do it like this. Keep yourself away from that!’ We are not like that. We just want to go into the wrong direction and so on. But an older person will tell you: ‘My child, that which you are doing, is wrong. Do like this, do like that.’ I was, actually, raised like that by my mother.

Many of the women are specific in their construction of dependence in positioning, in shifting the agency towards their mothers or other older women.

Michelle relates how she confided and trusted in an older woman.

*1st pregnancy; 1st trimester; 1st interview*

Interviewer: (.1) Hmm, wie was die eersde persoon vir wie jy gesê het?

Michelle: Hierdie antie

Interviewer: Ja

Michelle: {laughter} Vir haar eerste gesê.

Interviewer: En dan?

Michelle: Dan, toe gaan sy, toe praat sy met my ma saam.

Interviewer: (.1) Hmm, who was the first person you told?  
 Michelle: This auntie  
 Interviewer: Yes  
 Michelle: {laughter} Told her first.  
 Interviewer: And then?  
 Michelle: Then, she went, she went to go speak with my mother.

Michelle is constructing herself as being dependent on an older woman's support in facing the challenge of telling her parents about her pregnancy.

Some women feel that an older, experienced woman will know better than the clinic.

Katryn constructs herself as needing her mother's opinion, as being dependent. Thus she trusts her mother when she is told that she is pregnant.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Katryn: [Ja, ja, toe ek, ah, ah, toe ek nie begin vloei nie, toe is dit mos al daardie sewende wat ons hier is, toe sê ek vir hulle en nog voor my broer gesterf het. Toe sê ek ook vir my ma een dag, ek is swanger. Maar, maar, maar ek het vir haar – en 'n vroumens gee mos ook afskydings af né, soos as jou period miskien klaar is – daardie afskydings. Toe, toe – hoe het dit gebeur? Toe het ek my gewas, toe is ek daar by my ma. Toe het ek my gewas en toe wys ek dit vir my ma, toe sê die ma vir my, nee ek is swanger. Sy is mos nou al 'n groot vrou. Maar nog met sy swangerskap en met die – hoe kan ek sê – ek praat met my ma. Ek het vir haar ge sê ek is swanger.



Katryn: [Yes, yes, when I, ah, ah, when I didn't start flowing, then it was already that seventh, when we were here, then I told them and still before my brother passed away. Then, I told my mother too one day, I am pregnant. But, but, but I had for her – and a female also gives of secretions, right, like when your period is maybe over – those secretions. Then, then – how did it happen? Then I washed myself, then I was there at my mother's. Then I washed myself and then I showed it to my mother, then my mother told me, no, I am pregnant. She is already a big woman. But still with his pregnancy and with the – how can I say – I talk to my mother. I told her that I am pregnant.

In pregnancy one would rather count on the support of one's own mother than the support of the father of the child.

*Not 1st pregnancy; 3rd trimester; 3rd interview*

Interviewer: Hoekom wou hy nie dat jy na jou ma toe trek?

Maria: Aah, ek ken nie.

Interviewer: Wou hy gehad het jy moet by hom bly?

Maria: Ja

Interviewer: Ok, ok (.2) Vertel vir my hoekom wou jy graag na jou ma toe getrek het. Wat is beter daar as by Johnny?

Maria: (.2) Niks is beter nie maar my ma is beter omdat my ma is beter. Ek kan nie by hom bly nie en ek gaan kry babatjie.

Interviewer:	Why did he not want you to move to your mother?
Maria:	Hmm, I don't know.
Interviewer:	Did he want you to stay with him?
Maria:	Yes
Interviewer:	Ok, ok (.2) Tell me why you rather wanted to move to your mother. What is better there than at Johnny's?
Maria:	(.2) Nothing is better but my mother is better because my mother is better. I cannot stay with him and I am going to get a little baby.

Maria constructs herself as needing to be with the mother whom it will be better to stay with when the baby arrives. There is ambivalence in Maria's words. She cannot pinpoint what it is that makes it the better solution to stay at her mother's house. She cannot say that that plan is better but then goes on to say that it just is better. She thus prefers to construct herself as dependent on her mother and seems comfortable with this construction of self-as-dependent.

It seems as though the women are so firmly positioned within the Discourse of Dependence with regard to their mothers that the mother almost becomes part of the self. Maria implies that telling her mother about her pregnancy does not count as telling.

<i>Not 1st pregnancy; 1st trimester; 1st interview</i>	
Interviewer:	Toe het die menstruasie nie gekom nie. Ok. Hmm, wat het jy gedoen toe jy uitgevind het nou jy's swanger?
Maria:	(.2) Ek het net stil gebly en my ma gaan sê dat ek swanger is; ek het net bly gaan na die hospitaal, dan het die dokters vir my gekyk.

Interviewer: Then the menstruation did not come. Ok. Hmm, what did you do when you found out, that now you are pregnant?

Maria: (.2) I just kept quiet and told my mother that I am pregnant; I just kept going to the hospital, then the doctors looked at me.

Maria's words portray ambiguity. She did not tell anyone yet she told her mother. It seems that Maria constructs the relationship between herself and her mother as so close that telling her mother does not qualify as telling someone else. The mother-daughter relationship is thus constructed as one of closeness and dependence.

Furthermore, the women construct themselves as dependent in that they need to be supervised by their mothers. Michelle suggests that someone needs to check up on pregnant women because they do not necessarily know how to be pregnant.

*1st pregnancy; 1st trimester; 1st interview*

Interviewer: Ah, jene (.1) Hoe voel dit vir jou dat almal (.1) iets het om te sê?

Michelle: Ek voel nogal almal is overprotective - hulle wil vir my beskerm...

Interviewer: Is dit goed vir jou of irriteer dit?

Michelle: Oh ek, kyk hier, basies is dit nou – ek vat dit nou weer, ok, is my eerste - ek weet nie wat aangaan nie, so hulle het al experience wat sal gebeur met hulle self. So ek voel dis, dis goed dat hulle vir my kan waarsku van dinge af wat ek nou nie kan geweet het nie.

Interviewer: Ah, wow (.1) How does it feel to you that everyone (.1) has something to say?

Michelle: I feel like everyone is overprotective - they want to protect me...

*Continued:*

Interviewer: Is that good for you or does it irritate?

Michelle: Oh I, look here, basically it is now – I take it as, ok, it's my first – I don't know what is going on, so they already have experience of what will happen, with themselves. So, I feel it is good that they can warn

Michelle constructs herself as not knowing about pregnancy. Furthermore, she constructs herself as dependent on advice from someone more experienced, someone who is knowledgeable of pregnancy.

Baby recalls her mother's reaction when she told her about her pregnancy.

*1st pregnancy; 2nd trimester; 1st interview*

Interviewer: What did she say?

Baby: No, she was happy. I hope it is true! I hope you are going to be pregnant and she was like caring. I shall just be in bed, I shouldn't take heavy things, like that.

Baby constructs herself as someone who is prescribed appropriate behaviour by her mother. Her mother immediately begins prescribing certain behaviours to her daughter. She thus draws on the Discourse of Dependence in positioning her daughter within this discourse. In other words, Baby is being mothered for becoming a mother.

Maria explains that as a pregnant woman, one needs to be told what to do, as one is not always knowledgeable of everything.

*Not 1st pregnancy; 3rd trimester; 3rd interview*

Interviewer: Nou ek moet vir jou sê daar is baie vrouens wat kom - hulle kom eers met vier, vyf, ses, sewe maande vir die eerste keer. Hoekom het jy so mooi vroeg gekom?

Maria: (.2) My ma het my gesê as ek swanger is - op die eerste ene ek het miskien met drie, ja ek het ook met drie maande gekom[

Interviewer: Now, I must tell you there are many women who come – they come only with four, five, six, seven months for the first time. Why did you come so nice and early?

Maria: (.2) My mother told me that if I am pregnant - with the first one I maybe came with three, yes, I also came with three months[

Maria constructs herself as needing to be told to go to the antenatal clinic. Again, Maria constructs herself as someone who does not make these decisions but as someone who is told to do them.

The pregnant woman's mother has to help protect her from navigating pregnancy wrongly.

*1st pregnancy; 1st trimester; 1st interview*

Interviewer: Wat vertel jou ma vir jou?

Michelle: Hmm, sy help my reg waar ek verkeerd is {laughter}

Interviewer: Hmm

Michelle: Skel so nou en dan

*Continued:*

Interviewer: Soos wat? Waaroor skel sy?

Michelle: As ek nou miskien weer iets verkeerd gedoen het, as sy net sien hier het ek weer (...) geglip of loop kaalvoet. In die oggend opstaan - kaalvoet loop.

Interviewer: {laughter}

Michelle: Skel sy so vir my.

Interviewer: What does your mother tell you?

Michelle: Hmm, she corrects me, where I am wrong {laughter}

Interviewer: Hmm

Michelle: Scolds every now and then

Interviewer: Like what? About what does she scold?

Michelle: If I maybe did something wrong again, if she just sees that here I again (...) slipped or walked barefoot. Get up in the morning – walk barefoot.

Interviewer: {laughter}

Michelle: She scolds me so.

Michelle constructs herself as someone who does not know much and thus is wrong about many things. Furthermore, she constructs herself as someone who may jeopardise her pregnancy due to ignorance. She also constructs herself as someone who needs to be scolded by her mother and who is thus dependent on her mother for advice and guidance.

Michelle elaborates on the reasons for being dependent on her mother.

*1st pregnancy; 1st trimester; 1st interview*

Michelle: Weet jy ek is maar – ek is baie rof, ek is baie wild {laughter}

Interviewer: {laughter}

Michelle: Ek vergeet sommer ek is swanger en dan is ek weer tussen die seuns en  
(.1) dan moet my ma my eers daar weer kom praat {laughter}

Michelle: You know I am – I am very rowdy, I am very wild {laughter}

Interviewer: {laughter}

Michelle: I just forget that I am pregnant and then I am in between the boys again  
and (.1) then my mother must again come talk with me there {laughter}

Michelle constructs herself as needing to be disciplined. She also constructs herself as not being fully aware of her pregnancy at all times. Her positioning in the Discourse of Dependence is thus a necessity to help her be pregnant ‘correctly’.

Maria points out that one has to learn how to take care of a baby. Thus one is dependent on someone else in order to be taught and guided by that person.

*Not 1st pregnancy; 1st trimester; 1st interview*

Interviewer: Van wie het jy geleer?

Maria: (.6) Ek het by my ma geleer {laughter}

Interviewer: Hmm

Maria: Hmm (.3) Hoe om met ‘n babatjie bly en hoe moet ‘n[

Interviewer: Who did you learn from?

Maria: (.6) I learnt from my mother {laughter}

Interviewer: Hmm

Maria: Hmm (.3) How to stay with a baby and how must a[

Maria constructs herself as someone who learns about motherhood from her own mother. She thus constructs herself as not knowing ‘the way of being a mother’ by herself, hence constructing herself as dependent on her mother for guidance.

In Ansie’s case, there is no specific construction of dependence on an older person but rather, on any person available. Thus, when her niece is available to come to Windhoek to assist her, Ansie constructs herself as dependent on her.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Ja. Sal jy, sal jy alleen hospitaal toe gaan, as die babatjie kom, of sal jy iemand saamvat?

Ansie: Daar moet iemand saam met my kom.

Interviewer: Ja

Ansie: My suster se dogter sal met my (...).

Interviewer: Het julle al daaroor gepraat?

Ansie: Hmm

Interviewer: Dink jy dit sal jou beter laat voel om iemand daar te hê?

Ansie: Ja, daar is die een - een werk, maar daar is ene wat saam met my altyd by die huis is. My suster se dogter – die verpleegster se dogtertjie. Dis hoekom sy hier is. Dat sy gekom het. Dat sy saam met my hier is. Sy is ook nog by die huis. Sy is elke dag, elke tyd – hulle vra my as ek so sit, so stil is, dan vra hulle vir my: ‘Kry jy seer? Hoe voel jy?’[

Interviewer: [ahh]

Ansie: en so.



*Continued:*

Interviewer: So sy het van die suide af gekom?

Ansie: Ja, sy het van Mariental af gekom.

Interviewer: So wanneer het sy gekom?

Ansie: Sy het verlede maand tog gekom.

Interviewer: Ok. Om nou met die laaste maande by jou te wees?

Ansie: Ah-ha

Interviewer: Yes. Will you, will you go to hospital on your own, when the baby comes, or will you take someone along?

Ansie: Someone must come along with me.

Interviewer: Yes

Ansie: My sister's daughter will (...) with me.

Interviewer: Have you talked about it yet?

Ansie: Hmm

Interviewer: Do you think it will make you feel better, to have someone there?

Ansie: Yes, there is the one – the one works, but there is the one, who is always with me at the house. My sister's daughter – the nurse's daughter. That's why she is here. That she came. That she is here with me. She is also still at home. She is every day, every time – they ask me if I sit still like that, am quiet, then they ask me: 'Are you hurting? How are you feeling?'

Interviewer: [ahh]

Ansie: and so.

Interviewer: So she came from the South?

Ansie: Yes, she came from Mariental.

The second manner in which the women draw on the Discourse of Dependence is in placing agency and dependence onto the antenatal clinic. The women place agency onto the clinic in three instances. Firstly, they place agency on the medical staff during the pregnancy examinations. Secondly, they place agency on and thus construct themselves as dependent on the clinic during birthing. Finally, the women construct themselves as dependent on the clinic with regard to information, which they do not seem to receive.

Baby emphasizes that she felt helpless, 'at the mercy of' the medical staff, while she was being examined. Also she is concerned about 'being done to' by the student nurses.

*1st pregnancy; 2nd trimester; 1st interview*

Baby: Yes, you know for us who are the first time pregnant, you will find some nurses who are yelling (...), like: 'Don't walk like that!', 'Don't stand like that!' - you know, you don't know where to sit and where to go[

Interviewer: [Exactly, hmm ]

Baby: at the first time, so and you won't know what are they going to do to you; and: 'Like this, like that (...).' Won't exactly know what they are talking about[

Baby constructs herself as not knowing what happens at the clinic. She thus positions herself in the Discourse of Dependence with respect to the clinic. Baby also constructs herself as different to women who have already giving birth. She constructs herself as

a first-time mother. She also constructs herself as 'being done to'. Thus, she constructs herself as dependent and in a position where she is not allowed to make her own choices.

Baby further explains that her perception of vulnerability was increased by the manner in which she was treated – she was an object that the student nurses could look at.

*1st pregnancy; 2nd trimester; 1st interview*

Baby:            Hmm. Some of them are very clever, but really, the student nurses are problems to us.

Interviewer:   Really?

Baby:            I think when you are sitting (...) because sometimes you do find even five, there might be six in a room. They are standing like that, the one is examining you and everyone wants to see you how you are there[

Baby constructs herself as being at the mercy of student nurses. She constructs herself as 'being done to', thus constructing herself as being in a dependent, vulnerable position.

The women perceive quite some anxiety with regard to the nurses. Maria describes how when she missed an appointment, she was afraid of going to the clinic thereafter, for fear of being scolded for missing an appointment. She constructs the nurses as being in a position of power, thereby constructing herself as powerless, almost like a child who should be disciplined.

*Not 1st pregnancy; 3rd trimester; 3rd interview*

Maria: (.5) Omdat die susters vir jou daai dae gee, en jy het nie opgekom nie, hulle sal vir jou kom skel en sê ja hoekom het jy nie daai dag gekom nie?

Interviewer: Hmm. (.4) Is mense maar 'n bietjie bang vir die susters?

Maria: {laughter} Ja, die susters raas met 'n mens {laughter}

Maria: (.5) Because the nurses gave you that day, and you did not come, they will come scold you and say yes, why did you not come that day?

Interviewer: Hmm. (.4) Are the people a little scared of the nurses?

Maria: {laughter} Yes, the nurses scold you {laughter}

Maria constructs herself as someone who is disciplined when she does not adhere to rules. She thus buys into the medical system by acknowledging the rules.

It seems that some women do not feel free to ask questions unless they are asked about something by the nurses. The women are also powerless in expressing their need for information. Maria is worried about her heart pounding strongly at times, yet does not feel she can ask the nurses about this.

*Not 1st pregnancy; 1st trimester; 1st interview*

Interviewer: ...het jy die susters ook gevra?

Maria: Nee, miskien volgende dae want, hmm, nou vandag hulle het my nie gevra nie.

Interviewer: ...did you also ask the nurses?

Maria: No, maybe in the following days because, hmm, today they did not ask me.

Maria constructs herself as someone who cannot initiate a conversation or ask a question. She thus places the agency with the nurses and positions herself in the Discourse of Dependence as powerless.

The doctor is constructed as the final decision-maker. He is in a position of power, which the women acknowledge.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Dink jy dit sal dalk makliker wees as die ander geboorte?

Katryn: (.3) Soos sy vir my gesê het, is, hmm, dieselfde – die baba is nou weer daarso, maar die bloeddruk lyk goed, maar die dokter sal dit maar moet (...) (wat ek na die dokter moet)

Interviewer: Gaan jy nou eerste keer dokter toe?

Katryn: Ja, dat hy nou vir my sal sê of dit nou normale geboorte sal wees, of, of hulle nou weer 'n keisersnit maak.

Interviewer: Do you think it will perhaps be easier than the other birth?

Katryn: (.3) Like she told me, is, hmm, the same – the baby is again there, but the blood pressure looks good, but the doctor will have to (...) (when I must go to the doctor)

Interviewer: Are you going to the doctor for the first time now?

Katryn: Yes, so that he will tell me whether it will be normal birth, or, or whether they will do a caesarean section again.

Katryn constructs herself as someone who is dependent on someone else, who is an authoritative position, to tell her the best way of delivering her child.

The medical staff is constructed as being in control of everything. Baby would like her partner to accompany her when she is giving birth, yet she doubts ‘they’ will allow her to do this.

*1st pregnancy; 2nd trimester; 1st interview*

Baby: And he also wants to be there the day I am going to deliver. I don’t know whether these people will allow him or not, I don’t know. Because he is also my (fiancé).

Baby constructs herself as not having the freedom to make choices but as being controlled by the medical staff.

Although most women construct the medical staff as being in power, Born reasons differently. She does not construct herself as subjected to these persons in power. Born suggests that a pregnant woman is in charge of her own treatment in the clinic.

*Not 1st pregnancy; 1st twin pregnancy; 3rd trimester; 1st interview*

Interviewer: Ok, hmm, let me see...what was, hmm – people - ok we’ve talked about your family. Other people: How do they react to your pregnancy? Now you’re here at the hospital, at the clinic - how do people treat you?

Born: Hmm, because my first pregnancy - I gave my first pregnancy at the same clinic here. Hmm, I haven’t found any problem in up to now.

Interviewer: Hmm

Born: I find it quite good. It depends on you - how you come to the people

{ Interruption: Someone enters the room. }

*Continued:*

Born: So it depends on you, sometimes if you came in - 'cause they used to say if people are (...) they are quick to get angry but it depends on you how you (...) with the people, if you come in. So it depends on people to people, but I haven't experienced any problem.

Interviewer: Ok

Born: Even there is the nurses making quarrel in the (...) but it depends on people to people

Born constructs herself as being in control of her situation at the clinic. Also, she constructs herself as not drawing negative attention onto herself.

In describing her feelings about having to give birth at the hospital Ansie shifts agency over to the clinic. Ansie faces anxiety as result of constructing herself as powerless.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Ansie: Soms kry jy mos daardies wat (...). Dis wat ek mos reeds – ek het mos - ek is nie van Windhoek nie en jy weet nie hoe hulle - sal hulle vir jou[

Interviewer: [is so]

Ansie: so, jy is van suide. Meeste van verpleegsters ken jy daar, wat vir jou miskien as jy kom, kraamsaal hê, en help en ondersteuning gee. Maar die's ken jy mos nou nie. Ken nie hoe hulle sal optree nie. Daardie goetjies maak jou mos ook soms 'n bietjie bangerig. Soos die tyd kom, daar raak jy mos 'n bietjie bangerig.

*Continued:*

Maika: Hmm

Ansie: Hoe sal hierdie mense my ontvang? Sal hulle vir my mooi kyk? (...)  
gou kan help?

Ansie: Sometimes you get those which (...). That's what I already – as I had – I  
am not from Windhoek and you don't know how they will – will they  
for you[

Interviewer: [it's so]

Ansie: so, you are from the South. Most of the nurses you know there, who  
will perhaps if you come, to labour ward, and give help and support.  
But those you don't know. Don't know how they will act. Those things  
make you a little scared sometimes. As the time comes, then you  
become a little scared.

Maika: Hmm

Ansie: How will these people receive me? Will they look after me well? (...)  
be able to help quickly?

The idea of giving birth is disconcerting to Baby because she constructs herself as not being allowed involvement in the decision-making. She constructs herself as being at the mercy of the medical staff. Baby speaks of leaving it in God's hands, which is an interesting word play: Since the medical arena is in control at this point and Baby has



acknowledged before that she is dependent on them, is she placing control in God's hands or those of the medical staff? Baby has to relinquish control to someone else.

*1st pregnancy; 2nd trimester; 1st interview*

Baby: I don't know whether I'll be – where? In theatre or where I'm going to be or I'll be operated or something like that? I don't know where I'll be. Everything is just in God's hands.

Care constructs herself as powerless. She constructs the medical staff as being able to do things to her. Care fears that they will have to 'cut her'.

*1st pregnancy; 2nd trimester; 1st interview*

Interviewer: Ja. Wat verwag jy van die geboorte?

Care: Gaan seer wees {laughter}

Interviewer: Ja

Care: Hmm (ek gaan) baie swak (voel)

Interviewer: (...)

Care: (...) bang (vir dat hulle) sny (...) ek is nie bang maar hulle (vertel) mos eintlik jy word bang.

Interviewer: Yes. What do you expect from the birth?

Care: Will be painful {laughter}

Interviewer: Yes

Care: Hmm (I will feel) very weak

Interviewer: (...)

Care: (...) afraid (that they will) cut (...) I am not afraid but they (say), actually you become afraid.

Care constructs herself as someone who is not scared but who will give in to fear when it is part of the experience. Furthermore, she constructs herself as 'being done to'. She thus positions herself in the Discourse of Dependence as a patient who is not involved in decision-making.

Baby points out that she feels vulnerable as a first-time mother because she is worried about whether her baby is fine and she needs to be taken care of in the right way. She is concerned that the student nurses might not be able to take care of her well enough.

*1st pregnancy; 2nd trimester; 1st interview*

Baby: And you know, it's your first time to be pregnant. You want to see whether the child is breathing, or maybe, you know?

Interviewer: Hmm

Baby: You want to know everything, what the person did to me, was it exactly right?

Baby constructs herself as needing to monitor her unborn child. Furthermore she constructs herself as someone who needs to be checked on. Finally she constructs herself as someone who is vulnerable to being wronged, thereby positioning herself in the Discourse of Dependence as vulnerable.

Baby constructs herself as dependent on the clinic and its staff. She draws on the Discourse of Dependence in her need for information. She also constructs herself as not knowing. Her construction of lack of information appears to be a construction of lack of agency. It seems that Baby implies that through obtaining information she would be able to have more control.

*1st pregnancy; 3rd trimester; 2nd interview*

Interviewer: Do, do the sisters and doctors talk about it? Do they tell you what to expect?

Baby: No, they don't.

Interviewer: Would you like them to?

Baby: Exactly! They should because last – a, a month ago – ah, was a, ah, this lady who was in the newspaper who gave birth to these children who were (...)[

Interviewer: [yes, yes I saw that]

Baby: They, they didn't check that, ah, that, that lady to, to a sonar. They only checked her once and they didn't see whether there were twins. So what – I think they should change there a bit. Like maybe after, after eight – three months maybe should check sonar or after two months. Because there are things of placentas that, that is going in the neck of babies[

Interviewer: [oh, ja, yes]

Baby: or sometimes you – maybe the baby is used to be dead (...) in the tummy and you don't feel anything. So, I think they should give attention to the patients about that[

Interviewer: [ja]

Baby: They should listen to the complaints that their (...)

Interviewer: They don't do that, is it?

Baby: Hmm-mmh. They're just telling us that it's normal. We know – we are the beginners. We know nothing.

Interviewer: Ja (...)

Baby: Ja, and we want to be checked!

The third way in which the women draw on the Discourse of Dependence is in constructing themselves as helpless without shifting agency towards anyone else in this construction. This means that the women construct their experience of their pregnancies as something they are not in control of.

According to Maria, in pregnancy one is dependent and that she wants to be independent again.

*Not 1st pregnancy; 3rd trimester; 3rd interview*

Interviewer: Hmm (.2) Dink jy die dinge gaan verander as die babatjie kom?

Maria: Hmm (Dit sal...ek) dink so {laughter}

Interviewer: Wat hoop jy gaan gebeur, wat is jou drome?

Maria: (.3) (...) baba klaar gekry het sal ek begin werk en hy sal niks by Johnny vra of even by my ma vra nie.

Interviewer: Is dit vir jou erg om altyd vir hulle te moet vra?

Maria: Ja, hmm, by my ma daar is ook klein kindertjies wat ek moet ook help.[

Interviewer: Hmm (.2) Do you think things will change when the baby comes?

Maria: Hmm (It will...I) think so {laughter}

Interviewer: What do you hope will happen, what are your dreams?

Maria: (.3) (...) done having the baby, I will begin to work and he will ask nothing from Johnny or even my mother.

Interviewer: Is it difficult for you to always have to ask them?

Maria: Yes, hmm, at my mother's there are also little children, who I must also help[

Maria is constructing herself as someone who takes control and financial responsibility after delivery. She thus constructs herself it seems, as someone who cannot do these things during pregnancy thus positioning herself in the discourse of dependence during pregnancy.

Maria elaborates on this construction of dependence in pregnancy, as opposed to the construction of independence when one is not pregnant.

*Not 1st pregnancy; 3rd trimester; 3rd interview*

Maria: {laughter} (.2) As ek net so dink, dan dink ek net ek moet net baba kry  
dan[

Interviewer: [Hmm]

Maria: moet ek net bly soos ek gebly het. {laughter}

Interviewer: Wat bedoel jy as jy sê jy moet bly soos jy gebly het?

Maria: (.5) Hmm. Tot ek nou nie baba gehad het, toe was ek nou nie swanger nie,[

Interviewer: [Hmm]

Maria: Ek het self gestaan, en op my, hmm, ek het gewerk, en ek was nie by die huis nie, ek het net so self vir my gewerk. Nou (as ek nou) {laughter} - swanger is, dan voel ek alles is nou swaar vir my.

Maria: {laughter} (.2) If I just think like that, then I think I must just have the baby then[

Interviewer: [Hmm]

Maria: I must stay just the way I was. {laughter}

*Continued:*

Interviewer: What do you mean when you say you must stay the way you were?

Maria: (.5) Hmm. When I did not have the baby, then I was not pregnant[

Interviewer: [Hmm]

Maria: I stood on my own, and on my, ah, I worked, and I was not at home, I worked for myself. Now (when I now) {laughter} – am pregnant, then I feel everything is now difficult for me.

Maria constructs herself as dependent during her pregnancy and as losing her independence as result of falling pregnant. It is specifically financially, that she constructs herself as not having any control over.

Baby constructs herself as dependent because of her pregnancy. She is seemingly caught up in her pregnancy. Her construction of dependence is so strong that she has lost her old, independent self.

*1st pregnancy; 3rd trimester; 2nd interview*

Baby: Waiting for the twenty-eight to come so that this thing can get out of me.

Interviewer: Yes

Baby: So that I can get to be Baby {laughter}

Interviewer: {laughter} Agh, shame! Are you not Baby now?

Baby: I don't think I am the old Baby now.

Interviewer: {laughter} How so?

Baby: 'Cause you want to go out! I want to go out again.

Born describes how, in pregnancy, she feels incapacitated – almost childlike.

<i>Not 1st pregnancy; 1st twin pregnancy; 3rd trimester; 1st interview</i>	
Interviewer:	...how do you...do you feel that you have different needs from your family? Do you need more support maybe? Do they give you more support?
Born:	Yeah, yeah, yeah, yeah, yeah. I need more support and they give me more support.
Interviewer:	Tell me about that. What do you need from your mother and what do you need from your husband?
Born:	Attention, attention, I need more attention! Because sometimes of you wake up in the morning and you want to go to the toilet, then you can't get up because of that weight, you know {laughter}
Interviewer:	Hmm
Born:	So my mum needs to be there every time.
Interviewer:	Ja
Born:	And if I'm paining, I say: 'Mum, I'm paining! Could you please maybe make a (massage) or something which can help the pain?'

Born constructs herself as incapacitated, thus, positioning herself in the Discourse of Dependence as vulnerable.

Baby constructs herself as dependent until she has experienced giving birth. She anticipates that she will then have her own experience to draw on in order to construct herself as less dependent.

*1st pregnancy; 3rd trimester; 2nd interview*

Interviewer: Tell me about thinking about the birth.

Baby: (.2) {sigh} Really, there I don't have any idea. I just want that day to come.

Interviewer: Hmm

Baby: Just want to feel that pain.

Interviewer: And be done.

Baby: Be done! Oh! I know nothing. It's my first time and I know nothing. I don't know where it starts. I don't know where it ends. I don't know how you feel. I know nothing.

Interviewer: Is that bad to you – to be – to know so little?

Baby: I feel afraid.

Interviewer: Hmm

Baby: (...) 'cause the one is telling you: 'It's very painful and you will pain like somebody is burning.' Somebody is telling you: 'No, you will just feel nothing. You might just start laughing (...)'

Interviewer: Hmm. And that makes it even more difficult to get these mixed messages, né?

Baby: It do, it do makes you feel difficult. But you just want your own.

Interviewer: Ja

Baby: To have your own, your own proof[

Thus, for this pregnancy, she positions herself as vulnerable within the Discourse of Dependence.



The fourth manner, in which the women draw on the Discourse of Dependence, is in constructing the child as dependent on the woman. They construct themselves as responsible for their babies. Thus they draw on the Discourse of Dependence in constructing their unborn children.

Baby constructs herself as needing reassurance about her child's safety and health. She draws on the Discourse of Dependence when she positions herself in relation to the medical staff and she constructs her unborn child as dependent on her thus placing agency with herself in making sure that the child is fine.

*1st pregnancy; 2nd trimester; 1st interview*

Baby: And you know, it's your first time to be pregnant, you want to see whether the child is breathing, or maybe you know,

Interviewer: Hmm

Baby: You want to know everything, what the person did to me, was it exactly right?

Michelle emphasizes that as a mother you should make sure that nothing goes wrong.

If the mother does not take responsibility, she could be a threat to the child.

*1st pregnancy; 1st trimester; 1st interview*

Michelle: Ek sal eerder in Windhoek wil bly – naby die hospitaal wees.

Interviewer: Naby

Michelle: Ja, as iets skeefloop[

Interviewer: [Ja]

Michelle: Want ek sal mos nie 'n kind wil hê wat...of nou om 'n miskraam te kry

Michelle: I would rather want to stay in Windhoek – be close to the hospital.

Interviewer: Close

Michelle: Yes, if something goes wrong[

Interviewer: [Yes]

Michelle: Because I would not want a child, which...or then to have a miscarriage.

Michelle constructs herself as anticipating complications during her pregnancy as well as needing security. She also constructs herself as dependent on the hospital in order to cope with these potential problems. Lastly, she constructs her unborn child as dependent on her for ensuring its safety.

A mother could endanger her baby. Baby points out that she knows she should not be drinking alcohol, now that she is pregnant.

*1st pregnancy; 2nd trimester; 1st interview*

Baby: And I heard something like if you drink alcohol, the baby's brain won't be good or something like that.

Baby constructs herself as responsible for her child's health and thus constructs her unborn child as dependent on her.

The mother becomes a danger to the child when she behaves in a certain way. Born explains that in her culture (Otjiherero) there are things a woman is advised to do as well as not to do, so that she does not harm her baby.

*Not 1st pregnancy; 1st twin pregnancy; 3rd trimester; 1st interview*

Interviewer: Tell me about, tell me about the things that they tell you...

Born: About the things they tell us? Hmm, it's quite very difficult because the things they told us, they told us according to the traditional things.

Interviewer: Ok

Born: Hmm, like if you are pregnant you don't to eat a lot of, what you call it, I don't know how you call it in English...

Interviewer: What does it look like?

Born: Is it biltong?

Interviewer: Biltong? The meat?

Born: The meat, hmm

Interviewer: The dried meat.

Born: What you call it? The dried meat?

Interviewer: Yeah...The one that you hang...né?

Born: Hmm, the one that you hang, you're supposed not to eat that, you're supposed not to eat any - you can drink, you can drink the water but must a (ground) under the water - is one of their beliefs - and what else they do?

Interviewer: Do they explain to you why? Why you shouldn't eat that meat and why you should drink[

Born: [because they said that if you eat that meat, the day you give the birth you call it a (...) is it?]

Interviewer: Yeah, a (...)

*Continued:*

Born: The child is going to have like - sometimes they are having these things around them is one of the things who (makes that) and the (...) who said you are going to have your - now, the time you are going to have - before you start paining, contracting - then you get that water[

Interviewer: [Hmm, hmm]

Born: You are going to get too much water because you didn't put that ground in the water.

Interviewer: Ok. Well, what do you put in the water? What is that?

Born: It's sand

Interviewer: Just any? Just a little bit from the ground?

Born: Yeah, hmm.

Interviewer: Oh.

Born: What else do they talk? Some of those things I forgot now already (...) They talk about a lot of things. Not to make hair - the extensions[

Interviewer: [Not to braid it?]

Born: Not to make the extension, hmm[

Interviewer: [Why?]

Born: It's the same like the meat.

Interviewer: Ok

Born: {laughter} Not to do heavy things.

Interviewer: Hmm

Born: (.2) to rest[

Interviewer: [Yeah]

Born constructs herself as someone who is influenced by her culture. Yet, she also constructs herself as not being part of everything ‘traditional’. She speaks of “their beliefs”. Thus there is ambiguity in her construction. However, she does draw on her traditional belief system in constructing her unborn children as dependent on her.

In her third trimester of pregnancy, Baby’s narrative changes somewhat in her construction of the unborn child’s dependence on her. She no longer constructs herself as helpless with regard to her child’s dependence on her but takes on agency in overcoming her helplessness. She also anticipates her child’s needs and constructs herself as capable of dealing with these needs.

*1st pregnancy; 3rd trimester; 2nd interview*

Baby: Sometimes when you – when you are sleeping, he used to wake you up.

Interviewer: Ok

Baby: Like, he’s kicking a lot, especially when he is hungry. Then you have to put something in the stomach.

Interviewer: Ok

Baby: At least he can have a rest.

Interviewer: Ok

Baby: And you also will have a rest.

Interviewer: Ok

Baby: Sometimes when he is also not moving, you feel, now what has happened? Is he not excited or does he want to see the father, or what is wrong with him?

*Continued:*

Interviewer: Hmm

Baby: Then you try this: let me eat chocolate – let me take custard[

Interviewer: [ja]

Baby: let me take juice - maybe he will move. And after that he start moving maybe it was the things he wanted to eat.

Interviewer: Ok. So it seems to me really, that you associate movement with him being happy and if he's not moving you start to worry and try to get him to be[

Baby: [used to]

Interviewer: active again.

Baby: To (beat). So that he can be awake again.

Interviewer: Is it?

Baby: Maybe he might be sleeping.

While most of the discourse is centred on how the mother could endanger the child, Born also noted that her babies are making her feel vulnerable, through that implying that the babies could endanger the mother. This shifts the agency onto the babies.

*Not 1st pregnancy; 1st twin pregnancy; 3rd trimester; 1st interview*

Interviewer: How do you feel about (the babies inside you)?

*Continued:*

Born: In my stomach {laughter} I think it's difficult because they are not separated...they are separated, well, but because of the way they are lying, it's not an easy way they are lying, for the other one to move because the one is on the top and the other one is in the bottom. That is difficult really. If they want to move, you have it difficult for breathing, sometimes I find it difficult and sometimes you find your heart is banging fast which is not normal...

Born constructs herself as vulnerable to the unborn children's influence. She thus places agency with her children and positions herself in the Discourse of Dependence as vulnerable.

Finally, the women seem to draw on the Discourse of Dependence, in navigating the construction of their pregnancies, between medical and traditional system. There are times when the women have clarity in their construction as dependent on the medical system and not on their traditional belief system. At other times though, there is ambivalence in the women's constructions of self as dependent on both of these two systems.

Baby constructs her culture as being part of herself. She also constructs herself as being vulnerable to "dirty winds" during her pregnancy, thus positioning herself in the Discourse of Dependence, as influenced by her culture.

*1st pregnancy; 2nd trimester; 1st interview*

Interviewer: {laughter} Ja. Ok. What other messages or information have you gotten from other people?

Baby: About?

Interviewer: About birth, about pregnancy. 'Cause I know if you are pregnant, people will tell you things about (...)

Baby: Ja, when you are pregnant, they say you shouldn't walk too much around, especially (this – in my cultures). You shouldn't walk too much around[

Interviewer: [Hmm ]

Baby: you will get these, hmm, dirty winds, we call it dirty winds.

Interviewer: (Dirty winds) Ok.

Baby: Ja, (.2) hmm, or you might go (hang) yourself or you will argue with someone or you will be beaten or you will be kicked in the tummy (...), miscarriage or something like that.

In pregnancy one needs to decide whether one is part of the new generation (western, medical system) or the traditional system. Baby comes to the conclusion that the western way is normal; implying that the traditional way of viewing pregnancy is abnormal.

*1st pregnancy; 2nd trimester; 1st interview*

Interviewer: {laughter} Hmm, (.2) Ok, I wanted to ask you, you're saying that your culture, there is a lot of information coming from there[

Baby: [Ja]



*Continued:*

Interviewer: Is there still a big influence?

Baby: (.2) Hmm, well, generations changes you see[

Interviewer: [Hmm]

Baby: In the past it was like that but now it is not again like that. Well it is like that if you put your beliefs in, but if you're like: No, I'm just going to live normal, (...) [

Interviewer: [Hmm]

Baby: something (won't) happen to you, but (...) keep me like this way, and this way hmm[

Baby constructs herself as being part of a changing generation. She constructs herself as not being part of the old generation and their beliefs but as a 'normal' woman.

Yet, at times this becomes difficult to navigate and Baby is left confused. She thus, seems to shift between these medical and traditional constructions of herself-as-pregnant.

*1st pregnancy; 3rd trimester; 2nd interview*

Interviewer: I know – I can imagine

Baby: Ja

Interviewer: If you don't get it from them – answers. Where do you go look for them?

Baby: Just reading books

Interviewer: Hmm

*Continued:*

- Baby: Then you have to pay extra for another check-up – private check-up.
- Interviewer: Ja
- Baby: So when you (...)
- Interviewer: Hmm. Sjoe. Did your mother talk – do you talk to your mother or to other older women, maybe?
- Baby: I talk to mom. My mom gave birth in 1985
- Interviewer: Hmm
- Baby: Twenty-two years back. (...) So, I also think she (...) some of the things.
- Interviewer: Hmm
- Baby: That what she is telling me is just about their old traditional beliefs and I don't believe in any traditional beliefs.
- Interviewer: What are the traditional beliefs?
- Baby: I shouldn't drink too much water.
- Interviewer: Is it?
- Baby: Ja, shouldn't drink too much water. I should put like sand in the water. I shouldn't make yellow things, like eating oranges and drinking yellow juices[
- Interviewer: [Oros and all those things]
- Baby: Ja but here at the clinic then they used to tell us that we should eat more Vitamin C.
- Interviewer: Hmm

*Continued:*

Baby: but is[

Interviewer: [in all the orange fruit] {laughter}

Baby: Ja, in all the orange fruit. So you used to wonder, now which one should I use?

Interviewer: Hmm. I can imagine that being difficult – you know - your (.1) mother and the older people that you usually listen to, whose advice you usually take, then clashes[

Baby: [hmm]

Interviewer: with this.

Baby: I don't listen to them.

Interviewer: Ja

Baby: I just read the books. I used to buy this pregnancy books. Just run through them.

Interviewer: Ok, is that helping you a bit?

Baby: Ja, you get some information there. Then you use it.

Interviewer: But you want the information from the women – you want[

Baby: [Ja, you should have. You should share information. You should get the ones from the book and you should have these people who have experienced it already, so that come together.]

Baby constructs herself as having difficulty with constructing her pregnancy in light of conflicting information.

In conclusion it seems that the women draw on the Discourse of Dependence with the result of passing on agency to others. Through constructing themselves as vulnerable, helpless, and in need of reassurance, they are active in constructing others as the ones carrying responsibility for them. Yet, through this construction they, in actual fact, allow themselves to retain agency. Furthermore, by so rigidly positioning themselves within the Discourse of Dependence they inhibit others from constructing them in any other way. In other words, the women are active in constructing other people's constructions of their pregnancies. Thus, they are constructing themselves as dependent and vulnerable so that they can remain independent of others' constructions.

#### **8.4. The Discourse of Embodiment**

The women construct themselves as bodily beings and their pregnancies as bodily experiences. They use their constructions from the Discourse of Embodiment to make sense of their pregnancies, their bodies and also their physical discomfort with pregnancy. They thus, use this discourse to construct these experiences into something that suits their reality.

The women construct their bodies as big, as carrying weight. They also draw on the Discourse of Embodiment when they show worry that they are not looking the way they should. When they draw on this Discourse to construct pregnancy as supposedly comprising a correct embodiedness, they set themselves up for a stressful experience. Baby's drawing on this discourse is evident in that she constructs pregnancy as a time

when one should be fat. Baby worries because she is not gaining weight. She had expected weight gain during pregnancy.

<i>1st pregnancy; 2nd trimester; 1st interview</i>	
Baby:	And you know, I started losing weight[
Interviewer:	[Hmm]
Baby:	And I was wondering now, I heard people - when a person is pregnant you get more weight and everything[
Interviewer:	[ja]
Baby:	now how come my weight is losing?

Baby constructs herself as not undergoing the correct bodily experience.

Furthermore, the Discourse of Embodiment is also drawn on by others. The women's pregnancy is noticed by others, who comment on this with regard to their physical changes. Other people thus also draw on the Discourse of Embodiment in constructing the women as pregnant beings. In Maria's case people comment on her weight gain. Maria constructs her body as fat and large. She constructs her pregnancy as a bodily experience which is evident in her narrative. She does not tell everyone that she is pregnant when they comment on her weight gain. Thus she seems more comfortable with constructing herself-as-fat, rather than herself-as-pregnant. This provides insight into the use of the Discourse of Embodiment in positioning the self within the Discourse of Ownership of Pregnancy. It seems that Maria is more comfortable with a construction that disregards the ownership of pregnancy and focuses on her embodied experience.

*Not 1st pregnancy; 2nd trimester; 2nd interview*

Interviewer: Sê mense iets vir jou? As hulle jou op die straat sien – sê hulle iets vir jou?

Maria: (...)

Interviewer: Sê hulle dit vir jou?

Maria: Hmm

Interviewer: Is dit?

Maria: Ja, (ek is kamma baie vet) {laughter}

Interviewer: Wat sê jy vir hulle, as hulle dit sê?

Maria: Ek bly net stil. {laughter}

Interviewer: Wat dink jy?

Maria: {laughter} Sommige mense sê ek ja ek: 'Ja, ek is swanger', en (later dan praat hulle) (...) (saam). Mense wat vir jou (...) gee (...)

Interviewer: Hmm. (.3) Wie is die mense wat vir jou sê jy is vet? Is dit mense wat jy ken of is dit mense op die straat?

Maria: Is mense wat ek ken (of nie). Mense wat (...) lokasie bly.

Interviewer: Ok. Ja. (.2) Hoe laat dit jou voel as hulle dit sê?

Maria: Ek lag maar net. {laughter}

Interviewer: Jy lag maar net. Ok.

Interviewer: Do people say something to you? When they see you on the street – do they say something to you?

Maria: (...)

Interviewer: They say that to you?

Maria: Hmm

Interviewer: Is that so?

*Continued:*

- Maria: Yes, (I am apparently very fat) {laughter}
- Interviewer: What do you reply, when they say that?
- Maria: I just keep quiet. {laughter}
- Interviewer: What do you think?
- Maria: {laughter} Some people I tell, yes, I: 'Yes, I am pregnant', and (later then they talk) (...) (together). People who give (...)
- Interviewer: Hmm. (.3) Who are the people who tell you that you are fat? Are they people you know or are they people on the street?
- Maria: It's people I know (or not). People who (...) stay at the location.
- Interviewer: Ok. Yes. (.2) How does it make you feel if they say that?
- Maria: I just laugh. {laughter}
- Interviewer: You just laugh. Ok.

The bodiliness of pregnancy becomes apparent when the women draw on the Discourse of Embodiment through explaining the changes they are going through. The women construct their experience of pregnancy as physical. Changes are constructed in their physicality.

Baby constructs her pregnancy in drawing on the Discourse of Embodiment to construct her reality of transitions during her pregnancy.

*1st pregnancy; 2nd trimester; 1st interview*

- Baby: You know (.4) Then that first month, 'cause each and every month you do have changes[
- Interviewer: [hmm]
- Baby: Like the first month I (waited) (...)[
- Interviewer: [Yes]
- Baby: And the second month, I got pimples.
- Interviewer: Ok
- Baby: And the third month, I started getting this sooibrand.
- Interviewer: Ja
- Baby: And the fourth month was just normal.
- Interviewer: Oh, is it?
- Baby: And everything went.

Baby categorizes the experience of pregnancy according to the different physical components of pregnancy. She also constructs herself as waiting for something to happen. There is ambiguity in that. Although she seems to expect the physical characteristics of pregnancy and constructs herself as awaiting them and undergoing this transition, it seems that she also constructs them as 'abnormal'. She constructs herself thereafter as awaiting normality's return.

Every part of the pregnancy is constructed as being something 'of the body'.

*Not 1st pregnancy; 1st twin pregnancy; 3rd trimester; 1st interview*

- Born: But I find it difficult because my feet is always swell up, every day swelling up.
- Interviewer: Yeah
- Born: Every day swelling ups.



Born constructs herself as embodied in her pregnancy.

Grace constructs pregnancy as having to be embodied. She goes so far as saying that there must be something physical in pregnancy. Thus, in drawing on the Discourse of Embodiment she constructs herself as a pregnant being, as subject to an embodied experience. Thus, it seems that Grace draws on both the Discourse of Embodiment as well as the Discourse of Dependence. She constructs herself as dependent on her body as result of her pregnancy.

*1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Tell me about your body. How has your body changed?

Grace: Hmm-mmh. I'm not even fat. I'm just still like this. {laughter} Also, I'm feeling healthy but sometimes my heart is beating - when I was sleeping, I stay long hungry, né? Then I eat. Then my heart is starting so fast (...) getting.

Interviewer: Ok. What happens when your heart beats like that? What do you think?

Grace: I think so that big sleeping (...) because you get beating so fast, fast, fast that you cannot (do what you) want to. Just leaving them - it stops and you start doing what you want to do.

Interviewer: Sjoe. Do you tell somebody when that happens?

Grace: Hmm, my mother.

Interviewer: What does she say?

Grace: She just say that just leave it a little bit then (it stops)

Interviewer: Ok, hmm, do you think it's normal for someone in their pregnancy to experience things like that?

*Continued:*

Grace: Hmm, really (let me say) it's normal – when we are pregnant we must have something. Some people they have swelling and (...) (.2) Maybe it's the pregnant like that.

Interviewer: Do you worry about that?

Grace: Hmm

Interviewer: Is it? A lot?

Grace: Hmm, a lot. Maybe when you are asleep, it's beating when you are still sleeping at night, maybe midnight - there - ooh – the heart starting beating. Also, when you are not sleeping well.

To Serious her experience of pregnancy is tiring.

*Not 1st pregnancy; 2nd trimester; 1st interview*

Interviewer: Sjoe. (.4) Hhm, vertel vir my van jou gevoelens nou gedurende die swangerskap. Wat het verander?

Serious: (.4) moeg (...)

Interviewer: Hmm

Serious: (.6) (...) (net wil lê en slaap) (...)

Interviewer: Hmm. (.3)

Interviewer: Sjoe. (.4) Hmm, tell me about your feelings now during the pregnancy. What has changed?

Serious: (.4) tired (...)

Interviewer: Hmm

Serious: (.6) (...) (just want to lie down and sleep) (...)

Interviewer: Hmm. (.3)

Thus, it seems that Serious constructs her pregnancy in terms of having to surrender to the embodiedness thereof.

Maria also experiences her pregnancy as tiring.

*Not 1st pregnancy; 1st trimester; 1st interview*

Interviewer: Het nog iets in jou lewe bietjie verander, (.1) behalwe dat jy swanger is, enigiets anders wat verander het?

Maria: (.3) Hmmm[

Interviewer: [Hmm-mmh? Alles nog dieselfde?]

Maria: Ja

Interviewer: Ok (.2) Wat van jouself?

Maria: Sommige dae ek raak sommer so moeg!]

Interviewer: [Hmm]

Maria: {laughter} Maar, maar ek wil nou niks doen nie.

Interviewer: Has anything else in your life changed a little, (.1) except that you are pregnant, anything else that has changed?

Maria: (.3) Hmmm[

Interviewer: [Hmm-mmh? Everything still the same?]

Maria: Yes

Interviewer: Ok (.2) What about yourself?

Maria: Some days I get tired just like that!]

Interviewer: [Hmm]

Maria: {laughter} But, but I do not want to do anything now.

Maria constructs the embodied experience of pregnancy as ‘happening’ to her. She thus seems to surrender to the embodiedness in her construction thereof.

Pregnancy is constructed, as having agency and thus having effects on the women that they cannot change. There is thus a compliance of sorts in pregnancy.

To Michelle, pregnancy results in cravings for foods, which she never liked before.

<i>1st pregnancy; 1st trimester; 1st interview</i>	
Interviewer:	Enigiets anders in jou leefstyl wat verander het? Dinge wat jy gedoen het, wat jy nou nie meer doen nie?
Michelle:	Nie meer doen nie (.1) Ja, en basies, né, ek het geheel en al nie groente geëet nie.
Interviewer:	Ja
Michelle:	Ek het heel en al nie groente geëet nie[
Interviewer:	[Ja]
Michelle:	maar nou - ek begin nou al weefsel en groente eet {laughter}[
Interviewer:	[Is dit? {laughter} Voel jy jy het dit nodig? Het jy ‘n craving daarvoor?]
Michelle:	Dit is net so ‘n lus wat opkom[
Interviewer:	[Hmm]
Michelle:	en {laughter} jy wil dit net hê.

Interviewer: Anything else in your lifestyle which changed? Things you used to do, which you now do not do anymore?

Michelle: Do not do anymore (.1) Yes, and basically, né, I totally did not eat vegetables.

Interviewer: Yes

Michelle: I totally did not eat vegetables[

Interviewer: [Yes]

Michelle: but now: I began now already to eat fibre and vegetables {laughter}[

Interviewer: [Is that so? {laughter} Do you feel you need them? Do you have a craving for them?]

Michelle: It is just this kind of craving that comes up[

Interviewer: [Hmm]

Michelle: and {laughter} you just want it.

Michelle constructs herself as undergoing changes as result of the pregnancy. The pregnancy is awarded agency in that the changes that take place, for example the cravings for foods previously not enjoyed, are constructed as something that happens to the woman. The women are left without agency in the embodiment of pregnancy.

At times, this construction of pregnancy as an embodied experience and the self as embodied being; become very dominant. This physical, embodied construction then seemingly takes over the women's experience, making it almost entirely an embodied experience of pregnancy.

*Not 1st pregnancy; 1st trimester; 1st interview*

Interviewer: Jy's nou drie maande swanger het jy gesê [

Maria: [Ja]

Interviewer: Hoe voel jy?

Maria: (.3) Ek voel soos – ek, hoe sal ek sê...ek voel soos iemand wat wil opgooi, né, maar ek gooi nie op nie[

Interviewer: [Hmm]

Maria: voel baie sleg

Interviewer: Hmm, shame. Is dit die heelyd by jou daardie gevoel?

Maria: Ja, hele tyd – as ek even a cooldrink drink, né, voel ek so, voel ek nie orrait nie[

Interviewer: [Hmm, maar jy sê jy gooi nooit op]

Maria: Hmm, hmm

Interviewer: Dit wil nie uitkom nie[

Maria: [Hmm, hmm {laughter}]

Interviewer: Agh shame. Wat nog, hoe gaan dit nog met jou?

Maria: (.2) Hmm, sommige tyd...soos iemand wat wil (misdrusing) kry, né.

Interviewer: Hmm

Interviewer: You are now three months pregnant you said[

Maria: [Yes]

Interviewer: How do you feel?

Maria: (.3) I feel like – I, how can I say...I feel like someone who wants to vomit but I do not vomit[

*Continued:*

- Interviewer: [Hmm]
- Maria: feel very bad
- Interviewer: Hmm, shame. Is it all the time with you that feeling?
- Maria: Yes, all the time – even when I drink a cooldrink, né, I feel so, do not feel all right[
- Interviewer: [Hmm, but you say you never throw up]
- Maria: hmm, hmm
- Interviewer: It does not want to come out[
- Maria: [hmm, hmm {laughter}]
- Interviewer: Agh shame. What else, how are you further?
- Maria: (.2) hmm, sometimes...like someone who wants to (...), né
- Interviewer: Hmm

Maria constructs herself as undergoing a physical ordeal during her pregnancy. She constructs the physical experience as beyond her control.

Tangi is caught up in her embodied experience of her pregnancy. Tangi-as-pregnant is subjected to an embodied pregnancy, which is dominant in her construction of her emotional experience of her pregnancy.

*Not 1st pregnancy; 3rd trimester; 1st interview*

- Interviewer: Tell me about your body - how your body changed?
- Tangi: Oh, my body changed because (...)
- Interviewer: How does that feel to you?

*Continued:*

Tangi: Ah, ah. There is no feeling.

Interviewer: Do you like your body like this?

Tangi: {laughter} Ah-ah, I don't like my body like this!

The embodiment of pregnancy is also evident in the descriptions of the women regarding beauty. Furthermore, the women construct pregnancy as physically challenging and resulting in a restriction on activities they used to enjoy. Thus, they construct themselves as bound by pregnancy. Pregnancy is constructed as limiting.

The embodiment of pregnancy is also evident in the descriptions of the women regarding beauty. Pregnancy is not attractive. All the physical changes in pregnancy are overwhelming and Baby is very conscious thereof.

*1st pregnancy; 2nd trimester; 1st interview*

Interviewer: Hmm, ok. (.5) We talked about how your body changed and you said that before, you felt like a sexy woman. How did your identity change?  
Baby-before, Baby-now: How are you different?

Baby: (Not) so different because now my face looks (pimpled and I have spots), and I wonder when are they going back (...), 'cause everyone was: 'Oh, Baby, you were so beautiful, you were more than beautiful, and how comes you having pimples and[

Interviewer: [Hmm]

Baby: and everything.' You know, you do feel, now what are they trying to say? Do they want to say you are (...), or you always think of negative things[



*Continued:*

Interviewer: [Yes, yes, it's human {laughter}]

Baby: Ja, now what do they... Anyway, I never had pimples, so sometimes I do upset me, you know, you never had pimples, do you always expect me to be the same Baby - from the age of zero month up to now?

Interviewer: Hmm

Baby: There should be a little bit of difference 'cause I also have breasts. Why don't you talk about breasts or something?]

Interviewer: [Hmm – everything]

Baby: About my buttocks or something, about my hairs being long or, something[

Interviewer: [Yes]

Baby: Why do you actually continue about the face?

Interviewer: Hmm

Baby: (...) on your face, "how do you feel if you have pimples" (...)

Interviewer: Hmm

Baby: Ja

Interviewer: So you feel they are looking at you and just seeing the physical[

Baby: [Ja]

Baby constructs herself as aware of her body. She further constructs parts of her body as being faulty and imperfect as result of pregnancy.

Baby also speaks of the reactions and comments that others have about her pregnancy.

It is these reactions which she draws on in constructing herself-as-pregnant.

*1st pregnancy; 2nd trimester; 1st interview*

Baby: Hmm, (.3) (while) I'm pregnant I also (felt) of being pregnant. I also like what I'm wearing during my pregnancy, but the thing is (.2) when you wants to go out, with your friends, you won't even stand two hours standing like that.[]

Interviewer: [Hmm]

Baby: You feel like leaning or something, or something like that[]

Interviewer: [Hmm]

Baby: And sometimes it is also very, when you want to go out to clubs and people are like , hmm, would you like a cup of wine or something like that and you say yes, and the wine comes you don't want the wine, people are like: 'What's the use of coming?' And you don't want - you know so (.3). It's just stupid.

Interviewer: So your social life has also changed

Baby: My social life (...)

Interviewer: Tell me about how it has changed

Baby: Just getting very quick tired (...) tired

Interviewer: Hmm

Baby: (...) Like I can't even stand for two hours or three because I was a person who loved dancing, now[]

Interviewer: [Ja]

Baby: when I dance I am tired (...)

Interviewer: Beautiful (...)

*Continued:*

- Baby: Ja, now before the stomach got big,[
- Interviewer: [Ja]
- Baby: I wanted to tell them that I am pregnant, so that they can know[
- Interviewer: [Ja]
- Baby: so that that they can know, those are just hormones
- Interviewer: Ja
- Baby: (But I told them) 'cause it was a secret to me.
- Interviewer: Ok, did you want to keep it for yourself?
- Baby: (... myself...)

Baby constructs herself as physically different to the conventional idea of beauty. She constructs herself as having changed and constructs the pregnancy as causing this change. She thus gives agency to her pregnancy and her positioning becomes limited to the bodiliness of pregnancy. Furthermore, she constructs her body as not being fully part of herself. The embodied pregnancy seems to cause a split between self and pregnancy.

Katryn describes physical changes caused by pregnancy and that these are an inconvenience.

*Not 1st pregnancy; 3rd trimester; 1st interview*

- Katryn: [Van die begin tot en met so twee maande, was dit baie gemaklik want ek het nie eens nie 'n maag gehad nie. Ewe skielik het ek (...) gemaak
- Interviewer: Hoe so? Hoe is dit ongemaklik?

*Continued:*

Katryn: Soos in bewegings, verstaan jy? As jy miskien nou gaan lé en 'n vinnige opstaan, so die bewegings is eintlik 'n bietjie baie traag as jy nou so lê (...). Maar verder is ek nie soos ek met hom gewees het - was ek nou baie vet, om nou eerlik te sê. Ek was baie – ek was ook net by die huis gewees – maar nou met hierdie swangerskap – ek loop, as ek by 'n plek wil uitkom, en daar is nie taxigeld nie, dan stap ek, so...

Katryn: [From the beginning up until about the second month, it was very comfortable because I did not even have a bump. All of a sudden I (...) made

Interviewer: How so? How is it uncomfortable?

Katryn: Like in movements, you understand? If you maybe go and lie down and you get up quickly, so the movement is actually slightly sluggish if you lie like that (...). But other than that I am not like I was with him – I was very fat, to be honest about it. I was very – I was also only at home – but now with this pregnancy –I walk, if I want to get to a place, and there is no taxi money, then I walk, just like that...

She constructs herself as slow, lazy and restricted to the house. She thus seems to give agency to her pregnancy. She further elaborates on the change that has taken place, within her, from her first to her second pregnancy. She is less confined by the bodiliness of her pregnancy now, in her second pregnancy, than she was with her first. Thus, it seems that the women position themselves differently in the Discourse of

Embodiment depending on their previous experiences and interactions with the discourse.

Michelle suggests that one should bear one's own pain and problems to protect one's child. The pains of pregnancy should thus be tolerated.

*1st pregnancy; 1st trimester; 1st interview*

Michelle: {laughter} Nee, basies gee hulle my raad – ok, hulle gee my raad – hulle sal altyd vir my sê: “Doen nie dit nie, jy moet dit doen, jy maak nie[

Interviewer: [by voorbeeld?]

Michelle: Soos, ek het verkoue gehad {laughter}

Interviewer: Ok

Michelle: En ek het ‘n oneindige hoofpyn gehad wat nie wou verstil het...nou wou ek pynpille gedrink het[

Interviewer: [Ja]

Michelle: En (borstee) gedrink het.

Interviewer: Om te help met[

Michelle: [‘Jy mag nie dit drink nie!]

Interviewer: [ah]

Michelle: jy moenie dit!’ {laughter}

Interviewer: {laughter} jy moes die pyn verduur.

Michelle: {laughter} No, basically they give me advice – ok, they give me advice – they will always tell me: “Do not do this, you must do that, you do not make[

Interviewer: [for example?]

Michelle: Like, I had a cold {laughter}

Interviewer: Ok

Michelle: And I had a constant headache which did not want to quiet down...now I wanted to drink painkillers[

Interviewer: [Yes]

Michelle: And wanted to drink (lung-tea).

Interviewer: To help with the[

Michelle: [‘You may not drink that!]

Interviewer: [ah]

Michelle: You mustn’t this!’ {laughter}

Interviewer: {laughter} You must endure the pain.

Michelle thus constructs herself as bearing the physical pain in drawing on the Discourse of Embodiment.

Care is quite particular in her construction of self as tolerant of the physical discomfort. She describes normal pain and abnormal pain. Normal pain should be endured, for example, when the child turns the pain is normal.

*1st pregnancy; 2nd trimester; 1st interview*

Care: Ja en hmm (.4) die pyne en (...) as die kind sal opgaan en weer afkom, so die maag sal opkom en afgaan[

Interviewer: [Hmm]

Care: dan sal daar niks fout wees nie; en die maag (.1) en pyne – watter pyne: draaipyne...

Care:	Yes and hmm (.4) the pains and (...) if the child will move up and down, so the bump will move up and down[
Interviewer:	[Hmm]
Care:	then there is nothing wrong; and the belly (.1) and pains – which pains: turning-pains...

The construction of the pregnancy as an embodiment is presented as discomfort of pregnancy. Interestingly, although the women are uncomfortable with the bodily construction of pregnancy, they do not seem to construct the pregnancy differently. Rather they construct themselves as accepting and tolerant of pain and discomfort in both pregnancy and labour.

Birth is also constructed as an embodied experience. Maria constructs birth as a painful event, as though it is nothing more and nothing less than pain.

<i>Not 1st pregnancy; 3rd trimester; 3rd interview</i>	
Interviewer:	Ok. Hmm, wat is jou gedagtes oor die geboorte? Want dis mos nou naby.
Maria:	Hmm. Naby. {laughter} Hmm-mmh, hmm (.3) Ek dink net aan die
Interviewer:	Ok. Hmm, what are your thoughts about the birth? Because it's close to that time now.
Maria:	Hmm. Close. {laughter} Hmm-mmh, hmm. (.3) I just think about the pain. {laughter}

Maria, it seems, is not able to construct birthing in any other way than in terms of pain.

Maria describes not knowing how much pain to expect from birthing is a fearful experience. Having experienced a birth before, without much pain, Maria is still afraid of the pain to come.

*Not 1st pregnancy; 3rd trimester; 3rd interview*

Interviewer: Was die pyne by jou ander swangerskap erg?

Maria: Nee dit was nie erg nie.

Interviewer: Ok

Maria: Hmm (.1) Maar nou ken ek nou nie hmm, (.2) sal dit miskien erg wees of nie erg nie.

Interviewer: Were the pains of your other pregnancy bad?

Maria: No it was not bad.

Interviewer: Ok

Maria: Hmm (.1) But now I do not know hmm, (.2) will it maybe be bad or not bad.

Maria constructs birthing as an experience that is beyond control and anticipation. She constructs it as unpredictable. It is an experience for Maria during which she has no agency.

Giving birth is constructed as a traumatic, painful event, where things are done to a woman. The woman constructs herself as passive and without agency.

*1st pregnancy; 2nd trimester; 1st interview*

Interviewer: Is daar spesifieke stories of mites wat mense vir jou vertel het oor swangerskap, wat vir jou snaaks was, wat vir jou bang laat voel het?

Care: Nie (...) die pyne en dan die (verskriklik) bloei en nageboorte, (...) wat gesny is in die (...) hospitale

Interviewer: Ja



Interviewer: Are there specific stories or myths which people told you about pregnancy, which seemed weird to you, which made you feel scared?

Care: No (...) the pains and then the (horrible) bleeding and the afterbirth, (...) which was cut in the (...) hospital;

Interviewer: Yes

Care constructs birthing as an invasive as well as an embodied experience.

Maria constructs pregnancy as having to include an embodied experience. Thus, she seems tolerant of this embodiment of pregnancy. In Maria's words, one will not give birth to a normal baby without the normal pain during pregnancy.

*Not 1st pregnancy; 2nd trimester; 2nd interview*

Interviewer: Ja. Ja. Jou eie ervaring daarvan maak, né. (.2) Wat sê mense nog (.2) oor swangerskappe en geboorte en daai goed - wat sê mense?

Maria: (.4) Sommige mense sê as jy babatjie gaan kry moet a mens die (hoofpyne) ook gaan kry[

Interviewer: [Ja?]

Maria: (...)

Interviewer: Hmm

Maria: (Kind gaan kry maar hy)[

Interviewer: [(...)]

Maria: Hmm (...) Ai! {laughter}

Interviewer: Ek verstaan wat jy sê, ja.

Maria: Ja (.4) Sommige mense sê (gaan nie 'n goeie baba kry nie)

Interviewer: Nie 'n goeie baba kry nie?

Maria: (Ek sal 'n goeie baba kry)

Interviewer: Oh, jy sal 'n goeie, gesonde baba kry.

Interviewer: Yes. Yes. Make your own experience thereof, né. (.2) What else do people say (.2) about pregnancy and birth and those kinds of things - what do people say?

Maria: (.4) Some people say if you are going to have a baby you must get the (headaches) too[

Interviewer: [Yes?]

Maria: (...)

Interviewer: Hmm

Maria: (Will get a child but he)[

Interviewer: [(...)]

Maria: Hmm (...) Ai! {laughter}

Interviewer: I understand what you are saying, yes.

Maria: Yes (.4) Some people say (I will not get a good baby)

Interviewer: Will not get a good baby?

Maria: (I will get a good baby)

Interviewer: Oh, you will get a good, healthy baby.

Birthing is constructed as painful as well as something that just has to be overcome but also dealt with to an extent. Hence, to Baby there is a certain amount of pain one should accept.

*1st pregnancy; 2nd trimester; 1st interview*

Baby: But the pain[

Interviewer: [Hmm]

Baby: I'm afraid of the pain.

Interviewer: Hmm

Baby: And I don't know (have it in me) hmm, I don't know how[

Interviewer: [Hmm]

Baby: will the things change? I don't know how will that day be.

Interviewer: Yes

Baby: I don't know whether I'll be – where? In theatre, or where I'm going to be, or I'll be operated, or something like that, I don't know where I'll be, everything is just in God's hands

Interviewer: Hmm

Baby: But (.3) I don't feel, I do feel like, it only comes for one day or two days, then it's gone[

Interviewer: [Hmm]

Baby: (...) days, and after delivering there is no pain[

Interviewer: [Hmm]

Baby: Ja

Baby constructs giving birth as a fearful experience. She constructs it as something that should be endured by women and as something that women need resources for. Her fear of the pain and more specifically her fear of losing control as well as her doubt of whether she has the strength to face the ordeal of birthing, seem to stem from this construction. Baby constructs the pain of birthing as a pain different to other

pains. It is not supposed to be dulled by any medical intervention and should be accepted as part of the experience.

During her third trimester Baby's narrative looks somewhat different to the previous passage. There is resignation in her construction of being tolerant of the physical discomfort of birthing. She constructs herself as a pain-enduring woman.

*1st pregnancy; 3rd trimester; 2nd interview*

Interviewer: Tell me about thinking about the birth.

Baby: (.2) {sigh} Really, there I don't have any idea. I just want that day to come.

Interviewer: Hmm

Baby: Just want to feel that pain.

In co-constructing birthing with Baby, Baby's mother constructs the pain of birthing as minimal. She tells her daughter that it will be over after a few hours, suggesting that during labour Baby should focus on the outcome.

*1st pregnancy; 2nd trimester; 1st interview*

Baby: Ja, I do talk to my mom, you know, my mom is my best friend. I talk to her, and she said it is not really painful[

Interviewer: [Hmm]

Baby: 'Cause I know that she wants me to give birth[

Interviewer: [Ja]

*Continued:*

Baby: Ja, she is always encouraging me to give birth: 'No it's not painful, you can just go, it's nothing. It's just pain for those few hours then its (normal)[

Interviewer: [Hmm. Ok]

Baby: But after you get your baby, you put it on your chest, or you are - you speak to the baby, (do things) (...)'

Baby constructs birth as an ordeal that is secondary to the joys thereafter. She is instrumental in taking the agency from birthing and keeping it for herself. Thus, she positions herself in the Discourse of Embodiment of pregnancy in such a way that she maintains agency.

The women distinguish between the discourses they draw on in order to construct birthing. Where caesarean section is constructed using the Medical Discourse, vaginal birth is constructed drawing on the Discourse of Embodiment. The women construct themselves as women who give birth vaginally – 'naturally', rather than undergoing a caesarean section. They thus construct vaginal birth as the normal way of giving birth – the embodied experience of birthing – and caesarean sections as abnormal. It seems that a woman constructs herself as having more agency in vaginal birth than in birth through caesarean section. Interestingly, this is also in contrast to their construction of their pregnancies. In drawing on the Medical Discourse the women hand over agency during pregnancy only to then reclaim agency for birthing.

Birth is constructed as a time when one has less control. Born is fearful of being operated on. She seems to feel at the mercy of the medical staff. Interestingly, she has been told by a doctor in private practice that one of her babies is breech and that she will have to have a caesarean section done. It seems that no one at the antenatal clinic has said something about that to her and she thus assumes that she might have a chance of giving birth vaginally. She constructs caesarean section as something invasive during which she has no agency. In contrast, she constructs vaginal birth as natural – as a process during which she has agency and thus she will rather opt for that. She also constructs the caesarean section as leaving behind a scar that will always have to be cared for. The caesarean section is thus an invasion where the woman retains no agency – she is being done to.

*Not 1st pregnancy; 1st twin pregnancy; 3rd trimester; 1st interview*

Interviewer: Well, how do you feel about the birth? Do you think about that? The day the birth is going to happen?

Born: Yeah, now I think a lot because (.3) if I went to a private doctor, they used to say I am going to have an operation because of the child that is maybe not lying the right way, so sometimes (...) really (.2) because it's not an...I haven't been operated before[

Interviewer: [Hmm]

Born: but I don't think it's a nice thing to (...)

Interviewer: Hmm

Born: But if it comes, it comes

Interviewer: Yeah. What worries you about the operation?

*Continued:*

Born:            Hmm, {laughter}, now that is a (wound), you are going to have it forever.

Interviewer:    Forever.

Born:            Yeah, that you are going to have it forever. Hmm, if it's cold then you have to keep warm, hmm, too difficult really, I haven't been operated but the way you are (...) to the other people, everything they are saying (...) sometimes it is (too)...

In conclusion, the women draw on the Discourse of Embodiment to construct the way that their bodies should be. They thus draw on this discourse to construct the 'correct embodiedness' of pregnancy. Others also draw on the Discourse of Embodiment in constructing the women's pregnancies and the women as pregnant beings. The women draw on the Discourse of Embodiment to construct their pregnancies as embodied experiences. Thus they construct their pregnancy as having agency and to an extent control over the women.

At times the women construct themselves and their pregnancy drawing only on the Discourse of Embodiment. The experience becomes overwhelmingly embodied for the women. Also, the women draw on the Discourse of Embodiment to construct their suffering and discomfort. Furthermore, they draw on the Discourse of Embodiment to construct themselves as accepting of physical discomfort and pain. Lastly, the women draw on the Discourse of Embodiment in constructing the process of giving birth.

They draw on the Medical Discourse to construct caesarean sections as opposite to vaginal birth, which they construct, drawing on the Discourse of Embodiment.

### **8.5. The Discourse of Ownership of Pregnancy**

The women draw on the Discourse of Ownership of Pregnancy in a number of ways, often it seems, navigating their positioning within this discourse with quite some ambivalence. Firstly, the women construct their experience of pregnancy as owned through being in a position of power over when and how the pregnancy is acknowledged and by whom. Secondly, in drawing on the Discourse of Ownership of Pregnancy the women struggle to position themselves in this discourse, hence struggling with acceptance of their pregnancy. Thirdly, other persons co-construct the pregnant women's experience in also drawing on the Discourse of Ownership of Pregnancy. Finally, for those who cannot position themselves in this discourse, the experience seems to become stressful.

The women seem to know that they are pregnant and then 'allow' the clinic to verify this with their tests and medical knowledge. They thus allow the clinic to agree with their reality as they have constructed it. The women thus retain power in this situation. The agency throughout this whole process remains with them, although it is obscured at times. It seems that because the women draw on the Discourse of Ownership of Pregnancy, it allows them to remain in full control of their situation, thus also being able to courteously allow the doctors to be wrong about the status of their pregnancies. Furthermore, in the medical setting where the women have to wait for



someone to verify and acknowledge their pregnancy, they maintain control throughout by denying the clinic to seize the reality of their bodies and experiences.

There is not much trust in the clinic's ability to 'diagnose' pregnancy. They seem to have had it wrong before. Katryn recalls that the same happened in her first pregnancy as happened in this pregnancy. The clinic first said that she was not pregnant and then later confirmed her pregnancy.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Toe gaan jy die eerste keer kliniek toe. Hmm, toe jy – hmm, jy het gesê die dokter het gesê jy is nie swanger nie – toe jy toets gedoen het by hom. Hoe het dit vir jou laat voel? Want jy het gesê, jy het gevoel, jy het geweet jy is swanger.

Katryn: Nee, ek het eintlik van my weet – met hom was dit ook so...

Interviewer: Then you went to the clinic for the first time. Hmm, when you – hmm, you said the doctor said that you are not pregnant – when you did the test at the doctor's. How did that make you feel? Because you said, you felt you are pregnant, you knew that you were pregnant.

Katryn: No, actually I knew for myself – with him it was like that too...

Katryn constructs herself as owning her pregnancy and denies the clinic to own it. It does not really matter that the clinic has got it wrong. The ownership of her pregnancy lies with her, so the clinic does not need to assist in constructing it for her.

For Born, positioning herself in the Discourse of Ownership of Pregnancy is difficult. Although the clinic constructs her reality for her she does not draw on the Discourse of Ownership of Pregnancy.

*Not 1st pregnancy; 1st twin pregnancy; 3rd trimester; 1st interview*

Interviewer: Tell me about the day that you found out that you were pregnant.

Born: {laughter} The day I found out I was pregnant?

Interviewer: Hmm

Born: Wow, {laughter} I was very (bad) really

Interviewer: Why?

Born: Because I didn't know that I was pregnant, so I used to sleep every day, feeling weak, like I am ill; because I was having hmm, problems before, so I thought maybe it's that disease that I was having before; then I find out that I am pregnant but I find it very difficult, really. Because at the beginning of the pregnancy it was like I am having an infection hmm, hmm, (...) an infection. So they didn't find it at the beginning because they used to say that you are affected by those (blood pressure). So, I find it difficult (.2) to see that I am pregnant.

At times, a woman knows that she is pregnant but the clinic denies this. For these women there is ambivalence in whether to own the experience or to allow the clinic to construct their reality for them. This is perceived as quite stressful by the women.

*Not 1st pregnancy; 2nd trimester; 1st interview*

Interviewer: Hoe was dit vir jou toe hulle eers vir jou gesê het jy is nie swanger nie, maar jy voel jy is swanger.

Serious: {laughter} Ek was onrustig gewees.

Interviewer: How was it for you when they first told you that you are not pregnant, but you felt you were pregnant?

Serious: {laughter} I was restless.

Serious constructs herself as not having freedom in the experience of her pregnancy, as result of not owning f her pregnancy.

In the women's narrative about constructing the pregnancy they are quite specific about constructing that experience as 'knowing', rather than as 'finding out'. The agency thus remains with them and they draw on the Discourse of Ownership of Pregnancy. Thus, 'finding out' is a process of constructing self-as-pregnant, whereas 'knowing' implies a firm construction of self-as-pregnant.

Katryn explains that it's not a matter of finding out; rather a woman knows when she is pregnant.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Wanneer het jy uitgevind jy is swanger? Vertel my van die dag toe jy uitgevind het.

Katryn: Nee, ek het nie uitgevind nie – ek het maar net geweet.

Interviewer: When did you find out that you are pregnant? Tell me about that day when you found out.

Katryn: No, I did not find out – I just knew.

She constructs herself as someone who knows she is pregnant. She thus owns the experience of the reality of her pregnancy.

Rosie also draws in the Discourse of Ownership of Pregnancy in constructing herself-as-pregnant without the clinics involvement in the construction of her reality.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Hoe het jy uitgevind?

Rosie: Toe my maand (...) gestop het – toe vind ek uit.

Interviewer: Het jy vir toetse gegaan?

Rosie: Nee, ek het net geweet ek is swanger. Ek het mos nou al kinders.

Interviewer: How did you find out?

Rosie: When my monthly (...) stopped – then I found out.

Interviewer: Did you go for tests?

Rosie: No, I just knew I was pregnant. I have got children already.

Knowing that one is pregnant can be stronger than any clinical proof. Katryn's pregnancy test came back negative, yet she knew that she was pregnant.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Katryn: Hy doen toe die toets en die toets kom negatief uit, maar ek het nou geweet ek is swanger...

Katryn: He then did the test and the test comes out negative, but I knew that I was pregnant...

Katryn constructs herself as knowing – as owning her pregnancy, thereby keeping the medical arena from creating her reality for her. Hence, when the clinic tries to take over agency she does not allow this to happen and retains agency.

A woman knows she is pregnant before the clinic verifies it. Serious knew she was pregnant before she went to test for pregnancy.

*Not 1st pregnancy; 2nd trimester; 1st interview*

Interviewer: ...Vertel vir my wanneer het jy uitgevind dat jy swanger is.

Serious: Die Maart-maand.

Interviewer: Hmm

Serious: Dan het ek uitgevind dat ek swanger is (toe sê hy mos vir my ek is swanger) [

Interviewer: [Toe was jy nog daar gewees?]

Serious: Hmm (...) Toe kom ek terug, toe maak ek toetse (.2) April maand.[

Interviewer: ...Tell me, when did you find out that you are pregnant.

Serious: That March.

Interviewer: Hmm

Serious: Then I found out that I am pregnant (then he told me that I am pregnant)[

Interviewer: [Then you were still there?]

Serious: Hmm (...) Then I came back, then I did tests (.2) April.[

Serious constructs herself as someone who knows she is pregnant – as knowledgeable of her pregnancy. Yet she also constructs herself as someone who is told that she is

pregnant. There is thus ambivalence in Serious' narrative because she allows for agency to flow back and forth. Her construction of self-as-pregnant is thus not owned by her; rather her partner and the clinic are involved in constructing this for her. For these women who do not fully draw on the Discourse of Ownership of Pregnancy in constructing themselves as pregnant beings the process of their pregnancy is still one of accepting.

In Sofia's narrative there is some ambiguity. On the one hand, she states that she found out about her pregnancy in December. Then she states that she was not sure about being pregnant and later she goes to the clinic to verify this.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Vertel my van, hmm, wanneer het jy uitgevind dat jy swanger is?

Sofia: {laughter} Ek het uitgevind in Desember maand – op die laaste – miskien so by die hmm, ses-en-twintigste, sewe-en-twintigste – daar rond. Maar ek het – ek was nog nie doodseker nie dat ek swanger is nie, maar ek het so gevoel want ek het baie uitgegooi[

Interviewer: [ja]

Sofia: as ek iets eet, het ek net uitgegooi. Toe het ek eerste Januarie by die hospitaal gekom en my toetse kom doen. Toe sê hulle vir my ek is swanger.

Interviewer: En toe? Hoe het jy gevoel daaroor?

Sofia: Ek het maar net aanvaar.

Interviewer:	Tell me about, hmm, when did you find out that you are pregnant?
Sofia:	{laughter} I found out in December – at the latest – maybe around the hmm, twenty-sixth, twenty-seventh – around that time. But I had – I was not yet perfectly sure that I was pregnant, but I felt as though because I was throwing up a lot[
Interviewer:	[yes]
Sofia:	when I eat something, I just threw up. Then I came to the hospital on first January and came to do my tests. Then they told me I am pregnant.
Interviewer:	And then? How did you feel about that?
Sofia:	I just accepted.

Thus, Sofia initially did not take ownership of her pregnancy in constructing herself as pregnant. She is finally constructed as pregnant by the clinic and accepts this construction.

There is much ambivalence in Baby's narrative. Where she on the one hand constructs herself as wanting a child, on the other hand she constructs her pregnancy as being simply unbelievable.

	<i>1st pregnancy; 2nd trimester; 1st interview</i>
Baby:	Hmm, to me I didn't believe it[
Interviewer:	[Hmm]
Baby:	It was unbelievable.

Baby constructs herself as experiencing something unbelievable. She is, thus, unable to own the meaning of her pregnancy.

*1st pregnancy; 3rd trimester; 1st interview*

Grace: {laughter} Because, on my own I decided, I want to be pregnant when I am twenty-eight up. So it was not really – I was not feeling ok. But now I just (...)

Interviewer: So, the pregnancy was not planned – it was a big surprise, I can see it was a shock to you.

Grace: Yes it was shock to me – it was not planned.

Interviewer: Who did you tell? Who was the first person you told that you were pregnant?

Grace: My first person was there when I find out. It was my – wife of my uncle. She was there.

Interviewer: Did she come with you to the pharmacy?

Grace: Ah-ah. I just went alone. At the house – she was there.

Interviewer: Ok. And, what did she say?

Grace: She was surprised. She was happy. Laughing, what.

Grace is ambivalent in her construction of accepting her unplanned pregnancy. For an unplanned pregnancy, the positioning of self in the Discourse of Ownership of Pregnancy seems difficult. It is a process filled with ambiguity.

Grace is still in the process of constructing herself as pregnant. She draws on the Discourse of Ownership of Pregnancy to some extent but is still stressed by the changes pregnancy has brought with it. It is as though ownership is now held by the pregnancy over Grace and not by Grace over the pregnancy.



*1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Tell me what happens when you want to go and sleep and you lie down? What happens then, so that you can't sleep?

Grace: I don't know what is wrong.

Interviewer: But do you think a lot of things? Is it[

Grace: [ah! I think about when I have a baby - what I'm going to do. Or I'm just thinking that if the day come, what must I do. (Long now) I will become the mother of the baby, going to take care, what, what. Yeah, my life is going to change too!

Interviewer: Hmm. Do you worry a lot about all of these things? These changes?

Grace: I'm worried about them since I was not – it was not my decision – whatever – my plan.

Interviewer: Hmm, sjoe, hmm

Grace: But I (...)

Interviewer: You're going to?

Grace: Be (happy).

Ansie describes her pregnancy as unexpected and unplanned. Thus, she was then still navigating the Discourse of Ownership of Pregnancy in order to find her position within it. She then accepted the pregnancy and started thinking about names for the child. She thus, in the end constructs herself as owning this pregnancy.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Ok. (...) hoe vergelyk hierdie swangerskap met jou vorige swangerskap?

*Continued:*

Ansie: Oeh, (...) my vorige swangerskap was ek eintlik so – hy was ook onverwag gewees.

Interviewer: Hmm

Ansie: Ek aanvaar soos dit gekom het.

Interviewer: Hmm

Ansie: En so, my eerste swangerskap – daardie ene het ek so geverwag en ek was eens nie – die doktors het eens nie gesê nie dies ‘n seunskind, maar ek het geglo dis ‘n seunkind. Ek het hom klaar naam gegee. Hierdie ene ek het (êrens) ook naam gegee, maar ek is nie seker hy is ‘n seun of ‘n meisie maar die verwagting (...) is ‘n meisiekind.

Interviewer: Ok. (...) how does this pregnancy compare to your previous pregnancy?

Ansie: Oeh, (...) my previous pregnancy I was actually so – he was also unexpected.

Interviewer: Hmm

Ansie: I accept it as it came.

Interviewer: Hmm

Ansie: And so, my first pregnancy – that one I sort of expected and I wasn't even – the doctors did not even say this is a boy, but I believed it was a boy. I already gave him a name. This one I (somewhere) also gave a name, but I am not sure whether he is a boy or a girl but the expectation (...) is a girl.

For Clarence, her boyfriend is part of her construction of self-as-pregnant. His acceptance of her pregnancy allows her to draw on the Discourse of Ownership of Pregnancy and make her pregnancy her own.

*1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Who did you tell when you found out that you were pregnant?

Clarence: It was just my boyfriend

Interviewer: Ok. What did he say?

Clarence: He accepted.

In the following narrative it becomes quite obvious how the Discourse of Ownership of Pregnancy is drawn on and how Ansie then firmly positions herself within this discourse. Initially, she is navigating the reality of her unplanned pregnancy and the ambivalence experienced as result. She is ambivalent about on the one hand, not having planned the pregnancy and on the other hand, having expected a child at some point. She then allows an older, experienced woman to co-construct her reality with her and emphasizes that she has accepted her pregnancy. Therefore, it seems that in drawing on the Discourse of Dependence Ansie makes it possible for herself to position herself in the Discourse of Ownership of Pregnancy.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Ansie: In die begin was ek eintlik nie so orrait nie – ek het dit eintlik nie so verwag nie.

Interviewer: So dit was 'n onbeplande swangerskap. Hoe het jy uitgevind?

Ansie: ek het so opgegooi[

Interviewer: [is dit?]

*Continued:*

Ansie: opgegooi - ek wou nie geëet het nie, wou nie eintlik kos ruik, so (...)

Interviewer: Ok. En toe?

Ansie: Toe gaan ek – ek het eers gebly en ek het so die groterige persone gevra: ‘Watse symptome is dit as jy so opgooi, en opgooi en opgooi en nie (...)?’ Nee, toe sê hulle ek is seker swanger, so ek het (‘n swangertoets gebruik). Daardie manier wat ek uitgevind het, ek is swanger. Maar, ons altwee – op ‘n manier het ons ‘n kind verwag gehad.

Interviewer: Is dit?

Ansie: Ja. Maar ek het nou nie daardie tyd eintlik geverwag ek sal daardie tyd swanger geraak het. Maar ek is orrait met my swangerskap.

Ansie: In the beginning I was actually not all right – I actually did not expect it like this

Interviewer: So it was an unplanned pregnancy. How did you find out?

Ansie: I was throwing up[

Interviewer: [is that so?]

Ansie: threw up – I did not want to eat, did not actually want to smell food, so (...)

Interviewer: Ok. And then?

*Continued:*

Ansie: Then I went – I first stayed and asked the older persons: ‘Which symptoms are these when you throw up like this, and throw up and throw up and don’t (...).’ No, then they said I am probably pregnant, so I (did a pregnancy test). That way I found out that I am pregnant. But, we both – in a way expected a child.

Interviewer: Is that so?

Ansie: Yes. But I didn’t expect that time actually that I would fall pregnant that time. But I am all right with my pregnancy.

The positioning within the Discourse of Ownership of Pregnancy is at times supported by a shared ownership between the women and other persons. It seems that for those women who have difficulty positioning themselves in the Discourse of Ownership of Pregnancy shared ownership moderates this construction.

For Ansie who only wanted one child, the pregnancy is then unplanned. Just as in the previous passage she draws on the Discourse of Ownership of Pregnancy in sharing the ownership of her pregnancy. Finding out is a shared construction in this case, which leads to acceptance and thus ownership of the pregnancy.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Interviewer: (...) Wanneer het jy vir jou ou gesê?

Ansie: Ek het in daardie tyd – hy het seker geweet of ek weet nie. (Daar is mos) mansmense wat vinnig uitvind.

Interviewer: Hmm

*Continued:*

Ansie: Ons altwee het (sommer) daardie tyd uitgevind ek is swanger. Daar is nie 'n probleem nie – ons altwee is bly (...) swangerskap.

Interviewer: (...) So dit was 'n bietjie van 'n skok gewees

Ansie: Ja, dit was 'n bietjie skok gewees – iets wat jy nie daardie tyd verwag nie.

Interviewer: Wat het jy gedoen – wat was jou gedagtes? Het jy geworry?

Ansie: Ek het geworry volgens – hoe moet ek sê? Die, die – hoe moet ek sê? Die lewe wat ons nou volgens lewe – die onkoste – daardie goed. Ek het mos al klaar kind[

Interviewer: [hmm]

Ansie: en hy gaan nog skool. Ek moet (ook) vir hom onderhou. My beplanning was, ek wil net een kind in my lewe gehad het[

Interviewer: [hmm]

Ansie: so, (...) dan moet jy mos aanvaar – daardie ene is mos ook joune.

Interviewer: Hmm, sjoe. Hoe voel jy oor die baba?

Ansie: (...)

Interviewer: (...)

Ansie: nee, ek wil ook hê hy moet gelukkig wees – hy kan voel: dis my ma en pa. Dis my mense. Hy moet – hoe moet ek sê? Ek moet nie my kind wegstoot nie. Ek moet hom aanvaar as my kind.

Interviewer: Hmm

Ansie: (...) mos nie gevra om daar te wees nie.

Interviewer: (...) When did you tell your boyfriend?

Ansie: I did in that time – he probably knew or I don't know. (There are) men who find out quickly.

Interviewer: Hmm

Ansie: We both (just) found out around that time that I was pregnant. There is no problem – we both are glad (...) pregnancy.

Interviewer: (...) So it was a bit of a shock

Ansie: Yes, it was a bit of a shock – something you did not expect to happen that time.

Interviewer: What did you do – what were your thoughts? Did you worry?

Ansie: I worried about – how can I say? The, the – how can I say? The life we are living now – the expenses – those kinds of things. I already have a child[

Interviewer: [hmm]

Ansie: and he still goes to school. I must (also) support him. My plan was, I just wanted one child in my life[

Interviewer: [hmm]

Ansie: so, (...) then you have to accept – that one is also yours.

Interviewer: Hmm, sjoe. How do you feel about the baby?

Ansie: (...)

Interviewer: (...)

Ansie: no, I also want him to be happy – he can feel: this is my mother and my father. These are my people. He must – how can I say? I must not push my child away. I must accept him as my child.

Interviewer: Hmm

Ansie: (...) did not ask to be there, did he.

This ownership of pregnancy is expanded to those close to the women, like their mothers or partners who are included in this process of constructing the reality of pregnancy long before the clinic is allowed to verify it. Katryn also knew that she was pregnant before she went to the clinic to test for pregnancy. Her mother also knew which Katryn explains as result of her mother's experiences as an older woman. Thus, her mother also takes ownership of the pregnancy.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Katryn: [Ja, ja, toe ek, ah, ah, toe ek nie begin vloei nie, toe is dit mos al daardie sewende wat ons hier is, toe sê ek vir hulle en nog voor my broer gesterf het. Toe sê ek ook vir my ma een dag, ek is swanger. Maar, maar, maar ek het vir haar – en 'n vroumens gee mos ook afskydings af né, soos as jou period miskien klaar is – daardie afskydings. Toe, toe – hoe het dit gebeur? Toe het ek my gewas, toe is ek daar by my ma. Toe het ek my gewas en toe wys ek dit vir my ma, toe sê die ma vir my, nee ek is swanger. Sy is mos nou al 'n groot vrou. Maar nog met sy swangerskap en met die – hoe kan ek sê – ek praat met my ma. Ek het vir haar gesê ek is swanger.



Katryn: [Yes, yes, when I, ah, ah, when I did not start to flow, then it was almost that seventh when we were here, then I told them and even before my brother passed away. Then I also said to my mother one day, I am pregnant. But, but, but I told her – and a woman gives off this discharge né, like if your period is maybe done – that discharge. Then, then – how did it happen? Then I washed myself, then I was there with my mother. Then I washed myself and I showed it to my mother, then my mother said, no I am pregnant. She is a big woman. But with the pregnancy and with the – how can I say – I speak to my mother. I told her I was pregnant.

Katryn constructs herself as someone who is told she is pregnant by someone who is more experienced than she is. Also, she tells others about her pregnancy because she knows that she is pregnant. Hence, even though she allows for shared construction of her pregnancy there is still ambivalence in her construction of self-as-pregnant.

Grace is also allowing an older, experienced woman to co-construct her pregnancy with her.

*1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Tell me about the pregnancy. How has it been? From the beginning until now...

*Continued*

Grace: From the beginning, né, I was not (...) pregnant – so far – I find out I am not getting my menstruation anymore. Maybe from December (...) then I wait from January, February – sofar they – I’m not feeling (something). Then I go to another woman, then she told me I must just waiting from six months there and five month – maybe I’m going to feel something. Then so from six month, five month – then I feel sometimes – she say that, né – when you are (like on the bed) – down like this, you can feel something coming, ok, then it’s the birth. I find out from her (...) that I’m pregnant.

Interviewer: Did you then go to the clinic? And have a check done?

Grace: Hmm-mmh, I just buy pregnant-test and take it. And I use it. Then I was maybe four month.

Interviewer: Ok

Grace suggests that she is not feeling pregnant, but that the older woman then tells her that she is. The process of finding out, of constructing self-as-pregnant thus excludes the clinic.

In Baby’s case it was not she who took ownership of her pregnancy but her boyfriend. Different to the other women who knew before having a test done, is Baby who did not know but was told by her boyfriend.

*1st pregnancy; 2nd trimester; 1st interview*

Interviewer: (.2) When was this - when did you, when did you first realise that you were pregnant?

Baby: I didn't realise first, but my boyfriend was the one who realised it.

Interviewer: Ok

Baby: (It was) the first day he told me: 'You might be pregnant.' I said: 'No, I can't be pregnant. How can I be pregnant with these years we were together, with these[

Interviewer: [Ja]

Baby: (three) years I wasn't pregnant and I didn't use any contraceptive, I (happen) to be pregnant today?' (.3) And it was like: 'No I'm not!' 'You are!' 'I'm not!' It was just like that. And I waited - he - my boyfriend, knows exactly when am I getting my period, (...) (we are not staying) together[

Interviewer: [Ja]

Baby: and he probably phoned me and told me: Oh it's like three days and you didn't give me a call that you are on your period or something, which means you are pregnant. And I said: Hmm, we are going to wait, (.2) when I'm pregnant or not. Well I wanted a child[

Interviewer: [Hmm]

Baby: and he told me: No, you are pregnant. That was in February, hmm, when I had sex with him[

Baby constructs herself as someone who does not initially realize that she is pregnant. Thus she constructs herself as not owning the meaning. She furthermore constructs herself as someone who is told that she is pregnant. The ownership of the pregnancy is handed to her hence not being hers altogether. Baby also constructs herself as someone who cannot be pregnant thereby rejecting the ownership of pregnancy. She also constructs herself as waiting for confirmation of pregnancy. Thus she waits to own the meaning of pregnancy. Lastly, Baby constructs her unplanned pregnancy as wanting a child. It becomes obvious thus that Baby is experiencing much ambivalence about herself as a pregnant woman. The positioning in the Discourse of Ownership of Pregnancy is a difficult task for her.

For those women who do not fully draw on the Discourse of Ownership of Pregnancy the experience becomes a stressful one. They are torn between two realities and they construct themselves ambivalently. They are pregnant as well as not pregnant and fully own neither of these constructions.

Clarence finds it difficult to accept her unplanned pregnancy and initially, constructs herself as not pregnant.

*1st pregnancy; 3rd trimester; 1st interview*

Interviewer: That's fine. Tell me about the day that you found out that you were pregnant. Tell me about that day.

Clarence: I was not feeling fine – I was not ok.

Interviewer: Is it?

*Continued:*

Clarence: But ah, me, I thought that maybe I was not pregnant because sometimes I used to loose the month.

Interviewer: Hmm

Clarence: Then in March it's when I went to the hospital – the clinic at Mariental.

Interviewer: Ok

Clarence: Then they say I was positive. I was at school (...)

Interviewer: How did you feel when they said you were pregnant?

Clarence: I didn't feel good.

She constructs herself as owning the meaning of her pregnancy but constructs this pregnancy in negative terms.

In another part of Clarence's narrative, her ambivalent feelings are evident. There is much ambiguity in her construction of herself as pregnant.

*1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Tell me about the baby. How do you feel about the baby?

Clarence: (.3) I feel, hmm, I'm feeling good to have a baby. It's good.

Interviewer: Was it in the beginning also good or was it in the beginning...

Clarence: Hmm, in the beginning it was not nice, it was not good (yet) but now I can see that it is ok.

Clarence constructs her experience of pregnancy as both "good" and "not nice". Thus, she initially had quite some difficulty in positioning herself in the Discourse of Ownership of Pregnancy.

Some of the women construct themselves as someone to whom pregnancy comes as a shock. They construct their experience of finding out in traumatic terms. They thus draw on the Discourse of Ownership of Pregnancy but position themselves within this discourse in negative terms.

To Michelle, pregnancy comes as a shock. It is unbelievable to her.

*1st pregnancy; 1st trimester; 1st interview*

Interviewer: Hmm. Hoe dink jy gaan ander mense reageer as jy nou begin wys?

Michelle: Ek weet nie {laughter} Ek weet r rig nie. Hulle sal seker nie glo dis ek wat swanger is nie {laughter}

Interviewer: Hoekom?

Michelle: Ek weet r rig nie.

Interviewer: Hmm. How do you think other people will react when you start showing now?

Michelle: I do not know {laughter} I really do not know. They will probably not believe that I am pregnant {laughter}

Interviewer: How come?

Michelle: I really do not know

Michelle constructs herself as having done something that others won't be able to believe. She thus owns the meaning of her pregnancy yet that meaning is laced with perceived criticism of those around her.

Finding out that you are pregnant is a bad experience and it is difficult, according to Born.

*Not 1st pregnancy; 1st twin pregnancy; 3rd trimester; 1st interview*

Interviewer: Tell me about the day that you found out that you were pregnant.

Born: {laughter} The day I found out I was pregnant?

Interviewer: Hmm

Born: Wow, {laughter} I was very (bad) really

Born owns her pregnancy and constructs it as an unpleasant experience.

The construction of pregnancy at times is done along the mind-body split. For those women who are not fully positioned in the Discourse of Ownership of Pregnancy, the pregnancy is often constructed as owned only when it can be constructed as an embodied experience. Thus, it seems that in order for the women to own their pregnancy they need to construct it as an embodied experience.

There is a time when the reality of the pregnancy is not yet owned by the woman. Baby relates how she was not feeling pregnant during the first month of her pregnancy.

*1st pregnancy; 2nd trimester; 1st interview*

Baby: So within the whole month I didn't feel anything, I didn't feel that I was pregnant[

Baby constructs herself as needing to feel pregnant in order to own the meaning of her pregnancy. Thus, for her the body-mind duality is excluding her from positioning in the Discourse of Ownership of Pregnancy.

Pregnancy is acknowledged as soon as menstruation ceases. Then a woman knows she is pregnant, according to Maria. The embodied experience allows her to acknowledge her pregnancy and to begin her construction of self-as-pregnant.

*Not 1st pregnancy; 1st trimester; 1st interview*

Interviewer: Hmm (.3) hmm (.1) Hmm, vertel vir my van wanneer het jy uitgevind dat jy swanger is?

Maria: Hmm, nee hmm, Mei maand wat ek nou gesien het – ek kry mos vyf dae menstruation.

Interviewer: Hmm, hmm

Maria: So, toe het ek nou drie dae gekry en toe bly ek dan daardie hele maand so en toe wag ek, kry ek nou nie – kry ek nog nie weer nie (.1) (...)

Interviewer: Hmm. Ok. Het jy vir toetse gegaan? (.1) Of het jy net geweet jy is swanger?

Maria: Ja, ek het net geweet.

Interviewer: Hmm (.3) hmm (.1) Hmm, tell me about when you found out that you are pregnant?

Maria: Hmm, no hmm, May when I saw – I get five days menstruation.

Interviewer: Hmm, hmm

Maria: So, then I got three days and then I stayed like that for that whole month and then I waited, did not get – did not get again (.1) (...)

Interviewer: Hmm. Ok. Did you go for tests? (.1) Or did you just know that you are pregnant?

Maria: Yes, I just knew



Maria constructs herself as someone who has to wait for confirmation (or physical proof) of pregnancy. Yet, she also constructs herself as someone who knows already. Again, ambivalence underlies her construction of pregnancy.

Furthermore, Maria needs physical proof of her pregnancy. For her there is a time when you feel really pregnant and a time when you do not feel pregnant. After having had a sonar taken, Maria starts feeling pregnant.

*Not 1st pregnancy; 1st trimester; 1st interview*

Maria: Nee nou {laughter}. Wat moet ek sê? {laughter} Dit lyk vir my maar  
hmm, eerste swangerskap wat ek gehad het[

Interviewer: [Hmm]

Maria: ek het niks gevoel nie, maar nou voel ek dat ek is swanger {laughter}

Maria: No now {laughter}. What must I say? {laughter} It looks to me like  
hmm, first pregnancy I had[

Interviewer: [Hmm]

Maria: I did not feel anything, but now I feel that I am pregnant {laughter}

The embodied proof that she receives from the sonar allows her to draw on the Discourse of Ownership of Pregnancy.

In conclusion, the women draw on the Discourse of Ownership of Pregnancy to retain agency in their navigation of the experience of the antenatal clinic. They thus allow the clinic to agree with their construction of their reality. They do however, not allow the clinic to construct this reality for them. Hence, they not only own their pregnancy

but also the meaning thereof for their reality. Furthermore, the women draw on the Discourse of Ownership of Pregnancy in obscuring their own agency in the experience of their pregnancy. They differentiate between 'knowing' and 'finding out' that they are pregnant. It seems that their positioning in the Discourse of Ownership of Pregnancy as 'knowing', indicates that they have more firmly constructed their reality. Yet, when they position themselves in the Discourse of Ownership of Pregnancy as 'finding out', they are still in the process of navigating this construction of self-as-pregnant.

The women draw on the Discourse of Ownership of Pregnancy in order to make their pregnancies their own. Especially for those women who are experiencing an unplanned pregnancy the Discourse of Ownership of Pregnancy is drawn on to facilitate ownership. The process of accepting and coming to terms with their pregnancy reflects an integration of the body-mind dualism. For those women who find difficulty in constructing their reality as involving pregnancy, who find it 'unbelievable' that they should be pregnant, positioning in the Discourse of Ownership Pregnancy becomes a frustrating experience. In not having fully accepted their pregnancies as their reality the women position themselves in the Discourse of Ownership of Pregnancy as 'not owning yet'. They thus experience ambivalence. The physical embodiment of pregnancy seems closely linked with the cognitive and emotional ownership of pregnancy. This involves the women drawing on the Discourse of Embodiment in order to navigate the mind-body dualism of experiencing pregnancy.

Furthermore, the Discourse of Ownership of Pregnancy is drawn on by those close to the pregnant women. The ownership of their pregnancy and the meaning thereof thus becomes a shared ownership of pregnancy. Lastly, the Discourse of Embodiment is drawn on by the women in order to position themselves in the Discourse of Ownership of Pregnancy. Thus, the embodied experience of the pregnancy allows for ownership thereof.

### **8.6. The Discourse of Motherhood**

The women draw on the Discourse of Motherhood in positioning themselves in it. They also draw on this discourse in order to determine what a good and a bad mother is. Furthermore, they draw on the Discourse of Motherhood in constructing their own mothers. Finally, the Discourse of Motherhood is drawn on to position themselves within motherhood – be that as mother, as woman, or as girl.

Some women construct the commencement of motherhood as when the pregnancy becomes visible. It is thus the embodied pregnancy that allows for ownership thereof and thus for the women to position themselves in the Discourse of Motherhood. To Michelle, motherhood starts when the pregnancy becomes visible.

*1st pregnancy; 1st trimester; 1st interview*

Interviewer: Wanneer dink jy gaan jy begin soos 'n ma voel?

Michelle: Miskien as die maag begin uitkom

Interviewer: Ja

Michelle: Ek is nou nog nie ver nie, maar dan. Dan sal ek serious besef, nee ek word nou groot {laughter}

Interviewer:	When do you think you will start feeling like a mother?
Michelle:	Maybe when my belly starts showing
Interviewer:	Yes
Michelle:	I am now not far along yet, but then. Then I will seriously realize that I am becoming big {laughter}

Michelle constructs motherhood in physical terms. She also positions herself in the Discourse of Motherhood as not being a mother yet. She constructs herself as not realizing the reality of her pregnancy. Her positioning within the Discourse of Motherhood is thus not fully determined. Michelle's wordplay in Afrikaans shows how the Discourse of Motherhood is interwoven with the discourse of adulthood. Michelle notes that she is becoming big now. This could be either a construction of the physical growth of her pregnant belly or her own growth into womanhood and adulthood.

Other women construct motherhood as beginning after birth. Pregnancy is thus not positioned within the Discourse of Motherhood. Baby points out that in pregnancy one is not a mother yet.

<i>1st pregnancy; 2nd trimester; 1st interview</i>	
Interviewer:	Ok. (.5) Hhm, do you feel like a mother?
Baby:	Ja, I'm going to be a mother.
Interviewer:	You're going to be a mother. Ok.
Baby:	Hmm.

In Baby's answer lies some ambiguity. She answers the question about feeling like a mother affirmatively but then uses the future tense to indicate that she is not a mother yet. It seems difficult for Baby to position herself in the Discourse of Motherhood.

Care also states that motherhood starts when the baby is born.

*1st pregnancy; 2nd trimester; 1st interview*

Interviewer: ...Ons het nou net gepraat van jy dat jy soos 'n vrou voel (...) Voel jy al soos 'n ma?

Care: Nog nie.

Interviewer: Nog nie. Wanneer dink jy sal jy soos 'n ma voel?

Care: As ek die kind in my hande hou.

Interviewer: ...We just talked about that you feel like a woman (...) Do you already feel like a mother?

Care: Not yet.

Interviewer: Not yet. When do you think you will feel like a mother?

Care: When I am holding the child in my hands.

Care constructs herself as being aware of when motherhood begins. She constructs herself as a mother-to-be, hence a construction of not having reached motherhood yet. Care also constructs motherhood as a physical interaction between herself and her child. Motherhood starts when she holds her child in her arms. It seems that Care constructs motherhood as a role, rather than an experience.

The women draw on the Discourse of Motherhood in defining what a good mother is. This positioning within the Discourse of Motherhood is based on physical aspects of motherhood, namely being with the child as well as caring for the child.

Care explains that a good mother takes care of her child.

*1st pregnancy; 2nd trimester; 1st interview*

Interviewer: Wat, hmm, nog iets van ma-wees: Wat dink jy is 'n goeie ma? Wat is die eienskappe van 'n goeie ma?

Care: (...)

Interviewer: Hmm

Care: (...) hmm, te sorg (vir jou kind)

Interviewer: What, hmm, something more about being a mother: What do you think is a good mother? What are the characteristics of a good mother?

Care: (...)

Interviewer: Hmm

Care: (...) hmm, to care (for your child)

Care constructs motherhood as caring.

Furthermore the women construct the good mother as being a mother who talks to her child and prepares the child for things to come. Michelle describes a good mother as being honest with her child. A good mother teaches her child about right and wrong.

*1st pregnancy; 1st trimester; 1st interview*

Interviewer: (.2) Wat hmm, om terug te kom na die ma: Wat is vir jou 'n goeie ma?

Hoe sou jy sê?

Michelle: Ek voel 'n goeie ma is (.2) 'n persoon wat gesels met die kind, nie jou kind op elke punt (afdaag) nie. Wanneer jou kind jou iets vra, 'n antwoord - altyd wat jy kan.

Interviewer: Ja

Michelle: Jou kind vertel van die lewe daar buite – hoe is die lewe (.2) en basies nie 'n kind bederf tot (...) die kind nou 'n duisend Rand selfoon wil hê, nou gaan koop. Ek voel die kind moet voel hoe voel dit om 'n harde lewe te hê – om te gaan - om uit te kom waar jy (...) (vandag) (.3)

Interviewer: (.2) What hmm, to get back to the mother: What to you is a good mother? What would you say?

Michelle: I feel a good mother is (.2) a person who talks with her child, does not (break down) her child an every aspect. When your child asks something, an answer always what you can

Interviewer: Yes

Michelle: Tell your child about the life out there – how is the life (.2) and basically don't spoil a child until (...) the child now wants a thousand Rand cell phone, go buy now. I feel the child must feel what it means to have a tough life – to go – to get where you (...) (today) (.3)

Michelle constructs motherhood in two parts. Firstly, she constructs motherhood as consisting of things that one should not do as a mother. The second part of her

construction of motherhood consists of preparation of the child for hard times to come – the mother as an educator.

Maria suggests that a good mother makes sure her baby is never hungry. A good mother keeps her baby clean. Also, a good mother does not scold her child over unnecessary things.

*Not 1st pregnancy; 1st trimester; 1st interview*

Interviewer: ...Wat was vir jou, wat sal jy sê is 'n goeie ma, (.1) wat is die dinge wat 'n goeie ma doen?

Maria: (.2) Hmm. 'n Goeie ma (.1) is 'n ma wat nie met sy baba raas nie of (.2) wat nie sy baba net vuil hou nie[

Interviewer: [Hmm]

Maria: wat nie met sy baba met honger bly nie[

Interviewer: [Ja]

Maria: wat nie sy baba so oor simpel goed slaan nie {laughter}

Interviewer: Hmm

Maria: Hmm

Interviewer: ...What to you was, what would you say is a good mother, (.1) what are the things a good mother does?

Maria: (.2) Hmm. A good mother (.1) is a mother who does not scold her baby or (.2) who does not let her baby stay dirty[

Interviewer: [Hmm]

Maria: who does not let her baby remain hungry[



*Continued:*

Interviewer: [Yes]

Maria: who does not hit her baby over stupid things {laughter}

Interviewer: Hmm

Maria: Hmm

Maria constructs motherhood in terms of exclusion – what not to do. It seems thus as though she is not sure where to place herself in the Discourse of Motherhood. She constructs herself as not knowing what to.

Grace constructs the good mother as ever-loving and ever-caring. She thus constructs motherhood as a long-term commitment.

*1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Hmm. Tell me about – what, what is a good mother to – what is a good mother like?

Grace: Good mother like?

Interviewer: Hmm

Grace: Hmm, how do you mean? Good mother? Good mother like what? A nice child?

Interviewer: What is a - No, no, no. What, what, what does a good mother do? How is she good?

Grace: Why she's good?

Interviewer: Hmm

Grace: I think (mothering) is like my mom.

*Continued:*

Interviewer: Is it?

Grace: Hmm. Some of the mother doesn't like one child – they like two child.  
But my mother, she likes six of us.

Interviewer: Hmm

Grace: She take care six of us.

Interviewer: Hmm

Grace: She believe (...) My mother, she is a good mother. She's not even –  
when another day – she's like this, she is like this – hmm-mmh. She's  
just like the day that you meet her[

Interviewer: [Always the same]

Grace: the same. Many people like my mother.

Interviewer: Hmm

Grace: She's a good mother. Also, I want to be like her.

Interviewer: You want to be like your mother, with your children.

Baby also constructs motherhood in terms of constancy. She constructs the good mother as having to always be caring and loving, no matter what her situation is.

*1st pregnancy; 3rd trimester; 2nd interview*

Interviewer: What do you expect of motherhood?

Baby: I want to be a caring mother. Look after my own baby. And I want to  
be a perfect mom – one of the best mom – one of the best.

Interviewer: What's a best mom?

Baby: What's the best? Always being with my children – to look after them -  
helping them and good in bad times, always.

Ansie points out that motherhood is something one wants to achieve. A woman aims at good motherhood. She constructs motherhood as including love but also material support. She also constructs herself as having acquired her standards of motherhood through her own mother.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Hmm, vertel vir my van ma-wees. Soos, ons – as ons nog klein dogtertjies is, kyk ons na ma's en dan sien ons: oh, nee, ek sal nooit dit met my kind doen, maar daardie ene is vir my ... (By) wie het jy geleer?

Ansie: {laughter} Ek wil graag 'n goeie ma vir my kind wees soos wat ek by my ma gesien het – soos sy vir ons opgevoed het en liefde wat sy nog vir ons altyd het[

Interviewer: [hmm]

Ansie: met ons se kinders. So wil ek ook een dag my kind gaan ondersteun en daardie moederliefde gee. Eendag ook by plek (...) – soos my (neefie) ook wat altyd sê as ek hom iets gee: 'Ogh, dis tog lekker om ma te hê.'[

Interviewer: [hmm]

Ansie: ons praat mos. So ek wil tog daardie goeter wees - vir my kind iets eendag (gee).

Interviewer: Hmm

Ansie: Laat ek eendag by eie plek uitkom.

Interviewer: Hmm

- Interviewer: Hmm, tell me about being a mother. Like, we – if we are still small girls, we look at our mothers and then we see: oh, no, I will never do that with my child, but for me that one is... (From) who did you learn?
- Ansie: {laughter} I would like to be a good mother for my child like I saw with my mother – like she educated us and the love she still has for us[
- Interviewer: [hmm]
- Ansie: with us children. Like that I also want to one day support my child and give that mother-love. One day also at a place (...) – like my (cousin) too who always when I give him something says: ‘Ogh, it’s great to have a mother’[
- Interviewer: [hmm]
- Ansie: we do talk. So I do want to be those things – to my child something someday (give).
- Interviewer: Hmm
- Ansie: So that one day I will have my own place.
- Interviewer: Hmm

However, for some women there is still much ambiguity in motherhood. Not all of the women find it easy to draw on the Discourse of Motherhood and to position themselves within it. Grace is unsure about whether she is ‘becoming’ a mother. She thus constructs herself as uncertain about motherhood and her positioning within the Discourse of Motherhood.

*1st pregnancy; 3rd trimester; 1st interview*

- Interviewer: Hmm, tell me about being a mother. Have you thought about that a lot?
- Grace: Ah, I've thought about that a lot because I'm going to – I thought that: Am I going to be a mother? (...) It's the things that comes into your mind[
- Interviewer: [Hmm]
- Grace: Oh, I'm going to take care.

For some it is difficult to construct themselves as mothers. Yet, positioning oneself within the Discourse of Motherhood as a woman seems easier. Maria explains that one becomes a woman from the age of thirty.

*Not 1st pregnancy; 2nd trimester; 2nd interview*

- Interviewer: Hmm. Ok. (.3) Wanneer dink jy gaan 'n mens deur daai - wanneer stap 'n mens van 'n meisiekind na 'n vrou. Wanneer kom die verandering?
- Maria: {laughter} Ek weet nie.
- Interviewer: Wanneer dink jy gaan jy 'n vrou word?
- Maria: (.5) As ek dertig jaar oud is.
- Interviewer: As jy dertig jaar oud is.
- Maria: {laughter}
- Interviewer: Ok. En die gevoel van ma-wees. Wanneer gaan dit kom?
- Maria: (.8) {lag}

Interviewer: Hmm. Ok. (.3) When do you think one goes through that - when does one step from a girl to a woman? When does the change happen?

Maria: {laughter} I do not know.

Interviewer: When do you think you will become a woman?

Maria: (.5) When I am thirty years old.

Interviewer: When you are thirty years old.

Maria: {laughter}

Interviewer: Ok. And that feeling of being a mother. When will that come?

Maria: (.8) {laughter}

Maria constructs herself as being unaware of the change-over from being a girl to womanhood. She is thus not aware of her own positioning in the Discourse of Motherhood. She does however construct womanhood as related to age.

The Discourse of Motherhood is also drawn on in constructing the bad mother. Born constructs a bad mother as one who goes out and socializes.

*Not 1st pregnancy; 1st twin pregnancy; 3rd trimester; 1st interview*

Interviewer: Tell me about how you were before and how that's going to change now. How it's going to be different?

Born: I'm not going out any more because I am having the pregnancy and I have to look for them, so I have to be a mother, being home every day, making food for them, take care of them...hmm, so it's not going to be like before.

Born constructs motherhood as a responsibility. She thus constructs herself and her needs as being second in line – being less important than the babies. She also

constructs motherhood as caring. Thus, the positioning in the Discourse of Motherhood makes being socially active impossible.

To Clarence, motherhood is not something which is achieved automatically; rather she constructs motherhood as a process of learning. She thus place herself under less pressure in comparison with the other women who construct themselves as automatically becoming mothers – and often automatically having to become perfect mothers. It seems thus, that Clarence leaves herself a margin of error in her construction of motherhood.

*1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Tell me about being a mother.

Clarence: (.3) {laughter} I don't know. I just find out how to be a mother when you are responsible for your baby - when you take care of her or him.

Interviewer: Hmm

Clarence: And you have to love – love her.

Interviewer: Hmm

Clarence: Take care of her.

The women's own mothers are constructed as teachers and role models. The women position themselves in the Discourse of Motherhood based on their own mothers' guidance. Tangi constructs herself as having become a mother through her own mother's teachings.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Hmm, tell me about being a mother. We all – when we, when we grow up we look at other mothers and we see, ah, I want to be like that mother. I don't want to do what she is doing (...) Who did you learn from – being a mom?

Tangi: I learnt from my mother.

Interviewer: Hmm

Tangi: How he treat us.

Interviewer: Hmm

Tangi: And how we grow up.

Rosie constructs motherhood in ambiguous terms. Motherhood is constructed as both wonderful and difficult.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Vertel vir my van ma-wees en vrou-wees.

Rosie: Oehh, dis wonderlik. Dis ook bietjie moeilik.

Interviewer: Hmm

Rosie: Want jy het hier kinder en huis en alles wat jy (control). So, dis bietjie moeilik. (Maar) tog baie lekker om ma te wees.

Interviewer: Tell me about being a mother and being a woman.

Rosie: Oohh, it's wonderful. It's also a little difficult.

Interviewer: Hmm

Rosie: Because you have children and a house and everything which you (control). So, it's a little difficult. (But) still it's very nice to be a mother.



Sofia on the other hand constructs motherhood as hard work.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Sofia: Oeh! Dis baie erg! Om ma te wees moet jy sterk wees. Om ma te wees moet jy (gedeel het) vir die kinders. Want daar is – as jy ‘n ma is – jy moet goeters uitvat. Daar is klomp goed wat jy vir die kiders moet doen. Daar is tyd wat hulle wil hê jy moet met hulle speel[

Interviewer: [hmm]

Sofia: Jy moet so partytjie gehou het (...) (die heel tyd) die shopping, die skole en alles.

Interviewer: Baie werk

Sofia: Dis baie werk.

Sofia: Ooh! It's very bad! To be a mother you must be strong. To be a mother you must (share) with the children. Because there is – if you are a mother – you must exceed with things. There are many things which you must do for the children. There are times when they want you to play with them[

Interviewer: [hmm]

Sofia: You have to have a party (...) (the whole time) the shopping, the schools and everything.

Interviewer: A lot of work

Sofia: It's a lot of work.

Rosie constructs motherhood as something that should involve much preparation. She constructs motherhood as challenging. Furthermore, she constructs women as unprepared for motherhood.

*Not 1st pregnancy; 3rd trimester; 1st interview*

Interviewer: Iets wat jy wil byvoeg oor wat ons gepraat het?

Rosie: Soos maar as jy nie, ah, ah – wat wil ek nou sê – as jy (.1) as jy wil ma wees, (.1) wees maar eers klaar - maak maar eers klaar met alles wat jy rêrig wil doen, voor jy ma raak. Want as jy ma raak dan is alles nou verby. Dan is jou toekomsplanne nou verby as jy miskien gestudeer het. En sommige kere is dit ‘n fout wat jy gemaak het (...)

Interviewer: Hmm

Rosie: En dan voel dit vir jou die wêreld is uitmekaar uit. So as jy iets wil doen, maak eers klaar.

Interviewer: Hmm

Rosie: Dan beplan – stap vir stap (...) Dit is ‘n groot stap wat jy ingaan.

Interviewer: Hmm. Dink jy mense onderskat dit?

Rosie: Hmm

Interviewer: Hoe groot?

Rosie: Hmm (...)

Interviewer: Ok. Was dit vir jou – met jou eerste kind – was dit vir jou baie moeilik om te hanteer?

Rosie: Ja, dis baie

*Continued:*

Interviewer: Hmm

Rosie: Want die kinders se dingeses is ook – dis lankal – as hulle begin groot raak dan begin voel jy eers – atth – nou werk dit op ‘n mens.

Interviewer: Hmm

Rosie: Kindertjies is stout. Al daardie goedjies. (...) Dis nie so lekker nie. So, as jy wil ma-wees dan moet jy beplan. Alles beplan.

Interviewer: Something you want to add to what we talked about?

Rosie: Like if you don't, ah, ah – what do I want to say now – if you (.1) if you want to be a mother, (.1) first be done – first finish everything you really want to do, before you become a mother. Because when you become a mother everything is over. Then your future plans are over if you maybe studied. And sometimes it's a mistake you made (...)

Interviewer: Hmm

Rosie: And then it feels to you the world is upside down. So if you want to do something, finish first.

Interviewer: Hmm

Rosie: Then plan – step by step (...) It's a big move you're letting yourself in on.

Interviewer: Hmm. Do you think people underestimate it?

Rosie: Hmm

Interviewer: How much?

Rosie: Hmm (...)

*Continued:*

Interviewer: Ok. Was it to you – with your first child – was it very difficult for you to deal with?

Rosie: Yes, it's very

Interviewer: Hmm

Rosie: Because the children's things are also – it's a long time – if they start growing up then you start feeling only – atth – now it's getting to you.

Interviewer: Hmm

Rosie: Kiddies are naughty. All those things. (...) It's not so nice. So, if you want to be a mother then you must plan. Plan everything.

The women also draw on the Discourse of Motherhood to determine their positioning as women or girls. Maria does not feel like a mother or a woman yet, even though this is her second pregnancy.

*Not 1st pregnancy; 2nd trimester; 2nd interview*

Interviewer: ... Voel jy, voel jy nou soos 'n ma, of voel jy vrou, of voel jy soos 'n meisiekind?

Maria: {laughter} Ek voel soos 'n meisiekind {laughter}

Interviewer: ...Do you feel, do you feel like a mother, or do you feel like a woman, or do you feel like a girl?

Maria: {laughter} I feel like a girl {laughter}

Maria constructs herself as a girl within the Discourse of Motherhood.

Baby constructs herself as becoming a woman through pregnancy.

*1st pregnancy; 3rd trimester; 2nd interview*

Interviewer: What does your boyfriend say (...) about your body?

Baby: He's saying that I really look good – I am – I do look like a woman. I doesn't look childish again.

Interviewer: Ok

Baby: I do look like a woman.

Interviewer: Do you think that the pregnancy is sort of the transition from 'girlhood' to womanhood for you?

Baby: Exactly. And there should be a change if you love someone. You are (...) someone, there shall be a difference.

However, Baby also seems to have difficulty in maintaining this construction of womanhood. Baby feels guilty about not being a woman while she is pregnant. For Baby sexual intercourse is part of being a woman. Yet, because of her pregnancy it is uncomfortable for her to be sexually active.

*1st pregnancy; 2nd trimester; 1st interview*

Baby: And I also feel sorry for my boyfriend right now. Actually he loved this sex very much, now all of a sudden... I do feel sorry for him (...)

For Baby there is no compatibility between the different positions within the Discourse of Motherhood. Thus, it seems that the construction of self does not allow for coexistence between constructions of self as mother, woman and girl. It seems that within the Discourse of Motherhood the women position themselves quite rigidly in one direction.

In conclusion, it seems that the women position themselves within the Discourse of Motherhood, quite distinctively. Furthermore, they are all constructing themselves as obeying certain rules as mothers. It seems that they subscribe to a 'mothering-code'. They thus draw on the Discourse of Motherhood in order to define the rules of motherhood for themselves.

### **8.7. Summary**

The women in this sample drew on five different Discourses in order to position themselves as pregnant and in order to make sense of their experiences of pregnancy. Each Discourse seemed to be drawn on for certain experiences, however for some experiences more than one Discourse were used.

The Medical Discourse was drawn on by both the pregnant women as well as the antenatal clinic to construct pregnancy as symptomatic or as illness. This served the purpose of making sense of experiences that seemed outside of the norm for pregnancy. Furthermore, the women drew on this Discourse to construct pregnancy when the circumstances surrounding it were deemed unfavourable. The Medical Discourse in this instance prevented the women from positioning themselves in the Discourse of Ownership of Pregnancy as their pregnancies were not constructed as such but rather an illness. The Medical Discourse was further drawn on to construct conception and thus pregnancy as risky in the context of HIV/Aids. When this Discourse is drawn on strongly, pregnancy becomes inferior and the visit to the antenatal clinic is constructed as a HIV check-up and not a pregnancy check-up. The Medical Discourse is further drawn on to construct caesarean sections which are

constructed as the abnormal way of birthing. Lastly, the Medical Discourse is used to navigate the experience of pregnancy in light of conflicting information from the women's traditional belief systems.

The Discourse of Dependence is drawn on by the women to construct themselves as dependent during pregnancy. Therefore they shift agency to institutions or persons. They shift agency to older women or their mothers, who are constructed as knowledgeable to the extent that their opinion carries more weight than the information from the antenatal clinic. The older women are positioned in a supervising and guiding role. In some instances the Discourse of Dependence is so strong that the older woman becomes seemingly integrated into the younger, pregnant woman's self. Agency is also handed to the antenatal clinic in drawing on the Discourse of Dependence. Medical staff, especially nurses, are constructed as being in a position of power. Women construct themselves as passive and that medical procedures are being 'done' to them. Furthermore women construct themselves as dependent on the clinic in their need for information from the medical arena. In certain instances women construct themselves as dependent, yet do not shift agency to any person or institution. They construct themselves as incapacitated - temporarily dependent as result of their pregnancy. The unborn child is also constructed using the Discourse of Dependence. Women are constructed as threat to their unborn children, yet their unborn children are also constructed as threat to them. Lastly, the women draw on the Discourse of Dependence to navigate the opposing constructions of the Medical Discourse and their traditional belief systems.

The Discourse of Embodiment is drawn on to construct the body during pregnancy. When the pregnancy is positioned as wholly embodied, women seem to have an experience of surrendering to the physical. This seems to cause a split between the physical and emotions experience of pregnancy, thus restricting an inclusive experience of pregnancy. Furthermore, the Discourse of Embodiment is used in constructing a 'correct embodiedness'. This causes much anxiety for women who are pregnant for the first time or who are experiencing something new. However, the Discourse of Embodiment seems to facilitate positioning in the Discourse of Ownership of Pregnancy. Acknowledging pregnancy is made easier by physical changes – the ceasing of menstruation or the growing of the abdomen. Lastly, vaginal birth is constructed drawing on the Discourse of Embodiment. Agency is positioned in vaginal birth and thus it is constructed as the ideal.

The Discourse of Ownership of Pregnancy allows women agency and control over their experience of pregnancy, it seems. When they are firmly positioned in this Discourse, they have power over when and how their pregnancies are acknowledged. This leaves the antenatal clinic without agency, in that the women know they are pregnant and simply allow the clinic to verify what they have known all along. When women struggle to position themselves in the Discourse of Ownership of Pregnancy, accepting the pregnancy becomes difficult. Unplanned pregnancies, constructed like this thus have difficulty in becoming an accepted pregnancy, or perhaps a wanted pregnancy. The experience of pregnancy hence becomes stressful. Others co-construct the women's experience, in drawing on the Discourse of Ownership of Pregnancy. It thus becomes a shared ownership of pregnancy. The positioning in the Discourse of



Ownership of Pregnancy by a pregnant woman's mother or partner seems to facilitate her positioning in the Discourse of Ownership of Pregnancy.

The Discourse of Motherhood is drawn on by the women in determining their motherhood role. For some women motherhood is constructed as beginning when pregnancy becomes visible, for others when the child is born. Motherhood is constructed as something to be strived towards and something that needs preparation. The Discourse of Motherhood is drawn on in constructing the 'good mother' as responsible, ever-loving and ever-caring. The 'bad mother' is constructed as someone who puts her own needs first, for example a woman who goes out and socialises. Women also draw on the Discourse of Motherhood to construct their own mothers as their role models. Finally, the Discourse of Motherhood is drawn on to navigate other female roles, besides motherhood. The positioning of the self-as-woman is made difficult by the Discourse of Motherhood. Being a woman is linked to sexual activity, which is constructed in opposition to motherhood. Furthermore, it seems that to be able to position themselves as a mother, the women need to position themselves as women first.

## CHAPTER 9: DISCUSSION

### 9.1. Introduction

The objective of this study had been to expose the Discourses that underlie the experience of pregnancy in women from a low income background. The following research questions were addressed: Firstly, which Discourses did these pregnant women draw on during their pregnancy? Secondly, how did these women construct themselves as pregnant beings? Thirdly, how did these women construct themselves as pregnant beings from a specific culture? Fourthly, how did these women construct themselves as pregnant beings from a low income background?

Marginalisation of women is linked to culture and social practices (Stewart, 2008; Yen & Wilbraham, 2003), economic background (Liamputtong, 2005; Youngleson, 2006), mental health (Saris & Johnston-Robledo, 2000) and pregnancy. The marginalisation in pregnancy and the subsequent disadvantaged experience of pregnancy is said to be the result of dominant groups positioning these women in discourses (McDowell & Pringle, 1992). Hence, their views and privacy are overlooked (Cheetham, 1977). Discourse is language in action (Fairclough, 1995). It has meaning-making functions (Starks & Brown Trinidad, 2007) and conveys power and ideology (McGregor, n.d.). It is the positioning within a discourse which shapes experience. Positioning happens through language use and the drawing on certain discourses (Parker, 2005). Agency is “‘free will’ to act” (Allen & Hardin, 2001). According to Rúdólfsdóttir (2000) agency is influential on the experience of pregnancy of women.

The five most prominent Discourses, drawn on by the women, in this study, were the Medical Discourse, the Discourse of Dependence, the Discourse of Embodiment, the Discourse of Ownership of Pregnancy, and the Discourse of Motherhood.

## **9.2. The Medical Discourse**

For the women drawing on the Medical Discourse, when constructing their pregnancies, the resulting constructions varied. For some women, the Medical Discourse was drawn on, to construct their experience of pregnancy as symptomatic or as an illness. It seemed that the women constructed the experience of complications during their pregnancies, as illness-related. Lundquist (2008) has found similar constructions. The positioning of pregnancy as illness symptoms, or even food poisoning, was evident in her sample, as well. In the sample of this study, the construction of illness was co-constructed by the clinic as well as by other people. At times, the clinic would construct the women's experiences as symptomatic and disregard pregnancy. Tremain (2006) notes that antenatal testing and screening procedures are influential in the construction of prenatal impairment. In this study, the clinic took thus agency over constructing the women's reality. It was notable that this construction of pregnancy as illness resulted in an ambiguous as well as distressing experience of pregnancy.

The Medical Discourse was also drawn on by some women to construct those pregnancies for which the circumstances were unfavourable. The women as well as their partners, for example seemed to construct the experience as illness rather than pregnancy, when the pregnancy was unplanned or inconveniently timed. According to

Marshall and Woollett (2000) as a result of pregnancy being constructed in a specific way by society, any experience that does not fit with that construction becomes decontextualised. Thus, women are constantly striving towards this pre-constructed way of being pregnant and are marginalized if their experiences differ.

Some women seem to experience and construct the antenatal clinic, specifically, as a place where a woman's HIV status is checked-up on. The Medical Discourse is drawn on by the women to construct falling pregnant as 'risky' with regard to the threat of HIV infection. Spjeldnaes and associates (2007) have found similar constructions in their sample of South African women. They explain that constructions of reproduction are influenced by the HIV/AIDS crisis in South Africa. The "ABC slogan (abstinence, be faithful, condomise) of the HIV prevention campaign" (Spjeldnaes et al., 2007, p. 858) is a construction that pathologises reproductive behaviour and experiences.

Davis and Walker (2009) note the distressing nature of any kind of screening and testing for abnormalities during the antenatal period. Tremain (2006) argues that the idea of disability brings on that of impairment, and that these then allow for a greater regulatory control. The construction of pregnancy, in this study, thus, takes on a life-threatening, rather than life-giving connotation. For some women, this construction was so prominent that their pregnancy became secondary in importance to the risk of illness. When this construction carried so much weight, the experience for the women became exceptionally stressful, in that they bought into the pregnancy-as-potential-HIV-infection, in order to describe those experiences, which are 'abnormally' embodied. The Medical Discourse, it seems, leaves the woman without agency.

Pregnancy is constructed as something, which happens to women and which places them in danger, thus being a 'risk' (Marshall & Woollett, 2000). It is interesting at this point to mention Namibian research. The Ministry of Health and Social Services (2000) states that the biggest underlying cause of maternal mortality in Namibia is related to giving birth and not to death from HIV or Aids. One wonders then why the HIV campaign is so dominant in the antenatal clinics in Windhoek. A further concern is whether it might be these specific HIV campaigns and their influence on the construction of pregnancy that keep women away from the antenatal clinics.

Furthermore, the Medical Discourse was drawn on by the women to construct, specifically, caesarean sections. The women constructed themselves as rather giving birth vaginally, than giving birth through caesarean section. This is in contrast to the literature reviewed. In those studies, women constructed caesarean sections as the ideal (Davis & Walker, 2009; Liamputtong, 2004).

The current study is contrasted to the findings of literature reviewed, where vaginal birth is constructed as risky for baby and mother (Fenwick et al., 2006). In the current study, women constructed caesarean section as relinquishing of control; and vaginal birth as maintaining agency. However, when the baby's health is pitched against the woman's need for agency, ambivalence results. For example, in Maria's case, she wants a vaginal birth as that allows her more agency. However, she also wants a strong, healthy baby, which to her means it will be a big baby, delivered by caesarean section. This dilemma is also described in the literature, where there seems to be a perception that there would be an advantage to the baby in choosing caesarean section

(Fenwick et al., 2006). The discourse of “delivery of healthy babies” (Woollett & Marshall, 1997, p. 183) thus ties in with the biomedical discourse. It is interesting that the women in this study seem to position themselves against the Medical Discourse with regard to birthing, yet position themselves within this Discourse at the same time, in that they choose to give birth at the hospital. Hence, where the construction of vaginal birth rejects the Medical Discourse, the need to give birth at the hospital, repositions the women firmly within this Discourse. Rúdólfsdóttir (2000), too, noted ambivalence in her sample. The women perceived the control of the medical arena ambivalently, in that they welcomed the control of pain with medication, but were apprehensive about the medicalization of pregnancy when this left them without power over their own bodies.

The women in this sample drew on the Medical Discourse, in making sense of their traditional belief system. For some women, constructing themselves, using a western framework, allowed them to buy into the medical arena and visit the antenatal clinic. However, for those women, who could not position themselves in the Medical Discourse, in relation to their traditional belief system, the experience of visiting the antenatal clinic and the information received from there, resulted in conflict within them. LeBeau (1999) and Waters Lumpkin (1996) point out that for Namibians, drawing on a traditional framework, mental health and reproductive health are deemed social or spiritual constructs. Thus, people seem likely to seek out a traditional healer for help rather than the western health system. Waters Lumpkin (1996) further states that as result of the construction of pregnancy as being susceptible to sorcery, within the traditional construction thereof, antenatal clinics are

avoided. Opposed to these traditional constructions of pregnancy are those which discredit the pregnant woman's family and friends as information sources. Pregnancy guides and booklets, position optimum information sources as those linked to the medical discourse (Marshall & Woollett, 2000). The resulting ambivalence of those women torn between these constructions is not surprising then.

### **9.3. The Discourse of Dependence**

In this study, it became clear that the women drew on the Discourse of Dependence in a number of ways. The women positioned themselves in the Discourse of Dependence as dependent when they handed agency to others. However, through this construction of dependence, the women retained the agency and power about how they are experiencing their pregnancy. Thus, through constructing others as responsible for them, the women inhibited others from constructing them any differently, thus remaining, to an extent, independent from others' constructions.

The Discourse of Dependence was drawn on by some of the women to construct themselves as dependent and hand over agency to older women, mostly, their own mothers. They sought out older women's guidance and advice, in constructing the older women as more experienced and knowledgeable. The women thus constructed themselves as dependent on the older women. For the women in this study, this became evident, for example, in that the women did not doubt their mothers, when told by their mothers that they are pregnant. Darvill and associates (2008) and Liamputtong (2004) found that women preferred someone to take on a helping, mentoring role during pregnancy, as well as for birthing.

Furthermore, in this study, the dependence on the older woman is co-constructed by the older women, who reinforce the controlling, supervising and monitoring. Harrington (2002), as well as Uhlmann and Uhlmann (2005), believe that women are judged by others and that a kind of surveillance, from other women, who had already had children, was common. The older woman thus takes on agency.

Opposite to this construction of the wise, older woman, was the women's construction of themselves as ignorant of the proper way of being pregnant and, furthermore, as possibly endangering their own child as result of that. The women thus had to learn from someone, who is more knowledgeable, about 'the way of being a mother'. Seibold (2004) points out that pregnant women turn to their own mothers for support and advice, as well as reassurance. Cheetham (1977) has also noticed this, in that women, in pregnancy, are at times rendered dependent in the advice they receive about how to be pregnant.

Furthermore, this dependence on the older woman seems, at times, like an integration of the older woman into the self. For the women in the sample of Liamputtong and associates (2004), the construction of self-as-mother allowed them to become more aware of their own mothers' mothering. Thus, discussing pregnancy with the older woman is constructed as something separate to discussing it with others. Interestingly, the construction of dependence on older persons seemed more important than the construction of dependence on the clinic.



The Discourse of Dependence was furthermore drawn on by the women to construct themselves as dependent and hand over agency to the antenatal clinic – the medical arena. Redwood (1999) has also noticed dependence on the medical arena, in women. A discourse of ‘caring control’ is used by those in positions of authority over those who have no authority in this medical arena (Redwood, 1999). Liamputtong (2005) notes, that this controlling is not only the case for women from a lower socioeconomic background, but for all women.

The women, in this study, constructed themselves as being ‘done to’, for example, as being subjected to examinations and birthing practices. They thus constructed themselves as dependent in that they did not allow themselves to make their own choices. The women acknowledged the power of the medical staff and constructed themselves as needing to be told what to do by the medical staff. Uhlmann and Uhlmann (2005) found that women felt disciplined during pregnancy, especially within the medical arena. Women were denied choice in this arena (Fenwick et al., 2006) and were being turned “into passive and dependent patients” (Kyomuhendo, 2003, p. 21), to whom procedures were “done to” (Davis & Walker, 2009, p. 4). According to Beckett (2005) in the medical arena, a lack of intimacy exists. The body is scrutinised and thus objectified (Davis & Walker, 2009). For example, Baby emphasizes that she felt helpless, ‘at the mercy of’ and ‘being done to’ the medical staff, while she was being examined. The medical arena was thus, experienced as environment, where others yield control over the women and they are thus left feeling vulnerable and powerless (DiMatteo et al., 1993). Women seem to be set up against a “right way in pregnancy” (Woollett & Marshall, 1997, p. 179) in order to cope with

the prenatal impairment that is constructed to be definitive of pregnancy (Tremain, 2006).

However, there are those who constructed themselves as more independent and did not allow the medical arena to take all agency from them. It could be hypothesized that by drawing on the Discourse of Dependence, the women are resisting the medical arena in a covert manner. Rúdólfsdóttir (2000) also noted resistance, however, in her sample the resistance was more overt, since the women were complaining and challenging the medical arena. These women were thus still controlled (Marshall & Woollett, 2000). It seems therefore, by using the Discourse of Dependence, some of the women in this sample, although more covertly, had more success in resisting the medical arena. Women need to resist the domination and the abuse of power evident in the medical arena (Kitzinger, 1993), in order to banish the construction and treatment of women as objects (Rúdólfsdóttir, 2000).

Furthermore, the women drew on the Discourse of Dependence to construct their unborn children as dependent on them, the women. They constructed themselves as needing to monitor their unborn children's safety and health. Furthermore, they constructed themselves as potential threats to their children, thus needing to have control themselves. In this construction of the self as endangering the child, the medical arena becomes constructed as ensuring safety for the unborn child. For example, Michelle chose to stay in Windhoek, because of the safety of the hospital. She fears that something might 'go wrong'. Tremain (2006) notes that the increase in antenatal testing and screening procedures, with the aim of antenatal diagnosis, has

contributed greatly to the construction of prenatal impairment (Tremain, 2006). The foetus is perceived as vulnerable (Uken, 1976), becoming the “second patient” (Beckett, 2005, p. 266), to whom the pregnant woman is the principal threat. The motherly body becomes a risk to the foetus, and the biomedical discourse, thus, advocates for the monitoring of pregnancy and birth (Davis & Walker, 2009), as result of this discourse of foetal impairment and therefore prenatal impairment (Tremain, 2006). “Therefore, the focus of the antenatal visit becomes pathology rather than physiology” (Davis & Walker, 2009, p. 3).

It is the woman’s body, which is constructed as faulty (Davis & Walker, 2009), thus, this pushes women into emphasising safety, resulting in the women becoming anxious (Fenwick et al., 2006). Liamputtong (2004) also found women to place emphasis on the safety of hospitals. This construction of the child being dependent on the mother and thus, threatened by the mother, in this study, was further reinforced by the cultural influences in the women’s lives. For some of the women in this study, pregnancy was constructed as a time when one has to adhere to strict rules, in order to ‘remain safe’. On the other hand, for some women, the construction of dependence, with regard to the unborn child was one of the mother being endangered. The construction of the child as dependent on the mother places all responsibility on the mother and allows for control to be held over her by the medical arena (Marshall & Woollett, 2000).

In constructing themselves as helpless, the Discourse of Dependence was drawn on by the women. Yet, for some women, this construction of dependence was done without

shifting agency to any specific person or institution. Hence, in this instance they constructed themselves as 'not independent'. This construction was particularly noticeable with regard to financial matters. Some of the women constructed themselves as financially dependent, as result of their pregnancy, with the return of independence anticipated as occurring postnatal. Sims-Schouten and associates (2007) found that the women in their sample placed emphasis on returning to work after having given birth. Grossmann-Kendall and associates (2001) explain that for some women, the financial dependence during pregnancy is specifically on the husbands. However, in this study, there were also women, to whom it was specifically the pregnancy, which left them dependent.

Cheetham (1977) notes that in society, a pregnant woman will often be regarded as a "passive object", and that there is a "lack of privacy and respect for a woman's individuality" (p.43). Loss of independence, as result of having fallen pregnant was evident for many women (Dawid, 2003). In this study, the construction of dependence was interlinked with the Discourse of Embodiment and the construction of pregnancy as a purely embodied experience. The self was lost to a new self, which was embodied and left little room for other constructions. Some women constructed themselves as dependent, as result of being first time mothers. To them, gaining experience would allow for a less dependent construction in their next pregnancy.

The Discourse of Dependence was, furthermore, drawn on by the women to navigate their dependence on both the medical system, and their traditional belief system. Where, at times, some women constructed themselves, transparently, as dependent on

the medical arena, at other times women experienced conflict between medical and traditional constructions. They were aware, however, that for themselves, they needed to make a choice between these two constructions. There is much difficulty in navigating the two constructions though. For example, Baby and Born describe how the advice they receive from the elders in their culture, implies that they are at risk because of their pregnancy. Kruger and Smit (2002) note their concern about the portrayal of a woman's biological features, specifically her reproductive capacity, as resulting in her vulnerability (Kruger & Smit, 2002).

It became evident that the Discourse of Dependence was drawn on by the women in order to construct a complex experience, in which agency is handled fluidly and is shifted back and forth between the women and others. This obscuring of agency was effective in that it allowed women to be more in control of their agency. Beckett (2005) also feels that women are not mere victims. She emphasizes that the positioning within discourses creates meaning.

#### **9.4. The Discourse of Embodiment**

The Discourse of Embodiment was also drawn on by the women in order to construct themselves as pregnant. They drew on this Discourse in order to construct the 'proper' pregnancy. Also, they allowed others to draw on this Discourse, in order to construct them as undergoing an embodied rather than pregnant experience. Birth, too, was constructed drawing on the Discourse of Embodiment. Where the pregnancy was constructed too strongly, drawing on the Discourse of Embodiment, the women were left overwhelmed.

The women drew on the Discourse of Embodiment to construct themselves as undergoing a bodily experience. Their understanding of their pregnancies thus became embodied and it allowed them to better accommodate their discomfort with their bodies. However, the Discourse of Embodiment was also drawn on, when the women constructed their bodies as looking the way they should, in pregnancy. They thus distinguished a 'correct embodiedness'. Yet, when this did not hold true, the experience became stressful. Thus, for these women the embodied experience of carrying weight was constructed as an essential part of pregnancy. They construct themselves as tolerant and accepting the embodied pregnancy. In Seibold's (2004) sample, too, women were positive about their changing bodies and constructed them as fostering changes in their identity as mothers.

However, the embodiedness, also, was constructed as an inconvenience by some of the women. The pregnancy was awarded agency, in that it restricted the women to their homes. Yet, the women constructed this restrictive nature of pregnancy as only being severe in a first pregnancy. In pregnancies thereafter, the women felt that they could take back agency. The women's positioning within the Discourse of Embodiment, thus, seemed to depend on previous experience with pregnancy and their previous positioning in the Discourse of Embodiment.

Furthermore, the Discourse of Embodiment was drawn on by other people to construct the pregnant women as pregnant beings. People acknowledged the women's increase in weight as a means to acknowledging their pregnancy. There seemed to be an unspoken agreement that the women's pregnancies were discussed with other

people as 'fatness' and not pregnancy. This was so much so, that the women also did not correct those who commented on their increase in weight. They seemed to be more comfortable leaving the construction as self-as-fat rather than changing it to self-as-pregnant. Uhlmann and Uhlmann (2005) found that in pregnancy, women could ignore the strong views of society on body control and a slim waistline. From this study it thus appeared that the women were more comfortable with society's strictly embodied construction of them, than a pregnant construction. Earle (2003) also notes the mistaking of pregnancy as fatness. In her sample, this was upsetting to the women. Alternatively, the author suggests that by showing concern about their bodies, women want to avoid being cast into the stereotype of motherliness and the consequent loss of their sexuality. This is in contrast to this study where the women invite this 'mistaken identity' of fatness.

The women drew on the Discourse of Embodiment to construct the changes they were undergoing during their pregnancies. For some though, every part of the pregnancy was constructed in embodied terms. These women seemed to position themselves so strongly in the Discourse of Embodiment that a pregnancy without physical symptoms was constructed as an incorrect experience. Thus, pregnancy and the pregnant self were subjected to an embodied experience. For some of the women the Discourse of Embodiment became part of the self to such an extent that the experience of pregnancy did not allow for much more than an embodied experience. The women yielded to their embodied pregnancy, to which they awarded agency. The embodiedness and the experience along with that, was constructed as happening to women, leaving them without agency. This is reflected in the literature, where the

embodiedness is discussed as an opposition between mind and body, where the one excludes the other, according to RÚDÓLFSDÓTTIR (2000). It is this polarized construction, which results in the loss of agency for women.

The Discourse of Embodiment was also drawn on by some of the women to construct the changes in their physical beauty and their activities. In pregnancy these women constructed themselves as imperfect and as having lost their pre-pregnancy good looks. Also, their bodies were constructed as having lost all ability to do those activities previously enjoyed. Earle (2003) also notes that for some women, the change in physique creates apprehension, in that they are concerned about their bodies changing. Again, in this study, the body was given agency and the women thus felt powerless.

In constructing vaginal birth as an embodied experience, the Discourse of Embodiment was drawn on, by the women. Caesarean sections, on the other hand, were constructed, drawing on the Medical Discourse. The women constructed vaginal birth as the ideal, during which they maintain more agency than compared to caesarean section. The women in the sample of RÚDÓLFSDÓTTIR (2000) also perceived the medicalization of birth ambivalently. They were apprehensive about the medicalization of pregnancy when this left them without power over their own bodies. It is interesting that in the international literature, vaginal birth is constructed as unsafe and caesarean section as safe, in contrast to the findings of this study, where vaginal birth is preferred to caesarean sections. It seems that women construct vaginal birth as unpredictable (Fenwick et al., 2006), and caesarean sections as allowing them



more power over the birthing process (Liamputtong, 2005). A discourse of risk is dominant in constructing vaginal birth (Liamputtong, 2005), where the woman's body is constructed as faulty (Davis & Walker, 2009).

In anticipating birth, the women in this study constructed this as a time of passivity, when they would have to surrender all control and agency. Furthermore, birth was constructed as an invasion of the body. Yet, the women also constructed themselves as accepting this. Where vaginal birth was constructed as normal by the women, they construct themselves as tolerant of the pain. Yet, in this study, birth, in its construction, became restricted to an experience of pain, for some, and was not constructed beyond that. Some went as far as constructing birth as having to be painful. Woollett and Marshall (1997) reported similar findings. They explain that when childbirth is positioned as healthy, pain is constructed in such a manner that it should be a natural part of birthing. In contrast, when childbirth is positioned as an illness, pain is a threat that should be dealt with medically (Woollett & Marshall, 1997).

In this study, the normality of pain is constructed as being necessary for the child to be born under ideal conditions. The women thus constructed their needs as secondary to those of their unborn children. Pain should, thus, not be dulled by medication. Others too, constructed the embodied experience of birth as something to be tolerated. Mothers, in preparing their daughters for the birth, constructed the pain as fleeting and manageable. For some, the construction of birth was minimized, in that the focus fell on the time after birth. Through this the women retained some agency and felt more in

control. Yet, birth was still constructed as a time, when the women loose agency to the medical arena. There was thus to an extent a romanticizing of vaginal birth for some of the women, which Beckett (2005) argues, cannot necessarily be taken for granted as reality for all women either. Thus, the Discourse of Embodiment left the women without agency in various ways. One might speculate that this is so, as result of, the disintegrated pregnancy. Where the pregnancy was strictly embodied, an inclusion of it into the self was made difficult and agency was lost.

#### **9.5. The Discourse of Ownership of Pregnancy**

The Discourse of Ownership of Pregnancy was drawn on by the women in order to maintain agency in their experience of pregnancy, as well as to integrate the pregnancy into the reality of the self. The Discourse of Ownership of Pregnancy was drawn on by the women to construct themselves as being in control of and having agency over their pregnancies and selves. The women constructed themselves as knowing that they were pregnant. Thus, they constructed themselves as the authority over their own body, self and experience.

When women possessed agency to such an extent, they could then allow the antenatal clinic to co-construct their pregnancies. Yet, the antenatal clinic's constructions never carried much weight. They were merely 'allowed' to give an opinion. Furthermore, through drawing on the Discourse of Ownership of Pregnancy, these women were in a position of power, from where they allowed the antenatal clinic to agree with their reality, as they, the women had constructed it. This was taken even further, in that the clinic and the medical staff were allowed to be wrong about the woman's pregnancy

status. These women fully owned their experience of pregnancy and thus could allow the medical arena to be 'wrong' about their reality. They, thus, dis-empowered the antenatal clinic in that they did not allow the medical arena to seize their reality from them. It seems especially the women's certainty about their reality that makes this such a strong Discourse. The Discourse of Ownership of Pregnancy does not centre around constructing oneself as 'finding out' but it centres on constructing oneself as 'knowing'. The women were certain about their reality. This certainty exceeded any clinical proof from the antenatal clinic. However, not all women were always so firmly positioned in the Discourse of Ownership of Pregnancy. For some women, positioning themselves in the Discourse of Ownership of Pregnancy was a transitional process. Seibold (2004) describes that for the women in her sample ownership of pregnancy was a continuing process of creating acceptance.

For some of these women, the experience of the antenatal clinic became stressful, as they, neither, fully owned the experience of their pregnancy, nor, completely handed this over to the antenatal clinic. Kruger and Van der Spuy (2000) address this in explaining that some women cannot fully acknowledge pregnancy. Thus, pregnancy provokes a split-subjectivity in the woman (Kruger & Van der Spuy, 2000). In this study, for some women, the positioning in the Discourse of Ownership of Pregnancy was not possible and they could not accept their pregnancy. However, those women, who could not position themselves in this Discourse, did so at the beginning of their pregnancy. Later on, they were able to construct themselves as owning their pregnancy. Some of the women's reality, thus at a certain time, was torn between constructions of self-as-pregnant and self-as-not-pregnant. It seems, hence, for these

women, to be a process of 'accepting'. Adjustment to being pregnant was, thus, a continuing process of positioning the self in the Discourse of Ownership of Pregnancy. In this study, this was especially so for women whose pregnancy was unplanned. Ownership was sought out, yet a process of accepting needed to precede this. Cheetham (1977) clarifies that 'unplanned' or 'unwanted' pregnancies can turn into 'wanted' pregnancies.

At times, other persons, like the woman's partner or mother, were involved in the construction of ownership and the process of acceptance. This shared ownership allowed the women to find their position within this Discourse. Furthermore, some women positioned themselves in the Discourse of Ownership of Pregnancy, yet did so in negative terms. They constructed their realities as being pregnant, yet construct themselves as unhappy about that.

Positioning within the Discourse of Ownership of Pregnancy was, it seems, for some women, made easier by drawing on the Discourse of Embodiment. Thus, when they could physically experience their pregnancy or their child, they could construct themselves as pregnant. Hence, emotional and cognitive ownership, it seems, could not happen without physical ownership. Seibold (2004) noted a similar construction in that the women in her sample interpreted the physical changes their bodies were undergoing, as their babies' growth process, thereby acknowledging the ownership of their babies.

## **9.6. The Discourse of Motherhood**

The women in this study drew on the Discourse of Motherhood and navigated their positioning within this Discourse. Drawing on this Discourse allowed women to position themselves and construct their identity as both, women and mothers. The Discourse of Motherhood was also drawn on in order to construct good and bad mothering. The Discourse of Motherhood, furthermore, allowed the women to construct their own mothers as playing a role.

The Discourse of Motherhood was drawn on by the women to demarcate the beginning of motherhood. This was constructed in a number of ways. For some, motherhood was constructed as beginning as an embodied experience, thus as beginning when the pregnancy was visible. For others, motherhood was constructed as beginning after birth. Some of the women also constructed themselves as mothers-to-be, thus, constructing motherhood as a process, as something, which develops over time. Thus, motherhood was not achieved automatically in the women's construction thereof. Furthermore, they constructed motherhood as involving much preparation, as women, generally are constructed as unprepared for motherhood. According to Darvill and associates (2008) the transition to motherhood starts very early during pregnancy and is only complete, once the woman feels that she has regained some control. This is likely to occur some time after birth. Seibold (2004), in her sample, too, found the realization of motherhood to be a slow process. Interestingly, for those women in this study, who constructed motherhood as a process, the positioning was less strict and thus allowed them to navigate motherhood more freely.

Furthermore, for some women, pregnancy was a time during which they constructed themselves as women. Kruger (2003) points out that motherhood seems to be portrayed as integral to female identity. Through the defining of women according to the views of the greater society, women tend to feel that being a woman is solely defined through motherhood and that motherhood fulfils a woman (Kruger, 2003; Todorova & Kotzeva, 2003). Women must therefore seemingly fit this ideal of the 'true'-woman-as-a-mother. This Discourse restricts a woman's role to mothering (Chopra, 2001). Walker (1995) is concerned about the fact that there is no distinction between 'mothers' and 'women'. Yet, in some studies, women placed emphasis on the fact that they were not 'only mothers' but that there were other important areas in their lives that they needed to engage in (Harrington, 2002; Seibold, 2004).

In this study, to some women, motherhood was interlinked, specifically, with adulthood. Thus, it was difficult for some to construct themselves as mothers, when they had not yet constructed themselves as adults. At times, it was difficult for some of the women to position themselves as mothers in this Discourse. Constructing themselves as women, however, seemed easier to them. Interestingly, this was also true for women, for whom it was not a first pregnancy. Thus, having children did not necessarily seem to influence the women's constructions of self-as-mother or self-as-woman.

Furthermore, to some women, pregnancy excluded womanhood. When being a woman was constructed as being sexually active, this construction was not always compatible with pregnancy, for the women. Earle (2003) describes pregnant women's

body images are regulated by the norms cast upon them by contemporary society. Earle (2003) proposes that through worrying about their bodies during pregnancy, women are worrying about the possible loss of their sexuality during this time (Earle, 2003). Thus, the positioning within the Discourse of Motherhood was quite rigid for some of these women, in that it excluded their sexuality.

The women drew on the Discourse of Motherhood in order to construct both the good mother, as well as the bad mother. According to Peterson (1996), Woollett and Boyle (2000), and Youngleson (2006) motherhood is categorized into the good or a bad mother. In this study, the good mother was very much constructed in physical, embodied terms, rather than being an emotional construction. This was similar to Youngleson's (2006) findings, where motherhood was constructed by the women in her sample as lacking of emotionality. She speculates that the women are disempowered in their community, and that this keeps them from allowing their emotions about motherhood to come forth. Yet, for other women, constructions of motherhood involve more emotionality, for example in Bell's (2004) study.

The good mother, for the women in this study, was constructed as caring for and being with her child. Also, a good mother would prepare her child for things to come. She thus would talk to her child. A good mother was furthermore constructed as looking after her child's basic needs, like feeding and cleaning her baby. Lastly, the good mother was constructed as not punishing or scolding her child unnecessarily. The women in Harrington's (2002) sample, described the ideal mother as "someone who was capable of complete emotional control, she did not lose her temper but could

respond to her children consistently in an appropriate way” (Harrington, 2002, p. 117). “The good mother was described as always patient, tolerant and calm and provided her children with a sense of stability and with constant and unfailing love. She was always available for her children and had time and energy for them.” (Harrington, 2002, p. 117). Further qualities of a good mother, according to Youngleson (2006), include putting the child’s priorities ahead of the mother’s priorities, as well as taking care of her child herself and not leaving that up to someone else. These qualities imply a self-sacrificial view of mothering (Youngleson, 2006). Some women, in this study, positioned the good mother quite rigidly towards the one extent of the continuum of motherhood in that she should be loving and caring in totality, thus self-less. In Bell’s (2003) sample, women defined motherhood as implying selflessness. This selflessness is expected of mothers: “Putting children first is expected of mothers, in fact being a good mother is conditional upon this” (Bell, 2003, p. 133). The mother’s needs are neglected (Peterson, 1996) and children would have to be put first (Liamputtong et al., 2004).

However, “the social construction of motherhood imposes on women unrealistic standards of ideal motherhood” (Bell, 2003, p. 135). Thus, women aspire towards ideals of motherhood that are neither achievable nor realistic (Youngleson, 2006). The women are thus subjected to the discourse of the ‘perfect mother’, yet they inevitably fail to reach their goal. In this study, it is evident that a good mother should love her child. Furthermore, a good mother should put herself second in line, as motherhood then, is her responsibility.



The Discourse of Motherhood was also drawn on in constructing the bad mother, who is someone who goes out and socializes, thus putting her needs first. In Youngleson's (2006) study, the women described a 'bad' mother as someone who does not take responsibility of childrearing. 'Bad' mothers were seen to be egotistical and selfish, as well as neglectful of their children (Youngleson, 2006).

Furthermore, the Discourse of Motherhood was drawn on by the women to construct their own mothers as role models. The women, thus, constructed themselves as mothers, based on the teachings by their own mothers. This was also evident in the literature. Seibold (2004) found that pregnant women's mothers seem to be a great source of support, which often takes on the form of reassurance and information about pregnancy and birth. Women, also, expressed a need for closeness to their own mothers during this time (Seibold, 2004). The women in the sample of Liamputtong and associates (2004), also, mentioned that becoming a mother made them become more aware of what their mothers had done for them.

Motherhood was, at times, constructed in ambiguous terms, as both rewarding and difficult, for the women in this sample. This is reflected in the literature, where women are portrayed as being positive as well as negative about their pregnancies. Discourses of motherhood included happiness with motherhood (Jordan et al., 2005; Liamputtong et al., 2004). For other women, motherhood is constructed as tiring (Bell, 2004), difficult to define as well as overwhelming (Youngleson, 2006).

Perhaps it is as result of the positioning in this Discourse being exceptionally difficult and fraught with ambiguity that the women in this study position themselves so rigidly. It seems that when there is ambivalence in drawing on this Discourse, it might feel safer to buy into and obey a code of how-to-mother.

### **9.7. Interaction of Discourses**

These five Discourses do not exist in isolation of one another. They are at times also drawn on simultaneously and thus are interdependent. The Medical Discourse which the women draw on in order to construct themselves as ill and suffering from symptoms, is also interlinked with the Discourse of Dependence. The Medical Discourse results in a construction of pregnancy as something that renders women vulnerable and thus needs to be monitored. The women buy into the Medical Discourse in constructing themselves as needing to be checked on during their pregnancy, thus being dependent on the medical arena.

The positioning within the Discourse of Ownership of Pregnancy seems to be made easier through the drawing on Discourse of Dependence. For example, Baby constructs her unborn child as dependent on her. She thus tries to imagine her child's needs and eats something to still its hunger. Thus, in constructing the child as dependent on herself, Baby is allowed to take ownership. Balbernie (2003) found that mothers who created a mental space for their infant in their minds were through that allowed to foster a mother-child relationship.

The Discourse of Embodiment seems to have allowed the women to position themselves in the Discourse of Ownership of Pregnancy. By not allowing others to construct them as 'pregnant' and by allowing others to only construct them as 'fat', women kept their pregnancy to themselves, thus allowing ownership only to themselves. Furthermore, the embodied experience also allowed for ownership in that women construct the acceptance of pregnancy, in terms of seeing and feeling their pregnancies or children.

The positioning of their experience of pregnancy in the Medical Discourse, it seems, was navigated by the women in order to be able to draw on the Discourse of Ownership of Pregnancy at a later point. The construction of self-as-pregnant was complicated and delayed by the women's drawing on the Medical Discourse. Only once they could leave behind their construction of self-as-ill, could they begin their construction of self-as-pregnant. It is in this navigation of the Medical Discourse that the women feel ambiguous about the reality of their pregnancies.

The Discourse of Motherhood and the Discourse of Ownership of Pregnancy seem also interlinked. To the women, 'finding out' that they are pregnant was a process, yet 'knowing' that they are pregnant implied certainty. Thus, through 'knowing', women were more firmly positioned in the Discourse of Ownership of Pregnancy and were thus able to draw on the Discourse of Motherhood.

The Discourse of Motherhood and the Discourse of Dependence were interlinked in that the positioning in the Discourse of Motherhood was made easier for the women

by constructing themselves as dependent on their own mothers who had to teach them to position themselves in this Discourse.

It seems that the construction of self-as pregnant is one that is influenced by various Discourses, which each have a different effect on a woman's construction of herself. Hence, one can hypothesise that the ambivalence experienced by the women in their constructions of self-as-pregnant are due to the interrelatedness of these Discourses. For a woman to position herself in one discourse implies positioning in all of them, which translates into a complicated task.

## CHAPTER 10: CONCLUSION

### 10.1. Summary of findings

Before drawing any conclusions, the author would like to restate that the aim of this study was to shed light on the Discourses which pregnant women from a low income background draw on in constructing themselves as pregnant. The aim was thus not to draw specific conclusions about these Discourses but rather to expose them in order to allow for further research and questioning of the constructions, which these Discourses serve.

The main findings of this study clearly indicate that the pregnant women interviewed drew on five Discourses. The Medical Discourse was drawn on by the women to construct themselves as ill and their pregnancies as symptomatic. Furthermore, the Medical Discourse was drawn on to construct falling pregnant as a HIV risk. Positioning within the Medical Discourse made navigation of the information coming from the women's cultural background difficult. Also, the Medical Discourse was employed to construct caesarean section.

The Discourse of Embodiment on the other hand, was drawn on to construct vaginal birth. Furthermore, the Discourse of Embodiment was drawn on to make sense of the body, at times to such an extent that the construction of the self-as-pregnant remained solely embodied. The Discourse of Embodiment was also drawn on by other people to construct the pregnant women.

The Discourse of Dependence was drawn on by the women to construct themselves as dependent on older people as well as the antenatal clinic. Also they constructed their unborn children as dependent on them using this Discourse. Again, this Discourse resulted in the women experiencing ambivalence regarding the information they received from their cultural background.

The Discourse of Ownership of Pregnancy was drawn on by the women in order to retain agency over their pregnancy. The positioning in this Discourse was a continuing navigation of different positions. The Discourse of Ownership of Pregnancy was also drawn on by other people, who co-constructed the women-as-pregnant.

Finally, the women drew on the Discourse of Motherhood, which they utilised to construct themselves as mothers as well as women. Furthermore, the Discourse of Motherhood was drawn on in order to construct the good mother, as well as the women's own mothers.

In summarizing 'Discourse' we thus understand that Discourses do not drive talk, rather they are drawn on. Thus, the women are not subjected to Discourse; rather they select Discourses to construct themselves and their experiences. However, there is a subjection of sorts because women draw on Discourses that have been shaped by culture, society, language, and history. Thus, women are not marginalized by a Discourse per se, but by the cultural, historical, social and linguistic forces behind them. Hence, it is the positioning within Discourses that creates the 'other', the

marginalized woman. It is this which then removes the woman from the reality of her pregnancy, not allowing her to make meaning of her experience that is fully hers.

The author of this study concludes that women construct themselves in a manner that has consequences on, firstly, how they experience their pregnancies, secondly how others perceive and react towards them and thirdly the extent and quality of antenatal care they receive. Beckett (2005) argues that Discourses have consequences for those drawing on them and it is those which may not be ignored. Furthermore, each Discourse contributes towards the women's construction of self in this study. However, the author also concludes that the women find ways of retrieving agency so that in the end they do have some control.

It is concluded that the women construct themselves as beings from a low income background but that this construction only has relevance within certain Discourses and not within their whole self-as-pregnant. The same applies for the women's constructions of themselves as being from a specific cultural background.

Finally, the author concludes that there are various parties involved in the definition of the boundaries of legitimate discourse (what is talked about and how) for pregnant women. There are some key co-constructors in this – the women themselves, older women who mother the mother-to-be, the fathers of their babies, the antenatal clinic, the women's culture, books and magazines, and the women's communities. These co-constructors, besides the women themselves, are involved in defining the boundaries

of Discourse not only by their own accord but also through invitation by the pregnant women who shift agency towards them.

With regard to antenatal care the construction of pregnancy as a pathological event does not allow women much agency over – or enjoyment of - their pregnancies. However, these institutions serve a purpose which at times it seems becomes obscured by dominant Discourses. Rather than discrediting all antenatal care the author would like these institutions, their purposes as well as the key players to be revisited and redefined to suspend the marginalizing effect they have on women's lives.

The aim of this study was thus to create awareness of these Discourses in order to firstly challenge these and secondly, encourage a re-construction of as well as re-positioning within these Discourses. Thus, by no means does the author want this thesis to be understood as a voice for the 'voiceless' women. These women do have their own voices and to speak for them would distort their messages. Rather, the author intends this study to serve as a prompt for those who are viewing the marginalized from an 'unmarginalized' position to become aware of the Discourses behind this marginalization.

## **10.2. Limitations**

It is evident that this research yielded data reflecting the existence of dominant discourses, which the women in this study draw on in constructing their selves, pregnancies and experiences thereof. This research creates awareness as well as understanding of the constructions as they are based on the five prominent



Discourses. There are however limitations to this study. The first two limitations of the study are based on the exclusion criteria that were used during selection of participants. Firstly, data were obtained only from women who attend two specific antenatal clinics, namely the Katutura and Central Hospitals' antenatal clinics. Secondly, the data gathered reflects only that group of pregnant women who are fluent in Afrikaans and/or English. The generalizability of the data is therefore not guaranteed as the sample is non-representative. However, rather the aim of the study was to yield depth of data.

A further limitation of this research is that it cannot be said that the women drew on these discourses only as result of, or during their pregnancies. Perhaps, for some women these discourses are drawn on outside of pregnancy as well. Furthermore, with regard to the Medical Discourse the women attending the antenatal clinics might have found it easier to draw on this specific discourse. Thus, through the selection of participants at the antenatal clinics it might have been that participants were selected who draw on the Medical Discourse more readily than those who do not visit the antenatal clinics.

One specific limitation of this research was already addressed in the section on the author's reflections (see 7.6 Reflexivity of the researcher). In short: the limitation of this research as reflected on in that section rests in the theoretical background to this study which states that an analyst will always be co-constructing that which she analyses. Thus, the results generated cannot be viewed as an absolute truth of the research participants; rather it is a momentary glance at their constructions, as well as

the discourses they draw on, at a certain point in time, as co-constructed together with the researcher.

These limitations should however not be viewed merely as such but rather could become the incentive for further studies in this research area.

### **10.3. Recommendations**

As result of the limited scope of a Master thesis, much data was left unattended. There is thus so much more wealth in the data collected than this thesis gives credit to. These following recommendations are based on data left unattended, questions raised during the research process as well as limitations to this research. The recommendations are divided into recommendations for further research and recommendations for interventions.

It is suggested that further research be conducted on the topics following below. This research addressed only one aspect of the marginalization of women from a low income background. It would seem that these women are marginalized in many more areas of their lives than was shown in this study. Further inquiry into the nature of as well as processes behind their marginalization seems imperative. Also, it would seem interesting to obtain insight into the other areas of women's lives in which the five Discourses discussed in this study are active. Furthermore, this research should focus on Namibian women. As stated before, an absence of information on and understanding of women in Namibia will always be one of the greatest barriers to empowering these women. The five Discourses, which were discussed in this study

were specific for the time of the interviews. How these Discourses change over time would also make for interesting future research.

The sample of this study was restricted to the women attending the antenatal clinics. It would be of great interest to study the constructions as well as Discourses drawn on by those women who do not visit the antenatal clinics during pregnancy. Also, how these and other Discourses are drawn on by the women postnatally is of interest. The results obtained and discussed in this study centred on the constructions of the women-as-pregnant as well as the constructions of their experiences. Further research into the effect of these constructions on their experiences would certainly be insightful.

It is recommended that further research should also focus on the constructions as well as Discourses drawn on by all the key players in antenatal clinics, namely the nurses and doctors. Yet, research should not remain confined to the antenatal clinic. It is the decision makers higher up in the medical and political arenas who too are influential in creating these Discourses. The complexity and reach of these Discourses is thus a further area suggested for study. One Discourse that certainly should be studied further is the Medical Discourse specifically as it is constructed by information surrounding the HIV pandemic. It would seem that this Discourse has effects reaching further than just the antenatal clinics.

As the author has pointed out language is essential in the construction of the self and in the creation of Discourses. To research these constructions in the women's home

language would thus be ideal and would certainly make for important future research. Moreover, it is of critical importance that researchers, whose studies focus on women and the marginalization of women, remain aware of their own potential influence in creating such marginalization. Thus, critical awareness of the research process as well as a reflexive work ethic should be integral to all research.

With regard to recommended psychological interventions, it seems that creating awareness of these Discourses would be the first step towards challenging them. Secondly, the women's ambivalence should be focused on. For those women who had difficulty in positioning themselves in the Discourses the resulting ambivalence led to an upsetting experience of their pregnancies. Therapeutic interventions should thus target this ambivalence with the aim of helping women to navigate the Discourses without ambivalence. Thirdly, antenatal care should be made more accessible. Women should not have to take on the positions of objects but become key decision makers in this arena. This then is connected to the fourth suggestion, which implies that nurses and doctors should be made aware of these Discourses, as well as the role they play in effecting these Discourses.

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### Appendix A: Demographic information

Code	Code Name	Language	Age	1st pregnancy or not 1st pregnancy	Children	Household composition	Relationship status	Work: Participant
<i>P1</i>	<i>Mary</i>	English	28	1st	none	Participant + 1	married	unemployed
<i>P2</i>	<i>Jusnelda</i>	Nama + Afrikaans	22	1st	none	Participant + 4	no relationship	unemployed
<i>P3</i>	<i>Care</i>	Afrikaans	21	1st	none	Participant + 4	in relationship	unemployed
<i>P4</i>	<i>Baby</i>	Otjiherero	25	1st	none	Participant + 4	in relationship	student
<i>P5</i>	<i>Born</i>	Otjiherero	28	2nd (twins)	1 son	Participant + 9	married	unemployed
<i>P6</i>	<i>Katryn</i>	Afrikaans	26	2nd	1 son	Participant + 2	in relationship	unemployed
<i>P7</i>	<i>Nicky</i>	Otjiherero	27	3rd	2 sons	Participant + 2	in relationship	unemployed
<i>P8</i>	<i>Tangi</i>	Oshiwambo	28	2nd	1 daughter	Participant + 2	in relationship	sewing work
<i>P9</i>	<i>Rosie</i>	Afrikaans	27	4th	2 daughters, 1 son	Participant + 4	married	domestic work
<i>P10</i>	<i>Michelle</i>	Afrikaans	20	1st	none	Participant + 3	in relationship	unemployed
<i>D1</i>	<i>Grace</i>	Otjiherero	25	1st	none	Participant + 6	no relationship	domestic work
<i>D2</i>	<i>Clarence</i>	Silozi	25	1st	none	Participant + 4	in relationship	unemployed
<i>D3</i>	<i>Serious</i>	Damara	24	3rd	2 sons	Participant + 12	no relationship	unemployed
<i>D4</i>	<i>Ansie</i>	Nama	29	2nd	1 son	Participant + 3	in relationship	domestic work
<i>D5</i>	<i>Sofia</i>	Damara / Nama	25	3rd	1 daughter, 1 son	Participant + 2	in relationship	domestic work
<i>D6</i>	<i>Wendy</i>	Otjiherero	16	1st	none	Participant + 10	in relationship	unemployed
<i>D7</i>	<i>Maria</i>	Otjiherero	23	2nd	1 son	Participant + 5	in relationship	unemployed
<i>D8</i>	<i>Zero-One</i>	Rukwangali	21	1st	none	Participant + 7	in relationship	unemployed

<b>Code</b>	<b>Code Name</b>	<b>Work: Partner</b>	<b>Work: Parents</b>	<b>Monthly Income: Participant</b>	<b>Monthly Income: Partner</b>	<b>Monthly Income: Household</b>	<b>Literacy: read and write</b>
<i>P1</i>	<i>Mary</i>	pastor	parents passed away	none	N\$ 5000	N\$ 5000	yes
<i>P2</i>	<i>Jusnela</i>	n.a.	n.a.	none	n.a.	unknown	yes
<i>P3</i>	<i>Care</i>	child welfare officer	mother: child welfare	none	N\$ 3000	unknown	yes
<i>P4</i>	<i>Baby</i>	unknown	mother: part time work	N\$ 200	N\$ 4000	N\$ 1000	yes
<i>P5</i>	<i>Born</i>	student	retired	unknown	unknown	N\$ 835	yes
<i>P6</i>	<i>Katryn</i>	parts salesman	mother retired, father passed away	none	N\$ 4000	unknown	yes
<i>P7</i>	<i>Nicky</i>	delivery work	farmers	N\$ 2000	N\$ 500	unknown	yes
<i>P8</i>	<i>Tangi</i>	policeman	unemployed	N\$ 600	N\$ 1800	N\$ 1800	yes
<i>P9</i>	<i>Rosie</i>	policeman	retired	N\$ 1200	N\$ 3000	N\$ 4200	yes
<i>P10</i>	<i>Michelle</i>	farm worker	mother: domestic work, father: farm worker	none	unknown	unknown	yes
<i>D1</i>	<i>Grace</i>	n.a.	mother: unemployed	N\$ 400	n.a.	N\$ 900	yes
<i>D2</i>	<i>Clarence</i>	teacher	unemployed	none	unknown	unknown	yes
<i>D3</i>	<i>Serious</i>	n.a.	mother: domestic work	none	n.a.	unknown	yes
<i>D4</i>	<i>Ansie</i>	construction work	retired	N\$ 650	unknown	unknown	yes
<i>D5</i>	<i>Sofia</i>	hunting guide	mother: domestic work	N\$ 1200	N\$ 800	N\$ 1200	yes
<i>D6</i>	<i>Wendy</i>	garage work	unemployed	none	N\$ 1500	N\$ 1200	yes
<i>D7</i>	<i>Maria</i>	garage work	father: construction	none	unknown	unknown	yes
<i>D8</i>	<i>Zero-One</i>	unemployed	unemployed	none	none	N\$ 4000	yes

<b>Code</b>	<b>Code Name</b>	<b>Schooling until Grade</b>	<b>Religion</b>	<b>Actively involved at church</b>	<b>Years living in Windhoek</b>	<b>Rooms in house</b>	<b>Bedrooms in house</b>
<i>P1</i>	Mary	tertiary education	Christian	yes	1 year 3 months	6	3
<i>P2</i>	Jusnelda	Gr 10	Universal Church	yes	5 years	6	3
<i>P3</i>	Care	Gr 12	Lutheran Church	yes	since birth	7	4
<i>P4</i>	Baby	Gr 12 + studying further	Christian	yes	9 years	7	3
<i>P5</i>	Born	Gr 12	none	no	Rural	6	2
<i>P6</i>	Katryn	Gr 11	NG Kerk	no	15 years	1	part of the 1 room
<i>P7</i>	Nicky	Gr 12	Oruano	yes	7 - 10 years	rents one room	part of the 1 room
<i>P8</i>	Tangi	Gr 12	Lutheran Church	yes	5 years	2	2
<i>P9</i>	Rosie	Gr 10	AGS	no	9 years	5	2
<i>P10</i>	Michelle	Gr 12	Nazareena Church	yes	3 years	3	1
<i>D1</i>	Grace	Gr 10	Stan Steven	yes	since birth	rents one room	part of the 1 room
<i>D2</i>	Clarence	Gr 12	SDA Church	no	2 months	3	1
<i>D3</i>	Serious	Gr 10	Lutheran Church	yes	since birth	4	2
<i>D4</i>	Ansie	Gr 10	Lutheran Church	yes	4 years	5	2
<i>D5</i>	Sofia	Gr 8	Lutheran Church	yes	4 years	rents one room	part of the 1 room
<i>D6</i>	Wendy	Gr 8	Catholic	yes	since birth	4	1
<i>D7</i>	Maria	Gr 9	Christian	no	10 years	5	3
<i>D8</i>	Zero-One	Gr 12	Lutheran Church	yes	not resident in Whk	11	8



<b>Code</b>	<b>Code Name</b>	<b>Who shares bedroom with her</b>	<b>Bathroom</b>	<b>Electricity</b>	<b>Interviewed in 1st trim</b>	<b>Interviewed in 2nd trim</b>	<b>Interviewed in 3rd trim</b>
<i>P1</i>	<i>Mary</i>	husband	yes	yes	no	yes	yes
<i>P2</i>	<i>Jusnelda</i>	no one	yes	yes	no	no	yes
<i>P3</i>	<i>Care</i>	mother	yes	yes	no	yes	no
<i>P4</i>	<i>Baby</i>	no one	yes	yes	no	yes	yes
<i>P5</i>	<i>Born</i>	mother	yes	yes	no	no	yes
<i>P6</i>	<i>Katryn</i>	partner and son	yes	yes	no	no	yes
<i>P7</i>	<i>Nicky</i>	2 sons	outside	yes	no	no	yes
<i>P8</i>	<i>Tangi</i>	no one	yes	yes	no	no	yes
<i>P9</i>	<i>Rosie</i>	husband	yes	yes	no	no	yes
<i>P10</i>	<i>Michelle</i>	she sleeps in the sitting room	no	no	yes	no	no
<i>D1</i>	<i>Grace</i>	mother and 2 brothers	yes	yes	no	no	yes
<i>D2</i>	<i>Clarence</i>	she sleeps in the sitting room	yes	yes	no	no	yes
<i>D3</i>	<i>Serious</i>	2 sons + her sister	outside	yes	no	yes	no
<i>D4</i>	<i>Ansie</i>	sister's daughter	yes	yes	no	no	yes
<i>D5</i>	<i>Sofia</i>	son and daughter	no	yes	no	no	yes
<i>D6</i>	<i>Wendy</i>	mother and sister	yes	yes	no	no	yes
<i>D7</i>	<i>Maria</i>	no one	no	no	yes	yes	yes
<i>D8</i>	<i>Zero-One</i>	no one	no	yes	yes	no	no

## Appendix B: Unstructured interview guidelines

1. **You are now X months pregnant. How are you today? How do you feel emotionally/physically?**
2. **What does it feel like to you to be pregnant?**
3. **Tell me about the day you found out you were pregnant.**
  - *Story:* where, when, how, who?
  - *Feelings:* surprised, heartbroken, excited, ambivalent, anxious, strange, guilty, disappointed, proud, emotional, worried, ashamed, denial?
4. **What did you do after you found out?**
  - Told someone (who, why, what was their reaction?)
5. **Do you know how you fell pregnant? Tell me about that.**
  - *Story:* where, when, how, who?  
Planned/unplanned, wished for/unwished, agency, consciously/unconsciously?
6. **What is it like being pregnant? How have things changed and stayed the same?**
  - *Feelings now:*  
Surprised, heartbroken, excited, ambivalent, anxious, guilty, disappointed, proud, emotional, worried, ashamed, denial, scared, calm, irritated, tense, depressed, energetic, tired, alone, lonely?
  - *Interpretation (making “meaning”) of feelings and symptoms:*  
How do you feel about the pregnancy? What do the symptoms mean to you?
  - *Feelings about foetus (baby):*

Negative (hope for miscarriage, abortion, adoption, hides fact that pregnant, denies, impulse to hurt baby), scared, excited, angry?

Positive feelings

- *Attitude/feelings/reaction of others:*

Partner (who, married/unmarried), family (mother, father, own children, others), friends (ask about female friends), work (colleagues and boss), church, school, society?

Judgmental, supportive, excited, proud, worried?

- *Other women's reaction to your pregnancy*

How do other women react to your pregnancy? Are they supportive? In which manner do other women look at you? Do they give you advice/criticism?

- *Changes relating to relationships with others*

Partner (who, married/unmarried), family (mother, father, own children, others), friends (ask about female friends), work (colleagues and boss), church, school?

- *Changes relating to body and sexuality*

Physical symptoms (breasts, larger body, digestive system – constipation, nausea, indigestion –etc), more aware of body, feelings about feminine changes, vulnerable, powerful, more/less attractive, more/less sexual feelings, more/less sexually active?

- *Changes relating to work*

- *Changes relating to identity*

- *Changes relating to lifestyle*

Substances (smoking/drinking/drugs), sex, social activities, physical activities, exercises, eating, sleeping, getting dressed?

- *How are you experiencing all these changes?*

Do the changes feel good/bad?

- *Do you feel like a mother, do you feel more like a woman?*

**7. What bothers you now that you are pregnant? With what do you struggle?**

**8. Have your needs changed now that you are pregnant? What do you feel you need?**

- *From others*
- *From health services (doctors, nurses, clinic)*
- *From community*

**9. What type of care have you already received? How do you feel about it? Has it helped?**

- *Information: who, where, when, how, what*
- *Procedures: checkups, sonars, genetic tests, other tests, experience thereof?*
- *Special treatment from the people in your life*
- *What are the traditional ways of experiencing pregnancy?*

Witchcraft, witchdoctors, what behaviour is advised and what should be avoided?

**10. What information/advice are you being given from family, friends, your community regarding pregnancy?**

- *How does it feel to receive advice/information from others?*
- *Do you agree with the advice/information?*

- *Are there myths about pregnancy in your community/culture?*
- *How does the father of your child perceive this advice/information?*

**11. How do you feel about the birth, what do you think about it, what are your expectations?**

- *What have you been told/ by whom?*
- *Role of doctors, nurses, partner, others*
- *How do you think it should be (ideal birth)?*
- *Are you scared for the birth/ are you looking forward to it?*
- *How do you feel about medical interventions (natural birth, pain killers)?*

**12. How do you feel about becoming a mother? What do you expect?**

**13. What is a good mother? Do you know anybody who is a good mother? Was your mother a good mother?**

### Ongestruktueerde onderhoud riglyne

1. **Jy is nou X maande swanger. Hoe gaan dit vandag met jou? Hoe voel jy fisies/emosioneel?**
2. **Hoe voel dit vir jou om swanger te wees?**
3. **Vertel my van die dag toe jy uitgevind het jy is swanger**
  - *Storie:* waar, wanneer, hoe, wie?
  - *Gevoelens:* verras, hartseer, opgewonde, ambivalensie, verwydering, vervreemding, angstig, skuldig, teleurgesteld, trots, emosioneel, bekommerd, skaam, ontkenning?
4. **Wat het jy gedoen nadat jy uitgevind het?**
  - vir iemand vertel (vir wie, waarom, wat was hulle reaksie)
5. **Weet jy hoe jy swanger geraak het? Vertel my daarvan.**
  - *Storie:* waar, wanneer, hoe, wie?  
 Beplan/onbeplan, gewens/ongewens, agentskap,  
 bewustelik/onbewustelik?
6. **Hoe is dit om swanger te wees? Hoe het dinge verander en dieselfde gebly?**
  - *Gevoelens nou:*  
 Verras, hartseer, opgewonde, ambivalensie, verwydering, vervreemding, angstig, skuldig, teleurgesteld, trots, emosioneel, bekommerd, skaam, ontkenning, bang, kalm, geirriteerd, tense, depressief, energiek, moeg, alleen, eensaam?
  - *Interpretasie (om betekenis te maak) van gevoelens en simptome:*  
 Hoe voel jy oor die swangerskap? Wat beteken die simptome vir jou?

- *Gevoelens oor fetus (baba):*  
Negatief (hoop vir miskraam, aborsie, aanneming, steek swangerskap weg, ontken, impulse om baba seer te maak), bang, opgewonde, kwaad?  
Positiewe gevoelens
- *Houdig / gevoelens / optrede van ander:*  
Partner (wie, getroud/ongetroud), familie (Ma, pa, eie, kinders, ander), vriende (vra veral oor vriendinne), werk (werkgewers en kollegas) kerk, skool, gemeenskap?  
Veroordelend, ondersteunend, opgewonde, afstandelik, trots, bekommerd?
- *Die reaksies van ander vrouens oor jou swangerskap*  
Hoe reageer ander vrouens oor jou swangerskap? Is hulle ondersteunend? Op watter manier kyk ander vrouens na jou? Gee hulle vir jou raad/kritiek?
- *Verandering tov verhoudings met ander:*  
Partner (wie, getroud/ongetroud), familie (Ma, pa, eie, kinders, ander), vriende (vra veral oor vriendinne); werk (werkgewers en kollegas) kerk, skool?
- *Veranderinge tov liggaam en seksualiteit:*  
Fisiese simptome (borste, groter liggaam, spysvertering - hardlywigheid, naarheid, sooi-brand - ens), meer bewus van liggaam, gevoelens oor vroulike veranderinge, kwesbaar/"vulnerable", sterker/"powerful", meer/minder aantreklik, meer/minder begeerlikhoe voel, meer/minder seksuele gevoelens, meer/minder seksueel aktief?
- *Veranderinge tov werk*
- *Veranderinge tov identiteit*

- *Veranderinge tov leefstyl*

Substansse (rook/drink/"drugs"), seks, sosiale aktiwiteite, fisiese aktiwiteite, oefeninge, eet, slaap, aantrek

- *Hoe ervaar jy al hierdie veranderinge?*

Voel die veranderinge goed/sleg?

- *Voel jy soos 'n ma, voel jy meer soos 'n vrou?*

**7. Wat pla jou nou dat jy swanger is? Waarmee sukkel jy?**

**8. Het jou behoeftes verander nou dat jy swanger is? Wat voel jy het jy nodig?**

- *Van ander*

- *Van gesondheidsdienste (dokters, verpleegsters, klinieke)*

- *Van gemeenskap*

**9. Watter tipe versorging het jy alreeds gekry? Hoe voel jy daaroor? Help dit jou?**

- *Inligting: wie, waar, wanneer, hoe, wat?*

- *Prosedures: "checkups", "sonars", genetiese toetse, ander toetse, ervaring daarvan?*

- *Spesiale behandeling van die mense in jou lewe*

- *Wat is die tradisionele maniere om swangerskap te ervaar?*

Toordery, "witchdoctors", watter gedrag word aangeraai en wat moet vermy word?

**10. Watter informasie/raad kry jy van familie, vriende, jou gemeenskap tov swangerskap?**

- *Hoe voel dit om raad/informasie van anders te kry?*



- *Stem jy saam met die raad/informasie?*
- *Is daar mietes oor swangerskap in jou gemeenskap/kultuur?*
- *Hoe neem die pa van jou kind hierdie raad/informasie waar?*

**11. Hoe voel jy oor geboorte, hoe dink jy daaroor, wat verwag jy daarvan?**

- *Wat is jy daaroor vertel/ deur wie?*
- *Rol van dokters, verpleegsters, partner, ander*
- *Hoe dink jy moet dit wees (ideale geboorte)?*
- *Is jy bang vir die geboorte/ sien jy uit daarna?*
- *Wat dink jy oor mediese intervensies (natuurlike geboorte, pynverligting)?*

**12. Hoe voel jy daaroor om ma te word/ Wat verwag jy daarvan?**

**13. Wat is 'n goeie ma? Ken jy 'n goeie ma? Was jou ma 'n goeie ma ?**

### Appendix C: Demographic details questionnaire

Respondent number: _____ Codename: _____
Language: _____ Age: _____
<b>1. Household</b>
Composition of Household: _____ _____
Relationship status (In relationship? Married? Live together? How long?): _____
Children (gender and age): _____ _____
<b>2. Work</b>
Work (type / fulltime/ part-time/ unemployed):
Self: _____
Partner (man/boyfriend): _____
Parents: _____
<b>3. Income</b>
Self: _____ Partner: _____ Household: _____
<b>4. Literacy</b>
Comfortably read and write: _____ Schooled to standard: _____
<b>5. Religion</b>
Religious affiliation: _____ Actively involved: _____
<b>6. Accommodation</b>
Years in Windhoek: _____
No. of rooms in house: _____ No of bedrooms in house: _____
With whom do you sleep in a bedroom? _____
Is there a bathroom in the house? _____ Is there electricity in the house? _____

### Demografiese besonderhede vraelys

Respondentnommer: _____	Kodenaam: _____
Huistaal: _____	Ouderdom: _____
<b>1. Huishouding</b>	
Samestelling van huishouding: _____ _____	
Verhoudingstatus (In verhouding? Getroud? Bly saam? Hoe lank?): _____	
Kinders (geslag en ouderdomme): _____ _____	
<b>2. Werk</b>	
Werk (tipe / voltyds / deelyds / unemployed):	
Self: _____	
Partner (man/boyfriend): _____	
Ouers: _____	
<b>3. Inkomste</b>	
Self: _____ Partner: _____ Huishouding: _____	
<b>4. Geletterdheid</b>	
Gemaklik met lees en skryf: _____ Skool tot standerd: _____	
<b>5. Godsdiens</b>	
Godsdienstige affiliasie: _____ Aktief betrokke: _____	
<b>6. Verblyf</b>	
Jare in Windhoek: _____	
Aantal vertrekke in huis: _____ Aantal slaapkamers in huis: _____	
Met wie slaap jy in 'n slaapkamer? _____	
Is daar 'n badkamer in die huis? _____ Is daar elektrisiteit in 'n huis? _____	



**Appendix E: Consent form**

Dear Participant

I am a senior psychology student and would like to conduct interviews for a research study. I would herewith like to ask you to participate in a research study, which investigates how women experience pregnancy. I am interested in increasing my understanding about possible positive and negative aspects of these experiences and which factors contribute towards them. I hope that this research will contribute to more effective psychological support of pregnant women and mothers.

Should you be willing to take part in this study, I would like to conduct two or three interviews with you. The interviews will take between one and two hours. The interviews will be recorded on tape. The interviews will be conducted at the clinic or at any other place which is suitable for you, at a time which will suit you.

During the interviews, questions will be asked about your experience of pregnancy. I will ask questions about what impact these experiences had on you and your relationships and your work. In other words, I want to understand how it is to you to be pregnant and how it is to you to be a mother.

I trust that the interviews will be interesting and useful for everyone who takes part in this study. Some of the questions that will be asked will however be very personal and could elicit unpleasant memories. You must please take note that the interview can be ended at any time and that you can refuse to answer specific questions during the

interviews. Participants have the freedom to terminate their participation at any time. You can request that all data about you, which has been collected, this includes the tapes and the transcriptions of the tapes, be destroyed; should you withdraw from the study and it will be done.

To ensure the confidentiality of the research material, no names will be put on the interviews or forms. Each participant will be asked to choose a codename and a list will be compiled to show which participant corresponds with which codename. Only members of the research team will have access to any of the data, which includes tapes and transcriptions. These will be kept in a locked cabinet. All information will thus be kept confidential.

Reports about the study, including published work, will not mention any real names. Descriptions of all persons will be concealed so that they will not be recognizable to anyone who reads the study. Therefore, no piece of information collected by this study can be connected to any specific person or family. Considering that such information about the lives of women is so valuable, the tapes will be kept by the researcher as long as research in this area continues. As soon as the researcher completes this study, the tapes will be destroyed together with the list containing the names and codenames.

Should you find that the questions asked during the research interview, elicit painful or uncomfortable thoughts, and you would want to speak to someone about these feelings, I have a list of help services which you could contact. I can also help you to

obtain support, should I find out during the interview that you request psychological support.

Should you be interested in taking part in this study, please read the following statement and sign below.

**I understand that participation in this study is voluntary and I am aware of the possible risks, benefits, and inconveniences connected to my participation. I accept that I can ask questions freely, that I can refuse to answer questions, and that I can terminate a session at any time. I also understand that should I have any questions or problems regarding this research, I can contact the researcher, Maika Eysselein, at 081 2611 678.**

\_\_\_\_\_  
Signature of participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of interviewer

\_\_\_\_\_  
Date

### **Vorm vir oorwoë toestemming**

Beste Deelnemer

Ek is 'n senior student in Sielkunde en wil graag onderhoude voer vir 'n navorsingstudie. Hiermee wil ek u graag versoek om deel te neem aan 'n naavorsingstudie wat ondersoek instel na hoe vroue swangerskap ervaar. Ek stel daarin belang om meer te verstaan oor moontlike positiewe en negatiewe aspekte van hierdie ervaring en watter faktore daartoe bydra. Ek hoop dat hierdie navorsing sal bydra tot meer effektiewe sielkundige ondersteuning van swanger vroue en moeders.

Indien u bereid is om aan hierdie studie deel te neem, sal ek graag twee of drie onderhoude met u wil voer. Die onderhoude sal tussen een en twee ure duur. Die onderhoude sal op band opgeneem word. Die onderhoude sal gevoer word of by die kliniek of by enige ander plek wat vir u geskik is, op 'n tyd wat u pas.

Tydens die onderhoude sal vrae gestel word oor u ervarings van swangerskap. Ek sal vrae vra oor watter impak hierdie ervarings op u en u verhoudings en werk het. Ek wil met ander woorde verstaan hoe dit vir u is om swanger te wees.

Ek vertrou dat die onderhoud interessant en nuttig sal wees vir elkeen wat aan hierdie studie deelneem. Sommige van die vrae wat gestel word, sal egter hoogs persoonlik wees, en kan onaangename herinneringe oproep. U moet asseblief kennis neem dat u die onderhoude te enige tyd kan beëindig, en dat u tydens die onderhoude kan weier om spesifieke vrae te beantwoord. Deelnemers het die vryheid om hulle deelname te



enige tyd te beëindig. Indien u van die studie onttrek, kan u vra dat al die data wat oor u versamel is, dit sluit die bandopnames en die transkripsies van die bande in, vernietig word, en dit sal gedoen word.

Om die vertroulikheid van die navorsingsmateriaal te verseker, sal geen name op die onderhoude of vorms geplaas word nie. Elke deelnemer sal gevra word om 'n kodenaam te kies, en daar sal 'n lys saamgestel word om aan te toon watter deelnemer met watter kodenaam ooreenstem. Slegs lede van die navorsingspan sal toegang hê tot enige van die data, wat die bande en die transkripsies insluit. Dit sal in 'n toegesluite kas bewaar word. Alle inligting sal dus vertroulik gehou word.

Verslae oor die studie, dit sluit enige gepubliseerde werk in, sal nie enige ware name noem nie. Beskrywings van alle persone sal verbloem word sodat hulle nie herkenbaar sal wees vir enigiemand anders wat die studie lees nie. Daarom sal geen stuk inligting wat deur die studie versamel is op enige manier met enige spesifieke persoon of familie kan verbind word nie. Aangesien sodanige inligting oor lewens van vroue so waardevol is, sal die bande bewaar word solank as wat die navorser navorsing op hierdie terrein voortsit. Sodra die navorser hierdie studie voltooi, sal die bande vernietig word, tesame met die lys wat die name en kodename bevat.

Indien u vind dat die vrae wat tydens die navorsingsonderhoud gestel word, pynlike of onaangename herinneringe oproep, en u sou met iemand oor u gevoelens wou praat, het ek 'n lys hulpdienste wat u kan kontak. Ek kan u ook help om hulp te kry indien ons tydens die onderhoud agterkom dat u sielkundige ondersteuning verlang.

Indien u daarin belangstel om aan hierdie studie deel te neem, lees asseblief die volgende verklaring en teken hieronder.

**Ek begryp dat deelname aan hierdie studie vrywillig is, en is bewus van die moontlike risiko's, voordele, en ongerief verbonde aan my deelname. Ek aanvaar dat ek vrylik vrae kan vra, kan weier om vrae te beantwoord, en dat ek 'n sessie te eniger tyd kan beëindig. Ek begryp ook dat indien ek enige vrae of probleme het wat hierdie navorsing betref, ek die ondersoeker, Maika Eysselein by 081 2611 678, kan skakel.**

\_\_\_\_\_  
Handtekening van deelnemer

\_\_\_\_\_  
Datum

\_\_\_\_\_  
Handtekening van ondershoudvoerder

\_\_\_\_\_  
Datum

## Appendix F: Letter of approval by Ministry of Health and Social Services



REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198  
Windhoek  
Namibia

Ministerial Building  
Harvey Street  
Windhoek

Tel: (061) 2032125  
Fax: (061) 227607  
E-mail: [amuheua@mhss.gov.na](mailto:amuheua@mhss.gov.na)  
Date: 24 April 2006

Enquiries: Mr. A. Muheua Ref.: 17/1/1

### OFFICE OF THE PERMANENT SECRETARY

Ms. M. Eysselein  
P.O. Box 11341  
Windhoek

**Re: The experience of pregnancy in low income women in Windhoek, Namibia**

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. Kindly be informed that approval has been granted under the following conditions:
  - 3.1.1. The data collected is only to be used for your academic purposes;
  - 3.2. A quarterly progress report is to be submitted to the Ministry's Research Unit;
  - 3.3. Preliminary findings are to be submitted to the Ministry before the final report;
  - 3.4. Final report to be submitted upon completion of the study;
  - 3.5. Separate permission to be sought from the Ministry for the publication of the findings.

Wishing you success with your project.

Yours sincerely,

**DR. K. SHANGULA**  
PERMANENT SECRETARY




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Directorate: Policy, Planning and HRD  
Subdivision: Management Information and Research