WOMEN'S NARRATIVES ABOUT ALCOHOL USE DURING PREGNANCY: A NARRATIVE-DISCURSIVE STUDY

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SIBONGILE MATEBESE

Supervisor: Distinguished Professor Catriona Macleod

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Abstract

While research has explored the risk factors that contribute to alcohol use during pregnancy among South African women, such studies have mostly been quantitative in nature. There is a growing body of research that contextualises and articulates the attitudes, beliefs, and underlying motivations that influence drinking during pregnancy. However, few qualitative studies explore the cultural, economic, familial, and social contexts within which drinking during pregnancy takes place. Studies which have explored these contexts have been conducted in other geographical regions such as Australia, Canada, New Zealand, and the United States but their findings are not generalisable to South Africa.

Drawing on a feminist poststructuralist as well as a narrative-discursive approach including Foucault's (1978) theory of power, this study sought to explore women's narratives of the personal and interpersonal circumstances under which drinking during pregnancy takes place in terms of the discourses used to construct these narratives and the subject positions made available within these discourses. This allowed for the practice of alcohol use during pregnancy to be understood within the social and cultural narratives, practices, and discourses around pregnancy as well as gendered and social relations. Using the narrative interview method set out by Wengraf (2001), thirteen, unemployed 'Black' women from an area in the Eastern Cape were recruited and interviewed.

Seven discourses emerged from the narratives namely, a discourse of 'stress and coping' 'hegemonic masculinities', 'peer pressure', 'disablement and developmental delay', 'good mothering/appropriate pregnancies', 'culture', and 'religion'. These discourses informed the five narrative categories which emerged: narratives about the pregnancy, narratives about the drinking, narratives that justify/explain drinking, narratives that condemn the drinking, and narratives about the women knowing the effects of drinking during pregnancy. Within these narratives, the women mainly positioned themselves as dependent on alcohol during their pregnancies in order to cope with stress caused by various circumstances which were mainly centred on a lack of support from their partners, paternity denial, infidelity and unreliableness. As such, the women in this study mainly justified their drinking during pregnancy and in constructing this narrative, the 'stress and coping' discourse as well as the 'male/masculine provider' discourse were mainly drawn upon. In reflecting on this analysis, this study argues that alcohol use during pregnancy should be understood within the broader environmental and social context that makes a pregnancy challenging and/or difficult and thus necessitates drinking during pregnancy.

Recommendations for future research include expanding the diversity of participants as well as interviewing healthcare providers and women who are currently pregnant, drinking, and part of an intervention aimed at addressing alcohol use during pregnancy so as to obtain a holistic understanding of engaging in this practice. The study makes key recommendations for interventions in practice to help work towards ensuring that the practice of alcohol use during pregnancy is not individualised, decontextualized, and stigmatised.

Keywords: alcohol, pregnancy, women, drinking, discourse, narratives, subject positions, power relations

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Glossary of Terms

Term	Meaning
ha.a	An *isiXhosa* term meaning 'no' similar to the term *hayi*.
Hayke	An *isiXhosa* term meaning 'oh well'.
Indoda	An *isiXhosa* term used to refer to a man or a 'real man'.
inkwenkwe	An *isiXhosa* term used to refer to a boy or a young man who has not been circumcised.
mntasekhaya/bantasekhaya/bantakwethu	*IsiXhosa* terms meaning 'my people' used to refer to a person or a group of people of similar racial identity to whom the speaker may or may not be related by blood.
mos	An *Afrikaans* term used in various South African languages translatable to 'at least' or 'indeed'.
nhe/anhe	An *IsiXhosa* term meaning 'hey' or 'right' often used at the end of a sentence to check if the person listening is following, understands and/or agrees with what is being said.
preg	A slang term used to refer to being pregnant.
shebeen	An *Afrikaans* term for *tavern* used to refer to small scale illegal outlets that sell alcoholic beverages.
sisi	A term meaning 'sister' (as in sibling) used in Nguni languages (*isiXhosa, isiZulu*). This term is also used to convey respect to an older woman or female person who is too young to be called or referred to as a mother (*umama*) or by their actual name.
ukwaliswa/ukubukuzana	An *isiXhosa* term often used by pregnant women to describe the disappearance of their male partners during the pregnancy either temporarily or for good.
ukukhupha isisu	An *isiXhosa* term used to refer to having an abortion.

ukuphuncuka kwesisu	An *isiXhosa* term used to refer to having a miscarriage.
ulwaluko	An *isiXhosa* term used to refer to circumcision.
yabo	An *isiXhosa* term meaning ‘you see’.
yho	An *isiXhosa* term used (depending on the context) when reacting to something to express disgust, shock, or surprise, used throughout in South Africa.

List of Acronyms

AEP/AEPs	Alcohol Exposed Pregnancy(ies)
ARBD	Alcohol Related Birth Deficits
ARND	Alcohol Related Neurodevelopmental Disorders
AUDIT/AUDIT-C	Alcohol Use Disorders Identification Test/ Alcohol Use Disorders Identification Test for Consumption
CSSR	Critical Studies in Sexualities and Reproduction
FASD/FASDs	Foetal Alcohol Spectrum Disorder(s)
HMHB©	Healthy Mother Healthy Baby Programme©
FARR	Foundation for Alcohol Related Research
FAS	Foetal Alcohol Syndrome
IPV	Intimate Partner Violence
NGO/NGOs	Non-Governmental Organisation(s)
PFAS	Partial Foetal Alcohol Syndrome
RPERC	Research Projects Ethical Review Committee
RUESC	Rhodes University Ethical Standards Committee
SQUIN	Single Question aimed at Inducing Narrative
WHO	World Health Organisation

Chapter One: Introduction and Context

1. Introduction

Drinking during pregnancy can result in children experiencing lifelong developmental delays, disabilities, mental deficiencies, and physical anomalies which are collectively referred to as Foetal Alcohol Spectrum Disorders (FASDs) (May et al., 2009; Riley, Infante, & Warren, 2011; Stevens et al., 2013). The most severe form of FASD is Foetal Alcohol Syndrome (FAS). Due to alcohol exposure in the utero, children with FAS are born with physical and mental defects including facial deformities, growth deficits, and brain damage (Hankin, 2002). In addition to FAS, three other disorders are included on the FASD spectrum. These include Partial Foetal Alcohol Syndrome (PFAS), Alcohol Related Neurodevelopmental Disorders (ARNDs), and Alcohol Related Birth Deficits (ARBDs). PFAS is characterised by facial abnormalities and deformities in one or other area such as problems with brain growth structure or physical growth, while ARNDs are characterised by behavioural and cognitive disabilities and ARBDs involve structural abnormalities such as bone, heart, and kidney problems, difficulty hearing and seeing and reduced immune function (Hankin, 2002; Hoyme et al., 2005; May et al., 2009).

Most research conducted on alcohol use during pregnancy both in South Africa and internationally has been devoted to exploring the prevalence patterns of FASDs, particularly those of FAS. In addition, various studies have explored the effects of interventions and awareness campaigns aimed at informing women who are pregnant, non-pregnant or planning to be pregnant about the dangers of alcohol use during pregnancy. Research has also explored the risk factors that contribute to prenatal drinking and thus the increased prevalence of FAS.

In this introductory chapter, I present a brief overview of the literature on alcohol use during pregnancy. I start off by looking at alcohol use in South Africa with a particular focus on the historical influences which have resulted in excessive alcohol use. I then home in on literature focusing particularly on alcohol use during pregnancy with a specific focus on research about prevalence patterns, interventions and awareness campaigns as well as research conducted from the perspective of pregnant and/or previously pregnant women who drank during their pregnancies. I provide a rationale for this study followed by a brief explanation of the terms I use in this thesis. Lastly, I provide an overview of the chapters in this thesis.

2. Alcohol use in South Africa

According to the World Health Organisation (WHO) (2011), alcohol consumption in per capita rates in South Africa are among the highest in the world and these rates continue to increase. Among those who consume alcohol, approximately two in five women (41.2%) and one in two men (48.1%) engage in heavy drinking. South African adults aged fifteen years and older consume an average of 9.3 litres of pure alcohol annually (WHO, 2018). This is higher than the African regional average of 6.4 litres per person. The history of alcohol use in South Africa is closely linked to the history of apartheid (Rataemane & Rataemane, 2006). During this time, access to alcohol by the majority of 'Black'[1] people was limited and this led to the proliferation of homebrews (especially of sorghum beer) sold in *shebeens* also referred to as *taverns*. This resulted in excessive alcohol use despite shebeens being illegal. In addition to the history of apartheid, excessive alcohol use in South Africa can be traced back to the early years of Dutch settlement (Olivier, Curfs, & Viljoen, 2016). Dutch farmers coming into the Cape implemented the 'dop' system in which farm workers were paid in alcohol in addition to their wages (Olivier et al., 2016). While this system no longer exists, alcohol consumption in this region remains pervasive.

Binge/heavy drinking has become a common practice in South Africa where people refrain from drinking alcohol during the week and then drink excessively on weekends (Friday – Sunday) and at parties (May et al., 2004). This practice is further exacerbated by the existence of multiple *shebeens* where alcohol is easily accessible and affordable (Evans, 2015). These enable engagement in what Poole (2008) calls "unmonitored drinking" (e.g. no observation or control of underage or excessive drinking). In addition, because of the number of illegal outlets that exist in the country, any official measures aimed at reducing alcohol related harm and public disorder, heavy, risky and underage drinking and other problems within these establishments is limited. Evans (2015) further argues that an important outcome of the two historical influences is that they have resulted to the existence of a 'drinking culture' within the South African context and as such, excessive alcohol use has become a norm. That is, this 'drinking culture' promotes the excessive use of alcohol during leisure time as celebratory, cultural, and social events are organised around imbibing alcohol.

This history and current circumstances have led to communal and individual identities to come to be shaped by alcohol use (Gearing, McNeill, & Lozier, 2005; Meurk, Broom, Adams, Hall, & Lucke, 2014). Alcohol has, in the lives of many South Africans of different cultures and races, become an important social activity, which has consequently raised multiple public health concerns

[1] I use inverted commas to emphasise that race/this racial category (including the others I refer to in this thesis) is a construct.

ranging from alcohol related deaths in transport, risky sexual behaviour, to FAS (Olivier et al., 2016).

3. Prevalence patterns of FASDs

FASD has been documented across a variety of geographical locations and races worldwide. Nationwide, the prevalence of FAS in the United States is approximately 0.05 to 3.0 per 1000 births while among different racial and socioeconomic groups, the prevalence ranges from 2.0 to 7.0 per 1000 births (May & Gossage, 2002; May et al., 2009). In other countries such as New Zealand, the prevalence of FAS is estimated at 0.11 per 1000 births (Leversha & Marks, 1995) while in parts of France, the prevalence of FAS and FASD range from between 1.2 and 4.8 per 1000 births respectively (Dehaene et al., 1991). In various regions of Italy, FAS and PFAS prevalence rates range from 4.0 to 12.0 and 18.1 to 46.3 per 1000 (May et al., 2011). According to May et al. (2013), the highest known rates of FASDs are recorded in Africa specifically in the Western Cape province of South Africa where for every 1000 children born, approximately 59.3 to 91.0 are diagnosed with FAS. The majority of the studies conducted in the Western Cape to explore the prevalence patterns of FAS and other FASDs have been conducted in schools.

Studies conducted in schools in the Western Cape have shown that FASDs affect 72.3 per 1000 children, while in schools in the United States and some Western countries in Europe, FASDs affect 20 to 50 per 1000 children (May et al., 2009). In a study conducted in a Western Cape community in South Africa in 1997, FAS among the school children was recorded at 40.5 to 46.4 per 1000 (May et al., 2000). Two years later, this prevalence in the same community increased to 65.2 to 74.2 per 1000 (Viljoen et al., 2005). Both FAS and PFAS were measured in this community in 2002 and these disorders were found to affect between 68.0 to 89.2 school going children (May et al., 2007). A recent study conducted by May et al. (2013) in the same context which measured three of the disorders on the spectrum found that FAS affected 59.3 to 91.6 per 1000, PFAS affected 45.3 to 69.6 per 1000, and ARNDs affected 30.5 to 46.8 per 1000 school going children. High rates of FASDs have also been documented in the Northern Cape province of South Africa (Urban et al., 2008). In De Aar, FAS/PFAS were found to affect 199.4 per 1000 children while in Upington, 74.7 per 1000 children were affected. Across several communities of the Gauteng province, the prevalence of FAS was found to be 26.5 per 1000 children (Viljoen, Craig, Hymbauch, Boyle, & Blount, 2003). These findings provide a stark contrast with the estimated rates of 0.3 to 4.9 per 1000 among school going children in the United States (May & Gossage, 2001; May et al., 2009).

4. Interventions and awareness campaigns about alcohol use during pregnancy

The policy in many countries including South Africa is that no amount of alcohol during pregnancy is safe and pregnant women should avoid alcohol (Ntsabula, 2001; O'Leary, Heuzenroeder, Elliott, & Bower, 2007). Drawing from this policy, interventions aimed at preventing and/or reducing FASDs at present are targeted at women in an attempt to help them achieve abstinence from alcohol during pregnancy. Existing interventions can be divided into three categories, namely: 1) indicated; 2) selective; and 3) universal interventions (Barry et al., 2009; Hankin, 2002). Indicated interventions are aimed at women with the highest risk of Alcohol Exposed Pregnancies (AEPs) particularly women who are heavy drinkers dependent on alcohol or who already have a child with a FASD. Selective interventions are mainly targeted at women of reproductive age who use and/or consume alcohol who are at risk of giving birth to children with FASDs. These interventions have been shown to be effective in many primary healthcare settings where the routine screening of alcohol abuse and misuse often happens and is followed by brief interventions (Anderson, Chisholm, & Fuhr, 2009). Universal interventions are the most common type of interventions and are aimed at entire populations regardless of individual risk status to raise awareness about the risks of alcohol use during pregnancy at a population level (Barry et al., 2009; Hankin, 2002). In other contexts, electronic interventions (also called e-interventions) are used with selected women. These interventions are often delivered by computer, mobile phone or via the web and are said to be useful for risky drinkers who are hesitant to seek help or have problems accessing treatment (Du Plessis, Young, & Macleod, 2017).

The Healthy Mother Healthy Baby© (HMHB) programme run by the Foundation for Alcohol, Related Research (FARR) in the Western Cape in South Africa is an example of both an indicated and selective intervention. The HMHB© is aimed at women in high risk communities who report low or moderate levels of alcohol use during pregnancy as well as those who report heavy drinking and alcohol dependence (Foundation for Alcohol Related Research, 2015). The women who take part in the programme are recruited at primary healthcare clinics and before taking part, complete the Alcohol Use Disorders Identification Test (AUDIT). Based on their results, they are placed into one of four risk groups with group one involving low risk drinkers and group four involving women who drink heavily or are alcohol dependent. All participants take part in brief motivational interviews. Those who are high risk drinkers receive additional interviews and home visits. Furthermore, all participants, regardless of their risk group are encouraged and invited to attend health talks and other events. After birth, the women who remained on the programme are encouraged to continue taking part in the health talks and events and advised to take their children to a clinic where they are screened for FASD. On the other hand, in Alberta, women can sign up to

the Dry 9 Movement where they do the “Dry 9” and do not drink throughout their pregnancies. The women receive a t-shirt, emails of support, and short video clips about a variety of topics such as what happens during pregnancy, the dangers of drinking and its effects on the foetus as well as videos about other topics.

The use of beverage warning labels, educational campaigns, and the mass media are examples of universal interventions which, as argued by Barry et al. (2009), have been associated with an increase in awareness about the effects of drinking during pregnancy. However, what is unclear is whether or not this has a significant impact on drinking during pregnancy. Where changes in drinking behaviour have been found, due to warning labels for example as was the case in a study conducted by Hankin, Sloan, and Sokol (2000) among African American women, the effects disappeared over time and drinking returned to pre-intervention levels over a period of time. A number of universal interventions exist in various countries and South Africa. Annually, International FASD Day is observed globally on the 09th of September to recognise the importance of abstaining from alcohol during the nine months of pregnancy (South Africa Government News Agency, 2018). Recently in South Africa, the 999 campaign was launched in all nine provinces during the first nine days of September to create awareness and educate community members about the dangers of alcohol use during pregnancy as well as giving birth to a child with FAS (South African Government News Agency, 2018).

While a number of interventions and awareness campaigns about alcohol use during pregnancy exist as is evident above, it appears that the prevalence of FASDs has not decreased.[2] This raises a number of questions about the nature and focus of interventions and awareness campaigns about alcohol use during pregnancy. Is only focusing on the woman and emphasising abstinence given the context in which these women live (to be discussed below) enough to ensure a decrease in the incidence of FASD?

5. Alcohol use during pregnancy from the perspective of pregnant women

Research conducted on alcohol use during pregnancy from the perspective of women who were, at the time of the study, drinking or had drunk during their pregnancies has mainly identified various risk factors which contribute to prenatal drinking. These risk factors can be divided into seven categories, namely: 1) socio-cultural risk factors such as limited access to social resources, physical access to alcohol, and the social tolerance of drinking; 2) behavioural risk factors such as alcohol initiation at an early age, drug abuse, having multiple sexual partners and smoking; 3) educational

[2] The prevalence of FASD across the country is not known. Such research (assessing FASD) is complex and costly with studies being undertaken in only particular parts of the country (see discussion on page 3).

risk factors such as lower educational attainment; 4) familial risk factors such as having parents who consumed alcohol excessively; 5) interpersonal risk factors such as cohabitating with a partner or spouse who is a heavy drinker or alcoholic, being part of a social network where excessive alcohol use is emphasised, being in a violent relationship or having a partner who drinks; 6) non-alcohol related risk factors such as high gravidity and parity, a low socioeconomic status, low income or an unsupportable pregnancy; and 7) residential risk factors which include residing in a rural community (Desmond et al., 2012; May et al., 2005; 2008; Urban et al., 2008).

With regard to environmental risk factors, there is debate about what happens in the context in which pregnant women live that causes them to drink during their pregnancies. Some scholars (Desmond et al., 2012; Parry et al., 2005) have argued that alcohol use during pregnancy is prevalent among women diagnosed with HIV during pregnancy. Poor nutrition among pregnant women has also been suggested as amplifying the teratogenic effects of prenatal alcohol exposure (Keen et al., 2010). This link seems plausible as food insecurity (eating less due to of the unavailability of food) has been linked to alcohol consumption.

Most studies on risk factors have been quantitative. Their emphasis thus, has not been on articulating and contextualising the underlying attitudes, beliefs and motivations that influence these risk factors (Olufunto & Barry, 2015). It is unclear for example, which of these risk factors are pertinent in particular contexts. Do pregnant women who drink in excess do so because they were already engaged in high risk drinking prior to pregnancy and thus do not perceive alcohol use during this time as a risk to their health and that of the foetus? Is it because they have low educational attainment and are unaware of the risks associated with drinking during pregnancy? Further, it is also unclear how pregnant women navigate the social pressures of drinking and whether social expectations and interactions influence their inability to limit their alcohol use during pregnancy or abstain from alcohol during pregnancy.

Findings from qualitative studies conducted in Canada (Kruk & Banga, 2011; Zabokta, Bradley, & Escueta, 2017) and the United States (Jackson & Shannon, 2013; Zabokta et al., 2017) highlight the role played by stress and trauma in substance use during pregnancy. Findings from these studies have also indicated that pregnant women turn to alcohol and/or drugs in an attempt to cope with past and present stressors in their lives. Studies conducted in Australia and the United Kingdom (e.g. Meurk et al., 2014; Raymond, Beer, Glazebrook, & Sayal, 2009) have shown that some pregnant women drink during their pregnancies because alcohol is an important part of their social

lives and as such did not regard consumption of "acceptable" levels of alcohol (one glass of wine once or twice a week) as enough to put the foetus at risk. Many of the women in these studies expressed the benefits of drinking during pregnancy which include stress relief and relaxation outweighed the risks. As much as these findings provide useful insights into drinking during pregnancy, they cannot be generalised to South African women as there are varying contextual differences in these societies and cultures.

In South Africa, limited qualitative research has been conducted which explores alcohol use during pregnancy from the perspective of women who drank during their pregnancies. Like international studies, most research that has been done focuses on how alcohol is used as a coping mechanism during pregnancy. Pregnant women drink to avoid confronting stressors in their lives, as a means of dealing with stress or to overcome negative emotions resulting from these stressors (Eaton et al., 2014a; 2014b; Watt et al., 2014). A recently published study conducted by Kelly and Ward (2017) in a Western Cape community which aimed to explore how women who drank during pregnancy understood and made sense of alcohol use also supports some of the findings of the above studies as the participants perceived drinking as a way of coping with domestic problems. In addition, participants regarded alcohol use during pregnancy as a social activity, highlighting how alcohol use during pregnancy is rooted in a particular context.

The findings of the above studies may be particularly pertinent for women who have been marginalised due to the legacy of apartheid (Cloete & Ramugondo, 2015). For some South African women, drinking during pregnancy may be seen as a way of responding to living in a troubled society in which they have been exposed to adverse economic and socio-political conditions for an extended period of time (Cloete & Ramugondo, 2015). Further, the environment in which many pregnant women live may support and thus maintain their drinking, especially given the fact that in many parts of South Africa, alcohol use and abuse is normalised and socially acceptable (Cloete & Ramugondo, 2015; Evans, 2015; Watt et al., 2014). It is on this premise that in this study, I am interested in exploring and understanding the discursive context in which alcohol use during pregnancy takes place.

6. Rationale for the present study

This study is part of a bigger project consisting of three projects aimed at addressing the lack of research on alcohol use during pregnancy in the Eastern Cape and to support the implementation of an intervention. The first project is a quantitative summative evaluation in which the prevalence and patterns of alcohol use during pregnancy were recorded during antenatal clinic visits in a particular community and have been ascertained, as a baseline to, and at the end of, the intervention. The

second, (which the present study is part of), involves collecting data on the contextual factors that serve to either enhance alcohol use or support abstinence during pregnancy. This project has been divided into two – one focuses on women who drank during their pregnancies and the other on partners and family members of women who drank during their pregnancies. The third project is a formative evaluation in which qualitative data has been collected to assess and enhance various components of an intervention instituted by an NGO.

While the South African studies discussed in this chapter highlight important findings, a need for more research in the area of alcohol use during pregnancy from the perspective of previously pregnant women who drank still exists. A better understanding of the contextual, psychological, and social processes that contribute to alcohol use during pregnancy is needed not only to help prevent the occurrence of and/or reduce the high prevalence of FASDs but to guide interventions that have this aim. In particular, an understanding of the discursive and gendered power relations that enable or constrain particular actions and personal narratives would assist in honing interventions.

Using a narrative-discursive approach alongside poststructural feminist theory, this study explores women's narratives of the personal and interpersonal circumstances under which drinking during pregnancy takes place. To collect the data, individual interviews with women who drank during their pregnancies were conducted according to the narrative interview method developed by Wengraf (2001). Taylor and Littleton's (2006) narrative-discursive approach enabled an analysis of the discursive resources drawn upon by the women in constructing individual narratives of the journey of their pregnancies, while work on subject positioning/positioning theory (Davies & Harré, 2001) was used to analyse the subject positions made available within these discursive resources. In analysing the narratives for gendered power relations, Foucault's (1978) theory of power was used.

7. Terminology used in this thesis

I situate this study within a social constructionist paradigm as I am interested in how previously pregnant women narrate the journey of their pregnancy. In relation to this, social constructionism examines how, in particular cultures, social reality can be constituted in various ways (Burr, 1995; Willig, 2013). This paradigm, as Willig (2013) argues, examines what conditions allow for particular constructions of reality and what the consequences of these constructions are for human experience and social practice. While I discuss the key theoretical concepts I draw on from poststructural feminism in chapter three of this study, it is important to clarify these terms as I make reference to them earlier before engaging with them in depth. Briefly, I use the term narratives, as is done by Taylor (2006) and Taylor and Littleton (2006), to refer to stories people construct for a particular purpose around a consequence and sequence of events. In constructing narratives,

discourses are drawn upon. From a poststructuralist point of view, discourses are a coherent system of meaning which construct objects and position subjects (Davies & Harré, 2007; Parker, 1992). In constructing objects, discourses generate belief systems or knowledge which are socially and historically contingent. It is this contingency which results in changes in belief systems across contexts and over time. As such, discourses arise in particular socio-historical contexts, and as argued by Macleod (2011), discourses do not only give rise to coherence and regularity but also to instability and variability. Discourses further construct subject positions. Positioning refers to the process whereby people locate themselves and others, and are located, in narratives and discourses (Davies & Harré, 2007). In being positioned and positioning oneself or others, identities and relationships are constructed. The positioning of subjects in narratives and discourses show how discourses embody power – the power to construct and include or exclude subjects depending on the subject positions they take up or reject.

In this thesis, I refer to myself in the first person. I do this to keep in line with the tradition of feminist, qualitative, and social constructionist research and to emphasise the fact that I see myself as located in, rather than objective or separate from, the research process of knowledge production. Instead of using the term 'research subjects', I use the term 'participants' to highlight that I saw the women who took part in this study as actively involved in this study (although there were limitations to their involvement) rather than regarding them as people I observed. There are instances where I refer to the 'participants' of this study as 'women'. In doing so, I do not mean that the women are a homogenous group or have similar experiences. I use the term to foreground gender and as a general description of the participants of this study.

8. Overview of chapters

In the chapter that follows (chapter two), I review the literature on alcohol use during pregnancy. The chapter begins by looking at the various factors that contribute to alcohol use during pregnancy and thereafter shifts to focus on women's experiences of alcohol use during pregnancy. In this section, I discuss the various reasons for drinking during pregnancy as provided by women who were drinking or had drunk during their pregnancies as well as their experiences of healthcare and partner and/or family support. In taking these experiences further, I then look at attitude research on alcohol use during pregnancy. I focus on the implications engaging in this practice has for what motherhood means, focusing particularly on the dichotomy of the 'good' and the 'bad' mother which shows how the practice of alcohol use during pregnancy is stigmatised. The gendered nature of alcohol use is also explored in an attempt to demonstrate the role of power relations in the meanings and understandings of alcohol use during pregnancy.

Chapter three sets out the theoretical framework that informs this study. In this chapter, I discuss the core principles of the social constructionist paradigm within which this study is situated. I then discuss each of the key theoretical concepts I draw on from poststructural feminism which include narratives, as well as discursive resources, canonical narratives, discourses, subject positioning, and, with reference to Foucault's theory of power, I discuss power relations. In referring to each of these concepts, I outline how they are relevant to this study using examples, where applicable. The criticisms of Foucault's theory of power and feminist poststructuralism are discussed, as well as their usefulness for this study.

Having reviewed the literature on alcohol use during pregnancy and explained the theoretical framework and its related concepts relevant to this study, in chapter four, I provide a detailed explanation of the steps involved in conducting this study. This chapter includes details about the sampling and recruitment strategies, the methodology I used to collect the data/narratives of the women, its strengths and limitations (which I ground in the observations I made during data collection) as well as the methodology used to analyse the collected data. The ethical considerations related to this study are also discussed. The chapter includes a section on reflexivity and validation in which I speak to my involvement in the research process and the strategies I used to ensure trustworthiness in this study.

Chapter five is the first of two analytical chapters. In this chapter, I discuss the discourses that the women deployed in their narratives/telling their stories. I start off by outlining the overarching discourse of 'stress and coping' followed by the 'hegemonic masculinities' and 'male/masculine provider' discourses. I then turn to focus on the 'peer pressure' discourse, 'disablement and developmental delay' discourse, 'good mothering/appropriate pregnancies' discourse, and 'cultural' discourse. Finally, I discuss the 'religious' discourse.

In the second analytical chapter, chapter six, I focus on the women's stories of the journey of their pregnancy. I structured the chapter by dividing the narratives into five categories, which include: 1) stories about the pregnancy where I highlight how the women felt when they found out they were pregnant including the responses of partners and parents; 2) stories about the drinking in which the drinking patterns of the women are explored; 3) stories in which drinking during pregnancy is explained and/or justified and reasons for drinking are provided; 4) stories which condemn the drinking where this practice is constructed as preventing good mothering; and 5) stories about the women knowing the effects of drinking during pregnancy.

In chapter seven, I conclude the study. The chapter begins with a brief overview of the research process followed by a summary of the findings in which I discuss what has emerged from the data

about the context in which drinking during pregnancy takes place. I then pick up on certain aspects of the findings and use these to make recommendations for interventions aimed at addressing alcohol use during pregnancy. I end the chapter by discussing the limitations of this study and make recommendations for future research.

Chapter Two: Literature Review

1. Introduction

Most research conducted about alcohol use during pregnancy to date has focused on how alcohol affects the developing foetus and on identifying risk factors that contribute to prenatal drinking (Eaton et al., 2014b). While demonstrating important findings, there is very limited research that concentrates on providing an in-depth understanding of why some women drink during pregnancy, the processes that take place from risk to actual drinking and the role of the social context in promoting alcohol use during pregnancy. On an international level, a few studies have explored substance use (both alcohol and drug use) from the perspective of women who have used substances during pregnancy. Very little research has been conducted in South Africa that explores alcohol use from the perspective of women who drank while pregnant.

Forming part of the context in which the practice of alcohol use during pregnancy takes place are attitudes toward engagement in this practice. These are mainly informed by the knowledge individuals have, the messages received about the practice that normalise motherhood and construct alcohol use during pregnancy as bad and/or negative, and the stigma surrounding alcohol use during pregnancy that arise from these constructions. In this chapter, these various constructions will be discussed as they have featured in research about alcohol use during pregnancy and have also emerged as influences that shape women's experiences of engaging in the practice of alcohol use during pregnancy.

This chapter begins with a discussion of research on the factors contributing to alcohol use during pregnancy, followed by women's self-provided reasons for drinking during pregnancy. The discussion will then turn to research on women's experiences of alcohol use during pregnancy with a specific focus on women's experiences of healthcare and partner and/or family support. The chapter will then turn to research on the context that frames and influences alcohol use during pregnancy, that is, attitudes held about alcohol use during pregnancy, the stigma surrounding alcohol use during pregnancy, and the ways in which motherhood and alcohol use during pregnancy have been constructed. Lastly, in an attempt to evidence the fact that the practice of alcohol use during pregnancy is embedded in power relations, the gendered nature of alcohol use will be discussed.

2. Factors contributing to alcohol use during pregnancy

Like all other health related behaviours, alcohol use during pregnancy is influenced and shaped by numerous factors. Research which has considered these factors has found that a range of complex and interrelated biological, demographic, psychological, and socioeconomic factors contribute to alcohol use during pregnancy. Rendall-Mkosi et al. (2008) argue that these factors also influence the extent of damage to the foetus.

In a study conducted among township women in Cape Town, South Africa, to explore alcohol use prior to pregnancy, O'Connor et al. (2011) found that many women drank during their pregnancies because they were unaware that they were pregnant and this was closely linked to the fact that the pregnancy was unplanned. In addition, the study also found that even after discovering that they were pregnant, some women continued drinking (O'Connor et al., 2011). This indicates that although an individual or woman may know that she is pregnant, this is not enough to inhibit drinking thus emphasising the fact that when it comes to alcohol use during pregnancy, there are many other factors at play that contribute to engagement in this practice.

In their paper about maternal risk factors for FASDs, May and Gossage (2011) argue that one of these factors is adopting drinking habits at an early age while another, as identified by Choi et al. (2014a), is consuming alcohol at high levels before pregnancy. In their study conducted in Washington State among mothers who have given birth to children with FASDs, Astley, Bailey, Talbot, and Clarren (2000) found that these women started drinking at a young age and in addition to this drank significant amounts of alcohol before their pregnancy, which led to many being identified as alcohol dependent.

Apart from pre-pregnancy drinking patterns, a number of psychosocial factors have been identified as contributing to alcohol use during pregnancy. In a systematic review conducted by Esper and Furtado (2014) to identify maternal risk factors associated with FASD, the experience of physical and sexual abuse, including exposure to violence, were identified as risk factors for alcohol use during pregnancy. A related factor identified by Eaton et al. (2012) in their study conducted in areas of the Western Cape in South Africa was the experience of intimate partner violence (IPV) which was found to increase drinking during pregnancy as women resorted to drinking while pregnant to cope with this violence. Similar findings emerged in the study conducted by Astley et al. (2000) where the women reported using alcohol as a way to deal with the abuse they were experiencing in their intimate relationships. In their study, Choi et al. (2014a) further found that pregnant women who experienced childhood abuse or IPV reported drinking heavily even if they were low risk drinkers beforehand and regardless of their drinking levels before the pregnancy.

Some pregnant women have reported that they were unable to stop drinking both during and after the pregnancy because they are too depressed to do so (Astley et al., 2000). May and Gossage (2011) argue that depression is indeed a predictor of alcohol use during pregnancy as many women live in contexts with multiple life stressors which may cause depression. In cases where these women give birth to a child with a FASD, feelings of guilt and regret which also may cause depression are common. This finding has been connected to factors such as feeling sad and discouraged as well as having a few interests during pregnancy which are also considered to predict alcohol use during this time (Leonardson, Loudenburg, & Struck, 2007; May & Gossage, 2011; May et al., 2005). Other demographic and biological factors which can be closely linked to the psychosocial influence of depression on alcohol use during pregnancy include coming from a low socioeconomic background, receiving a low income, being single, a smoker, and being unemployed (May & Gossage, 2011; O'Connor et al., 2011; Peadon et al., 2011).

Moving away from psychosocial influences, numerous demographic and biological factors have been identified as contributing to alcohol use during pregnancy, including giving birth to or having a child with a FASD. Mothers of children with FAS or any other FASD may have a family history of alcohol abuse; thus, women who drink during pregnancy may be biologically predisposed to heavy alcohol consumption and/or alcohol dependency (May et al., 2005).

Education and religion also play a role in alcohol use during pregnancy (May et al., 2004). In a study conducted by Viljoen, Croxford, Gossage, Kodituwakku, and May (2002) among mothers of children with FAS in South Africa, lower educational levels and less regular religious practices were identified as characteristics of mothers of children with FAS. Due to a lack of education or limited educational attainment, women may be unaware of the harms associated with prenatal alcohol use on the foetus or they may hold multiple misconceptions about the risks associated with drinking during pregnancy (Branco & Kaskutas, 2001; Eaton et al., 2014a). Women who uphold the belief that any amount of alcohol is safe to drink during pregnancy as well as women who lack knowledge about the effects of alcohol on the foetus, for example as was evidenced in a study conducted by Elek et al. (2013), have been identified as vulnerable to drinking during pregnancy. On the contrary, Branco and Kaskutas (2001) have argued that even though women may be aware of the risks associated with alcohol use during pregnancy, the social support needed to encourage abstinence may be limited.

With regard to religion, Kovacs, Piko, and Fitzpatrick (2011), in their study conducted in Hungary, argue that religiosity is a protective factor against substance use. Higher religiosity plays an important role in preventing substance use and other risky behaviours. In the study conducted by

Viljoen et al. (2002) mothers of children with FAS reported lower religiosity. Although not directly causing FAS, this characteristic was considered to be a risk factor for excessive and early substance use among mothers of children with FAS and other pregnant women.

Although low levels of education, receiving a low income, and being unemployed are considered to be factors contributing to alcohol use during pregnancy, it is important to note that this is not always the case across different contexts as having higher levels of education, receiving a higher income, and being employed have also been identified as factors contributing to alcohol use during pregnancy (Ethen et al., 2009; Skagerstróm, Chang, & Nilsen, 2011). This association between a higher socioeconomic status and higher alcohol consumption, however, is mainly a result of light social drinking as opposed to heavy binge drinking (Ethen et al., 2009).

The studies discussed above have explored the various factors contributing to alcohol use during pregnancy. Emerging research (Guise & Gill, 2007; O'Connor, Heron, Golding, & Glover, 2002; Rolfe, Orford, & Dalton, 2009) has begun to explore the various reasons for drinking during pregnancy as provided by women who drank during a current or previous pregnancy. The following section discusses these reasons in depth in an attempt to show that engagement in the practice of alcohol use during pregnancy is multifaceted and does not only rest on single factors.

3. Women's self-provided reasons for drinking during pregnancy

Reasons for engaging in the practice of alcohol use during pregnancy differ from individual to individual with each reason having certain implications. Emerging research on alcohol use during pregnancy has emphasised the existing and growing relationship between alcohol use and individual problems (Cloete & Ramugondo, 2015; Kelly & Ward, 2017; Watt et al., 2014). Strongly emphasised in this research is the fact that many women consider pregnancy to be a difficult and stressful life transition (Watt et al., 2014) and this view may interact with other life stressors and encourage drinking during pregnancy (Cloete & Ramugondo, 2015; Kelly & Ward, 2017). A study conducted by Rolfe et al. (2009) in the West Midlands of England among women who were heavy drinkers found that alcohol use during pregnancy was described as a coping strategy where drinking was used as a way to reduce and regulate unwanted internal experiences. Most of the participants reported consuming alcohol while pregnant in order to deal with the hurt and pain associated with their partners' unfaithfulness or infidelity while others reported using alcohol to avoid, escape, and forget about things like financial and food insecurity (Rolfe et al., 2009). Such findings were also reported in studies conducted in South Africa by Eaton et al. (2014b) and Watt et al. (2014). Some pregnant women in a study conducted by O'Connor et al. (2002) in the United Kingdom (Avon) considered alcohol consumption during pregnancy as beneficial, claiming that since prenatal

anxiety has been associated with mental health problems in children, some alcohol intake for the purpose of stress relief holds more potential benefits than risks to the developing foetus.

In using drinking as a coping strategy, women draw on the notion of self-medication in which alcohol is used as a means of coping with emotional pain and/or stressful life circumstances as well as a strategy for self-care where the symptoms associated with stressful events and experiences can be medicated (Drabble & Trocki, 2013; Gueta & Addad, 2013; Reid, Greaves, & Poole, 2008). As Rolfe et al. (2009) state, "drink is frequently talked about as having drug-like qualities and as being used by women as a 'pick-me-up' and mood altering substance, as a comfort and to help women cope and to function" (p.329). By drawing on the notion of self-medication to explain engagement in the practice of alcohol use during pregnancy, women are generally positioned as dependent on something (alcohol in this case) to cope with their problems and thus seen or labelled as bad mothers (Rolfe et al., 2009). Pregnant women who have used alcohol for purposes of coping (although they became addicted) have challenged this subject position and emphasised the fact that they did not use alcohol in a destructive manner (further employing a discourse of self-control) but as a means to help them function better, thus positioning themselves as having serious reasons for drinking (Rolfe et al., 2009).

Although alcohol was used to deal with, overcome, and forget about existing problems as highlighted in the above studies, participants acknowledged the fact that alcohol does not offer a long term solution to their problems but can aggravate them (Eaton et al., 2014a, 2014b; Watt et al., 2014; Rolfe et al., 2009). Furthermore, in contrast to alcohol being used as a coping strategy, participants, particularly those in the study conducted by Watt et al. (2014), highlighted that it can also cause problems such as arguments and fights as well as interpersonal conflict including violence especially among intimate partners.

For some pregnant women, including women who were previously pregnant and drank during their pregnancies, alcohol use, instead of being considered a means of coping, was considered a social and pleasure-filled activity which takes place among peers (Cloete & Ramugondo, 2015; Rolfe et al., 2009; Watt et al., 2014). For these women, drinking fuels social interactions and is a source of enjoyment including relaxation (Branco & Kaskutas, 2001; Cloete, 2012). The study conducted by Rolfe et al. (2009) supports the above as drinking during pregnancy was linked to leisure and 'time out' from work (this may include taking care of the baby, doing chores while pregnant and other tasks). Drinking was thus regarded as a reward. In such cases, women draw on a discourse Niland, Lyons, Goodwin, and Hutton (2013), in their study conducted in New Zealand, call the "friendship fun" (p.530) discourse. In this discourse, alcohol use is regarded as something that is done for

enjoyment and sociability (Lyons & Willott, 2008; Niland et al., 2013). Rather than being considered an individual activity or experience, it is constructed as a social pleasure and collective or group activity, a finding also evidenced in Guise and Gill's (2007) study conducted in Scotland where participants described binge drinking as something that is done together by a social group rather than an activity an individual engages in alone.

By constructing and framing alcohol use during pregnancy as a social rather than an individual activity, the friendship fun discourse legitimises and normalises alcohol use within a particular social setting. In discussion about alcohol use (be it during pregnancy or generally), individuals will refer to others in their context as drinking the same as they do, as was evidenced in the study conducted by Watt et al. (2014). Personal responsibility for one's drinking is, therefore, limited (Guise & Gill, 2007; Niland et al., 2013). Furthermore, this discourse, in opposition to the notion of self-medication, defends drinking behaviour against stigmatisation. Given the fact that drinking is seen as a way to bond and have fun with one's peers, alcohol use by pregnant women and/or mothers is considered acceptable and strong judgement and social pressure against drinking is limited. Pregnant women and/or mothers who drink, as will be explored in more detail further on in this chapter, are heavily stigmatised because of their drinking. They, therefore, may feel the need to defend and justify their use of alcohol because of this stigma in order to avoid being labelled as bad mothers. When alcohol use is framed and constructed as an activity done as a group rather than on one's own, drinking behaviour is presented as part of the 'normal' social activities of peer groups and is therefore less problematised.

4. Experiences of support during pregnancy

Studies on social support and pregnancy can be divided into three categories, studies that: (1) examine the relationship between a pregnant woman's prenatal support and her pregnancy outcomes (e.g. Elsenbruch et al., 2007; Feldman, Dunkel-Schetter, Sandman, & Wadhwa, 2000); (2) explore the benefits of social support programs or interventions made available to pregnant women (e.g. Maimbolwa, Ahmed, Diwan, & Arvidson, 2003; Milgrom, Schembri, Ericksen, Ross, & Gemmill, 2011); and (3) focus on the presence of a supportive individual during delivery (e.g. Moyer et al., 2014; Kaye et al., 2014). Emerging research now explores the relationship between social support and various health behaviours such as drinking, smoking, and other substance use (e.g. Crawford-Williams et al., 2015; Donatelle, Prows, Champeau & Hudson, 2000; Hammer & Iglin, 2014; Meurk et al., 2014).

4.1 Women's experiences of healthcare

Research conducted with the aim of exploring pregnant and previously pregnant alcohol-consuming women's experiences of healthcare has mainly focused on these women's healthcare seeking practises (e.g. Abrahams, Jewkes, & Mvo, 2001; Ahmed, Creanga, Gillspie, & Tsui, 2010) including their use of antenatal and prenatal care services (e.g. Mrisho et al., 2009; Silal, Penn-Kekana, Harris, Birch, & McIntyne, 2012; Telfer, Rowley, & Walraven, 2002; Wabiri et al., 2013). The above studies have revealed that the utilisation of healthcare as well as antenatal and postnatal care services by these women is low. Various barriers have been identified as contributing to this. As with other studies (e.g. Finlayson & Downe, 2013; Simkhada, Van Teijlingen, Porter, & Simkhada, 2008) that have explored barriers to antenatal care for pregnant women, these studies have outlined similar barriers to care experienced by this population segment of pregnant women. These barriers include the women's proximity to the healthcare facility or the accessibility of the healthcare facility: many women in the above studies reported living very far from healthcare facilities and that there was a lack of and/or inadequate transport. The main barrier that these women regarded as preventing them from making use of available services at healthcare facilities was their experiences of interacting with healthcare providers including doctors, nurses, and midwives as well as staff.

With regard to these interactions, experiences were varied with both positive and negative experiences being reported. Positive experiences included descriptions of healthcare service providers and staff as caring, kind, gentle, supportive, and understanding (Abrahams et al., 2001; Telfer et al., 2002). Negative experiences included descriptions of healthcare service providers and staff as cold, ignorant, rude, as well as lacking understanding and knowledge about certain things such as the processes of pregnancy (e.g. foetal development) including the consequences of antenatal alcohol use (Abrahams et al., 2001; Ahmed et al., 2010; Telfer et al., 2002). Such negative experiences have mainly been documented in studies which explore the role of healthcare professionals in providing pregnant women with information about alcohol use during pregnancy.

Although some women may perceive healthcare providers as understanding why they had been drinking, a study conducted in Australia (e.g. Crawford-Williams, Steen, Esterman, Fielder, & Mikocka-Walus, 2015) among pregnant women, newly delivered mothers, and their partners found that midwives were very rude and judgemental of the women's behaviour (that of drinking during a current or previous pregnancy). Most women stated that this drove them away from the facility. Pregnant women who drank lightly or moderately in studies conducted in Switzerland (e.g. Hammer & Inglin, 2014) as well as in the United Kingdom (Raymond et al., 2009) felt that when it came to alcohol use during pregnancy, healthcare professionals provided advice that was conflicting

and unclear – some healthcare professionals endorsed low alcohol use during pregnancy while others recommended complete abstinence. In addition to this conflicting and unclear advice, a study conducted among Dutch midwives, pregnant women, and their partners (e.g. van de Wulp, Hoving, & de Vries, 2013) found that some healthcare professionals do not provide information or have conversations about alcohol use during pregnancy as the practitioners often assumed that women know that they have to abstain from alcohol when pregnant. The only instances where alcohol use during pregnancy would be spoken about would be when a pregnant woman admits to using alcohol or other substances during the pregnancy. However, such talks were described as informal and sporadic (van de Wulp et al., 2013).

Many pregnant and/or previously pregnant women as argued by Crawford-Williams et al. (2015) see healthcare professionals as trusted sources of information about alcohol use during pregnancy in that they are knowledgeable about the subject and provide helpful and useful information. As the studies discussed above show, this is not always the case. Pregnant and/or previously pregnant women may instead rely on their partners and/or family members for information and support about alcohol use during pregnancy.

4.2 Women's experiences of partner and/or family support

Most studies on social support have been conducted quantitatively with limited qualitative studies existing. These qualitative studies have focused specifically on the role partners and/or family members of pregnant and previously pregnant women play in either encouraging these women to abstain from alcohol and other substances during pregnancy or to continue drinking and making use of other substances while pregnant.

Meurk et al. (2014) argue that women whose partners and/or family members abstain from alcohol during their pregnancies live in what they refer to as "abstinence supportive social-environments" (p.6) further allowing them to have positive experiences of their pregnancies. This was made evident in Crawford-Williams et al's. (2015) study where some pregnant women and newly delivered mothers who were drinking and had drank during their pregnancies reported that their partners and/or family members showed support not only financially, but also by cutting back their drinking which made them consider their own drinking practices. Additionally, feelings of happiness were reported by these women when this had happened. These women further reported that they stopped drinking during their pregnancies because their partners and/or family members did the same.

In contrast to these findings, studies conducted by Homish and Leonard (2008) and Testa and Leonard (1995) found that the social network of pregnant women may not always support

abstinence from alcohol during pregnancy. Postpartum Native American and African American women in a study conducted by Branco and Kaskutas (2001) in Los Angeles California felt that their decision to abstain from alcohol when they were pregnant was a lonely choice as their family members, friends, and partners continued drinking despite their abstinence. The women further reported finding it difficult to abstain either because they felt lonely or because their partners drank excessively and they experienced some form of violence because of this. As such, they found themselves drinking again to avoid being lonely and to cope with the violence they had experienced. Similarly, findings from a study conducted by Watt et al. (2014) in a South African community have evidenced that although pregnant and non-pregnant women receive several anti-drinking messages which they deemed to be believable and understandable from multiple sources (e.g. nurses in clinics, family members such as mothers and grandmothers), the messages were not highly valued. The messages, as stated by the women, often contradicted what they had observed in their peer groups where it was reported that drinking while pregnant in the community was a common practice. Others mentioned that most of their friends drank while pregnant.

The above studies highlight the fact that the drinking behaviours of pregnant, and/or previously pregnant women cannot be understood in isolation. Their behaviours may be influenced by their social network, especially family and partners, and the social norms of heavy drinking in their communities. They may feel pressure to continue drinking because of their social group even though they may have decided to abstain (Branco & Kaskutas, 2001; Homish & Leonard, 2008; Testa & Leonard, 1995).

5. The context in which alcohol use during pregnancy takes place: Knowledge, attitudes, stigma, and discourse

Women's experiences of support including healthcare and partner and/or family support inform their different understandings, perceptions, and interpretations about engaging in the practice of alcohol use during pregnancy. These experiences have also informed pregnant, previously pregnant, and non-pregnant women's perceptions, attitudes, and beliefs with regard to alcohol use during pregnancy. In the following section, I review research focusing on these factors.

5.1 Research on attitudes, beliefs, knowledge and perceptions on alcohol use during pregnancy

Most research conducted with the aim of exploring and determining attitudes towards alcohol use during pregnancy has been quantitative (Raymond et al., 2009). Studies seek to measure the attitudes of specific categories of people or to compare them across a variety of factors such as educational level/attainment (e.g. Kesmodel & Kesmodel, 2002). This kind of research has been conducted mostly in Western contexts where pregnant women and those planning to be pregnant in

future are urged to abstain from alcohol. For example, studies have been conducted in Australia (e.g. Anderson, Hure, Kay-Lambkin, & Luxton, 2014; Jones & Telenta, 2012; Jones, Telenta, Shorten, & Johnson, 2011), France (e.g. Elek et al., 2013; Lelong, Kaminski, Chawlow, Bean, & Subtil, 1995; Toutain, 2010) and Switzerland (Hammer & Inglin, 2014). Attitude research has also been conducted in contexts where alcohol use during pregnancy is illegal such as Wisconsin (e.g. Centres for Disease Control and Prevention, 2002).

Studies where attitudes towards alcohol use during pregnancy have been measured among participants from one social category include those conducted among: pregnant women (Hammer & Inglin, 2014; Raymond et al., 2009), non-pregnant women (e.g. Peadon et al., 2011) partners of pregnant women, partners of non-pregnant women (e.g. Cohen et al., 2016), fathers of children with FASDs (e.g. Gearing et al., 2005), midwives and medical practitioners (Jones et al., 2011). Comparative attitude research has included studies that seek to compare attitudes between men and women attending drinking establishments (Eaton et al., 2014a) between abstainers and binge drinkers, and between primiparous and multiparous women (Kesmodel & Kesmodel, 2002). Research has also been conducted to explore the beliefs, knowledge, and perceptions non-pregnant, pregnant, and previously pregnant women have about alcohol use during pregnancy. A number of studies have explored pregnant women's beliefs about alcohol use during pregnancy (Eaton et al., 2014a; Lelong et al.,, 1995; Raymond et al., 2009) while others have explored both pregnant and non-pregnant women's knowledge of the risks associated with various levels of alcohol use during pregnancy (Kesmodel & Kesmodel, 2002; Peadon et al., 2011).

In a study conducted to explore the beliefs of pregnant and non-pregnant women attending alcohol serving establishments in Cape Town, South Africa, it was found that compared to non-pregnant women, pregnant women, were less likely to believe that they should not drink during pregnancy and that alcohol can harm the foetus (Eaton et al., 2014a). A study conducted among pregnant Danish women in an antenatal clinic found that most of these women believed that alcohol use during pregnancy is acceptable which is why they drank during their pregnancies (Kesmodel & Kesmodel, 2002). Similarly, a study conducted in France among pregnant and postpartum women found that some women upheld a number of misconceptions as they believed that when pregnant, drinking two drinks per day was reasonable and beneficial not only for themselves but also for the developing foetus (Lelong et al., 1995). In supporting this, most women believed that drinking during pregnancy could enhance the foetus' intelligence and behaviour.

In contrast to the above studies, findings from a study conducted in New Zealand among non-pregnant women showed that only a few women believe that there is no safe level of alcohol use

during pregnancy (Parackal, Parackal, Harraway, & Ferguson, 2009). In addition, the study conducted by Lelong et al. (1995) demonstrated that although some women believe that alcohol use during pregnancy is acceptable, most women know that engaging in this practice could have an effect on the developing foetus. A recent study conducted in Australia among non-pregnant and previously pregnant women obtained different findings (Peadon et al., 2011). The study found that only half of the participants have ever heard about FAS and these women were said to have a vague idea of the effects of alcohol use during pregnancy on the foetus including those of FAS and other FASDs. Those who claimed to have heard of FAS were said to be aware of the dangers of alcohol use during pregnancy but could not name any particular effects of FAS and other FASDs.

The findings of the above studies provide us with some insight(s) into non-pregnant, pregnant, and previously pregnant women's attitudes, knowledge, and perceptions about alcohol use during pregnancy and associated risks. However, as is evidenced in the discussion of these studies above, it is clear that these attitudes, beliefs and knowledge differ across contexts/countries. Most of these studies have also shown that knowledge about the dangers associated with alcohol use during pregnancy is not necessarily related to an individual's beliefs or level of alcohol consumption during pregnancy (Kesmodel & Kesmodel, 2002; Lelong et al., 1995). Raymond et al. (2009) argue that most pregnant women are hesitant to follow recommendations urging abstinence from alcohol during pregnancy and they may believe that some alcohol consumption during pregnancy is acceptable. This has led to the practice of alcohol use during pregnancy becoming highly controversial particularly when discussed in relation to motherhood.

5.2 Motherhood and alcohol use during pregnancy

Research about motherhood has mainly been conducted within a framework of cultural assumptions where numerous assumption about what constitutes 'good mothering' exist (Kruger, 2006). In this framework, motherhood and mothering are portrayed as self-sacrificing acts (Arendell, 2000; Mamabolo, Langa, & Kiguwa, 2009). Motherhood is viewed as being 'natural', 'normal' and desirable for all women with the act of having a child considered a crucial element of being a 'real' woman (Kruger, 2006; Mamabolo et al., 2009). Simply put, this framework makes motherhood obligatory for all women. According to Mamabolo et al. (2009), women who deviate from such standards, by deciding to remain childfree, pursuing a career or consuming alcohol during pregnancy and/or motherhood, have negative characteristics attributed to them. In this section, both the positive and negative constructions of motherhood will be explored in depth and discourses associated with motherhood will be discussed and critiqued in relation to the present study.

Pregnancy is a significant life event during which positive decisions with regard to health-related behaviours are often made and pregnant women often express a strong desire to create healthy and beneficial conditions for the development and growth of the foetus (Greaves & Poole, 2005). In studies conducted in Norway (Söderström, 2012) and the United Kingdom (e.g. Radcliffe, 2011) that include mothers and pregnant women undergoing treatment for substance abuse problems, participants reported that discovering that they were pregnant was a "turning point" (Radcliffe, 2011, p.986) or a "moment of change" (Söderström, 2012, p. 462) for them and this led them to reconsider their substance use and get help by undergoing treatment. Pregnant women who stopped drinking during their pregnancy, following a brief intervention in a study conducted in Boston Massachusetts (e.g. Chang, Goetz, Wilkins-Haug, & Berman, 2000), emphasised that a strong motivating factor in this decision was their desire to have a healthy baby. For most participants in the study, alcohol use during pregnancy was considered to be a practice that would hinder this desire to have a healthy baby (Chang et al., 2000). These studies have been said to support two problematic discourses namely, the discourse of responsible mothering as well as the discourse of competing rights (Baxter, Hirokawa, Lowe, Nathan, & Pearce, 2004; Benoit et al., 2014).

5.2.1 Responsible mothering and competing rights

By prioritising the health of the foetus over alcohol use during pregnancy, pregnant women draw on the discourse of responsible mothering which has been closely associated with the discourses of personal responsibility and liberal individualism (Jacques & Radtke, 2012). According to the discourse of responsible mothering, motherhood begins with pregnancy and comes with the obligation and responsibility to place and consider the needs of the foetus as primary (Jacques & Radtke, 2012; Kruger, 2006). In this discourse, mothers are positioned as being morally obligated to optimise and protect the health and well-being of the foetus and to place the foetus's needs before their own (Kruger, 2006). Further, this discourse according to Lupton (2011) portrays the desire of pregnant women to conform to the responsible mothering ideal. Studies conducted in Iowa (e.g. Baxter et al., 2004), the United Kingdom (Radcliffe, 2011) and South Africa (Watt et al., 2014) among women who were currently pregnant or recently postpartum who reported drinking during pregnancy have evidenced this. Some of the participants in these studies reported that the pregnancy opened up an opportunity for them to stop drinking as their desire to give birth to healthy babies motivated them to cease their drinking (Baxter et al., 2004; Radcliffe, 2011; Watt et al., 2014). This suggests that the participants perceived non-drinking during pregnancy as an imperative or moral obligation where drinking was portrayed as something that would prevent them from fulfilling their obligation as responsible mothers to ensure the good health and well-being of the foetus.

In contrast, women who were resistant to becoming mothers as well as women who did not express a strong attachment to the developing foetus' or the pregnancy as reported by Watt et al. (2014), continued to drink heavily during their pregnancies. This lack of attachment was closely associated with the fact that the pregnancy was unplanned and some participants reported heavy drinking during the early stages of their pregnancies in an attempt to abort the foetus (Watt et al., 2014). In such cases, it is important to note that the discourse of responsible mothering may not resonate with women who are having reservations about carrying the foetus to full term because if they feel obligated to put the needs of the foetus before their own, they may feel pressured to continue with a pregnancy for which they were unprepared or a pregnancy they do not want (Lupton, 2011). Furthermore, if they are unable to conform to the responsible mothering ideal, they may be overwhelmed with feelings of guilt and shame (Lupton, 2011).

Greaves and Poole (2005), in their paper about public responses to substance-using pregnant women, argue that the prioritisation of the health and well-being of the foetus has introduced another problematic discourse – the discourse of competing rights. Due to numerous developments continuously taking place in biomedical technology it has become possible to 'see' the developing foetus in the womb which has led to an improved understanding of the developmental needs of the foetus (Logan, 1999; Lupton, 2011). As Logan (1999) states, these developments have "legitimised a vision of the foetus as a 'second patient' reviving the notion of the mother as 'vessel' who merely provides a host environment for the growing embryo" (p. 131). Due to the above, there is debate about whether the foetus has "rights" that need to be protected (Flavin & Paltrov, 2010). Given such debates, the law, media, and the public often mainly focus on the health and well-being of the foetus, with that of the pregnant woman hardly ever being of concern. In other words, as argued by Flavin and Paltrov (2010), the rights of pregnant women, when placed in opposition to those of the foetus, are often placed second. Benoit et al. (2014) have confirmed this in a study they conducted in Canada among providers of a harm reduction intervention where it was found that the providers were very critical and judgemental of women who drank during their pregnancies, thus showing that the health and well-being of pregnant women is positioned as less important than that of the foetus.

A problem with the discourse of competing rights is that it disregards significant social problems such as limited access to healthcare services which is a considerable problem for some pregnant women (Flavin & Paltrov, 2010). In three studies conducted in South Africa (Abrahams et al., 2001; Silal et al., 2012; Wabiri et al., 2013) among pregnant women who utilise maternal health services and women who were pregnant or had a child, it was found that many pregnant women have limited access to healthcare services. Various barriers were identified: limited accessibility to healthcare

facilities due to living far, a lack of and/or inadequate transport, and negative experiences of interacting with healthcare providers. Further, the discourse fails to contextualise the experiences, health, and lives of pregnant women (Greaves & Poole, 2005). In other studies (Choi et al., 2014a; Eaton et al., 2014b), it was found that social problems pregnant women face go beyond limited access to healthcare. They also include a number of difficulties such as poor mental health, poverty, and trauma as well as multiple psychosocial stressors highlighted previously such as the infidelity of partners, physical and sexual abuse as well as unemployment. These are factors which are believed to contribute to drinking during pregnancy which have been discussed in a previous section of this chapter.

An inherent danger of both the discourse of competing rights and that of responsible mothering is that if too much attention is focused on the needs and rights of the foetus, attention will be detracted from the health and well-being of the pregnant woman including the social context in which the practice of alcohol use during pregnancy needs to be understood (Greaves & Poole, 2005; Sun, 2014). It is of paramount importance to note that both these discourses have given rise to a dichotomy between women who drink during pregnancy who come to be labelled as bad mothers and those who do not as good mothers, stigmatising women who engage in this practice (Poole & Isaac, 2001). This dichotomy is explored in-depth below.

5.2.2 The bad mother versus the good mother: The stigma surrounding alcohol use during pregnancy

According to Conners et al. (2004), pregnant women and/or mothers who have alcohol or any other substance use problems may not be able to meet the needs of their children, thus putting these children at risk of academic, physical, and social-emotional problems. These women have come to be labelled as ‘bad’ and/or ‘unfit’ mothers (Reid et al., 2008). In a study conducted by Gueta and Addad (2013) among mothers in different stages of recovery from drug addiction, the women were further considered to be selfish and irresponsible where labels such as ‘monster moms’ and ‘failed women’ were given to them as well. The ‘bad mother’ discourse dominates public discourses on substance-using pregnant women and mothers. It positions pregnant women or mothers as posing threats both to their communities and children. The bad mother is viewed as adding to social decline as their children require extra educational and health assistance (Bell, McNaughton, & Salmon, 2009; Reid et al., 2008). This finding was echoed in a study conducted by Jacobs and Jacobs (2014) in South Africa among women from the Alcoholics Anonymous (AA) organisation who reported that when they had been drinking they felt they were unable to fulfil their motherly duties which included attending to their children’s needs and taking care of them.

Reid et al. (2008) argue that a problem with the bad mother discourse is that not only is it harmful to women, but the label is assigned to those who could be poorly treated when using governmental services. In addition, women, like those in the study conducted by Jacobs and Jacobs (2014), may internalise the label. A consequence of both the assignment and internalisation of the 'bad mother' label, as argued by Green, Cook, Racine and Bell (2015) and Greaves and Poole (2005), is that it may serve as a barrier to accessing interventions and other services that would contribute to an improved quality of life for both the pregnant woman and the developing foetus. Pregnant women who consume alcohol experience judgement from healthcare professionals and others which gives rise to a lot of guilt, shame, and secrecy. This often exacerbates the existing barriers in seeking treatment and may lead many women to not make use of available services, which compounds the difficulties they face. However, this label, like the discourses of responsible mothering and personal responsibility, fails to take into account the contextual and structural factors that contribute to "bad mothering," framing the behaviour as an individual choice without locating it within the broader social context.

As highlighted above, the belief that alcohol use during pregnancy and/or motherhood prevents good mothering and the desire of many women to be good mothers falls within a broader gendered discourse within which the natural and instinctual position of a woman is to be a mother (Gueta & Addad, 2013). Since the 19th century "motherhood and womanhood have been constructed as synonymous identities" (Gueta & Addad, 2013, p. 34). Desiring to be or being a mother, as argued by Arendell (2000) and Jacques and Radtke (2012), has been viewed as a dominant influence in the lives of many women and is presumed to be the primary identity of most adult women. The good mother, within a normative motherhood framework, is characterised as someone who is instinctual, protective, and self-sacrificing including someone who is firmly dedicated and devoted to caring and meeting the emotional and physical needs of her children (Arendell, 2000).

The good mother discourse, like that of responsible mothering can be drawn upon in a positive way by some pregnant women or mothers as was evidenced in the study conducted by Jackson and Shannon (2013) where most of the women reported that their desire to be good mothers motivated them to stop drinking. Nevertheless, taking note of the limitations of this discourse as well as the ideal of motherhood in its complexity is important. Given the fact that motherhood is conceptualised as something that is meant to be instinctual and natural, women are expected to find the experience naturally rewarding and have a maternal instinct to care for and love their children, making it difficult for women to express feelings of anger, disappointment, dissatisfaction or frustration which they may have because of the mothering experience (Gueta & Addad, 2013; Mamabolo, Langa, & Kiguwa, 2009). In addition to the above, as argued by Kruger (2006), women

run the risk of being pathologised if they do not find the mothering experience fulfilling and rewarding.

The ideology of the "good mother" sets high standards for pregnant women and mothers as it expects them to be selflessly devoted to their children and to meet all their needs. In cases where women do not live up to this ideal (by drinking during pregnancy and/or motherhood, for example), they are made to feel as if they are unfit mothers as they are seen to deviate from societal norms and are stigmatised on the basis of their failure to fulfil their gendered reproductive role as mothers (Greaves & Poole, 2005; Reid et al., 2008; Sanders, 2012; Stegel, 2014). In addition, they may be at risk of being publicly shamed and punished for their actions. In a study conducted by Young (1994) in the United States, for example, extreme measures against pregnant addicts such as criminal prosecution have been taken. Another limitation of the good mother discourse, as highlighted by Eddy, Thompson-de Boor, and Mphaka (2013) in their study conducted in Johannesburg South Africa among fathers who were absent from the lives of their children, is that this discourse perpetuates the idea that women should be the primary caregivers of children. Men, on the other hand, are expected to be financial providers – a factor which may prevent them from occupying a caregiving role in the lives of their children. In order to evidence the foundation of the constructions related to alcohol use during pregnancy highlighted in the above sections, this discussion now turns to the gendered nature of alcohol use which has informed dominant discourses about this practice.

6. Power relations: The raced, classed, and gendered nature of alcohol use

In looking at power relations related to alcohol use, it is important to note that the classed and racial nature of alcohol use needs to be considered. There are however, few studies which explore these power dynamics.

Most research that has explored the racial nature of alcohol use has been conducted among men (e.g. Jones-Webb, Snowden, Herd, Short, & Hannan, 2015) whereas in studies conducted among women, race is rarely highlighted as a factor contributing to alcohol use (e.g. Leonardson et al., 2007). Some studies (e.g. London, 2000; Urban et al., 2015) have indicated that alcohol use, particularly during pregnancy, is a practice in which 'Black' and 'Coloured' women mainly engage. This may, however, be because most studies about alcohol use during pregnancy have been conducted predominantly among 'Black' and 'Coloured' communities in South Africa, particularly in various areas of the Western Cape. While alcohol use during pregnancy among 'White' women has been explored (Hammer & Inglin, 2014), more studies are needed among these women as well as studies that have a combination of participants from various racial groups.

With regard to the classed nature of alcohol use, studies have been limited to looking at the role of employment and unemployment in alcohol use where it has been found that heavy binge drinking is common among poor people predominantly those who are unemployed or who earn a very small income (e.g. May et al., 2011; Peadon et al., 2011). Such findings have been challenged where other scholars (Ethen et al., 2009) have argued that such drinking practices are also common among those who are rich and employed and who earn a good income. To date, no studies have clarified or disputed these findings.

For the present study, power dynamics in alcohol use during pregnancy must particularly be seen in the context of gendered power relations. According to De Visser and McDonnell (2012), alcohol use (particularly heavy alcohol use) has predominantly and traditionally been considered a male or masculine activity where being able to drink heavily and hold down one's liquor have been regarded as important elements of masculinity. Although this is the case, young women's drinking has increased over the years and has resulted in multiple gender double standards around alcohol use (De Visser & McDonnell, 2012). In contrast to the alcohol consumption of men, women who drink heavily are often positioned as unfeminine due to the fact that their alcohol use can result in engagement in 'unwomanly' conduct such as impaired maternal behaviour and sexual disinhibition which may lead to unplanned pregnancies as well as other unfeminine behaviours such as arguing and fighting or putting oneself in potentially risky situations (De Visser & McDonnell, 2012; Lyons & Willott, 2008). In the study conducted by Rolfe et al. (2009), women heavy drinkers were further labelled as 'manly women' and 'women out of control' and were also considered to be lacking respect for themselves. Similarly, a study conducted by Månsson (2014), in which an analysis of fashion reports from six Swedish magazines was conducted, it was found that in the media, women who drank were labelled as 'irresponsible', 'disturbing', and behaving "like men".

In arguing that female drinking leads to sexual disinhibition, the discourse of vulnerability is brought up where women are positioned as being in danger in cases where they are intoxicated, particularly in danger of being physically and sexually assaulted by men (De Visser & McDonnell, 2012; Lyons & Willott, 2008). Like the discourse of patriarchy, the discourse of vulnerability creates an imbalance between men and women where the position occupied by men is a controlling and dominant one with women occupying a passive and vulnerable position. The discourse of vulnerability also emphasises the fact that alcohol use, as argued by Jewkes (2002), is associated with increased risk of interpersonal violence in all its forms inclusive of sexual assault.

Although alcohol use by women has been closely associated with vulnerability, a study conducted by Watt et al. (2012) in South African drinking venues to better understand the practice of

exchanging alcohol for sex found that women who drink and engage in transactional sex believe that this practice provides them with a greater sense of control over their lives and sexualities. It allows them to gain access to resources such as money which they use to buy household items like food and to take care of themselves. This challenges both the discourses of vulnerability and patriarchy. While participants in the study challenge the two discourses, the fact that the practice of transactional sex reinforces the commoditisation and undervaluing of women as well as the fact that the practice puts women at risk of rape and contracting HIV are important factors that cannot be ignored (Watt et al., 2012). In the study conducted by Månsson (2014), the analysis also revealed that the media is slowly beginning to represent female drinking as an important part of modern and successful femininity, thus making positive representations of women who drink possible.

Despite the possibility of positive representations of women who drink, pregnant women and/or mothers who drink are positioned as unfeminine because they have been regarded as breaking traditional gender roles (Guetta & Addad, 2013). In this case, the gender role alcohol consuming women break is that of being a mother, particularly a good and responsible mother. Traditional discourses of femininity expect women to remain responsible and in control and alcohol consuming women are considered to be lacking such qualities (De Visser & McDonnell, 2012). This is why alcohol use during pregnancy is highly problematised and stigmatised as highlighted in the section of the good mother versus the bad mother.

7. Summation

Like all other practices, alcohol use during pregnancy is a social practice constructed in certain ways and invested with specific meanings. As suggested by Baxter et al. (2004) and Benoit et al. (2014), constructions of alcohol use during pregnancy cannot be considered in isolation from dominant discourses of motherhood which inform and shape them.

This chapter started off by looking at research about the various factors contributing to alcohol use during pregnancy and research about women's self-provided reasons for drinking during pregnancy. Research in the area has shown that multiple factors contribute to alcohol use during pregnancy and can be grouped into four interconnected categories: biological, demographic, socioeconomic and psychological factors. It has also demonstrated that for some women, drinking during pregnancy is a way of coping while for others drinking is a social and pleasure-filled activity, thus forming an important part of an individual's social links and relationships.

The discussion then turned to research on women's experiences of alcohol use during pregnancy, particularly those related to healthcare as well as partner and/or family support. Research in this

area has shown that women's experiences of healthcare as well as partner and/or family support differ with both positive and negative experiences being reported.

The chapter then looked at research most relevant to this study: research on the context in which alcohol use during pregnancy takes place. Research about attitudes towards alcohol use during pregnancy was discussed. Various attitudes, beliefs, and perceptions about alcohol use during pregnancy exist. While some women uphold misconceptions about alcohol use during pregnancy, some are aware of the fact that alcohol use during pregnancy can affect the developing foetus in multiple ways. In this section, the link between alcohol use during pregnancy and motherhood as well as the dominant discourses within this link were explored.

Lastly, the chapter looked at power relations, particularly the gendered nature of alcohol use. The unequal positioning of men and women was highlighted as well as why the practice of alcohol use during pregnancy has been problematised and stigmatised despite women challenging discourses which frame their alcohol use as an unfeminine practice further positioning them as vulnerable (Månsson, 2014; Watt et al., 2012). In the following chapter, I discuss the theoretical underpinnings of the present study.

Chapter Three: Theoretical Framework

1. Introduction

Forming the central problematic of this research are the discourses drawn upon to construct narratives about the journey of a pregnancy, the subject positions enabled in these narratives and discourses, and the gendered power relations referred to in these narratives and discourses. Given this problematic, this chapter begins with a discussion of the overarching paradigm of this research, social constructionism. I will then discuss feminist poststructuralism/poststructural feminism, drawing from the work of Nicola Gavey (1989, 1996) and Chris Weedon (1987). Following this discussion, the key concepts that I draw on and the criticisms of this theory will be discussed in depth. Lastly, this chapter will argue why this theory is appropriate for the present study.

Before proceeding to the discussion on social constructionism, it is important to clarify a few issues about this paradigm. For some scholars, social constructionism is used as a label for a collection of different theoretical approaches that "exist side by side" (see Edley, 2001b, p.433). Poststructuralism, for these scholars, is seen as a form of social constructionism. For other scholars (Phelan, 1990), social constructionism and poststructuralism are seen as the same thing and, as such, it is argued that they can be used interchangeably. In line with the former argument, I first discuss social constructionism and then proceed to poststructural feminism given post structuralism's emphasis on power relations which is not foregrounded in all forms of social constructionism. In discussing the assumptions and features of social constructionism, I draw on the work of various writers.

2. Social constructionism

According to Burr (1995), the first assumption of social constructionist approaches is that knowledge is not a direct reflection of social reality "out there". This means that social constructionists oppose the positivist view that "knowledge maps or mirrors the actualities of the real world" (Gergen, 1985, p.269) and the view that "reality is both prior to and independent of representation" (Edley, 2001b, p.435). In rejecting these views, social constructionist approaches, especially those referred to as poststructuralist, share the understanding that an arbitrary relationship exists between the words we use to refer to objects (the 'signifier') and the objects themselves (the 'signified') (Edley, 2001b). Put in simple terms, these approaches emphasise the fact that the words used for particular objects do not refer to some meaning or essence contained within the object (Burr, 1995). Based on this view, social constructionist approaches can therefore be said to be anti-essentialist as they reject the notion that objects have 'essences' (Burr, 1995). This means that no

direct relationship exists between the signifier and the signified in a language system of similarity and difference because a particular word can only rely on another for its meaning (Burr, 1995; Edley, 2001b). That is, language cannot refer to the nature of the word but can only refer to itself. Representation, then, for social constructionists is seen as being prior to reality as language produces reality in that it constitutes it (Terre Blanche & Durrheim, 1999). If language does not reflect an external and objective reality (as maintained by positivist approaches), a fixed reality beyond and outside of language does not exist (Terre Blanche & Durrheim, 1999) but reality is seen to be "both the subject of and the result of what talk is about" (Edley, 2001b, p.435). For social constructionists, therefore, a critical stance towards taken-for-granted knowledge is crucial.

The second assumption of social constructionist approaches is that knowledge is culturally and historically specific (Burr, 1995). That is, ways of understanding the world vary according to culture and time period or rather, where one lives in the world and when. This, therefore, implies that the meaning of a particular social practice (for example, alcohol use during pregnancy) depends largely on the culture and the historical period or specific time in which it occurs (Burr, 1995; Terre Blanche & Durrheim, 1999). Simply put, this assumption of social constructionist approaches emphasises the fact that the meanings associated with social practices are not static but change and shift across cultures and over time and within specific cultures and time periods. Knowledge is therefore regarded as being constructed in everyday interactions between people (Burr, 1995). In taking this assumption further, the idea of a single reality, 'truth' or essence is rejected by social constructionists and the view that multiple versions of reality or 'truth' exist is emphasised.

The third and final assumption shared by social constructionist approaches is that knowledge and social action are intertwined (Burr, 1995). By using language, some kind of social action is performed and as argued by Gergen (1985), "descriptions and explanations form integral parts of social patterns" (p.268). According to Edley (2001b), this assumption has to do with the understanding that "any attempt to describe the nature of the social world is subject to the rules of discourse" (p.437). In constructing an object or social practice in a particular way, certain types of social action are encouraged and others discouraged. For example, the construction of alcohol use during pregnancy as a practice/act that prevents good mothering has consequences for those engaging in this practice: women who find themselves in difficult circumstances or believe that drinking when pregnant helps them deal with stress may need to develop strategies (e.g. secrecy) to not be positioned as bad mothers. In elaborating on the idea of language as social action, social constructionist approaches argue that social arrangements and practices are maintained and organised through discourses (see later discussion on this concept) and can further be transformed through discourse (Burr, 1995; Terre Blanche & Durrheim, 1999).

3. Feminist poststructuralism/Poststructural feminism

Feminism is not comprised of one single feminist theory and because of this, feminist theories each have their own unique epistemological standpoints (Harding, 1986). Boonzaier and Shefer (2006) and Harding (1986) distinguish between three epistemological standpoints within feminism namely, feminist empiricism, feminist standpoint theories, and feminist poststructuralism. As the present study is rooted in a feminist poststructuralist epistemology, focus will only be on this approach.

3.1 Basic tenets of feminist poststructuralism/poststructural feminism

Poststructural feminism is defined by Weedon (1987) as "a mode of knowledge production which uses poststructural theories of language, subjectivity, social processes and institutions to understand existing power relations and identify areas and strategies for change" (p.40). Simply put, a poststructural feminist approach focuses on the relation between language, subjectivity, social organisation, and power (Price & Cheek, 1996). Further, it is a means of exposing, changing, and understanding hierarchical social networks that use power to marginalise and silence discourses related to gender (Buzzanell & Lui, 2005; Engoren, 2002). In doing so, it opens up everyday practices and structures to scrutiny by transcending the individual-social divide, regarding individuals as immersed within the social world rather than separate from it. Reality within this approach is thus considered to be socially constructed – the experiences of women are specific in the cultural and historic context and are a product of interaction between an individual and others.

The 'essence' of a feminist poststructuralist approach is captured by Boonzaier and de la Rey (2003) in the following quote:

> "A poststructural feminist approach acknowledges that there are multiple interpretations of any given situation and that language offers various subject positions. Individuals through talk and various actions situate themselves within particular discourses and take up various subject positions by drawing on social, cultural, and historical resources" (p.1005).

From the above, it is evident that the possibility of absolute truth or objectivity is rejected by poststructural theory. As such, a poststructural feminist approach contends that individuals and practices (e.g. women who consumed alcohol during their pregnancy in this case) are not the outcome of social production processes that result in a fixed end product but are constituted and reconstructed through various discursive practices in which individuals participate (Gannon & Davies, 2012). In addition to seeing reality as being socially constructed, a poststructural feminist approach considers reality to be transient, and momentarily unstable: there are a few, if any

universal truths (Boonzaier & de la Rey, 2003). Furthermore, knowledge in this approach is understood to be closely associated with power (Gavey, 1989; Weedon, 1987).

The key concepts within poststructural feminism that I draw on include narratives, discourses, subject positioning/subject positions, and power relations specifically gendered power relations. An in-depth discussion of each of these key concepts follows.

3.2 Narratives

The decision to discuss this key concept of poststructural feminism first rests on the fact that in this study, narratives are a key avenue through which discourses, subject positions, and power relations are deployed. As such, it is important to discuss what narrative entails before discussing other theoretical concepts. Phoenix (2008) argues that as a research method, narrative psychology is relatively new but also diverse and popular. Narratives, according to Reissman (1993, as cited in Willig, 2013), are stories told by people about their experiences drawing from a social world known to them. Similarly, Jovchelovitch and Bauer (2000) argue that narratives are "stories with words and meanings" (p.58) that are associated with particular communities and social groups which inform the experiences and way of life of these communities and groups.

From the above definitions, it is clear that narratives allow us to make sense of our lives and "enable human experiences to be seen as socially positioned and culturally grounded" (Hiles & Čermák, 2008, p.148). That is, narratives reflect the wider culture (such as that of a society dominated by a 'drinking culture') as the stories we tell are informed by our social context (or where we come from) including the experiences we have had which are culturally and socially located. Further, when constructing a narrative, especially in the context of a research interview, multiple, small and interrelated micro-narratives are produced (Fok, 2011). Fok (2011) refers to micro-narratives as "small personal stories" (p. 503) constructed in telling a narrative.

My use of the term (narratives), as mentioned previously in chapter one, follows from Taylor (2006) and Taylor and Littleton (2006) who refer to narratives as stories people construct around a consequence and sequence of events for a particular purpose. Taylor (2006) argues that expressions like 'so' evidence consequence while 'next' or 'then' evidence sequence. This definition is important because it shows that narratives, as has been traditionally argued, are not only made up of sequence but also consequence (Taylor, 2006). This means that in telling stories, we do not simply talk about or describe events as they happened; we also focus on the effects of certain experiences and events in our lives.

In addition to seeing narratives as made up of consequence and sequence, Taylor (2006) and Taylor and Littleton (2006) see narratives as both a construction and a discursive resource. Narratives are considered constructions as they delineate the broader social meanings available in particular contexts (Taylor, 2006). As argued by Hole (2007) "cultural representations and language are tools with which we construct meanings of lived experiences" (p.699). In constructing narratives or telling stories, individuals draw upon various discursive resources (I discuss this concept shortly) to produce narratives that are contextual(ised) and local to their experiences (Burr, 1995; Hole, 2007; Taylor, 2006; Terre Blanche & Durrheim, 1999). As a resource, speakers employ narratives in order to accomplish a particular discursive purpose such as to argue, blame, or convince (Smith & Sparkes, 2008). In this study, therefore, narratives help us examine how alcohol use during pregnancy is assigned meaning through the various discursive resources drawn upon to construct the narrative, and is linked to cultural and social discourses and practices.

3.2.1 Discursive resources

Discursive resources, according to Taylor and Littleton (2006, as cited in Morison, 2011), include "sets of meanings, metaphors, representations, images, stories, statements, and so forth" (p.102). Defined simply, discursive resources are 'tools' that are commonly available which are used in constructing individual narratives. They entail dominant socio-cultural understandings existing in a particular context in which the narrative is located and those existing in the discursive language practices of a society (Morison & Macleod, 2013). In constructing narratives, as noted previously, individuals draw upon various discursive resources which are available to them existing in a particular culture so as to formulate contextual and localised narratives about a particular event, experience, or person (Burr, 1995; Hole, 2007; Taylor, 2006). As a resource, narratives consist of broader socially and culturally available meanings including what Bruner (1987) calls canonical narratives.

3.2.2 Canonical narratives

Canonical narratives are a type of discursive resource available to speakers which provide them with culturally established ways of describing experiences and life events (Bruner, 1987; Taylor & Littleton, 2006). As argued by Taylor and Littleton (2006), they contain "expected connections of sequence and consequence" (p.23) and provide an idea that is culturally familiar of "how a life "should" unfold or at least one way for it to do so" (p.33). Similarly, Bruner (1987) argues that canonical narratives "reflect the prevailing theories about "possible lives" that are part of one's culture" (p.694).

To illustrate, Taylor and Littleton (2006, p.24) speak of the "dominant coupledom narrative" as an example of a canonical narrative which involves "the story of life which progresses through the stages and events of coupledom, getting married and becoming parents". From this example, it is evident that some similarity exists between canonical narratives and discourses as they both provide individuals with culturally familiar ways of describing events, experiences, and phenomena in their lives (Taylor & Littleton, 2006). Canonical narratives, however, differ from other discursive resources as they provide patterns of sequential ordering with distinct endpoints that are socio-culturally established. Given such, canonical narratives thus "provide a logic for talking about personal circumstances, life stories and decisions" (Taylor, 2006, p.97).

3.3 Discourses

Van Dijk (1997) argues that "the notion of discourses is essentially fuzzy" (p.1). This means that the term discourse is used in different ways and is conceptualised differently depending on its usage. Thus, it is necessary for the term to be defined. In this study, I use the term discourse as it has been conceptualised in poststructuralist writings. As such, the following definitions (each making evident central defining characteristics of discourse) are utilised. Hollway (1983, as cited in Gavey, 1989) defines discourse as an "interrelated system of statements which cohere around common meanings and values [that] are a product of social factors, of powers and practices, rather than an individual's set of ideas" (p.463-464). From this definition, it is evident that discourse is situated or varies both across and within cultures as well as over time and is therefore not fixed or static (Burr, 1995; Edley, 2001a). Discourse has been defined by Phelan (1990) as "the body of rules which define and limit the sorts of statements that we can make" (p.422), thus emphasising the regularity of discourse. For Schiffrin (1994), "discourse is viewed as a systematic (a socially and culturally organised way of speaking) through which particular functions are realized" (p.32) highlighting another important aspect of discourse: discourse is action oriented or rather produced in a certain way to accomplish and achieve specific actions (Terre Blanche & Durrheim, 1999). In essence, discourses provide a system of meaning for acting, experiencing, and understanding the world.

As the term discourse is conceptualised and used differently, Macleod (2002, p.18) in her discussion about discourse argues that three features are central to the various conceptualisations of discourse: (1) discourse has an underlying regularity; (2) discourse has constructive effects; and (3) discourse has "implications in terms of meanings and practices". The argument that discourse has an underlying regularity suggests that within a discursive group, statements around a particular topic arise based on culturally available understandings of that topic (Macleod, 2002). These statements, as Macleod (2002) argues, are "achieved over time and within particular contexts of

power relations" (p.18). In other words, it is on the basis of power relations that discourses are transformed. Discourses are said to be constructive because "they do not simply describe the social world but are the mode through which the world of 'reality' emerges" (Macleod, 2002, p.18). Potter and Wetherell (1987) add an additional dimension as they argue that discourses are not only constructive but also functional. In elaborating on this feature, Potter and Wetherell (1987) argue that "people use language to do things" (p.32) although this may not be evident to them. Language also functions to "construct versions of the social world" (p. 33). They argue that the constructive and functional nature of discourse enables variation in talk as an individual's talk will vary based on the function or purpose of the talk (Potter & Wetherell, 1987). Acknowledging variation in talk and in the meaning of language is central to a poststructural feminist approach as it emphasises that individuals are not to be viewed as rational, unitary beings who provide fixed or static versions of themselves in the world (Gavey, 1989; Weedon, 1987). With reference to this study, for example, the same person/participant, in order to achieve a variety of functions in their talk, may provide differing versions of the social world and the practice of consuming alcohol during pregnancy and draw upon contradictory discourses. In a Foucauldian sense, discourses have "implications in terms of meanings and practices" as they should be deconstructed in an attempt to uncover their underlying meanings so as to disrupt "dominant taken for granted notions of a subject" (Dant, 1991, as cited in Macleod, 2002, p.18).

From my reading around discourses, two other important features of the term emerged. The first is that discourses are imbued with power (Macleod, 2002; Parker, 1992). That is, discourses reflect existing power relations and inequalities and construct and reproduce power imbalances. In Parker's (1992, p.17-20) seven characteristics for distinguishing discourses, three criteria emphasise this feature: (1) "discourses support institutions"; (2) "discourses reproduce power relations"; and (3) "discourses have ideological effects". Going back to the characteristic of variation in talk, it is important to emphasise here (as is done in Hollway's definition) that discourses are contextual and historical and change over space and time (Parker, 1992; Potter & Wetherell, 1987). Given such, discourses construct, reflect, and reconstruct certain power positions and relations in a particular context and therefore cannot be reified as universal versions of power.

The second feature also related to that of power is that discourses construct, reflect, and reproduce resistance (Parker, 1992). Resistance in discourse analysis, according to Parker (1992), is seen as a "refusal of dominant meanings" (p.18) while for Hollway (1984), it refers to the emergence of 'new' or 'alternative' discourses (p.260). As much as discourse constructs, reflects, and reproduces power imbalances, it presents alternative, challenging, contradictory, and transgressive accounts to dominant and hegemonic discourses (Burr, 1995; Gavey, 1989; Weedon, 1987). This resistance in

poststructuralist work creates contradictions between and in discourses and subjects, thus facilitating change.

As discourse is functional including the possibility of discourse reproducing resistance, Macleod (2002) argues that “it has a dual character simultaneously constructing and restricting what can be known, said, or experienced at any particular socio-historic moment” (p.18). This dual nature of discourse results to the positioning of subjects in discourse (Weedon, 1987) where certain subject positions are enabled and others are disabled or invalidated.

3.4 Subject positioning

According to Langenhove and Harré (1999), subject positions emerge and are identified by focusing on the discourses manifested between individuals and by noticing the effects that the discourses have. The use of discourses, therefore, creates subject positions and the available positions depend on the individual’s understanding of the discourse (Burr, 1995). Davies and Harré (2007), whose work will be relied on in this discussion, define subject positioning as “the discursive process whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced story lines” (p.15). Simply defined, subject positions can be referred to as ‘locations’ or ‘slots’ within narratives and discourses (Burr, 1995; Edley, 2001a). They are identities in which people place themselves and/or others through the use of language in talk. The process by which individuals position themselves during talk is referred to as reflexive positioning (Davies & Harré, 2007). In contrast, the process by which individuals position others is referred to as interactive positioning (Davies & Harré, 2007). Positions may be taken up or rejected.

In addition to defining subject positioning, and in line with the argument made by Langenhove and Harré (1999), Davies and Harré (2007) link positioning to discourse. In doing so, they acknowledge the fact that people are both products of and producers of discourse. In the social constructionist sense, they are products in that their identities “come to be produced by socially and culturally available discourse” (Burr, 1995, p.140). They are producers in the individual sense in that they “manoeuvre in the prevailing discourses” (Burr, 1995, p.141). The use of narratives and discourses in social interaction thus creates various subject positions and positioning refers to this process of negotiated identity and account construction (Langenhove & Harré, 1999).

Additionally, in linking positioning to discourse, Davies and Harré, (2007) argue that the positions available within narratives and discourses bring with them a ‘structure of rights’ (p.6). This means that each subject position not only provides a sense of “who we are” (Burr, 1995, p.141) but also provides the possibilities and limitations for action within a particular narrative and discourse (Davies & Harré, 2007). Different constructions of an interaction can thus offer different subject

positions which include different obligations, possibilities, and rights for action (Burr, 1995). As narratives and discourses allow for the positioning of subjects to take place in talk, the notion of positioning makes multiple subjectivities possible. Subject positions therefore have implications for power relations as they limit what an individual can say or do when positioned in a particular way (Davies & Harré, 2007). Simply put, individuals are exposed to a multiplicity of narratives and discourses which construct a variety of subject positions, structure of rights, obligations, and possibilities of action, each carrying different power implications.

3.5 Power relations

Power has traditionally been regarded as essentially negative and as something that holds us back or constrains us (Burr, 1995; Sawicki, 1986). This traditional view Foucault (1987) refers to as the "juridico-discursive" (p.82) conception of power and is underpinned by three basic assumptions: (1) power is a possession or is possessed by a class, by individuals in the state or by the people; (2) power flows from a central source from top to bottom and (3) power is primarily restrictive or repressive in its exercise (Sawicki, 1986). In *The History of Sexuality Volume 1*, Foucault (1978) criticises this view of power as, for him, it describes one form of power ignoring other various forms of power relations that exist in society. Further, Foucault argues that this view disregards the agency and freedom of individuals as well as the way in which they can resist relations of power/power relations in an attempt to transform their lives (Cooper, 1994; Jackson & Mazzei, 2012).

In his theory of power[3], Foucault (1978) was interested in how power was exercised. He focused particularly on the mechanisms used to gain power as well as the effects of power rather than who was exercising power and over whom. As such, he provides an alternative model or rather a productive model (Mills, 2004) which views power in four key ways. For Foucault (1978), power is exercised rather than possessed, power is described as productive rather than purely repressive, it is not centralised but exists throughout all social relations and most importantly, it brings about the possibility of resistance. In this section, I discuss Foucault's conceptualisation of power based on these four key tenets, illustrating how the productive model of power is useful for the present study with reference to analysing the narratives and discourses drawn upon for gendered power relations.

First, power for Foucault (1978) is not a resource that belongs to groups or individuals where if some have more power, others will automatically have less and vice versa. Rather, as argued by Barrett (1991, as cited in Cooper, 1994), it is "incorporated into numerous practices" (p.437). Power

[3] In the *History of Sexuality Volume 1*, Foucault (1978) argues that his conceptualization of power is more of an 'analytics' rather than a theory of power. I am more comfortable with using the latter due to the simplicity it provides me with when understanding the way in which Foucault (1978) conceptualizes power.

is exercised by people through the effects their actions have on those of others (Cooper, 1994; Foucault, 1978). In the context of alcohol use during pregnancy, for example, the drinking behaviours of partners, peers, friends, and family members who live with or are regularly around the individual drinking may lead a pregnant woman to drink or consume alcohol while pregnant. Power in this sense thus operates by structuring the field of choices, decisions, and practices.

In expanding the argument that power is exercised rather than possessed, Jackson and Mazzei (2012) and Foucault (1980) argue that individuals are simultaneously undergoing and exercising power; they are not sites of power application nor are they an endpoint of power; rather, as stated by Foucault (1980, p. 98), they are the "vehicles of power" and "the individual is an effect of power… [and] the element of its articulation". The reason, as argued by Foucault (1980), is because power has the ability to reach "into the very grain of individuals, [it] touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives" (p.39). In addition to this point, it is important to note that power can work from, on, and through people (Jackson & Mazzei, 2012). It does not only oppress them but can be negotiated and resisted (using techniques such as accusations and denials) in various discursive environments such as among a group of friends, in a family, at home, or in a *tavern*.

The second tenet of Foucault's (1978) conceptualisation of power is the notion of power as productive. That is, power, as mentioned previously, is not regarded as a possession but is rather regarded as something which dictates what constitutes 'normal' or 'abnormal' and 'acceptable' or 'unacceptable' behaviours (Mills, 2004). As such, power relations create particular kinds or types of behaviours and subjects rather than only repressing them. This type of power (productive rather than repressive) motivates people to behave in a certain fashion, giving people the competence to act "in this fashion without necessarily having an iron fisted approach or utilising a sheer dominating force" (Purdy, 2015, p.5). Given such, Foucault (1978, 2000b) argues that power operates in anonymous, invisible, and subtle ways. That is, it is not constituted by force or violence but rather acts to constrain possible actions. In the exercise of power, violence is not necessary and is not synonymous with power. However, it can be used as an instrument or tool in the exercise of power (Foucault, 2000b). Furthermore, as Jackson and Mazzei (2012) argue, "power is employed and exercised through a net-like organisation" (p.56). That is, it forms a chain that is dependent on relations between people to advance, branch out, and multiply into social networks. As networks of social, cultural, and material power relations connect and disconnect, conditions or rules for living in the world are produced and regulated.

In arguing that power is productive, Foucault thus emphasises the fact that power is normalising – it turns us into people who automatically (by our own will) do what is socially acceptable in particular contexts without forcing us to do certain things. To illustrate the productive and normalising nature of power, Foucault (1975), in his book *Discipline and Punish: The Birth of the Prison*, uses Jeremy Bentham's notion of the panopticon "as an "ideal type" of structure of power relations between people" (Purdy, 2015, p.5) where everyone is watched without them knowing. The panopticon, thus, is a metaphor for individuals internalising social norms to produce self-monitoring subjects (Cooper, 1994). As mentioned previously, force is rarely required to maintain societal standards as individuals in society ensure their own conformity to societal norms. In the context of alcohol use during pregnancy, power can be productive in two ways. The existence of a 'drinking culture' in society which constructs drinking as a social rather than an individual activity normalises drinking during pregnancy in the context of this study. Thus, pregnant women may drink because "most people" and "almost everyone" or "almost every pregnant woman" drinks which thus makes drinking during pregnancy 'acceptable' and 'normal'. On the other hand, not drinking during pregnancy produces subjects or women who fit traditional gender roles of motherhood who are thus considered 'good' and 'responsible' mothers due to their non-drinking behaviour (De Visser & McDonnell, 2012; Guetta & Addad, 2013).

For Foucault (1997), power, as illustrated above, has the ability to generate discourses of truth which in turn have "powerful effects" (p.24). As such, he argues that power relations and discourses are intrinsically linked as discourses, through their production, accumulation, and circulation in society, enable power relations to function (Burr, 1995; Foucault, 2000a). Simply put, power is established, exercised, maintained, and enabled to be productive through discourse.

The third aspect of Foucault's (1978) conceptualisation of power is that power does not belong to a class, group, or person. Rather, it is everywhere and many different forms of power co-exist with other relations (Foucault, 1978; Gavey, 2005). Sawicki (1986), in supporting Foucault, argues that power runs throughout the various institutions of society and does not originate from a specific, single source such as the law or sovereign. As power relations differ or are idiosyncratic in situations, there is no "single source of power" (Foucault, 2000 as cited in Jackson & Mazzei, p.59) that can be negotiated or resisted. Given such, Foucault (1978; 2000a 2000b) emphasises the fact that there are no spaces in which power relations/relations of power do not exist as they are constantly negotiated between individuals. To support this, he states: "power is everywhere not because it embraces everything but because it comes from everywhere" (Foucault, 1978, p.93). Power, therefore, is inescapable.

In arguing that power is not centralised, Foucault (1997, as cited in Connell, 2002, p.59) further suggests that there is not a "unified, central agent of power in society". Rather it is distributed widely and functions in an intimate and diffuse manner. In addition to functioning in an intimate and diffuse manner, power also operates in a discursive manner in that it is produced in the way we talk, think, and write. It functions up close instead of far away on people's bodies, further influencing the way people think about and identify themselves as well as their place in the world. This discursive power can, however, be challenged and resisted.

One of Foucault's (1978) well known statements is that "where there is power there is resistance" (p.95). The fourth important element of Foucault's (1978) conceptualisation of power is that of resistance which emphasises the fact that relations of power are not unidirectional (Foucault, 1980). In supporting this, Foucault (1980, p.147) states, "there are no relations of power without resistances; the latter are all the more real and effective because they are formed right at the point where relations of power are exercised". In other words, resistance does not occur outside of power but is embedded in it and in systems of power relations; resistance is not a possibility but inevitable. Resistance thus can then be regarded as an exercise of power where a person resists the shaping of their conduct by another. Resistance to power in the context of this study may be seen in ways in which women resist the discourse of the 'bad' mother by drawing on a discourse of self-control where drinking is constructed as a practice that helps them function better or cope rather than putting the foetus at risk. Furthermore, the discourse of self-control may enable women to resist being treated unequally to men due to their drinking (given the gendered nature of alcohol use) where, instead of being regarded as unfeminine and unwomanly for drinking (De Visser & McDonnell, 2012; Lyons & Willott, 2008), women can position themselves as being responsible drinkers who drink for particular reasons rather than being intoxicated and engaging in inappropriate behaviour.

For Foucault, resistance brings about change – a result of shifts in knowledge throughout history (Faith, 1994). In other words, "resistance to power is resistance to specific strategies by which power relations are patterned" (Faith, 1994, p.58). Foucault has also argued that resistance may not take place all at once or at the same time but may take place in an attempt to address different groups in society and in different places.

3.5.1 The power/knowledge nexus

The nexus between power and knowledge is important to consider in the above discussion on power. As mentioned previously, power should not be regarded as a 'thing'. Rather, as argued by Jackson and Mazzei (2012), it should be seen as a "relation – as always moving and circulating

among people also enabling a different analysis of knowledge: how knowledge is an *effect* of power" (p.49).

The effects of power relations are interweaving. Foucault (1980), in *Power/Knowledge: Selected Interviews and other Writings 1972-1977*, argues that what enables power to be accepted and operate continuously is that "it doesn't only weigh on us as a force that says no" (p.119); it also says "yes" – it forms knowledge, induces pleasure, and produces discourse. As such, Foucault suggests that one form of power (the power of the law or sovereign[4]) is not replaced by a new form of power (disciplinary power[5] for example). Instead, the different forms of power coexist and interact in a network of power relations. Within networks of power relations, specific practices are important for the way they spread knowledge as well as how they disrupt or sustain power relations rather than for their truth value or meanings (Foucault, 1980).

Knowledge can also be regarded as an effect of power (Jackson & Mazzei, 2012). That is, power and knowledge "merge and become visible as forms of power/knowledge in cultural and material practices within specific conditions" (Jackson & Mazzei, 2012, p.60) instead of restraining one another. Power can be demonstrated in the distribution or restraint of knowledge while knowledge can be seen in acts that are practices of power such as taking up or rejecting particular subject positions.

In addition to knowledge being regarded as an effect of power, power and knowledge in social practices work with one another. Power is not knowledge and knowledge is not power (Foucault, 1980). Rather, power and knowledge are effects of one another and express one another. As stated by Jackson and Mazzei (2012), "power/knowledge is a perpetual and reciprocal (rather than causal) relationship in which power creates and accumulates knowledge and knowledge induced effects of power" (p.62). As such, the power/knowledge nexus allows us to see "how people's actions are local reactions and responses and are temporarily embedded within specific and shifting relations of power" (Jackson & Mazzei, 2012, p.49).

Power and knowledge are also linked to the notion that power produces particular or certain types of knowledge about subjects or people, allowing us to see how people are understood and how they accept, navigate, negotiate, and disrupt power relations and knowledge about themselves. Subjects then, may, over time, respond to power relations in different ways depending on what knowledge they acquire and process. An example of this can be a woman who drinks during pregnancy through

[4] Sovereign power is power that is invested in the 'king' or sovereign and is bound up with the rule of law, it is a power that prohibits or represses (Foucault, 1975).

[5] In contrast to sovereign power, disciplinary power is power which guides, molds and shapes the conduct of individuals without acting directly on the body through physical punishment (Foucault, 1975).

knowledge that drinking is a common practice among pregnant women in a society. Thus, peers have the right to exclude her from the friendship circle should she not be drinking during this time. Once she has acquired new knowledge about this practice and herself, she may attempt to resist the pressure from friends to drink and unequal power relations which play a role in this pressure as she is now aware and knows that this is unacceptable.

3.5.2 Criticisms and usefulness of Foucault's theory of power

Foucault's theory of power has been subject to a number of criticisms. Most criticisms of Foucault's theory of power have been linked to sexuality and gender as it is often argued that he did not discuss the dynamics of gender adequately specifically in relation to how sex may be used as a form of power which may be different between women and men (Gavey, 2005). In addition, Foucault has been criticised for dismissing gender in unpacking the discursive foundations of power relations thus contributing to and representing the "androcentricity of dominant discourses" (Faith, 1994, p.61).

Despite these criticisms, Gavey (2005) argues that adopting a Foucauldian lens for analysing gendered power relations in a research study is helpful as it provides researchers with the opportunity to explore the links that exist between language, discourse, subject positions, and power, a task that this study aims to achieve. Foucault's theory has also been applauded for initiating a shift away from viewing power as something men possess to control, dominate, and suppress women towards detailing the different ways in which power operates to achieve its gendered effects (Cooper, 1994). As such for this study, Foucault's theory of power is useful for analysing gendered power relations the women may refer to in their narratives and discourses.

The socially constructed nature of choices, desires, and interests is another useful aspect of emphasis in Foucault's theory of power. Foucault's theory, by centring power, provides an explanatory framework that contests and denaturalises an essentialist subjectivity. As such, pregnancy and motherhood, which seem to reflect the 'true self' of women, are not only socially constructed but the result of a power that is most effective when 'agency' appears strongest (Cooper, 1994). Given such, the theory in its complexity will help provide a holistic understanding of alcohol use during pregnancy as well as the gendered power relations involved in this practice.

Like Foucault's theory of power, poststructural feminism has been met with a number of criticisms although it enables an analysis of narratives, discourses, subject positions, and power relations. In the section that follows, I discuss these criticisms and in doing so, highlight why this approach is useful for the present study.

4. Critiquing and defending feminism poststructuralism/poststructural feminism

The criticisms associated with poststructural feminism have been well documented and relate to the compatibility of poststructuralist principles and the foundations of feminism. Feminist poststructuralism has been critiqued for not focusing on or rather ignoring the individual. Feminist poststructuralism holds that female experience is dependent on discursive and social processes and is constituted by them. It does not give individual female experience priority (Gavey, 1989) which leads to disregarding the different contexts in which women are located, thus homogenising their accounts and experiences of drinking during pregnancy, for example (Sawicki, 1986). Another criticism launched at poststructural feminism, similar to the one provided above, emerges from the poststructuralist insight that there is no single/singular feminine subject or feminist approach. For this reason, poststructural feminism has been critiqued for taking the "heat off patriarchy" (Bell & Klein, 1996 as cited in Roseneil, 1999, p.163) and is seen as refusing to engage with grand structures of oppression such as male domination as the rival challenge for feminism (Roseneil, 1999). A third possible critique of poststructuralist theory is its relativism (Gavey, 1989). The theory suggests that there is no objective basis for distinguishing between true and false beliefs, which may result in power alone determining the outcome of competing claims to truth (Flax, 1987). To those who are oppressed, Gavey (1989), suggests this may be a frightening prospect. However, Weedon (1987) reminds us that our understandings of practices/acts and other phenomena are always subjective, which is also true for persons being interviewed. This is important in the present study as I aim to explore the subjective understandings and meaning-making associated with alcohol use during pregnancy for women who were previously pregnant.

Some feminists argue that poststructural feminism is more descriptive than explanatory (Lloyd, 2005). In line with this, another criticism against poststructural feminism is that it is unable to bring about social transformation (Lloyd, 2005). There has been widespread concern and debate around the argument that a feminist theory "cannot proceed without presuming the materiality of women's bodies, the materiality of sex" (Butler, 1992, p.17) as well as the question of whether or not as their foundation, feminist politics require the existence of a stable category of 'woman' (Roseneil, 1999). It is on this premise that poststructural feminism has been critiqued for undermining the feminist commitment to women's agency and is therefore seen as incompatible with feminist politics (Dietz, 1985; Shepherd, 2006). Baxter (2003) argues that feminism and poststructuralism take up different positions. As feminism takes up an emancipatory stance and poststructuralism has a deconstructive purpose, a "contradiction in terms" (Baxter, 2003, p.2) has resulted. Some feminists, because of this, reject the idea of truth as an abstract reality while others uphold the belief that truth is the foundation of or underpins feminism (Lloyd, 2005).

The proliferation of studies addressing feminist issues from a poststructural feminist approach, however, emphasises how this approach does not undermine feminism but results in new possibilities for feminist theorising (Boonzaier & Shefer, 2006). Studies have, for example, focused on women's sexual desire and negotiation (Shefer, 1999), violence (Boonzaier & de la Rey, 2003), women's understandings of intimate femicide (Dekel, 2013) as well as women's narratives of abortion decision-making (Mavuso, 2014). The use of a poststructural feminism approach for this study allowed for a multiplicity of advantages.

Locating the present study within a poststructural feminism approach proved fruitful as it enabled a critical analysis of gendered discursive practices (Buzzanell & Lui, 2005; Cassidy, Goldberg, & Aston, 2016; Engoren, 2002;). Further, it allowed for an exploration of the complex patterns and processes of power that emerged throughout the participants' narratives, where dominant discourses on alcohol use, motherhood, and pregnancy provided the context within which the women positioned themselves and others in these narratives and discourses (Burr, 1995; Davies & Harré, 2007; Gavey, 1989; Weedon, 1987). Moreover, not only did the approach give credence to women's active resistance to oppression and thus to patriarchal power, but it offered promising ways of theorising about change that are crucial to feminism (Gavey, 1989).

A further advantage of this approach for the present study rests on the notion that subjectivities are socially produced in socially specific ways through language and discourse (Weedon, 1987). Feminist poststructuralism has emphasised that women's subjectivities are far from fixed (Gannon & Davies, 2012; Weedon, 1987). In the context of alcohol use during pregnancy, a poststructural feminist approach showed that women construct numerous forms of subjectivity that are filtered through dynamic cultural, historical, and social moments. A feminist poststructuralist approach is valuable in that it permits researchers to acknowledge and even embrace contradiction, multiplicity, and inconsistency (Gavey, 1989). I therefore agree with Gavey (1996) who suggests that our academic endeavours should afford us a stance that allows for competing discourses of subjectivity. For example, women might identify with, and conform to traditional constructions of femininity, motherhood, and pregnancy or they may resist or challenge these (Gavey, 1989). Finally, a poststructural feminism approach will provide a broad and dynamic understanding of alcohol use during pregnancy which goes beyond individualistic understandings of the problem (Boonzaier & de la Rey, 2003; Gavey, 1989).

5. Summation

This theoretical chapter started off by looking at the social constructionist paradigm which underpins this research. In this discussion, it becomes evident that within this paradigm, language

constructs reality rather than reflecting it and because of such, the knowledge of the world is culturally and historically specific. Following this discussion, I then proceeded to overview feminist poststructuralism, an approach which acknowledges difference in the experiences of women, makes it possible for narratives, discourses, and subject positions to be analysed as well as understand the way gendered power relations are embedded in the meanings associated with a particular practice. Each of the key concepts of feminist poststructuralism that I draw on in this study were then discussed in depth, with links established between these concepts. Lastly, the discussion provided the criticisms of poststructural feminism as they relate to the compatibility of poststructural insights and the foundations of feminism. In this section, the usefulness of this approach for this study was argued for. In the following chapter, I discuss the methodological approach as well as the data collection and analysis methods adopted in this study.

Chapter Four: Methodology

1. Introduction

As described by Taylor (2005), a narrative-discursive approach to research is one that links individual narratives with social discourses and practices. Morison and Macleod (2013) argue that a narrative-discursive approach has three main focal points. The first is that talk is situated in a wide range of multifaceted contexts which constructs different stories depending on the situation (Morison & Macleod, 2013). This means that an individual's narrative about the journey of their pregnancy is, over time, accumulated from broader cultural and social contexts; what an individual says in a narrative depends on the place or situation in which an individual may find themselves (Taylor & Littleton, 2006). The second focus is that talk is social and various discursive resources are drawn upon by the speaker when speaking (Morison & Macleod, 2013). Simply put, a speaker, in constructing a narrative, draws upon a variety of beliefs, norms, stories, and values found within their culture to provide an account of "the unique circumstances of a particular life" (Taylor, 2005, p.47). The third and final focus is that social constraints exist in talk (these are the discourses speakers draw upon in constructing narratives) and because of such, consistency in talk and identity with regard to the speakers previous identities and what the society accepts and recognises is required (Morison & Macleod, 2013; Taylor & Littleton, 2006). There are two forms of social constraint. In the first, discursive resources within a particular socio-historical space constrain (and enable) what may be said in narratives. Secondly, as identities are expected to be consistent, there is the social and self-imposed expectation that the identities invoked by narrators will be similar to those invoked in previous narratives/micro-narratives/conversations.

A narrative-discursive approach is useful in this research for two reasons. Firstly, it allows for questions related to the ways in which individuals produce accounts of the circumstances that promote alcohol use during pregnancy which are particular to their lives to be addressed. Secondly, it enables an exploration of common discursive practices and resources in the construction of individual accounts, thereby linking the individual to the broader discursive context in which subjectivities are situated. To be able to address these questions, a number of decisions were taken regarding how to carry out a study with these narrative-discursive aims. Given such, this chapter provides a detailed description of the procedures and steps (including the motivations behind them) involved in carrying out this research.

I begin this chapter by providing the aims and research questions guiding this study. The methods used for recruiting participants are discussed followed by a discussion of the data collection and analysis procedures. The core research ethics as they relate to this study are discussed. I have also

included a section on reflexivity in which I critically comment on and engage with my involvement in the research process as well as a section on evaluation and validation where I discuss the criteria and strategies used to ensure trustworthiness in carrying out this research.

2. Research questions and aims

The main aims of this study were to explore: women's narratives of the personal and interpersonal circumstances under which drinking during pregnancy takes place; the practice of alcohol use during pregnancy within the social and cultural narratives, practices, and discourses around pregnancy; and the gendered and social relations underpinning the practice. In order to achieve these aims, the following research question and sub-questions were used as a guide:

Main research question:

How do women who have drunk alcohol while pregnant narrate the journey of their pregnancy?

Sub-questions:

1. What social, cultural, gendered, religious, and socio-economic discourses are drawn upon in narrating these stories?
2. What subject positions are enabled in these narratives and discourses?
3. What gendered power relations are referred to in these narratives and discourses?

3. Methods

Willig (2013) argues that "A good qualitative research design is one in which the method of data analysis is appropriate to the research question, and where the method of data collection generates data that are appropriate to the method of analysis" (p.103). In the section that follows, I discuss the sampling strategies used for recruiting participants/the women who took part in this study. The procedure followed for recruiting participants is explained in depth.

3.1 Sampling

Convenience and purposive sampling were the strategies used in this study due to the availability of participants and the need for a particular kind of participant (Durrheim & Painter, 1999). Convenience sampling is described by Teddlie and Yu (2007) as a strategy which involves the selection of participants or cases that are easily accessible and willing to participate in a study. Often contrasted with random sampling which aims for representativeness and generalisability (Durrheim & Painter, 1999), purposive sampling is described as a technique involving the selection of specific cases or participants for particular purposes (Teddlie & Yu, 2007).

In this study, convenience and purposive sampling were used to select women who: 1) were 18 years and older (for reasons related to the ability to give consent); 2) drank during a previous pregnancy at moderate or harmful levels (this was established through the use of the AUDIT-C questionnaire[6]); and 3) were willing (due to the sensitivity of the topic) to narrate (in the context of a research interview) the journey of their pregnancy from before they were pregnant. The AUDIT-C is scored on a scale of 0-12. A score below 5 indicates lower risk drinking while a score of 5+ indicates increasing risk of alcohol dependence and misuse. This criteria does not apply during pregnancy but only under normal circumstances when a person is not pregnant as to our knowledge, there is no definitive level of alcohol that is safe to drink during this time. This is why non-drinking during pregnancy is often advised. The AUDIT-C is a three-item screening tool used to help identify persons who are (or were) hazardous drinkers, abusing and/or dependent on alcohol (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). It was administered after the first sub-session/the initial narrative sub-session (further details are provided in the section on conducting the interviews). All participants but one had experienced the pregnancy about which they spoke in the past five years.

3.2 Recruiting participants

As mentioned in the introductory chapter in chapter one, this study is part of a bigger project and this particular project has been divided into two. As such, in conducting this study, I worked with another student who I refer to as my co-researcher whose study focused on the narratives of partners and family members of women who drank during their pregnancies. Both studies used the same recruitment and data collection methods with different approaches adopted for analysing the data.

Participants for this study were recruited through a non-governmental organisation (NGO) in the Eastern Cape which aims to reduce alcohol use during pregnancy through educating members of the public including pregnant women about the effects of alcohol use during pregnancy. At the time when this study was conducted, research support was being provided to the NGO by the Critical Studies in Sexualities and Reproduction (CSSR) research unit. Furthermore, the NGO was providing services in the communities from which the participants were recruited. Prior to recruiting participants, my co-researcher and I made arrangements with the social worker in charge to present our project to the mentors of the organisation who provide peer support to women who drink during their pregnancies to request assistance with recruiting. Following the mentors' agreement, recruitment commenced.

[6] The AUDIT-C was not used as a selection criterion or tool for sampling as it was not administered before the interviews so as to limit the possibility of having the women judged for their drinking. Rather, it was used to confirm whether the women drank at moderate or harmful levels.

A two-phase approach was followed in recruiting participants at the NGO. Mentors from the NGO gave all potential participants who they believed drank harmfully during their pregnancy a research information card (Appendix A) which briefly outlined what the research was about and requested potential participants to decide whether or not they would like to hear more about the study. In cases where potential participants did not want to hear more about the study, the mentors were asked not to put any pressure on potential participants to change their mind. If potential participants wanted to know more about the study, they were asked to indicate on the information card whether they give the mentor(s) permission to provide me with their names and numbers in order to contact them with more information about the study.

Upon receiving a list from the mentors with the names and contact details of potential participants who had shown interest in the study, I contacted them and set up an information session where potential participants were given study information sheets (Appendix B). These included in depth information about the study such as what their participation may involve, the duration of the study, time commitments, and the implications of their participation. Potential participants were also given an opportunity to ask questions during this session and to consent to participate in this study. Those who agreed to participate in this study then signed a consent form (Appendix C). From an ethics point of view, this method of recruiting participants was preferred as it protects the confidentiality of women not wishing to participate and allows such women to manage and protect their identities. Further, this method involved individuals whom the potential participants already knew and trusted, thus making them more open to hearing about the study and deciding to participate (Bryman, 2012). While useful, this method did come with some limitations during recruitment.

Recruiting participants for this study was challenging. Numerous NGOs which dealt with general child and family issues were approached, informed about the study, and asked to help with recruitment. However, most requests were declined. Reasons for declining ranged from the sensitivity of the study (although many NGOs acknowledged that this study is necessary and useful), difficulties in approaching the women, as well as the possibility that the study may drive the women away from the organisation as it may come across as judging them for drinking during their pregnancy. Given such challenges, a decision was made to stick with the NGO with which we were working and which focuses specifically on alcohol use during pregnancy. This also came with some challenges. While the mentors from the NGO worked in different communities, it was only mentors from one community who assisted with recruiting participants. As such, recruiting participants this way did not enable this study to keep in line with poststructural feminism's emphasis on difference in the subjective experiences of women across various lines such as geographical location, race, and

socio-economic circumstances. This meant that little diversity existed among the women who agreed to participate in this study.

3.3 Participant information

As the same recruitment method was used both by my co-researcher and me, recruitment of the women, partners and family members took place concurrently. A total of 31 potential participants (women, partners and family members) were recruited by the NGO mentors for this study. Fourteen women out of 31 potential participants made it to the information session and 12 out of 14 women agreed to participate in this study. The 13th participant (Khethiwe) was a family member who told her own story of the journey of her pregnancy as well as that of her daughter who drank during her pregnancy. As such, my co-researcher and I made the decision to each use this narrative for our respective studies.

Below I have included a table that provides information about the participants' age, racial identity, relationship and employment status, languages spoken, level of education, number of people in the household, the number of children they have, and their AUDIT-C scores of drinking during the pregnancy. The table has been arranged in alphabetical order according to pseudonym. These pseudonyms were chosen by the researcher for each of the participants. As can be seen from the table, participants were mostly similar with regard to racial identity, level of education, and employment status. All 13 women were 'Black'. In filling in her demographic form, Nono mentioned that she is a 'Coloured' woman but she identifies as a 'Black' woman. 10 out of 13 women had a high school (grades 8-11) level of education, two had reached matric (grade 12) and one only went up to primary school (grades 1-7). All 13 women were unemployed. Although in her narrative Lola mentioned that she was working as a domestic worker, in filling in her demographic form, she mentioned that she prefers to say that she is unemployed as she only works three days a week and her job is not a full time one. With regard to the AUDIT-C scores, 3 of the women engaged in lower risk drinking[7] during their pregnancies while the remaining 10 women drank at moderate, risky or harmful levels.

In this study, a translated version of the AUDIT-C (from English to isiXhosa) was used. The isiXhosa version was constructed using a rigorous forward and backward/back translation procedure. Forward translation is a method in which a document or questionnaire is translated from the source language to the target language, while backward translation is a method in which the same document or questionnaire is translated back from the target language to the source (original)

[7] As the drinking of the women in this study is considered during pregnancy rather than under normal circumstances (see discussion on page 49), a score of 4 indicates that the participant drank often or engaged in binge drinking even though under normal circumstances this score does not indicate high risk drinking.

language (Chen & Boore, 2010). This method is crucial as it is used to identify conversion errors when translating back from the target language to the source language (Chen & Boore, 2010). The services of language experts in the Rhodes University School of Languages were used to conduct the translations and to resolve any linguistic or conceptual differences between the various versions.

Table 1: Characteristics of participants

Pseudonym	Age	Racial Identity	Relationship Status	Language(s) Spoken	Level of Education	Employment Status	Number of people in Household	Number of Children	AUDIT-C Score
Cindy	23	Black	Single	IsiXhosa	Matric	Unemployed	2	1	4
Dineo	20	Black	Single	IsiXhosa	High School	Unemployed	3	1	5
Hope	23	Black	Married	IsiXhosa	High School	Unemployed	4	1	5
Khethiwe	48	Black	Widowed	IsiXhosa	Primary School	Unemployed	3	2	6
Lola	27	Black	Single	IsiXhosa and English	High School	Unemployed	7	3	10
Lucy	36	Black	Single	IsiXhosa	High School	Unemployed	2	1	7
Morongwa	32	Black	Married	IsiXhosa	High School	Unemployed	4	2	4
Nina	25	Black	Single	IsiXhosa	High School	Unemployed	3	1	8
Nonny	24	Black	Single	IsiXhosa	High School	Unemployed	1	1	4
Nono	43	Black	In a relationship	IsiXhosa, English and Afrikaans	Matric	Unemployed	4	6	7
Pearl	40	Black	Single	IsiXhosa	High School	Unemployed	6	5	10
Pretty	27	Black	In a relationship	IsiXhosa	High School	Unemployed	3	2	6
Rosey	22	Black	In a relationship	IsiXhosa	High School	Unemployed	3	2	10

4. Data collection

In their paper on methods of data collection in qualitative research, Gill, Steward, Treasure, and Chadwick (2008) argue that "The purpose of the research interview is to explore the views, experiences, beliefs, and/or motivations of individuals on specific matters and provide a deeper understanding of social phenomena" (p.292). In this regard, the narrative interview is particularly useful. The narrative interview method used in this study, the way the interviews were conducted when data were collected, and the limitations of the narrative interview are discussed in the following section.

4.1 Narrative interviewing

The method of data collection used for this study was the narrative interview as delineated in the work of Wengraf (2001, 2004). Narrative interviews are a means of collecting the participants' own stories about their experiences of something and allow the researcher to understand the experiences and behaviours of the participants (Anderson & Kirkpatrick, 2016; Jovchelovitch & Bauer, 2000). As a method and an approach to interviewing, the narrative interview emerged in response to the criticisms of two types of interviews mainly used in social science research which adopt a question-and-answer format namely, structured and semi-structured interviews (Jovchelovitch & Bauer, 2000; Muylaert, Sarubbi, Gallo, Neto, & Reis, 2014). These interviews have been critiqued for producing responses that are in line with the researcher's interests, therefore saying very little about the position of the interviewee and more about that of the interviewer (Gill et al., 2008; Jovchelovitch & Bauer, 2000;).

The narrative interview, in contrast to structured and semi-structured interviews, aims to limit the researcher's influence (although the influence of researchers in any qualitative study can never be completely removed) through the use of a method and style of interviewing that provides participants with an opportunity to narrate their stories in their own way (Hollway & Jefferson, 2000; Jovchelovitch & Bauer, 2000). Simply put, narrative interviews, as argued by Anderson and Kirkpatrick (2016), "provide an opportunity to prioritise the story teller's perspective rather than imposing a more specific agenda" (p.631-632). In this type of interview, "the researcher's responsibility is to be a good listener and the interviewee is a story-teller rather than a respondent" (Hollway & Jefferson, 2000, p. 31). Furthermore, while the topic of the narration is chosen by the researcher, the process and style of the interview (to be discussed in depth below) enables the narrative of the interviewee as well as the language used to construct the narrative to remain the central focus.

4.2 Wengraf's (2001) narrative interview

Wengraf's (2001) narrative interview is different from that of Schütze (1977, as cited in Jovchelovitch & Bauer, 2000) who originally developed the narrative interview. The latter consists of four sub-sessions which are conducted over a single interview while the former condenses three sub-sessions into two interviews.

In the first or main interview, two sub-sessions take place. In the first sub-session, the initial narrative sub-session, the interviewer poses one narrative question or what Wengraf (2001) calls a Single Question aimed at Inducing Narrative (SQUIN) which enables the participant to start telling her story. It is important to note that during this and the second sub-session, two researchers are present. One asks the SQUIN and the other (referred to as the co-researcher) quietly takes notes. For this study, the SQUIN did not make reference to alcohol use so as to help establish rapport with the participants, avoid upsetting them and making them feel embarrassed or judged for drinking during pregnancy. The SQUIN used for this study was as follows: "Please tell me the story of your pregnancy from before you were pregnant through to when your child was born including the events and experiences that were important to you during this time". Before the SQUIN was posed, the interviewees were told that: 1) the co-researcher would take notes which we, as researchers would discuss; 2) in telling their stories, they would not be interrupted; 3) there were no right or wrong answers to the question; and 4) they could take all the time they needed to answer the question and could start wherever they liked (Wengraf, 2001, 2004). Further, they were encouraged to say as much as they wanted to when telling their stories and assured that they would not receive any judgement from both the researcher and co-researcher for any information they choose to disclose. These measures were put in place so as to support the interviewee in answering the SQUIN or telling their story.

In the second sub-session of the main interview, the narrative follow up, the interviewee was asked to leave the room and the researcher and her co-researcher spent 15 minutes composing questions to ask the interviewee based on the notes taken by the co-researcher (Wengraf, 2001). In this sub-session, three guidelines were adhered to (Wengraf, 2001, 2004). Firstly, the interviewer asked the interviewee narrative-pointed questions or rather, questions related to the story that was told. Secondly, the questions asked were based on the topics raised by the interviewee in the first sub-session. Lastly, in asking about the topics raised, the interviewer did so in the order in which they were raised, one at a time, using the exact words of the interviewee. The purpose of this sub-session, according to Wengraf (2001), is to ask the participant for more narratives.

The second interview is where sub-session three takes place. This sub-session took place after the data from the first interview (the first and second sub-sessions) had been transcribed (verbatim) and read over (Wengraf, 2001). In this sub-session, the interviewee was re-interviewed and the interviewer was given the opportunity to ask further and/or additional questions (narrative, non-narrative or other kinds of questions) that emerged from what was said or not said in the first interview (Wengraf, 2001, 2004). It is important for the interviewer to reflect on the experience of doing the interviews after each one is completed (Jovchelovitch & Bauer, 2000). These reflections become useful in data analysis.

Wengraf's (2001) narrative interview was chosen for this study for several reasons. Firstly, narrative interviews, according to Anderson & Kirkpatrick (2016) and Maylaert et al. (2014), are useful to talk through sensitive issues. Given the sensitive nature of the topic under investigation, this method of interviewing is respectful for the interviewees (while generating rich data at the same time) as the content, direction, and pace of the interview was controlled by the interviewees rather than the interviewer (Anderson & Kirkpatrick, 2016). In other research conducted about alcohol use during pregnancy (e.g. Choi et al., 2014b; van de Wulp, Hoving, & de Vries, 2013), this has not been the case as structured and semi-structured interviews have been used to collect data. For this study, it was hoped that the narrative interview would be helpful not only for data collection but for the women especially in talking through the complexities of their pregnancy (see section on benefit and harm in discussion on ethical considerations). Secondly, the second interview in which sub-session three takes place becomes useful in cases where the interviewee does not speak about anything related to the research in the first interview (Wengraf, 2001). In cases where drinking was not spoken about in the first interview, I decided to refer to alcohol use and/or drinking in a sensitive manner in the third interview as I had anticipated that rapport with the participants would have been established by the time this interview took place.

4.3 The mock interview

In an attempt to better prepare myself for the actual interviews, my supervisor suggested that I do a mock interview. For this interview, I only practiced the first and second sub-sessions of the first interview (following the method set out above) as my supervisor and I decided that this would provide me with enough of an opportunity to experience the workings and interview dynamics of Wengraf's (2001) methodology. The mock interview was observed by my colleagues at the CSSR some of whom have used this methodology in their own research.

In the feedback from my colleagues about the interview, concerns were raised about the SQUIN not making reference to drinking. I explained why this was the case (see section 4.2 above). For the

second sub-session, I was encouraged to start a question about the narrative with a statement such as 'you mentioned that' or 'you spoke about' to show the participant that I was listening to and following their narrative and thus wanted to know more about a particular topic they had raised. With regard to asking questions, I was encouraged to ask more open ended questions so as to elicit details from the participants rather than asking too many 'why' and closed-ended ('yes' or 'no') questions. It was felt that it may be difficult for the participants to answer these questions and may limit them from providing more narratives. Furthermore, I was advised not to rush through the questions in order to allow the participants to reflect on a particular question and to add more narratives if they wanted. The issues that emerged and were addressed during this mock interview were carried through to the actual interviews.

The mock interview was very helpful for various reasons. It provided me with a sense of direction for the actual interviews as practising the interview allowed me to get an idea of how I would go about doing the interviews. As such, it allowed me to experience how interviewing the women would be like and the awareness of being respectful of, sensitive to, and interested in the narratives. My colleagues also provided me with helpful interview etiquette and advice regarding the construction of questions which helped with eliciting good data.

4.4 Conducting the interviews

A total of 13 interviews were conducted for this study. All interviews were conducted in a small room in a community hall close to where the participants lived. The hall is located in front of a taxi rank and a *tavern*. On the premises of the hall was a playground for school children. As such, the area in which the hall was located was very busy and loud as there was often music playing from the taxi rank as well as the tavern and school children playing and screaming during their lunch break as well as after school. For each interview, my co-researcher was present. All interviews were conducted predominantly in isiXhosa as all of the participants were isiXhosa speakers, although all the women combined isiXhosa with some English in their interviews. Following the process outlined above, the interviews were conducted by me (the researcher). I had organised the dates and times of the interviews with the participants prior to the two sub-sessions.

Even though my co-researcher and I had met the participants who agreed to take part in this study during the information session, I reminded them of who we are before the start of each of the interviews, explained the role of the co-researcher, reminded them about the purposes of this study, the consent form they signed and gave each participant a copy of their signed form. Before proceeding with the interviews, I explained to each of the participants what would happen during the two sessions; then I asked each of the women for permission to record the interviews after

explaining why recording was important. After permission was sought, the women signed a tape recording consent form (Appendix D). Only one participant expressed hesitation when I had requested permission to record her interview as she mentioned that she was not too sure about what I was going to do with the recording. I negotiated this in a number of ways. I explained to the participant why recording the interview was important, informed her that I would transcribe the recording and assured her that only my co-researcher and I would listen to the recording (which was the case). Further, I informed the participant that if any of my colleagues from the CSSR would handle the recording, they would do so in a respectful manner and that I would not use her real name. Following this, the participant ended up consenting.

I started each of the interviews by posing the SQUIN and many of the participants were very interested to talk and share their stories. While telling their stories, I encouraged the women to continue by providing prompts such as ‘uh-huh’ or ‘yes’, which also indicated that I was listening to and following the stories. The initial narratives ranged from 3 – 10 minutes and all of the women made reference to or spoke about drinking during pregnancy in their narratives despite the fact that the SQUIN did not make reference to this practice and a concern regarding this was raised during the mock interview. This could be because the women knew what the study was about as they were told about the purpose of the study during the information session and I had reminded them about these purposes prior to the interview. Most of the women shared stories about more than one pregnancy (one of the participants who had two children asked which story she should share) and this was when I noted that the SQUIN did not take this into consideration but asked for the story of a pregnancy.

I allowed the narration to continue until the participant indicated that they had nothing more to say or through being silent or smiling. At the end of the narration, instead of asking the participant to leave the room, as Wengraf (2001) suggests, participants were left in the room in which the interview was conducted and asked to fill in a demographic form (Appendix E) as well as the AUDIT-C questionnaire (Appendix F); it was my co-researcher and I who left the room. In cases where there was any distress during the interview (e.g. if the participant had been crying), the form and the questionnaire were completed at the end of sub-session two. Some participants also asked me to fill in the form and questionnaire with them at the end of the interview.

After the first sub-session was completed, the co-researcher and I, as mentioned above, left the room for 15 minutes (in some instances we left the room for less than 15 minutes) to compose further questions for the participant based on the notes taken by the co-researcher. This break was useful as it allowed the co-researcher and I to summarise the narratives and discuss aspects of them

that may have been unclear and to comfort each other when the story that was shared evoked a lot of emotions. There were instances where some participants did not provide us with much narrative content to compose questions which required the co-researcher and I think hard about what would be useful to follow up on. Some participants, for example, focused on one particular event or experience that was important during their pregnancy and related this to their drinking. Drawing on what we learnt during the mock interview, we decided to compose questions starting with 'please tell us more about' that encouraged the participants to speak more and give additional details about the event or experience.

During the second sub-session, I noticed that most of the participants were comfortable with being asked questions and spoke for as long as they thought was necessary. To indicate that they had finished they would say 'yes' or 'okay' and I would proceed to the next question. There were some interviews where I did not know if a participant had finished answering a question as they remained silent for some time. As I was uncertain if the silence was an indication of having nothing more to say or a space in which the participant was thinking, I made the decision to continue with the interview as it was difficult not to feel awkward during these silences. In listening to the audio recordings of the first interviews (sub-sessions one and two), I realise that I should have allowed more or long silences in order to provide the participants with a chance to say more. My inability to do this means that I may have lost some opportunities for gaining good quality data by not allowing the participants to think and speak more in these instances.

After conducting the two sub-sessions of the first interview with the participants, I transcribed each of the interviews (verbatim) in preparation for the third sub-session/the second round of interviews. I provide more details about transcription later in this chapter. After I had completed transcription, I read through each of the transcripts while listening to the interview recordings to ensure accuracy. This also allowed me to reflect on the content of the interviews, familiarise myself with the data and decide on what aspects of the narratives to follow up on before conducting the third sub-sessions. In preparing for the third sub-sessions, in light of the research questions guiding this study and on the basis of the preliminary analysis of the transcripts, I developed a set of questions for each of the participants. These questions were the same type of story-eliciting questions that had been used in the first and second sub-sessions and were unique to each participant's narrative. In preparing the questions I made comments and constructed rough questions on the sections of the transcriptions that I thought were interesting and relevant to my research questions. I then shared these with my co-researcher for further comments and perusal. Her comments gave me guidance as to which questions I should alter/phrase differently or keep. While my supervisor did not check and provide comments on these questions, she suggested that I read through my literature review and formulate

general questions for the participants based on what emerged in the literature. This was helpful as this revealed a lot about the participants' views about motherhood and especially religion and drinking during pregnancy, topics about which there was a lot of silence in the initial interviews. Once I had collated questions for each of the participants and the general questions, I went back to the community together with my co-researcher and conducted the third and final sub-sessions. The time and date of each participant's sub-session was organised in advance as was done for the first and second sub-sessions.

The interviews conducted during the third sub-sessions were longer than those of the first and second sub-sessions. This, I feel, was because I had a number of questions for each participant and I knew that this was the last chance I would have to interview the women. As such, I took opportunities to follow up on questions that I thought would be important and interesting to my research questions. During these interviews, I was much more relaxed compared to the first and second sub-sessions as I had an idea of what to expect in the interviews in terms of dynamics. Further, I felt slightly familiar with each of the women as we had spent time together previously and had had the chance to build a relationship.

4.5 Limitations of the narrative interview

Although narrative interviewing was a useful method of data collection for this study, it was not without limitations. Anderson and Kirkpatrick (2016) argue that during the narrative interview, some interviewees may find it very challenging to tell their story to an interviewer or rather a person they have never met before. In line with this argument, Jovchelovitch and Bauer (2000) argue that the narratives of some participants may be under-produced or, in the process of telling a story, re-traumatisation may occur. To support this, Jovchelovitch and Bauer (2000) state that "As much as narration can heal, it can also produce a renewal of the pain and anxiety associated with the experience it narrates" (p.68). In conducting the interviews, I was surprised by how comfortable most of the participants were with sharing their stories with me as well as by how much they shared with me, not only about what happened during their pregnancies but also things that happened and were happening in their lives in general. This is not to say that none of the narratives were under-produced. In conducting the interviews, some of the women did not share much with me in their narratives and I did feel that some of these were incomplete and there was more to tell. In telling their stories, some of the participants experienced re-traumatisation as some of the women cried when speaking about some events and experiences which indicated that talking about these events and experiences brought back the pain associated with them. When reflecting on the interview process in the third sub-session, these women spoke about how the space provided during the

interview was one they regarded as safe and non-judgmental. As such, most of the women who experienced re-traumatisation spoke about how these factors enabled them to continue sharing their stories as they felt they were listened to, acknowledged, understood, and comforted.

In addition to the above limitation, it has been argued that in asking participants to share past experiences, the narrative interview is susceptible to reconstructive memory (Jovchelovitch & Bauer, 2000). That is, participants may tell stories that they expect the researcher wants to hear, overproduce, or change their story. Although this is a limitation of narrative interviews, the narratives of participants are not open to evidence and cannot be judged as "they express the truth of a point of view, of a specific location in space and time" (Jovchelovitch & Bauer, 2000, p.72). In conducting the interviews, there were cases where I found myself searching for consistency in the narratives of some of the women if their partner or a family member took part in my co-researchers study. In negotiating this situation, I reminded myself that even if the stories were not consistent, people understand and reflect on events and experiences differently.

An important limitation to consider for narrative interviews which include follow up sessions (including Wengraf's (2001) method) is that of the difficulty of sustaining the participants' participation over a period of time as well as the organisation involved in follow up interviews such as contacting the participants, arranging a place where the interviews will be conducted, and the costs involved in this process (Anderson & Kirkpatrick, 2016; Muylaert et al., 2014). The third sub-sessions for this study took place a month after the first and second sub-sessions as Wengraf (2001) recommends. Only 10 out of the 13 women were able to make it to the third sub-session. Hope had found a job and her work day often ended late. I asked her to set a time for after work which she did. However, she was not able to make it to the sub-session as she had other commitments after work. Morongwa had a family ceremony to attend while Pretty was not reachable over the phone and I did not have an alternative number on which I could contact her.

Anderson and Kirkpatrick (2016) argue that as a lot of data are often obtained from narrative interviews, data analysis is often said to be a long process. Data analysis for this study was a long process as various processes were engaged in (I elaborate on this in the section that follows) and during this time, I felt very overwhelmed by the data. There were also times where I felt that in analysing, I was not speaking or making reference to all the narratives. With the help of my supervisor who read my transcripts and provided very useful feedback for the first drafts of my analyses chapters, I was able to manage the data better and ensure that the chapters reflect what all the women had said in their narratives.

5. Analysis and interpretation

In the following section, the procedure I followed in analysing and interpreting the women's narratives of the journey of their pregnancy is described. Willig (2013) states that "It is important to understand that the research question, data collection technique and method of data analysis are dependent on one another. They cannot be considered separately and they should not be chosen independently from one another" (p.103). In line with this argument and based on the research questions and data collection method of this study, I employed Taylor and Littleton's (2006) narrative-discursive approach for analysis.

5.1 Narrative-discursive analysis

A narrative-discursive approach to analysis is based on a social constructionist assumption that talk, including discourse and narratives, are constitutive of subjectivities and social realties (Taylor & Littleton, 2006). A narrative within this approach is seen in two ways: (1) as something constructed through the use of discursive resources such as discourses, images, and symbols, canonical narratives; and (2) as a resource that will be used in future conversations (Taylor, 2006). As a synthetic approach, various methods of analysis are drawn upon in a narrative-discursive analysis namely, narrative analysis and discourse analysis (Taylor & Littleton, 2006). This approach has been used mainly in the analysis of identity work specifically in the work of Taylor and Littleton (2006) (see also Taylor, 2006). It has also been used in research by Graham (2014) about the discourses young people employ in their talk about high school sexualities and sexuality education, by Morison (2011) in analysing "white" Afrikaners' narratives about parenthood decision-making as well as in research by Chiweshe (2015) and Mavuso (2014) in the analysis of women's narratives and micro-narratives about abortion decision-making in Zimbabwe and South Africa.

From discursive psychology, a synthetic narrative-discursive approach draws on a particular type of identity work called positioning (Taylor, 2006; Taylor & Littleton, 2006) which has been discussed in depth previously in the theory chapter in chapter three. In telling a story, individuals position themselves and others in relation to the meanings and values offered in particular discourses – there are certain positions they will claim and those which they will reject. As narratives are seen as an opportunity to construct a new identity or recreate a previous one depending on the situation, an identity can be changed and reworked in light of the new situation. Additionally, it is through narratives that identity is negotiated and re-negotiated in ways that allow for discrimination and/or oppression to be challenged for example, the same way that poststructural theory acknowledges the possibility of resistance to dominant discourses.

From discourse analysis, the narrative-discursive approach takes up the focus on broader discourses and narratives, a focus which emerges from the assumption that the narratives of individuals are shaped and informed by broader narratives including cultural and/or social discourses or frameworks of meaning (Bell, 2002; Pavlenko, 2002; Taylor & Littleton, 2006). These broader discourses and narratives can be seen as examples of discursive resources. The task of a narrative analysis, as captured by Crossley (2000, as cited in Parker, 2004), is therefore to locate narratives in broader structures of discourse and power so as to fully understand their implications and ramifications, a task of data analysis that includes going beyond the told story to the assumptions held within the story (Bell, 2002). As such, I utilised a narrative-discursive approach in analysing the narratives because it permitted me as the researcher to see the content of the narratives and provided me with a means of examining what discourses the women drew upon in constructing their narratives which allowed for the personal stories of the women to be understood within the broader cultural, gendered, and social discourses and practices from which they are told.

The narrative-discursive analytic process, as stated by Taylor and Littleton (2006), is no different to other qualitative methods of data analysis as it is not a step-by-step process. Rather, it is best described as iterative. The process begins with the verbatim transcription of the audio recorded interview material followed by two tasks described in detail below.

5.2 Translation and transcription

In research where the collected data are in a language different to that which is used by the researcher, Twinn (1997) argues that the translation work that needs to be done before the data are analysed raises a lot of questions about the transcribed data's accuracy and thus the credibility of the analytic argument. This is due to the fact that different languages consist of various grammatical structures which have certain implications for meaning as well as the role played by culture and language in giving social practices meaning.

Regarding concerns over the accuracy of translated material, Temple and Young (2004) argue that complete accuracy of interpretation is not attainable for researchers working within the social constructionist paradigm as speakers who are fluent in the same language could produce interpretations that are different for the same text. Apart from questions related to accuracy, the authors emphasise two other important issues when it comes to translation in the research process. The first concerns the issue of whether or not, in the methodological discussions of the research process, the researcher acknowledges that translation work has been done. As Temple and Young (2004) argue, failing to acknowledge that such work was done dismisses the role of language in constructing meaning. The second issue relates to the identity of the person doing the translation

work including whether or not he/she is best able to speak on behalf of others. As an alternative to accuracy in translation work, it may be useful to speak about equivalence, specifically linguistic and conceptual equivalence (Yinhua, 2011). Linguistic equivalence refers to creating versions that speak to or rather acknowledge the different grammatical structures of languages while conceptual equivalence on the other hand acknowledges the cultural meaning making aspects (Yinhua, 2011). The latter requires not only being fluent in both languages but also being steeped in cultural meanings of the languages.

In this study, translation work was necessary during two phases namely, in preparing the information card, the study information sheet as well as the consent forms and during the transcription phase. With regard to translating the research information card, the study information sheet and the consent forms, I translated the English versions of these forms into isiXhosa as I am a fluent isiXhosa speaker. The process of checking the transcriptions (described below) was adopted for checking the translations of the research forms. In transcribing the data, I used Parker's (1992) transcription conventions (Appendix G) due to the level of detail required (although minimal) and appropriate when the focus is on discourse (content) compared to the structure of interactions and minute workings as is the case in conversational analysis for example. I also translated and transcribed the isiXhosa audio data/recordings directly into English myself, leaving phrases and words about which I was unsure in isiXhosa. Thereafter, my transcripts were checked by my co-researcher who is also a fluent isiXhosa speaker to ensure equivalence and to identify differences in interpretations. I handed over the audio data/recordings as well as the English transcripts and asked my co-researcher to compare and contrast the translated interviews with the content of the audio data/recordings. My co-researcher and I then set up a meeting to discuss any differences in opinion, direct translations, and the complexities of finding an equivalent term or word for translation where relevant (Twinn, 1997). Each of us argued for our own sense-making processes and the most plausible translations were added to the interview transcripts.

In cases where there was disagreement between my co-researcher and me with the translations of the research information card, study information sheet, and consent forms, we reached consensus and decided to use terminology that would make the forms clear, and easy to read. With regard to disagreements in the translations of the audio data/recordings, I returned to the data and used the participants' preceding and successive statements including the question I had posed to ground my understanding. I preferred translating the audio data/recordings myself because it immersed me in the data, and as such, I became familiar with the text and was able to gain a firm grasp of the details and nuances within the transcripts.

5.3 The analytic process

Transcription is a vital and necessary first step in data analysis (Bryman, 2012; Willig, 2013). This step, as noted by Bryman (2012) and Willig (2013), not only enables the researcher to conduct a full analysis of the data but to engage in a close reading of the data and start thinking about how the data are related or not related to the research questions.

Two tasks are completed during a narrative-discursive analytic process (Taylor & Littleton, 2006). In the first, discursive resources are identified within individual narratives and across narratives. For this task, I looked specifically for social, cultural, gendered, religious, and socio-economic discourses that were drawn upon in constructing narratives. The second task involves locating the discursive resources within the specific narratives in which they occur. Within this task, the analysis involves looking at the way in which participants position themselves and others as well as the way they are positioned by others in the narratives. Using Davies and Harré's (2007) positioning theory; the second task in this study involved an analysis of subject positions. Using Foucault's theory of power, I also analysed the narratives for gendered power relations referred to by the women by looking at instances where references were made to the gendered role and expectations of men and women during pregnancy and in society as well as to the role of friends and/or peer groups, male partners, family members, and others in drinking during pregnancy and/or fostering a context for drinking during pregnancy.

6. Ethical considerations

Shaw (2008), in his paper discusses various approaches to qualitative research ethics. Focusing only on codes and principles, one approach isolates ethical aspects from the research process, thus treating them as something that should be considered at the beginning and at end of the research process during the compilation of the research report. The approach which Shaw (2008) argues for and which is adopted in this study positions research ethics within the research process recognising the fact that ethical aspects need to be considered in all stages of the research process from gate-keeping and recruitment to data collection including data analysis. Drawing on Watts' (2006) feminist approach to research ethics, I discuss the qualitative research ethical aspects related to this study in the following section.

6.1 Gatekeepers and recruitment

Prior to approaching gatekeepers from the NGO, ethical clearance from several bodies was required (Guillemin & Gillam, 2004). Initially, ethical clearance was sought from the Department of Psychology Research Projects and Ethics Review Committee (RPERC) which, owing to the sensitive nature of the topic was referred to the institutional ethics committee, the Rhodes

University Ethical Standards Committee (RUESC), after providing constructive input. See Appendix H and Appendix I for the ethical clearance letters from these committees.

After ethical clearance was obtained from the latter committee, permission to conduct the research at the NGO was required from the relevant individuals in management. Permission to conduct the research at the NGO was granted by the organisation's director and social worker after they reviewed the proposed research. Once entry into the NGO was granted, women were recruited by the mentors to participate in the study.

6.2 Respect for participants

The ethical principle of informed consent is related to the need to respect the autonomy of individuals (Shaw, 2008). Bryman (2012) defines autonomy as the right of an individual to determine what activities they will or will not participate in. Informed consent therefore based on the above refers to consent given voluntarily by the potential participant after being informed about the study's purposes including the form and nature of his/her participation in the study.

To have respect for the autonomy of participants, consent to participate must take into consideration the right to withdraw participation (Orb, Eisenhauer, Wynaden, 2000). In relation to this point, Shaw (2008) raises a question around the consent given particularly the "genuine voluntariness of the consent" (p.405). Where introduction to the research and participation requests are facilitated by gatekeepers, this is particularly questionable as consent given in such situations can be influenced by gatekeepers (Watts, 2006). Given the possibility of this occurring in this study, my co-researcher and I made sure to emphasise the voluntary nature of participation with all the women who agreed to have their contact details given to us by the mentors and agreed to attend the information session. In addition, attempts were made to assure the women that their participation or non-participation would in no way affect their relationship with, or the services they received from, the NGO. Following this, the women were asked whether they wanted to participate and were encouraged to answer freely.

Informed consent was obtained from the participants in writing so as to protect the participants as well as the researcher and her co-researcher. Informed consent forms, as mentioned previously, contained in-depth information about the study/research, the nature of participants' participation, the voluntary nature of their participation, their right to withdraw, and the role of the co-researcher. Informed consent forms also included my contact details and those of my supervisor for the participants to use if they wished to. The forms were signed by the participant, myself, and the co-researcher. As a means of protecting the privacy and anonymity of the participants, they were encouraged to provide and/or use a pseudonym (Bryman, 2012; Orb et al., 2000) where the form

required their name. (Bryman, 2012; Orb et al., 2000). However, all the women did not do this which I why I gave each participant a pseudonym (see discussion on page 52). The women were also given a tape recording consent form that asked for their permission to audio record the interview in conjunction with the informed consent form.

6.3 Benefit and harm

In the research process, the researcher can cause harm if he/she perceives participants in utilitarian terms (Watts, 2006). In cases where participation in a research interview causes distress, Orb et al. (2000) argue that the researcher's response amounts to a statement of the value placed by him/her on the participants' well-being compared to the value of the data for the research. Deciding to continue with the interview without having checked on the well-being of the participant shows that the process of gathering data outweighs the distress of participants (Orb et al., 2000).

A decision was made before data collection that in cases where any of the women became distressed during the interview, the interview would be stopped and the researcher would aim to contain the situation. Thereafter, participants would be asked whether they would like to receive counselling services from the service provider NGO where recruitment took place or whether they would like to be referred to another service provider NGO with which we were working in close collaboration. A number of the women who took part in this study did become distressed but, when I had stopped the interview and checked up on them, they indicated that they were okay and requested that we continue. Three out of the thirteen women were referred to another service provider NGO (with their consent) for counselling services. Two of the women indicated that they live far from the NGO and thus could not make it to their sessions. Alternative arrangements were made for these participants at NGOs in close proximity to their homes. However, one of the women changed her mind about receiving counselling services and the other was able to receive support.

Orb et al. (2000) argue that "researchers have the obligation to anticipate the possible outcomes of an interview and weight both benefits and potential harm" (p.94). One way in which this was done in this study was considering possible distress caused by discussing sensitive issues around drinking during pregnancy. Another is related to the need to be aware of the fact that talking through the journey of the pregnancy especially drinking during pregnancy might (with or without the interviewer's intention to do so) result in embarrassment. Keeping this in mind, the aims of the research were explained to participants clearly, emphasising that they would not be judged in any way and that there were no right or wrong answers. This was further facilitated by the interview method used in this study which meant that the interviews could be conducted in a way that is

sensitive to the issue of drinking during pregnancy and respectful of the women's own stories (Anderson & Kirkpatrick, 2016; Muylaert et al., 2014).

In a context where a 'drinking culture' (Evans, 2015) exists, such as in South Africa, but where stigma around alcohol use during pregnancy persists, speaking about engaging in this practice is difficult. The opportunity to speak to a researcher who is willing to listen and is non-judgemental may have been of benefit to the participants. In reflecting on how it was like taking part in this research in her third/final sub-session, Pearl said:

Pearl: (3) *I felt I felt alright bantasekhaya[my people] no I felt alright as I told […] that no it's a bit better ever since [I took part in this research] I was able to speak about my problem[s] you understand? At least I am now a person who is a bit better I mean when I speak I always say that something will happen but will go one by one [things take time] everything is slow it's not fast it goes like this and like this but at least I do get some sleep it's a bit better because I could wake up at around twelve and just think and just think and just think about things*

In the above extract, Pearl describes how she feels *a bit better* after taking part in this research. Further, she explains that she can now sleep better and no longer thinks about her problems as much as she used to. As such, she highlights how the narrative interview was useful for her in talking about the complexities of her pregnancy.

6.4 Remuneration

As a token of appreciation for their time, participants were given a R200 shopping voucher after the first interview (sub-sessions one and two) was completed. The mentors also received a R100 shopping voucher for helping with the recruitment of participants. In recruiting participants for this project, my co-researcher and I (together with our supervisor) had to decide whether or not participants were informed about the token by the mentors. In her paper Head (2009) states that "Paying participants has implications in terms of the ethical requirement for consent and may have consequences in terms of recruitment for research projects and the data collected" (p.335). That is, providing remuneration for participation in research may compromise the key ethical principle of participation in research, that of free/voluntary, informed consent. Paying attention to the fact that data for our studies would be collected in an economically marginalised context, our debates concerned: 1) the possibility that this information may mean that people participate to receive the token, when they would not; and 2) the need for full informed consent in which one is transparent about all the research processes. We made the decision to inform the participants about the token as we believe it is important to disclose everything related to the research to the participants and to

further ensure open and honest communication with the participants about all aspects of the research.

Informing participants about the token came with a number of challenges. Firstly, there were instances where I felt that some of the women participated in this study to get the token especially those whose narratives I felt were short and rushed. Having spoken about this with my supervisor and co-researcher before data collection commenced, I reminded myself that it was a possibility. Secondly, during data collection, there was a time when multiple people from the community came to the hall where interviews were being conducted asking about the token as they had heard about it from other people who had participated in the study. My co-researcher and I negotiated this situation by informing these community members that we aimed to recruit a particular number of people for our respective studies and had already obtained the required number. Turning away many people who we knew needed the voucher was very difficult considering the economic context in which they lived.

6.5 Privacy, anonymity, and confidentiality of data

The pseudonyms used to identify participants in the interview transcripts were also used in the analysis chapters which follow in order to protect the rights to privacy and anonymity of the participants (Orb et al., 2000). Furthermore, any information that was personally identifiable such as names of places and other people who were mentioned during the course of the interviews were omitted from the data and do not appear in the extracts.

With regard to confidentiality of the data, apart from myself and my co-researcher, the only person who had access to the audio recordings was the project administrator. Regarding access to the transcripts of the interviews, other researchers at the CSSR that this research is part of will have access. The interview recordings and transcripts will be stored in a password protected computer in the CSSR building for five years. When this period of time has passed, the recordings and transcripts will be destroyed. Hard copies of the transcripts will also be locked away in the CSSR building. During this period, other researchers at the research unit may use the collected data for other research purposes as this is a requirement for all CSSR research. All ethical requirements in relation to anonymity will be followed by these researchers. All the participants are aware of these requirements as it formed part of the informed consent process.

7. Reflexivity

In critical qualitative research, reflexivity "involves critical reflection of how the researcher constructs knowledge from the research process – what sorts of factors influence the researcher's construction of knowledge and how these influences are revealed in the planning, conduct, and

writing up of the research" (Guillemin & Gillam, 2004, p.275). Simply put, reflexivity refers to the process by which the researcher explicates his/her involvement in the research process and the implications of this involvement in shaping the collected data and the knowledge produced. This is achieved by being self-reflexive and reflecting on, or "disclosing", the researcher's own subjectivities, being transparent, and opening the researchers practices and processes to scrutiny, revealing its messiness, pitfalls and problems. To encourage reflexivity in this study, I kept a research/field diary in which I documented my experiences and thoughts. In this section, I draw on extracts from this journal.

7.1 Positioning the researcher

Drawing on her own research experience with women who do not identify with feminist aims, Watts (2006) explains how assumptions made about the researcher, including the way in which the researcher is positioned, has implications for how the research is conducted. As mentioned previously, the mentors from the NGO were relied upon to introduce this study to previously pregnant women who drank during their pregnancies in the communities in which they work in order to recruit participants. This meant that the way in which my presence and purpose (including that of my co-researcher) in the community was described would have implications for, firstly, whether or not the women would want to participate and secondly, what their expectations were when they first met us during the information session. I use an example to illustrate this point.

When my co-researcher and I first met with the potential participants, we noticed that the women had little and different information about who we were as well as very little information about the purposes of the research. Some of the women referred to us as social workers while others knew that we were students working together with the NGO. The women who referred to us as social workers expressed that they thought we were going to take their children away from them because they had drank during their pregnancies. Given these differences, my co-researcher and I explained who we were and our purpose for being in the community and conducting the research. We also clarified the fact that we would not take their children away from them nor would we share their stories with anyone else. We then asked the participants if they had any questions for us before asking them if they were interested in participating. Only one of the potential participants declined participation and she expressed surprise upon not encountering resistance with respect to her decision.

Although helpful, our two phase approach to recruiting participants as described earlier in this chapter may have conferred outsider status to my co-researcher and me, creating suspicion among some of the women who participated in this study. Among others, it may have conferred insider

status due to the study being institutionally endorsed, thus providing it with 'credibility' and 'validity' (see Watts, 2006). Further, in locating my co-researcher and me within the NGO setting, some of the mentors enabled the research to be seen as less threatening than may otherwise have been the case. Although this may have been the case, it is important to note that this may have been problematic when it comes to the question of voluntary consent as this endorsement may explain the difficulty some of the women had when it came to declining or refusing to participate in this study. With reference to feminist work on insider/outsider positions, I take this discussion further below.

7.2 Insider/outsider positions

During the process of data collection, there were aspects of my identity that gave me insider status while others meant that I occupied the position an outsider. Being 'Black', a woman, and an isiXhosa speaker meant that I was similar to all of the women who participated in this study. My socio-economic status made me different to most of the women who participated in this study. As a student, an identity of mine which was foregrounded by this study, I was different to most of the participants, majority of whom had a high school level of education. An identity of mine I was most aware of was that of being a researcher which positioned me as an outsider as well as an expert (Bhavnani, 1990, as cited in Macleod, 2002). However, the interview methodology I used to collect data for this study allowed me to place the participants rather than myself in the position of expert as I did not enter the interviews with predetermined questions. Further, by allowing the participants to share their stories and experiences with me and using their narratives of experience to construct further questions ensured that they were able to maintain this position. I elaborate on the position of the researcher as the expert below when I discuss the relationship between the researcher and participants.

Collins (1986) argues that while occupying an outsider position might come with disadvantages, there are some benefits. One of these benefits includes "the tendency for people to confide in a 'stranger' in ways they never would with each other; and the ability of the 'stranger' to see patterns that may be more difficult for those immersed in the situation to see" (Collins, 1986, p.S15). Lucy alluded to this in the extract below:

Sbosh: *Okay and then uhm how did you feel taking part in this research?*

Lucy: *It made me feel like I can advise other people*

Sbosh: *So it was easy to speak about the things you spoke about and share your story with both of us being people you have never met? Obviously you saw us at the information session but we were people you just met and so on*

Lucy: *No it was easy (.) I am generally a person who usually wants to take something [that is bothering me] out and talk so that it can be [get] better*

Lucy, in the above extract mentions that it was easy for her to share her story with my co-researcher and me despite the fact that we were strangers. Further, she highlights that talking about things that are bothering or troubling her is something that she normally does and in doing so, she is able to confide in a stranger(s) to find comfort given the fact that the stranger, it is assumed, may not be encountered regularly.

7.3 Relationships in the research process

Parker (2005), in his chapter on reflexivity, emphasises that attention to the different relationships between those involved in the research process is important when the researcher aims to critically account for the influence of various aspects of the research in knowledge production. In this chapter, Parker (2005) speaks of three relationships which I discuss below: 1) between the researcher and participants; 2) between the researcher and co-researcher; and 3) between the researcher and supervisor.

7.3.1 Between the researcher and participants

Guillemin and Gillam (2004) emphasise the close connection between ethics and reflexivity, arguing that the manner in which the researcher manages the relationships between himself/herself and his/her participants is a reflection of the way in which the participants are viewed. During the research process, there were times where I found myself relying on the privileges linked to my position as a researcher (I illustrate this with an example shortly), although I had intended to manage the relationship in a way that treated the participants as equals. In the interview process, Bhavnani (1990, in Macleod, 2002) suggests that one of the power relations within a research relationship, especially between the researcher and his/her participants is that of the researcher occupying the expert position which often guards the researcher from being checked or questioned.

After Lucy and Morongwa had shared their narratives in the first sub-session and I informed them that my co-researcher and I would be leaving the room to compile questions for them, both these women asked why we were not compiling these questions in their presence. I had recorded the following in my research diary about this incident:

Today was another productive day and something that stood out for me today when doing the interviews was how Lucy and Morongwa questioned me about why we were going to develop questions for them outside and not inside with them around. I was very surprised by this because I did not expect the women to ask questions about why some things were done in a certain way.

Unable to explain this specific requirement of the methodology, I informed the participants that our intentions were pure. As I had not expected my participants to question certain aspects of the methodology, I realised that I had assumed that the participants would trust my judgement. As such, I had slipped into the position of the researcher as expert.

7.3.2 Between the researcher and co-researcher

The research process, as Parker (2005) notes, is a collective one. Apart from the researcher and the participants, there may be other people such as co-researchers involved in this process depending on the nature of the research. As this study is part of a bigger project and two individuals are working on the current study but on different aspects, my co-researcher was a colleague of mine from the CSSR whose project focuses on the narratives of the partners and family members of women who drank during their pregnancies. I acted as co-researcher for her research. As mentioned previously in this chapter, the role of the co-researcher during the narrative interviews was mainly to listen to the narratives of the participants and take notes which we would use to compile questions for the second sub-session.

Working with a co-researcher in this study was very enjoyable and helpful. The note taking of the co-researcher during the first sub-session enabled me to be respectful of my participants as I was able to give my participants my full attention when they were telling their stories. Having my co-researcher present in the room during the interviews also made me feel less nervous about being observed as was the case during the mock interview. In conducting the actual interviews, I was comfortable and relaxed. When we left the room for 15 minutes to compose questions for the second sub-session, the co-researcher and I composed questions productively and quickly given the fact that the content of the narratives was still fresh in our minds. We also reminded each other about asking questions that would elicit more detail from the participants. During this time, the co-researcher and I were also able to talk about the content of the narratives, process and debrief about some of the difficult experiences that were shared by the participants. During the interviews, my co-researcher respected my status as the main researcher and I did the same during her interviews. As such, she also did not attempt to take over the interviews during the second and third sub-sessions to ask her own questions. After I had finished asking the participant questions in both these sub-sessions, I would ask her if she had any questions to ask. This was helpful for both of us as we picked up on interesting things that the main researcher may have not picked up on or things that we may have forgotten to ask about.

One issue that emerged in working with a co-researcher in this study was that when some of the participants were telling their stories, the co-researcher would react to some events that were shared by saying *yho*. I was unsure about discussing this with my co-researcher as I was aware of the fact that this may have been happening unconsciously. However, my co-researcher and I did discuss this and we decided to remind each other prior to the participant entering the room before their interview to avoid reacting to what is said to avoid the possibility of making the participant feel like they are being judged.

7.3.3 Between the researcher and supervisor

In conducting a research project, a number of decisions between the researcher and his/her supervisor are made. These decisions include (but are not limited to) the topic and aims of the research, the research questions, the theory or theories that will be used to guide both the research process including data analysis and interpretation, who the participants will be and the strategies to be followed in recruiting them including the methods to be used for data collection and analysis. This study has been shaped by an interactive decision making process between my supervisor and me.

While the decision to conduct this research was mine, the aims, approaches to data collection and analysis had been developed by my supervisor as it forms part of a bigger project on alcohol use during pregnancy. Although this was the case, the relationship between my supervisor and I was conducted in a way that my input in the decision making process was encouraged as I will demonstrate by way of examples below. As I was aware of my supervisor's knowledge in conducting research and guiding students in this process, I would defer to her expertise when I was uncertain about how to solve a particular problem related to this study.

Following my decision to conduct this study, my supervisor and I had initial discussions, for example, about which women would be included in this study and whether they had to have a child diagnosed with FAS. We jointly decided against this as FAS is very difficult to diagnose and rather recruit women who drank during their pregnancies. Our initial discussions also dealt with decisions around how and from where the women would be recruited. Recruiting from the NGO that we did use was an idea that my supervisor had suggested after my attempts to recruit women from NGOs which dealt with child and family related issues were not successful. With regard to the research questions guiding this study, the main research question and the first sub question were taken from the initial proposal of this project which was compiled by my supervisor. I compiled the other two sub-questions given the theory guiding this study which I also selected. During the course of putting this thesis together, my supervisor provided very useful advice and feedback.

7.4 The researchers' expectations

After having read and critically engaging with the literature on drinking during pregnancy, including some research that has been done to highlight the contextual factors that contribute to drinking during pregnancy, I believed I was prepared and open minded enough to listen to and co-produce the narratives of the participants. When I read over the reflections I had made at the end of each day of interviews, a different picture emerged. Below, I include a reflection from the research diary I kept and comment on how my expectations influenced the process of data collection. The reflection is taken from a journal entry of my second interview with Dineo. As evident below, I commented on the length of the interview and the absence of events and experiences that were important during the pregnancy:

The second interview of the day was very short. Dineo's narrative was 3 minutes and I don't think I did enough to encourage her to tell her story because she only spoke about one event but the question asked her for events and experiences not just one event or experience

In reflecting further on the above, I now realise that in going into the field to conduct the interviews, I expected the women to tell in-depth stories. When I listened to the audio recording of this particular interview, I realised that I was listening for a particular kind of story; I had not expected a story where the participant would only share one event or experience with my co-researcher and me. After Dineo had indicated that she had finished telling me her story, I asked her if she had anything more to say. The extract below from her interview shows this:

Sbosh: *Okay (.) is there anything else you would like to tell us maybe that happened during the time when you were pregnant?*

Dineo: *I thought that my stress would go away when I was drinking but when the alcohol finished I used to think [about these things] again so it's the same thing like I was wasting mos. The stress was always there sisi and things just become worse*

What is evident in the extract above is that by asking Dineo to tell us about anything else that happened during the time she was pregnant, I was attempting to shape her response into one that was in line with my expectations. As such, I failed to respect her role in shaping both the direction and content of the interview (Anderson & Kirkpatrick, 2016) and therefore producing her own story.

8. Evaluation and validation

A number of scholars (Mays & Pope, 2000; Schwandt, Lincoln, & Guba, 2007; Shenton, 2004; Tracy, 2010) have argued that the criteria used to ensure the quality of a quantitative study including generalisability, objectivity, reliability, and validity cannot be used to assess the quality of a qualitative study. Rather, researchers have suggested that qualitative researchers speak about ensuring trustworthiness through the use of criteria like credibility, confirmability, and transferability which are more appropriate than the above (Schwandt et al., 2007; Shenton, 2004; Tracy, 2010). The way in which trustworthiness was ensured in this study is discussed below.

8.1 Credibility and confirmability

Shenton (2004) defines credibility as the researcher's "attempt to demonstrate that a true picture of the phenomenon under scrutiny is being presented" (p.63). Confirmability involves the researcher taking certain steps to ensure that the findings of the study emerge from the dataset in relation to the theory applied rather than from his/her own interpretations (Shenton, 2004). To ensure these two criteria in this study, three strategies were used namely, member checking, participant orientation, and peer debriefing.

Member checking involves the constant checking of the interviewer's understanding of the participants' narratives with the participants and co-researcher (Agbedahin, 2012; Schwandt et al., 2007; Shenton, 2004). This process can take place continuously both during and after data collection. In this study, member checks could not take place during the first interview in sub-session one as the participant could not be interrupted when telling their story. However, the second sub-session in the first interview and the second interview in which sub-session three takes place opened up the possibility of these checks to take place both with my co-researcher and participants as I had an instant opportunity to correct and confirm my understanding of the participants' narrative when we were formulating follow up questions and with the participant when asking them follow up questions and re-interviewing them.

Another strategy for ensuring credibility and confirmability useful to this study was participant orientation or the use of the participants' own phrases and words (Potter & Wetherell, 1987). In this study, participant orientation involved the transcription of the interviews which were conducted as well as providing and using extracts from the transcripts to support the conducted analysis.

The third and final strategy used to ensure credibility and confirmability was peer debriefing. This strategy involves the researcher engaging in dialogue with colleagues who have experience with the same topic, population, and methods utilised in the research to find out if he/she is on the right track

(Agbedahin, 2012; Schwandt et al., 2007; Shenton, 2004). Access to my supervisor and other CSSR researchers who have conducted research utilising the same or a similar methodology and who have also conducted research of a sensitive nature were very helpful every time I had questions and was confused. They offered guidance where necessary and provided valuable feedback during the mock interview and presentations of preliminary findings. The CSSR also has regular work-in-progress colloquia and research retreats. In these spaces, my colleagues listened carefully to my work, asked questions where necessary, and provided input concerning potential improvements which also helped in conducting this study. It is hoped that my use of the above strategies as well as my inclusion of a section on reflexivity have, in some way contributed to ensuring trustworthiness in this study.

8.2 Transferability

Transferability in qualitative research refers to the applicability of the findings or research to other contexts and populations other than those within which the data and findings were obtained (Schwandt et al., 2007; Shenton, 2004). This strategy according to Tracy (2010) "is achieved when readers feel as though the story of the research overlaps with their own situation" (p.845). Thick descriptions of the context of participants, the participants themselves without risking exposure of their identities, and of data, including examples of participants' own words need to be offered by the researcher for transferability to be achieved (Tracy, 2010).

9. Summation

In this chapter, I outlined the steps and procedures I followed in order to make this study possible. I started by discussing the methods of convenience and purposive sampling I employed for recruiting the women who participated in this study. This discussion was followed by a detailed explanation of the narrative interview I used to collect narrative data. Steps taken in analysing and interpreting the women's narratives were also outlined. Using an approach to research ethics that views ethics as important at all stages of the research process (Shaw, 2008), I discussed the ethical considerations related to this study. Thereafter, I critically reflected on my involvement in the research process, looking particularly at the role of my position as the researcher, my experience of the different research relationships as well as my expectations and the implications these have had on the data and knowledge produced in this study and the final research thesis. Lastly, I discussed the various strategies used to ensure trustworthiness in this study with reference to the criteria of credibility, confirmability, and transferability (Schwandt et al., 2007; Shenton, 2004; Tracy, 2010).

Having outlined the methodology of this study, I will now present the findings. The next chapter is the first of two analysis chapters and discusses the discourses drawn upon by the women. In the

second analysis chapter, I discuss how the discursive resources are drawn upon in constructing narratives, the subject positions enabled, and the gendered power relations referred to in the narratives and discourses.

Chapter Five: The discourses the women deployed in telling their stories

1. Introduction

This is the first of two chapters in which I present the analysis and interpretation of my research findings. The focus of this chapter is on the discourses drawn upon by the women in this study in constructing their narratives of the journey of their pregnancy. In narrating their stories, the women employed discursive resources around 'stress and coping', 'gender', 'peer pressure', 'disability and development', 'good mothering/appropriate pregnancies' 'culture' as well as 'religion'. In doing so, I argue that the participants speak about drinking during pregnancy in two ways: 1) as a practice which helped them cope with the challenges and issues they experienced during their pregnancies, and 2) as a socially sanctioned practice.

In an attempt to highlight how drinking during pregnancy was a helpful practice for the women in this study, I begin this chapter by outlining the overarching discourse of 'stress and coping'. I move on to focus on the 'hegemonic masculinities' discourse which is followed by the 'peer pressure' discourse. I discuss the 'disablement and developmental delay' discourse which is followed by the 'good mothering/appropriate pregnancies' discourse, the 'cultural' discourse and finally, the 'religious' discourse. I use inverted commas for the names of the discourses the women deployed so as to emphasise that they are constructions in and of themselves and that discourses are not stable or fixed.

Bacchi (1999) notes that social problems are the products of historical, political and socio-cultural circumstances and, as such, the discussion and construction of social problems does not occur in a vacuum. Based on this, in this chapter, I outline women's use of the discourses in their narratives of drinking during pregnancy, as these discourses are embedded in the socio-cultural and gendered power relations of the South African socio-historical space.

2. A 'stress and coping' discourse

In utilising this discursive resource, the women in this study highlight the relationship that exists between alcohol use, and their personal problems or circumstances, thus explaining and/or justifying their drinking. The women considered drinking as a way to cope with the problems they experienced in their lives, echoing findings in the studies conducted by Eaton et al. (2014b), Rolfe et al. (2009) and Watt et al. (2014) discussed in the literature review in chapter two. All of the women in this study spoke about the problems they experienced before and after their pregnancies but most spoke about the problems they experienced during their pregnancies. As such, in employing a 'stress and coping' discourse, the women position themselves as dependent on alcohol

in order to cope. Hope, Cindy, and Lucy explain why they drank during their pregnancies in the extracts below:

Extract 1

Hope: *Okay when I was pregnant (.) I (.) I (.) found out that I was pregnant in February. Okay (.) then I went to go get tested and I found out [that I was pregnant]. At the clinic they don't test one thing (.) the fact that you are pregnant (.) they test a lot of things so (.) and it doesn't depend on whether you want to or you don't want to (.) it is a must that you are tested [for other things] when you find out that you are pregnant so I found out that I am HIV positive and then I couldn't (.) I couldn't (.) [clears throat] I couldn't stay and keep this [I couldn't handle] so I started drinking alcohol (.) okay (.) during my pregnancy. I couldn't believe that I was pregnant and HIV positive so the alcohol helped me forget about this sisi. I also didn't take my pills [antiretrovirals]*

Extract 2

Cindy: *[...] said that the baby was not his and this made me very stressed so this is when I started drinking (.) drinking made the stress better. When I was eight months [ahead] [clears throat] my father passed away after he was stabbed in another area that is located above where we live so this made my drinking worse. When I drank I forgot that my partner denied my child and that my father was gone*

Extract 3

Lucy: *I found out that I was pregnant (.) I saw when I was three months [ahead] ha.a I saw when I was three (.) no three months yes and he [my partner] (.) when I told him he never came to see me again and I ended up drinking. Most of the time I felt like I should drink (.) it felt like I was alright when I drank alcohol and then I lost the tummy [had a miscarriage] when I was four (.) during four and a half [months] then I drank some more after this then he (.) and then I got pregnant again and then he used to come [and see me] and he kept doing this on and off and he used to come and then I got pregnant again with [...] (.) a child called [...] until I (.) and he didn't want to see me until he fell in love [with someone else] below my house and made someone pregnant there as well. These are some of the things that made me drink because I used to always (.) it was like I didn't want to think most of the time because when I thought about these things I would worry and realise that I was really struggling [it was] worse when I saw him with that girl cause that girl lived at the bottom of my house and we used to do everything together so it was like she was a friend*

In the above extracts, we see that in explaining/justifying their drinking, the women spend time providing details regarding how their circumstances lead to negative emotions and therefore stress.

Hope (extract 1), in showing these negative emotions, says *I couldn't (.) I couldn't* repeatedly. She indicates that her HIV diagnosis caused her stress when she says *I couldn't believe I was pregnant and HIV positive*. Cindy (extract 2) in describing how she felt when her partner denied the baby says *this made me very stressed* and the death of her father exacerbated her drinking. Lucy (extract 3) mentions that the fact that her partner never came to see her after she told him she was pregnant made her stressed and as she says *I would worry and realise that I was really struggling*. Like Cindy, whose drinking was exacerbated by loss, Lucy's drinking increased due to the loss of her first potential child.

Although the discourse of 'stress and coping' has an element of individual agency (the women used the active form of description), in explaining their circumstances of stress, the women construct their problems and circumstances as compelling them to drink as the only coping mechanism. As such, drinking during their pregnancies relieved the stress they experienced due to the relational and domestic problems they faced. This is evidenced in their use of terms and phrases such as *helped me forget* (Hope), *made stress better* (Cindy) and *I didn't want to think* (Lucy). As such, alcohol use is described as a coping strategy and is spoken about as having drug or medicine-like qualities (Drabble & Trocki, 2013; Rolfe et al., 2009), where drinking is used as a way to reduce and regulate unwanted internal experiences, to diminish stress (Watt et al., 2014b), and to forget about the hurt and pain associated with their circumstances of stress such as an HIV diagnosis, pregnancy and paternity denial, infidelity, and the death of a family member as well as a potential child.

One of the women in this study (Dineo) acknowledged that while alcohol can help a person cope with their problems, it does not provide a long term solution. In doing so, Dineo does two things. Firstly, she illustrates how a 'stress and coping' discourse has limited utility in justifying drinking during pregnancy and, secondly, she shows how discourses, as argued by Parker (1992), may reflect on one another. She said:

Extract 4

Dineo: *I thought that my stress would go away when I was drinking but when the alcohol finished I used to think [about these things] again so it's the same thing like I was wasting mos. <u>The stress was always there sisi</u> and things just become worse*

In her initial narrative, Dineo mentioned that she drank because of her partner's failure to support her and her potential child as well as his infidelity. In the above extract, she highlights the fact that drinking in order to cope with her problems has some limitations – it did not solve or get rid of her problems but rather exacerbates them.

3. **'**<u>Hegemonic masculinities' discourse</u>

Carrigan, Connell, and Lee (1985) argue that hegemonic masculinity is "a question of how particular groups of men inhabit positions of power and wealth and how they legitimate and reproduce the social relationships that generate their dominance" (p.572). In simple terms, hegemonic masculinity can be understood as one version or kind of masculinity which represents a dominant form of masculinity where this version or kind is presented as the cultural ideal determining the standards against which other masculinities are both defined and subordinated (Connell, & Messerschmidt, 2005; Morrell, 1998). From the above, it is essential to highlight that masculinities are not created equally, thus multiple and diverse masculinities exist (Mfecane, 2016). Connell and Messerschmidt (2005) in supporting the above argue that "certain masculinities are more socially central or more associated with authority and social power than others" (p.846). Simply put, hegemonic masculinities are not the same everywhere: masculinities take up different cultural forms and in particular cultural spaces; certain things about being a man will be valued over others.

In the Xhosa culture, for example, circumcision also known as *ulwaluko*, an initiation ritual performed to mark the transition from boyhood to manhood, is crucial to being regarded as a real man or *indoda* and this affords him certain rights and privileges (Goniwe, 2004; Mfecane, 2016). This practice allows a man to actively participate in community discussions and rituals, build a homestead and marry. In addition, a man is expected to reproduce and thus provide for those in his homestead (Ntombana, 2011). A change in behaviour according to Ntombana (2011) is the main important characteristic of a new initiate. As emphasis is placed on behaviour during the practice of *ulwaluko*, a distinction is evident between one who is circumcised and one who is not circumcised or has done the practice medically (Gitywa, 1976; Ntombana, 2011). Mavundla, Netswera, Bottoman, and Toth (2009) argue that initiates are considered to be men while those uncircumcised or circumcised medically even when they are older are considered to be boys or *inkwenkwe*. Amongst the Xhosa in South Africa, therefore, the practice of *ulwaluko* endorses and regulates culturally accepted norms of heterosexual manhood.

In line with the above, within a discourse of 'hegemonic masculinities', the women construct men/their male partners as individuals who have the right to control them (through being violent due to drinking or non-drinking) and the right to be listened to. They are the heads of the household, thus taking up the role of being breadwinners/financial providers. As such, in this discourse, the dominant position of men/male partners is emphasised and it becomes evident that the heterosexual, romantic relationships that the women have with their partners are patriarchal in nature. That is, the

relationships are constructed as unequal and unfair. Nono and Lucy in the extracts below illustrate the ‘hegemonic masculinities’ discourse:

Extract 5

Nono: *Okay (.) when I was pregnant the first time I didn’t know. I used to drink a lot with my husband you understand? We fought and I am a person who gets angry easily/quickly (.) I fought back and I ended up being stronger than him but he ended up beating me and after he beat me I had a miscarriage (.) <u>I hated him and I did not want him</u> but here even I thought I should leave him and go live by myself/on my own but here even I did not stop drinking. I went to live in another place (.) I found myself another place and then he came to my house and apologised and I let him back in. I thought things would change but we used to fight and he used to beat me but sometimes he used to control himself even though I was the one that always provoked him*

Extract 6

Lucy: *When I got pregnant I told myself that I would stop drinking but my partner kept on telling me to drink because he cannot drink alone and I used to say ‘no I am pregnant’. One time he beat me because I didn’t want to drink so after that day (.) I (.) I (.) I decided that I would drink with him and we did not fight a lot when we drank together*

Nono (extract 5) shows how her own alcohol use and that of her partner during her first pregnancy resulted in them fighting and caused her to miscarry. Even though she decided to leave him after this happened and she expresses that she hated him and did not want him, she states *he came to my house and apologised and I let him back in*. The reason behind this is that her partner had fulltime employment, as she mentioned in her narrative, while she did not, thus she was dependent on him to support her. Here, we see that Nono is financially dependent on her partner, a notable tenet of hegemonic masculinity (see Connell, 2002). Even though the fights continued, Nono justifies the violence when she says *I was the one that always provoked him* and thus blames herself for the continued violence further defending her partner when she says *but sometimes he used to control himself*. Unlike Nono, Lucy’s (extract 6) non-drinking during her pregnancy led her partner to become violent. As such, she drank in order to prevent her partner from becoming violent although that it was not completely successful, as she says *we did not fight* ***a lot*** *when we drank together*; this hints to the fact that there possibly was some fighting. In this instance we see power operating in a repressive manner as Lucy’s partner, through being violent, got her to do what he wanted her to do (to drink with him) despite the fact that she was pregnant. Lucy also highlights how her partner failed to support her decision to stop drinking during her pregnancy.

Although Nono and Lucy narrate taking agentic positions (leaving the partner, deciding to not drink), in the end they take up a powerless and submissive subject position with their partners positioned as controlling and dominant. Another important element of hegemonic masculinities evident in the above extracts is that men, as opposed to women, are said to hold more power. In South Africa, hegemonic masculinity is mainly associated with the subordination and oppression of women. Jewkes and Morrell (2010, p.3) state "In a highly gender-inequitable country like South Africa, hegemonic masculinity mobilises and legitimates the subordination and control of women by men". The IPV experienced by both Nono and Lucy falls within this discursive framework as it is an illustration of the violent authority and control their male partners have over them. Given the prevalence of patriarchal beliefs and values in South Africa, an environment where women experience high rates of abuse and violence has been fostered (Choi et al., 2014b; Jewkes & Morrell, 2010).

Lyons and Willott (2008), in their study conducted in Auckland New Zealand with both women and men who drank, found that some women were able to assert themselves when they had drunk and challenge unequal partner dynamics. This was also evident in the present study as Nono mentions that she *fought back* although her partner ended up beating her. It could be assumed that the drinking gave her the power and/or courage to fight back. As Lucy was unable to assert herself, it could be argued that she drank (although she had decided to stop due to becoming pregnant) because she may have felt that she was unable to stand up to her partner. The 'hegemonic masculinities' discourse is taken further below in the 'male/masculine provider' discourse.

3.1 The 'male/masculine provider' discourse

The 'male/masculine provider' discourse draws on the gendered notion of men as breadwinners who provide for both their partners and children. The women in this study drew upon this discourse when speaking about instances of men or their partners denying responsibility for the pregnancy. For many of the women, this meant that their partners/these men would not be available to provide for the pregnant woman as well as the potential child once it is born. In the following extract, Dineo sees her partner as a provider:

Extract 7

Dineo: *Okay ke sisi (.) before I got pregnant the father of my child and I were on good terms. He used to do nice things for me really (.) he used to take care of me but when I told him I was four months pregnant he said 'okay' and things started to change. I (.) I (.) he used to do funny/weird things for me and I would ask him 'why have you changed and are the way you are?' and he didn't respond. After this he stopped buying me clothes and food and then I could not get hold of him over*

the phone until I found out that he changed his number. He does not even buy baby stuff [things for the baby] now

In extract 7, Dineo draws upon the ‘male/masculine provider’ discourse when she talks about the expectation of men to be providers. Being pregnant without a reliable, solid heterosexual partner means that gendered expectations of the roles of men and women (men being the providers and women the child rearers) cannot be met, thus problematising the pregnancy. Dineo speaks to her partner ‘doing nice things and taking care of her’ and this may include both emotional and financial support.

In instances where a man cannot fulfil the male/masculine provider role, his family is expected to fulfil this role if they can confirm, together with the father, that the child is his particularly after birth. Cindy said:

Extract 8

Cindy: *When I found out I was pregnant I told my boyfriend and he said that the child was not his. I think he told his grandmothers and they called me and said ‘we hear you are pregnant’ and I said ‘yes I am pregnant’ and they asked ‘who made you pregnant?’ and I said ‘[…] made me pregnant’ then they asked if I was sure about what I was saying and I said ‘yes’ and they asked ‘how do you know that […] is the one that made you pregnant?’ and I said ‘I know because since the day I came back home from him I got home and vomited’ and they said ‘hayke we will see how the baby looks’. After the baby was born […] was in Cape Town (.) his friend told me that he left. I took the baby to the grandmothers and they said they cannot tell if the child is […] or not because he was not around so (.) so (.) they cannot accept the child. When I left their house I was crying all the way to the taxi rank*

Cindy, in extract 8, shows how her boyfriend’s family refused to take over the role of the man by taking responsibility for the pregnancy. This meant that she could not take care of the child alone as she did not have the financial means to do so. In this instance, the family, like the man, have failed to fulfil the male/masculine provider role. Of interest here is that Cindy, in her narrative follow-up session shared that her partner’s mother wanted to start supporting the child when he was four months old after she was told by her son that he had indeed made Cindy pregnant. Instead of using the money to buy things for the baby, Cindy mentioned that she used the money to buy alcohol. A possible reason for this could be the fact that her mother was already supporting her son and she may have felt it was already too late for the partner’s family to take up the male/masculine provider

role as they had not believed her when she told them that their grandson made her pregnant but rather positioned her as untruthful/dishonest by questioning her about the father of the child.

When it comes to drinking during pregnancy, the 'male/masculine provider' discourse, as mentioned previously, draws from expected gender norms within the society. In this instance, the societal context is the Xhosa culture in South Africa. In drawing upon the 'male/masculine provider' discourse, the women in this study positioned men and or/their partners as irresponsible and unreliable. The extracts discussed in this discourse can thus be summarised as constructing a male/masculine provider as a man who: 1) does not deny responsibility when there is a pregnancy or disappears once told about a pregnancy; and 2) is able to take care of the potential child and the woman financially both during and after the pregnancy. Such qualities, as the women in this study have shown, are missing in the men about whom they spoke.

4. <u>'Peer pressure' discourse</u>

In a discourse of 'peer pressure', the influence or role of others (e.g. friends) in influencing an individual's drinking behaviour during their pregnancy is highlighted. Further, the women highlight how drinking during pregnancy is actively encouraged by peers. In highlighting the role of peer pressure and explaining why she continued to drink during her pregnancy, Cindy said:

Extract 9

Cindy: *The reason [is that] I was forced by my friends even when I told myself that I wasn't going to drink (.) they brought alcohol and they told me to come and drink and I also ended up going to drink*

In extract 9 above, Cindy draws on a 'peer pressure' discourse when she says *I was forced by my friends even when I told myself that I wasn't going to drink*. In doing so, she shows that her friends had an influence on her decision to continue drinking during her pregnancy although she told herself that she was not going to do so. She further emphasises that she was actively encouraged when she says *they told me to come and drink*, further indicating that she was unable to resist the pressure or say no when her friends had come around. The reason why Cindy was unable to resist this pressure from her friends may have been because should she have said no, there would have been consequences such as being excluded from the friendship circle. As Foucault (1978) would argue, power in this instance is operating in a productive manner as Cindy was not forced (through the use of physical force or violence) to drink. Instead, she drank out of her 'own free will'. In this instance, power is thus normalising as drinking amongst peers is the norm.

Unlike Cindy, Lola was able to resist the pressure from her friends to drink during her pregnancy. She said:

Extract 10

Lola: *I didn't drink during the first [pregnancy] and my friends who I used to drink with had a problem with me not drinking. They said I was boring and making myself better than them so (.) so we did not talk for some time. They also stopped coming to see me.*

In extract 10, Lola shows how her non-drinking during her pregnancy affected her relationship with her friends with whom she used to drink before. In doing so, she highlights how in friendship circles, non-drinking is problematised as drinking in many communities is considered a norm. That is, drinking is seen to be an activity that fuels (and maintains) social interactions, as it is a means of having a good time being a pleasure filled activity (Branco & Kaskutas, 2001; Cloete, 2012). Instead of positioning Lola as a good and responsible mother for her non-drinking, her friends position her as boring given the fact that she went against such norms by choosing not to drink during her pregnancy. In relation to the discourse of 'peer pressure' Lola shows that even though her friends had a problem with her non-drinking, she was able to resist their influence as she maintained her decision of not drinking during her pregnancy, despite the fact that she lost friends and was regarded as boring for doing so. Lola's narrative indicates the costs associated with resisting norms.

5. <u>A 'disablement and developmental delay' discourse</u>

In constructing their narratives, most of the women utilised a 'disablement and developmental delay' discourse to emphasise the widely held view that drinking during pregnancy is detrimental to the foetus. Below, the women share their views:

Extract 11

Nonny: *She [my mother] told me that a pregnant person doesn't drink (.) I should never drink alcohol because I will ruin the baby (.) otherwise, when you drink the baby comes out wrong and they will come out looking disabled if he/she*[8] *was not going to be [disabled] that's what people say*

Extract 12

[8] No gender pronouns are found in African languages (including isiXhosa). Pronouns are only derived from noun classes.

Lucy: *(2) Yes [I know] just a little but I have heard people speak (.) when you drink when you are [pregnant] the child can come out deformed and underweight and may struggle at school*

Extract 13

Dineo: *Well (.) they say that when a pregnant woman drinks when she is pregnant the child's brain gets disturbed (.) I don't know if this is true (.) I don't know about other things*

From the above extracts, it is clear that the women in this study are aware of the effects of drinking during pregnancy on the foetus. These effects, as mentioned, range from the potential child becoming or being born disabled or deformed, being underweight, and being brain damaged which will lead to struggling at school. Such effects are widely highlighted in the literature on drinking during pregnancy (e.g. Murray et al., 2016; Sundelin-Wahlsten, Hallberg, & Helander, 2016). Unlike Nonny and Lucy, Dineo expresses doubts regarding the authenticity of brain damage associated with drinking during pregnancy hence she says *I don't know if this is true*.

Lola and Khethiwe expanded on the effects of drinking during pregnancy when they said:

Extract 14

Lola: *My first child is alright as I didn't drink during my first pregnancy but the one I drank a lot when I was carrying she doesn't listen at all (.) if I say no now she will go stand in a corner and say I'll say no again and then smack her [but] she does the same things I asked her not to do (.) it's like she is a different child (.) I don't know (.) I wish she could have her brain checked (.) if I had money I would take her to the brain doctor [neuropsychologist] cause I don't get her and my mother says that its maybe because I drank a lot of alcohol [when I was pregnant]*

Extract 15

Khethiwe: *The dangers of using alcohol when I was pregnant are the those I am seeing now (.) my child didn't come out normal like the child of a person who did not drink [when they were pregnant] (.) when I met up with the doctors they said my child was a laties and that his/her things would be late (.) when I gave birth to my child the time came for him to start crawling nhe (.) he did not crawl (.) when he had to sit (.) I mean the things he did (.) he did not do the right way he was supposed to (.) he had a failure you see (.) I mean when he had to sit he didn't sit (.) when he had to crawl he didn't crawl*

In extract 14, Lola highlights how her drinking has caused behavioural problems for her child when she states *she doesn't listen at all* while Khethiwe in extract 15 speaks to how her drinking caused

developmental problems for her child particularly when it came to him crawling and sitting. Both women in the above extracts draw on the 'disablement and developmental delay' discourse to construct children born from mothers who drink during their pregnancies as different and/or abnormal. Lola does this by comparing her first child for whom she did not drink and who she refers to as being alright to the second, highlighting the problems she is experiencing with her. Similarly, Khethiwe states that *my child didn't come out normal like the child of a person who did not drink [when they were pregnant]* and her child's difference is further confirmed by the doctors who call him a *laties* or a child whose development is delayed.

An important element of the 'disablement and developmental delay' discourse that needs to be highlighted is that while the effects of drinking during pregnancy the women speak to are factually correct, such a discourse dominates in discussions regarding alcohol use during pregnancy and provides a lens through which everything around drinking during pregnancy is understood. That is, the focus in discussions about drinking during pregnancy is primarily on the effects or outcomes of engaging in this practice and less on the role of the context in enabling drinking during this time. Further, this hegemony results in stigma, not only for the women who drink during their pregnancies but for children born from mothers who drink during their pregnancies. I expand on stigma in chapter six, the second analytical chapter.

6. <u>A discourse of 'good mothering/appropriate pregnancies'</u>

In telling their stories, the women deployed a discourse of 'good mothering/appropriate pregnancies' in which they spoke about the things that a good mother should and should not do. They also spoke about the timing of a pregnancy and how getting pregnant at a particular time as opposed to another is seen. Below, Dineo and Morongwa deploy the 'good mothering/appropriate pregnancies' discourse:

Extract 16

Dineo: *Firstly sisi (.) I want to say that when I was pregnant I <u>never</u> drank at the shebeen because everyone in the community would know that I am a pregnant woman who drinks and people here talk (.) many women who are pregnant and who drink in the community are called bad mothers and I don't want that (.) when I was pregnant I drank a lot (.) my mother did not know because I used to buy my drinks (.) put them in a place where no one could see them and drink when I was alone and no one was around in the house*

Extract 17

Morongwa: *I bought myself a bottle [of brandy] from next door (.) next door is a she [been] a tavern (.) I got myself my bottle and my carrypack [six pack of ciders] and I put it somewhere and I knew that no one was going to find them because I used to hide them in shoe boxes in my cupboard (.) when I got back from work he [my partner] was not around because he worked night shifts (.) I would go to my spot [the cupboard] get my cider or brandy or both and I would drink until I sleep so no one knew I was drinking when I was pregnant because no one saw me (.) I drank when I was on my own (.) I didn't drink next door [at the tavern] because people in the community who know me drink there and I didn't want them to talk and call* <u>*me a woman who does not care about her child*</u>

In extracts 16 and 17 above, Dineo and Morongwa speak to how a good mother does not or should not drink as there are certain consequences associated with doing so. Morongwa (extract 17) mentions that should she be seen drinking by people in the community who know her, this will lead to her being referred to as *a woman who does not care about her child*. Similarly, Dineo (extract 16) mentions that in her community, women who drink during their pregnancies *are called bad mothers.* As highlighted in the literature review in chapter two, a good mother is someone who is firmly dedicated to caring and meeting the emotional and physical needs of her children, someone who is instinctual, protective, and self-sacrificing (Arendell, 2000). Drinking during pregnancy, as is made evident by the two women in the above extracts, prevents and/or limits good mothering. Put differently, women who drink during their pregnancies cannot engage in good mothering/be good mothers as drinking prevents them from caring for their children and leads to them neglecting the children's needs. An important aspect to highlight from the above extracts is that Morongwa attempts to avoid being positioned as an uncaring woman/mother and Dineo a bad mother. Both women do this by keeping their drinking a secret – Dineo hides her drinking from her mother while Morongwa does so from her partner. They drink alone, in private, when no one is around instead of at the *shebeen*. In addition to not drinking in public, Dineo, unlike Morongwa, does not only attempt to avoid being positioned as a bad mother but she resists this interactive subject position when she says *many women who are pregnant and who drink in the community are called bad mothers and I don't want that*.

While Dineo and Morongwa spoke about something a good mother does not or should not do, some of the women in this study spoke about things that a good mother does, should do, or consider doing. Cindy, Nono, and Nonny in relation to this said:

Extract 18

Sbosh[9]: *Okay and then from your knowledge (.) what makes a parent (.) so let's say a person is pregnant nhe and this person will give birth to her child (.) what will make her be a right [good] mother and a mother that is not right [a bad mother]*

Cindy: *The thing that will make her a right [good] mother will be loving her child and supporting her child in an appropriate way*

Sbosh: *And then are there things that will make her not be a right mother or a bad mother?*

Cindy: *Yes by leaving the baby with other people in different places with people who drink*

Extract 19

Nono: *With the things that a mother can do to be a mother that is right [good] towards the child (.) the mother must try by all means (.) yes it is not easy to stop alcohol [but try and] avoid alcohol and try and eat healthy food.*

Extract 20

Nonny: *I am a good mother because when we are at home I play with my child and I'm always alright when I am with my child and its <u>only</u> him that makes me not worry*

Cindy (extract 18) and Nonny (extract 20) emphasise how a good mother should provide care, love, and support to her child by being around for and engaging with the child by playing with him or her as Nonny mentions. Although I did not ask Cindy to elaborate on what she meant when she said a good mother must *support her child in an appropriate way*, it is assumed that she meant that a good mother is always around for her child and does not leave him/her with other people, something which she was unable to do after giving birth as she mentioned that she used to leave her child with her mother and in cases where she (her mother) was not around, she would leave her child with her neighbours and go drink. In contrast to Cindy and Nonny, Nono (extract 19) speaks to how a good mother must try and avoid alcohol during her pregnancy and eat healthy food. Like Dineo who acknowledged that drinking has some limitations when it comes to helping a person cope with their problems (see extract 4), Nono acknowledges that abstaining from alcohol during pregnancy is not easy when she says *yes it is not easy to stop alcohol*. From the above, a particular kind of good

[9] This is the researcher. The question asked in this extract emerged when I was formulating questions for the second interviews (sub session three) based the dichotomy of the 'good' and 'bad' mother which emerged in the literature I reviewed. What is interesting in the answers given by the women is that they are somehow formulaic. In other words, the women are giving the 'correct' answers. This may be due to the fact that in the interactive space created by my questions, the only answer is the culturally acceptable one or what is seen as normative.

mothering emerges – one which requires engagement with children through providing them with attention and care. This kind of mothering is child-focused and invokes the image of the 'selfless mother' who always considers her child's well-being and in doing so obtains satisfaction as Nonny mentions when she says *I'm always alright when I am with my child*.

With regard to the timing of a pregnancy, the women spoke about getting pregnant at school and how this was regarded as inappropriate by various people. Pretty and Cindy said:

Extract 21

Pretty: *Okay uhm (3) firstly with my firstborn I got pregnant when I was still young and still in school (.) my father was a strict Xhosa man and he was <u>very disappointed</u>*

Extract 22

Cindy: *I mean that our teachers (.) teachers like involving themselves in school children's business (.) they would have shouted at me (.) asked me if I know who the father of the child is and things like that and where he is from*

In the above extracts, we see that getting pregnant at school is regarded as inappropriate by parents and teachers. Pretty in extract 21 speaks about how her father was disappointed when she got pregnant when she was still in school. This disappointment thus emphasises the inappropriateness, not only of getting pregnant while still at school but also at a young age. In her initial narrative, Cindy mentioned that she got pregnant while still in grade eleven and hid the pregnancy from her teachers. By speaking about how her teachers would have shouted at and questioned her if they knew about the pregnancy, Cindy in extract 22, similar to Pretty, shows how teachers see and/or disapprove of pregnancy at school, regarding it as inappropriate. As school pregnancies can result in negative reactions such as disappointment, shouting, and questioning, young women who get pregnant at school are thus positioned as irresponsible.

In a study conducted by Bhana, Morrell, Shefer, and Ngabaza (2010) to explore the views of teachers towards pregnant learners in South African schools in the Western Cape and KwaZulu-Natal, it was found that teachers believe that schools should be "spaces of sexual innocence" (p.874) and learners who get pregnant while still at school are sexually immoral. Some teachers expressed anger and hostility towards learners who were pregnant at school as such learners were said to be disrupting their academic life and disrupting their leap from education to employment. It is possible that Cindy's teachers would have taken up this position should they have known that she was pregnant.

With regard to parental views about getting pregnant while still at school, in a study conducted by James, Van Rooyen, and Strümpher (2008) on the experiences of teenage pregnancy among Xhosa families in Port Elizabeth, South Africa, in which pregnant teenagers and their family members (mothers, fathers and grandparents) were interviewed, it was found that the pregnancy resulted in drastic changes particularly in the relationship between the teenagers and their fathers as they were disappointed, shocked, and unhappy about their daughters getting pregnant (as was the case with Pretty whose father was disappointed). Some of the mothers who took part in the study expressed similar emotions and highlighted how their daughters would be unable to take care of their potential children once they are born as they were too young and still in school and needed to go back to school after birth and complete their schooling in an attempt to better their lives. The mothers also spoke about how this meant that they would take over mothering duties together with the grandparents of the teenagers. As such, getting pregnant at a young age/as a teenager and while still in school is constructed as not only inappropriate but also as preventing good mothering which means that a teenage mother cannot be a good mother. Relating this to the above extracts, it is assumed that by getting pregnant while still in school and at a young age, both Pretty and Cindy will have to negotiate their roles as scholars and mothers. Given the fact that schooling/education in many families is regarded as important, they may have to focus more on their school work than their children. As such, they will be not be regarded as good mothers. Appropriate pregnancies, therefore, are those which happen when an individual is older, has completed their schooling or is no longer in school. Further, these circumstances enable good mothering.

In the third sub-session, I followed up on Pearl mentioning that she was not expecting her child and asked her when she thinks the 'right time' to have a child is. She said:

Extract 23

Pearl: *I mean a child (.) I mean yes there is a time when you know that (.) I mean you have a budget that maybe you understand (.) when you understand you have a budget that (.) I mean you are in a (.) in a [position] where you can have this child (.) I mean you understand that you are right [ready] (.) I mean you understand (.) I mean it's the same thing with a person who is married where you know that you start by getting married then you fix your things (.) after you know that everything is in order then you decide that you should try for a baby you understand (.) with your partner I mean something like that*

In extract 23, the 'right time' to have a child as Pearl shows is when a person is in a position where they can have a child and this position consists of having a budget (possibly funds or money in this case) to ensure that the child can be provided for. This would then mean that a person is ready to

have a child. Pearl then draws on the 'conjugalisation of reproduction' discursive resource (I discuss this in detail in the following section) to further describe that the most suitable time to get pregnant is when a person is married. In this context, Pearl further mentions that a decision must jointly be made by the woman and her partner to try for a baby. The reason why Pearl described her pregnancy as she did in her narrative (see extract 2 in the following chapter, chapter six) could be attributed to the fact that she regarded herself as not ready to have a baby as: 1) she did not have a budget as she was unemployed and described in her narrative that she comes from a poor family; and 2) she was not married. The idea of there being a 'right time' to have a child is taken further in the 'cultural' discourse.

7. 'Cultural' discourse

In drawing upon a 'cultural' discourse in their narratives, the women in this study emphasised the importance of culture in their lives. Here, the 'cultural' discourse refers to mores, norms, practices, and values identified by the women in their environment. A feature of this discourse is the use of the phrase "in our culture" which indicates that culture is referred to as a 'real thing'. Certain practices are understood as cultural as Pretty and Nina state:

Extract 24

Pretty: *In the Xhosa culture I did a lot of things that are embarrassing (.)*

Extract 25

Nina: *There is a right time for having a child in our culture [the Xhosa culture]*

The above extracts (24 and 25) show the homogenisation of culture in such a way that it becomes objectified. This means that Xhosa culture is seen as a systematically-harmonised whole comprising of a shared and stable system of beliefs, knowledge, sets of practices, and values. The cultural discourse in this study was drawn upon in two ways: 1) to emphasise cultural views on drinking during pregnancy, and 2) to highlight how culture views early pregnancies and reproduction outside of marriage. I expand on these below.

7.1 Drinking during pregnancy as culturally shameful

The women in this study mainly saw drinking during pregnancy as culturally shameful and taboo. Below, Pretty and Rosey show how the Xhosa culture views drinking during pregnancy:

Extract 26

Pretty: *In the Xhosa culture I did a lot of things that are embarrassing (.) The biggest one is that when I got pregnant I drank and old people in the community would swear and (.) shout at me when they saw me drunk or drinking (.) they said it is not right to do this [drink when you are pregnant]*

Extract 27

Rosey: *In our culture it has always been said that (.) a pregnant woman* <u>cannot</u> *drink (.) I was told this a lot when I grew up. We speak about other people who are drinking when they are pregnant (.) we never speak about our own drinking*

By using the term 'Xhosa culture', Pretty (extract 26) shows her view of a homogeneous culture in which a correct way of doing certain things as perceived by that particular culture exists. Pretty's view of Xhosa culture shows that certain acts are viewed as embarrassing and/or shameful, acts which include drinking during pregnancy. People in Pretty's community in this case are positioned as being the custodians of this culture and thus they stigmatise those who go against cultural beliefs by drinking while pregnant through swearing and shouting at them. Rosey (extract 27) draws on 'culture' to indicate how drinking during pregnancy is positioned as wrong. She also shows how culture involves silence around drinking during pregnancy as it is unmentionable.

Taking these views further, Pearl, Lucy, and Khethiwe said:

Extract 28

Pearl: *Our culture says that a pregnant woman should not drink. Even the Bible says it [drinking during pregnancy] is not right*

Extract 29

Lucy: *Drinking when you are pregnant in our culture is wrong. You can be called a bad mother.*

Extract 30

Khethiwe: *My children (.) in our culture it has always been said that drinking during pregnancy is not right because it harms the baby. I used to drink and I knew it was wrong and I knew that the elderly people were going to want to discipline me but I did it [I drank] anyway*

In extract 28, Pearl shows how the belief that drinking during pregnancy is perceived as wrong and/or inappropriate in 'our culture' is based on the Bible's principles thus making a link between culture and religion. Pearl's argument is thus in line with the observation that "customary practices

have been incorporated into religion, and ultimately have come to be believed by their practitioners to be demanded by their adopted gods, whoever they may be" (Lightfoot-Klein, 1989, as cited in Okome, 2003, p.71). Lucy in extract 29 shows how drinking during pregnancy becomes culturally shameful due to its association with bad mothering. This is significant as pregnant women who drink or have drunk during their pregnancies are viewed as people who do not adhere to cultural norms and rules related to their gendered reproductive role as mothers (Greaves & Poole, 2005; Reid et al., 2018). These roles include being protective and meeting all the needs of the child. Dineo and Morongwa also highlighted this in extracts 16 and 17. In extract 30, Khethiwe highlights how she went against the cultural norm of not drinking during pregnancy despite knowing that this is wrong and that there would be consequences for engaging in this practice. In her narrative follow-up, she mentioned that she was indeed disciplined for her drinking and in explaining this, she mentioned that she was called to a meeting with a group of women from the community organised by her mother where she was told what was expected of her during her pregnancy. Although I did not ask for more details about what was said during the meeting in terms of what was expected of her, it is assumed that she was told to stop drinking, stay indoors and take care of both herself and her potential child.

7.2 Culture, early pregnancies, and reproduction outside of marriage

The women in this study also drew upon the 'cultural' discourse to emphasise how, in the Xhosa culture, being pregnant at a very young age is something that is regarded as inappropriate and how being pregnant and having children outside of marriage is problematised.

In the study conducted by James et al. (2008), teenagers' significant others spoke about how the young girls failed to meet cultural familial expectations centred on the timing of the pregnancy which was expected to happen during or after marriage rather than while at school or at a young age. In addition to the parents of these teenagers being overwhelmed with emotion due to a failure to meet this expectation, some pregnant teenagers spoke about how they were resented by their families as the pregnancy brought shame and embarrassment to the family's name. Feelings of anger were also expressed/reported by the family members as the pregnancies were unexpected which prevented them from supporting their children or grandchildren during their pregnancies. With regard to the shame and embarrassment a teenage pregnancy brings to a Xhosa family, this embarrassment can lead to the pregnant teenager being thrown out of her home or being rejected by her parents and family, leading to a loss of parental support during pregnancy. Similar findings emerged in this study. Nina, Pretty, and Lucy share their experiences in the extracts below:

Extract 31

Nina: *There is a right time for having a child in our culture [the Xhosa culture] (.) first I must get an education (.) get::: get married (.) then have sex (.) and get pregnant then have a child. If this does not happen in this order like with me (.) you will be in trouble*

Extract 32

Pretty: *I got pregnant when I was still young and still in school (.) my father was a strict Xhosa man and he was <u>very disappointed</u> because he was very well known in the community so people started talking and saying that he did not raise me well (.) I even got a beating when he found out I was pregnant and we also did not speak for weeks (.) the expectation in our culture is that a girl will only have sex and (.) get pregnant and have children when she is married*

Extract 33

Lucy: *Being pregnant when you are young in our culture is not right (.) many people in the community and even some of my family members said that I was a loose girl [participant crying] (10) and this happens to many girls that get pregnant when they are young (.) they did not even know how I got pregnant (.) I was raped by my boyfriend sisi [participant crying] (5) and my mother did not believe me (.) she said I wanted to have sex and this still hurts me*

Participants in the above extracts draw on a 'cultural' discourse to construct Xhosa culture as viewing being pregnant at a young age as something that should be avoided. Should this happen, a young girl will get into trouble, get a beating or be subjected to silent treatment as Nina (extract 31) and Pretty (extract 32) contend. Getting into trouble, Nina explained in her narrative follow-up, would include being disowned by one's parents or kicked out to go and live with the boy or man responsible for the pregnancy. In extract 32, Pretty also shows how being pregnant at a young age has an impact on the reputation of a young girl's parents where they end up being positioned as unable to raise their children well. Her pregnancy led her father to being disappointed which further led to people talking and saying that he did not raise her well. This could be because of the Xhosa belief that when the parents of a female child are strict, the child will behave accordingly and avoid "bad" things like having sex at a young age, becoming pregnant, drinking alcohol or smoking (James et al., 2008). Lucy (extract 33) on the other hand highlights how in the Xhosa culture being pregnant at a young age is stigmatised. She states *many people in the community and even some of my family members said I was a loose girl and this happens to many girls that get pregnant when they are young*. It is also important to consider the fact that Lucy further highlights how culture often does not accommodate or take any other "explanation" for an early pregnancy (such as an

early pregnancy taking place because of rape) into consideration apart from the young woman wanting to engage in sexual intercourse or being a loose girl.

In her study on women's micro-narratives about abortion-decision making, Mavuso (2014, p.81) found that most participants drew on a 'conjugalisation of reproduction' discourse in which "pregnancy and child-bearing outside of marriage are problematised and marriage is constructed as the proper, legitimate place for reproduction to occur". In this study and from the above extracts, the women made it clear that within the Xhosa culture, having children and marriage are inextricably linked. Pretty and Nina drew on the 'conjugalisation of reproduction' discourse (as well as the dominant coupledom discursive resource discussed in the theory chapter in chapter three) to highlight how marriage must precede reproduction. Pretty said *the expectation in our culture is that a girl will only have sex and (.) get pregnant and have children when she is married*. Similarly, Nina said *first I must get an education (.) get::: get married (.) then have sex (.) and get pregnant then have a child*. In extract 30, Nina also speaks about a *right time for having a child*. The rest of her extract indicates that this 'right' time (although she did not explicitly say so) is when a woman is married. The fact that in instances where the order she speaks about in the life course is not followed will get a person into trouble indicates how being pregnant and having children outside of marriage is problematised in her culture.

8. <u>'Religious' discourse</u>

Within a 'religious' discourse, drinking during pregnancy is constructed as an act of killing and therefore as a sinful practice. In drawing upon this discourse, personhood is assigned to the foetus which is regarded as a life. Terms such as "baby" and "child" were used by the women when referring to the foetus. As such, women who drink during their pregnancies are positioned as sinners. In the extract below, Nonny, who shared that she lost her first child because of her drinking shows how the religious discourse operates:

Extract 34

Nonny: *I come from a family that goes to church a lot. At church we:: (.) the Bible says that a baby is a gift from God and the Ten Commandments (.) one of them says <u>do not kill</u> [thou shalt not kill]. When I was pregnant I drank like I said (.) sisi my baby died [participant crying] (5) I killed my baby [participant crying] (15) <u>I knew it [the drinking] was wrong but I had problems and I did not know of another way to solve them</u>*

In extract 34 above, Nonny explains that she comes *from a family that goes to church a lot.* By making reference to the Bible, specifically the fact that a potential child is *a gift from God* including

one of the Ten Commandments (thou shalt not kill), she sees her drinking as an act that led to her killing her potential child. As such, Nonny constructs drinking during pregnancy as killing thus positioning herself as culpable. However, Nonny tries to alleviate some of the blame and responsibility for the death of her potential child by justifying her drinking when she states: *I knew it [the drinking] was wrong but I had problems and I did not know of another way to solve them*. In doing so, Nonny emphasises the fact that she did not kill her potential child on purpose (which would position her as wilfully sinful) but because she did not know of any other way of solving the problems she experienced during her pregnancy rather than through drinking.

One of the interesting aspects about the religious discourse is that despite the fact that all the women in this study made use of a language of foetal personhood, it was only Nonny who drew upon the religious discourse to construct drinking during pregnancy as an act of killing. The second interesting aspect is that, despite the fact that Nonny constructed drinking during pregnancy as an act of killing and something that is wrong, she highlighted how redemption exists and this is made possible by a forgiving God. She said:

Extract 35

Nonny: *Even if I killed my child I know that God was punishing me for drinking at that time [when I was pregnant] (.) God has forgiven me now because I prayed (.) I continue to pray (.) I made a mistake but He forgives those who sin*

In extract 35, Nonny emphasises two important things. First, she perceives the death of her potential child as a punishment for drinking during her pregnancy. By equating drinking during pregnancy with killing means that the act, based on Christian teachings and/or beliefs, cannot go unpunished. Secondly, Nonny shows that despite seeing drinking during pregnancy as an act of killing and a sin, there is room for forgiveness from God. In this instance the same God who can punish is also seen to have mercy. The forgiveness Nonny speaks to here redeems the individual act of drinking during pregnancy. However, it reinforces the association of drinking during pregnancy with killing rather than undoing it. Nonny acknowledges the fact that she did something wrong by saying *I made a mistake* but she is a sinner who recognises her mistake and repents through prayer.

In contrast to Nonny, Nono and Pearl spoke about religion by making reference to the church and the role it played during their pregnancies. Nono spoke about going to church as something that helped her limit her drinking during her pregnancy. This finding is consistent with that of the study conducted by Kovacs et al. (2011) discussed in the literature review in chapter two. Nono said:

Extract 36

Sbosh: *And then mama (.) are there things that helped you not drink when you were pregnant?*

Nono: *Yes there were mntasekhaya*

Sbosh: *What things helped you?*

Nono: *The main thing was going to church (.) it really helped me because most of the time I would not drink after coming back from church but it was only for that day [the Sunday] (.) if I did not go I would drink*

Nono in extract 36 shows how going to church helped her not drink when she was pregnant, particularly on a Sunday. However, if she did not go to church on a Sunday, she drank. Her non-drinking after church on a Sunday could be explained by the Christian belief that going to church "washes away" a person's sins thus it is important, or there is an obligation, not to do anything that is 'bad', 'wrong', or sinful that day. Alternatively, as Sunday is often observed as a day of rest among Christians, Nono's non-drinking after church could be seen as a way of resting or taking a break from drinking. The fact that she drank if she did not go to church could be because she may have felt that she had already sinned (by drinking while she was pregnant) thus she was not obliged to take a break or not drink on a Sunday.

For Pearl, church was a space where she was able to talk about a variety of things that were happening and were affecting her during her pregnancy. She said:

Extract 37

Pearl: *When we had problems at home when I was pregnant I used to tell the pastor at church and other people that usually helped me were from the church as well as the pastor and I spoke about my problems (.) [spoke] about them [my problems] in church (.) they were some of the people who would give me strength you understand? They used to listen to me and not swear or shout at me like my family did. I mean I wasn't getting the right thing [support] from my family at home*

Pearl in extract 37 shows how the church, particularly the pastor and other members of the church instead of her family are a source of support during her pregnancy. She states *They used to listen to me and not swear or shout at me like my family did*. By comparing her family to the pastor and the church members, Pearl indicates that the church, instead of her home, was a safe space for her. The people from church with whom she shares her problems and those of her family are non-judgemental as she was listened to and not shouted or sworn at. In this case, she thus positions her

family as unsupportive. In addition, Pearl mentions that the pastor and people in the church gave her strength. This could mean that after talking about her problems and feeling the way she did, Pearl felt that she was able to deal with and/or manage her problems as well as those of her family.

Although Pearl portrays the church as a place of support, comfort, safety, and strength, in her narrative, she also regarded the church as a place of judgment and one she had to avoid as she was pregnant and unmarried. This indicates how in their narratives, people can draw upon discourses in contradictory ways. She said:

Extract 38

Pearl: *I used to go to church during the time when I was pregnant but then I stopped because at church (.) at the church where I go (.) when you are a woman (.) you cannot be a woman who has a child while you are not married so I just stopped [going to church] after that [I got pregnant] and I haven't gone back yet*

In extract 38, Pearl highlights how churches set out certain 'rules' which have to be followed by its members. The 'rule' in this case is that a churchgoing woman cannot be pregnant outside of marriage. Religiously, engaging in sex outside of marriage is considered a sin. As such, this could explain why Pearl stopped going to church. In addition, the fact that she has not yet gone back to church may mean that she is avoiding being ridiculed and labelled as sexually immoral. Although Pearl does not explicitly make a link between culture and religion, in the above extract she highlights how reproduction outside of marriage is not only problematised within a cultural context but also in a religious context.

9. Summation

In this chapter, I outlined the discourses that the women in this study deployed in constructing their narratives about the journey of their pregnancy. I started the chapter by showing how, through a discourse of 'stress and coping/a 'stress and coping' discourse, the women in this study explain and/or justify their drinking and regard it as a way of coping with the various problems they experienced during their pregnancies. Acknowledgement of the fact that drinking does not solve but rather exacerbates and individual's problems was evident from one woman in this study. In drawing upon a 'hegemonic masculinities' discourse, the women in this study highlighted the patriarchal nature of their relationships with their partners or rather, how their relationships with their partners are unequal. This was evidenced through instances of IPV which was the outcome of either drinking or non-drinking during pregnancy. Further, in the 'male/masculine provider' discourse, the women positioned their partners as providers and themselves as financially dependent on them in order to

provide for the potential child once it is born and them as well. Within the 'disablement and developmental delay' discourse, the women were able to show that they know about the detrimental effects of drinking during pregnancy on the foetus and although this was the case, they drank during their pregnancies thus highlighting how the 'disablement and developmental delay' discourse and a 'stress and coping' discourse are competing discourses in this study.

A 'good mothering/appropriate pregnancies' discourse was then discussed and in this discourse the women spoke to the various things that make a woman a good mother speaking both to things that she should and should not do. Getting pregnant while still young and in school which was considered as an inappropriate time to get pregnant as it meant that good mothering would not be possible. A 'cultural' discourse allowed the women in this study to speak about culture as a 'thing' and show how drinking during pregnancy based on cultural norms, beliefs, and values is regarded as culturally shameful. Furthermore, this discourse showed how, within the Xhosa culture, early pregnancy as well as reproduction outside of marriage are problematised.

Drinking during pregnancy within a 'religious' discourse is constructed as an act of killing and thus as a sinful practice. The church in this discourse was also spoken about as a helpful context when it came to limiting drinking and talking about things that were happening during pregnancy.

While I have discussed these discourses separately in this chapter, it is important to note that the participants seldom drew upon one discourse in constructing their narratives. Further, other discursive resources which did not feature prominently in the narratives such as the 'conjugalisation of reproduction', and the dominant coupledom discursive resources were draw upon by some of the women. As I am committed to showing a multiplicity of voices and experiences, I felt that it was important to also discuss these discourses. In the following chapter, which is my second analytical chapter, I focus particularly on the narratives that the women constructed and how the discourses I have discussed in this chapter were used in producing these narratives.

Chapter Six: Women's stories about drinking during pregnancy

1. Introduction

The previous chapter examined the discourses that the women drew upon in constructing their narratives. In an attempt to show how the women put these discursive resources to work in their narratives, this chapter focuses on the women's stories of drinking during pregnancy. I have divided the chapter into five sections to draw attention to the five broad narrative categories in which the stories of the women in this study are situated. In the first section, I speak to stories about the pregnancy. In the second, I focus on stories about drinking then I move on to focus on stories that justify/explain drinking during pregnancy and stories that condemn the drinking. Lastly, I focus on stories about how the women knew the effects of drinking during pregnancy. Each narrative category is discussed in depth using micro-narratives from the broader narratives the women shared about the journey of their pregnancy.

2. Stories about the pregnancy

In their narratives about the journey of their pregnancy, the women in this study shared narratives about their experiences of being pregnant. These narratives included how they felt when they found out they were pregnant as well as their parents' and partners' reactions to the pregnancy.

2.1 'I was shocked and scared'

In finding out about their pregnancies, feelings of shock and being scared were reported by the women. Based on the 'good mothering/appropriate pregnancies' discourse, these feelings were associated with a pregnancy being unexpected and possibly leading to disappointment among parents due to pregnancy's timing. In the extracts below, Nina and Pearl share their experiences:

Extract 1

Nina: *Okay (.) during the time when I was pregnant (.) I found out that I was pregnant as I was vomiting bile nhe so my mother told me to go to the healthcare centre and my older sister accompanied me and at the clinic they discovered that (.) I was tested and they saw that I was pregnant and I asked them to <u>please</u> test me again because I didn't believe [that I was pregnant] and they tested me again and they discovered that I was pregnant. I came back home and when I came back my mother asked me what the outcome was and I asked her to send me somewhere and I told her that it can be anywhere even to the shop and she really sent me [to the shop] and she asked my sister because I was scared of telling her that I was pregnant as I was the most trusted person at home.*

Extract 2

Pearl: *I don't have a mother. I was left with my grandmother while I had four children (.) now the fifth child (.) I mean I didn't [plan her] you understand? she just came out (.) out of the blue (.) she came out through my drinking and everything involved with drinking because I didn't use a condom and I didn't use the [contraceptive] needle*

In the above extracts, Nina and Pearl draw on the discourse of 'good mothering/appropriate pregnancies' to construct their own pregnancies as problematic. In extract 1, Nina shows how she did not expect to get pregnant. Further, when she found out that she was pregnant, she was shocked. This is seen through her disbelief when she says *I didn't believe I was pregnant* and her begging to be tested for a second time in order to make sure that she was indeed pregnant despite the results of the first test. Upon discovering that she was pregnant, Nina further highlights how she was scared of telling her mother as she was *the most trusted person at home* (and therefore expected not to have an inappropriate pregnancy). In explaining what she meant by this during her narrative follow-up session, Nina said that her mother wanted her to complete her schooling as she had reached grade 12 and to further her education. Pearl in extract 2 highlights that her pregnancy was unplanned when she says *now the fifth child (.) I mean I didn't [plan her] you understand? she just came out (.) out of the blue* demonstrating the shock she felt. Further, because of her drinking, Pearl positions herself as irresponsible as she did not use protection during intercourse or use her normal contraceptive. In positioning herself in this way, Pearl draws on the 'good mothering/appropriate pregnancies' discourse as planning pregnancies is a tenet of this discourse.

Similar to Nina, Nonny (extract 3 below) spoke about how she was shocked and scared when she found that she was pregnant indicating the emotional consequences of not adhering to a 'good mothering/appropriate pregnancies' discourse. She said:

Extract 3

Sbosh: *When you discovered you were pregnant nhe how did you feel?*

Nonny: *I was shocked and felt scared*

Sbosh: *Please tell us more about your fear/being scared. What were you scared of or fearful of maybe?*

Nonny: *I was scared about what they were going to say at home because I was still in school at that time*

Sbosh: *So you say you were scared about what they were going to say at home. So after you shared the news at home that you were pregnant what did the people say? How did the people at home react?*

Nonny: *But my mother when she heard from the neighbours she didn't have a problem and she didn't show [that she had a problem] she didn't swear at me and everything*

Nonny in the above extract highlights how she was shocked when she found out that she was pregnant and scared of sharing the news with her family as she did not know how they would react because, as she says, *I was still in school at that time* (and therefore disrupting the "appropriate pregnancies" norm). In the above extract, we see that Nonny anticipated that her mother (and possibly other people in her family) would react to her news negatively as getting pregnant while still in school is regarded as inappropriate. However, this was not the case. This could be linked to the fact that she was not the one to share the news with her mother as she (her mother) heard from the neighbours. It is assumed that Nonny's mother, should she have been upset, was calmed down by the neighbours and by the time Nonny told her the news she already knew and did not have a problem as Nonny expected. This shows how Nonny's family, particularly her mother supported her pregnancy rather than problematising it based on the time which it occurred, thus undermining the 'good mothering/appropriate pregnancies' discourse.

2.2 'My pregnancy resulted in shame and stigma'

Among some of the women in this study, narratives of shame and stigma were evident. These were linked to getting pregnant while still in school and thus disrupting the 'good mothering/appropriate pregnancies' discourse. Cindy said:

Extract 4

Sbosh: *Okay (.) okay (.) okay (.) and then how was it going to school when you were pregnant?*

Cindy: *No it was alright because my teachers (.) my teachers couldn't see that I was pregnant because I used to wear a windbreaker (.) the school children knew [that I was pregnant] and it was nice (.) there was nothing [no problems/issues] because they never asked about anything (.) they just asked if the child is alright that's all*

Sbosh: *Okay (.) so you say you wore a windbreaker*

Cindy: *Yes*

Sbosh: *Can I maybe ask why?*

Cindy: *I felt very ashamed so I was hiding from the teachers that I was pregnant because they would have asked me a lot of things*

Here, Cindy talks about feeling ashamed (that is, the internalised sense of having done something wrong) about the 'wrong' that she has committed by being pregnant while still at school. This feeling of shame is evidenced through the fact that she wore a windbreaker to school to hide her pregnancy from the teachers in order to avoid anticipated negative attitudes of her teachers such as anger and hostility. This anticipation is not unrealistic as illustrated by some teachers' attitudes when they spoke about school pregnancies in the study conducted by Bhana et al. (2010) discussed in the previous chapter.

Irrespective of the fact that *the school children knew* that Cindy was pregnant *and it was nice*, as she describes, her shame is compounded by the stigma she might face – what people (particularly her teachers) would say or do if they found out about her pregnancy. Stigma here speaks to the actions others will engage in in order to render the pregnancy as problematic while shame refers to the internalised sense of having done something wrong. In extract 4 Cindy indicates that she does not face any stigma from her peers. Although she does not give a reason as to why this is the case, it could be that, in her context, it is not unusual for school-going children to get pregnant, but rather the norm.

Stigma has been defined by Goffman (1963, p.3) as "an attribute that is deeply discrediting" which can transform an individual "from a whole and usual person to a tainted, discounted one". In extract 4 (above), Cindy would be tainted and questioned for becoming pregnant while at school, an act that is often considered shameful. Fife and Wright (2000, as cited in Shellenberg et al., 2011, p.114) argue that stigma and shame are linked as they describe internalised stigma as "the extent to which the stigmatised individual incorporates negative perceptions, beliefs and/or experiences into his/her own self" leading to feelings of guilt or shame or other negative feelings about oneself.

In contrast to Cindy, Pretty (extract 5 below) shows how shame is not only experienced by the women themselves but also their families. She said:

Extract 5

Pretty: *I was told to leave school when I got pregnant (.) my father said that I must stop going to school because I had already embarrassed him in the community and now I was going to embarrass him at school.*

In Extract 5, Pretty shows how shame is also experienced by her father. This shame led her father to make attempts to avoid further stigma through restricting Pretty's movements into spaces where stigma may operate which is why he told her to leave school when she got pregnant. By telling her to leave school, her father is not only punishing her but, in this way, he attempts to "save face" or rather protect his reputation given the fact that he was positioned as a parent that did not raise her daughter well because of her early pregnancy (see extract 31 in previous chapter).

The consequences of stigma and shame were also highlighted by some of the women in their narratives. Cindy, who shows how shame and stigma leads to exclusion from schooling spaces said:

Extract 6

Cindy: *I drank because I was worried and stressed that by being pregnant while at school I will not be able to go back to school [clears throat] pass grade eleven and do my matric and go to university. My parents had even started saving up money for me. The drinking made me avoid thinking about how much I had ruined my future by getting pregnant*

In the above extract, Cindy indicates that she drank to *avoid thinking about how much I had ruined my future by getting pregnant*. The notion of a ruined future draws on the 'good mothering/appropriate pregnancies' discourse and dominant narratives on motherhood and femininity, with drinking relieving the pressure. Instead of holding positive feelings about her pregnancy and being a mother as well as embracing this, Cindy indicates that she wants to complete her studies with the hope, it is assumed, of getting a job and thus earn an income (Kruger, 2006; Mabobolo et al., 2009). These two activities (mothering, schooling) are seen in this extract as mutually exclusive. The above extract also falls within the narrative category of stories that justify/explain drinking as Cindy draws upon a 'stress and coping' discourse to highlight that her pregnancy led her to worry and stress about her future which she ruined as she did not adhere to the "appropriate pregnancies" norm and thus, in an attempt to overcome this worry, she drank.

2.3 'My family were unhappy about my pregnancy'

The women in this study also spoke about instances of parental displeasure when their parents found out about the pregnancy. Nina spoke about parental displeasure when she said:

Extract 7

Sbosh: *So when you got pregnant at that time, how did it affect you and your family maybe?*

Nina: *It really affected me because my mother became stressed and she swore at me.*

Sbosh: *And then after your mother swore at you, and she became stressed, what did you do maybe?*

Nina: *My mother did it again [she swore at me] I tried to take it [the tummy] out [have an abortion] nhe and then my mother heard then she tried to calm herself down okay and come to terms with the fact that this had happened [I was pregnant] it had happened and she calmed herself down then she spoke to me and then she was at peace.*

In extract 7, it is evident that Nina's mother was not pleased when she found out about her daughter's pregnancy. In her study conducted in Nyanga East, a township in the Western Cape, to explore the circumstances and reactions that surround teenage pregnancy, Mkhwanazi (2010) found that some parents reacted to the pregnancy by crying and accepting the pregnancy, others did not talk to their daughters for the duration of the pregnancy while others shouted at them. Nina's pregnancy, as is evident in extract 7, led her mother to become stressed possibly because Nina would not be able to further her education as she had hoped. Parental displeasure is also evident in the case of Pretty (see extract 5 above); this displeasure threatened her schooling as she was told to leave school. In the previous chapter, Pretty (see extract 21) spoke about how her father was disappointed when she got pregnant at a young age while she was still in school. Similar to Pretty, Nina's mother, by swearing at her, may have been punishing her for going against the norm of appropriate pregnancies. Interestingly, in Nina's narrative, we see that her mother ended up accepting the fact that her daughter was pregnant (and thus possibly supported her during the pregnancy) after she had heard that she attempted to abort the potential child. This, it is assumed, could be because Nina's mother holds negative views about the act of abortion such as the view that abortion is an act of killing or murder. Thus, she may have accepted the pregnancy to ensure that her daughter does not continue to drink to abort given these views.

2.4 'My partner's reactions were confusing'

Most of the women who took part in this study spoke about having informed their partners about the pregnancy. In doing so, the women described how their partners denied the pregnancy while in some instances partners reacted in ways that confused them. Sharing their experiences, Lucy and Rosey said:

Extract 8

Lucy: *After I (.) After I (.) After I told him that I was pregnant he was he was he was happy because he said he doesn't have a child and so on then I don't know what happened during the miscarriage. I saw that he used to get annoyed/irritated even when I asked him something he just got angry*

Extract 9

Rosey: *When I told him I was pregnant he was very happy shame but I don't know what made him leave me.*

Lucy and Rosey in extracts 8 and 9 highlight how their partners were happy when they told them that they were pregnant. Lucy mentions that the reason her partner was happy was *because he said he doesn't have a child*. Related to the notion of hegemonic masculinities, this can be linked to the view among Xhosa men and in the Xhosa culture that being able to reproduce or "plant a seed" enables an individual to be considered 'masculine'. Although their partners were happy about the pregnancies, both Lucy and Rosey question their changed behaviour – Lucy wonders why her partner gets annoyed/irritated by her and just gets angry when she talks to him, while Rosey wonders why her partner left her. In a study conducted by Bottoman (2017), the women referred to the disappearance of their male partners during the pregnancy as *ukwaliswa/ukubukuzana* which refers to the time when a man/partner leaves the pregnant woman temporarily during the pregnancy. In some cases, the partners/men do not come back as was the case for some of the women in the present study. During this time, men/partners have affairs with other women and their whereabouts are not questioned. The behaviour of both Lucy and Rosey's partners could possibly be linked to this practice.

3. Stories about the drinking

In this narrative category, the women in this study speak about their drinking patterns during and after the pregnancy. Instances of drinking regularly, limiting drinking and finding alternative ways to continue drinking were spoken about by the women in this category.

3.1 'I drank a lot'

A prominent micro narrative constructed by the women in this study when describing their drinking patterns during the pregnancy was one in which the participants indicated that they drank regularly. A feature of this micro-narrative was the use of repetition in describing the practice of drinking. Nina and Dineo said:

Extract 10

Nina: *I continued taking brandy daily (.) red brandy (.) it was Commando and I kept on taking the brandy and drinking and drinking the brandy*

Extract 11

Dineo: *I stayed at home stayed at home and I constantly thought about this and kept thinking about it and thinking about it then I drank and drank hey I used to drink and drink and drink*

In the above extracts, Nina (extract 10) and Dineo (extract 11) show how they drank constantly during their pregnancies. Nina mentions that she drank daily and also says *I kept on taking the brandy and drinking and drinking the brandy* while Dineo says *I drank and drank hey I used to drink and drink and drink*. The repetition in these narratives can be read as a confession that these women drank excessively during their pregnancies.

In her narrative, Pearl described her drinking in the following way:

Extract 12

Pearl: *I am a person who likes to [drink] (.) I would like to always be [drunk] you understand and always be [drunk] (.) given the fact that I am a person who generally drinks who also comes from a poor family that is not alright*

In extract 12, Pearl describes drinking as something that she generally does and enjoys doing. As such, she says *I would like to always be [drunk]* and this is because of her family circumstances about which, it is assumed, through drinking, she was able to forget or not worry about. This also indicates that Pearl drank a lot.

3.2 'I restricted my drinking'

While some women in this study drank regularly, other women spoke about limiting their drinking during and/or after the pregnancy. Cindy said:

Extract 13

Cindy: *I used to drink part-time*

Sbosh: *Okay, okay when you say you [drank] part-time what do you mean?*

Cindy: *I mean that in the way that (.) after I gave birth I used to drink every weekend so when I was pregnant I used to drink just for one weekend and then drink after maybe another weekend*

In contrast to Nina and Dineo (extracts 10 and 11 above) who drank a lot during their pregnancies, Cindy in the above extract mentions that during her pregnancy she drank part time. That is, she used to drink on a particular weekend and not drink the following weekend. In doing so, Cindy positions herself as having some self-control. Further, she speaks to how her drinking continued after her

pregnancy and her drinking patterns changed from drinking part time during her pregnancy to drinking regularly, every weekend.

Similar to Cindy, Pearl spoke about her drinking after her pregnancy. She said:

Extract 14

Pearl: *Even after I gave birth to the child (.) and (.) I gave birth to the child and I really tried to stop drinking but I haven't stopped drinking but I remember the day when I went to give birth I hadn't drunk that day*

In extract 14, Pearl, like Cindy, mentions how she has not stopped drinking after giving birth. By saying *I really tried to stop drinking*, Pearl hints to how challenging it was for her to stop drinking further showing that her attempt at restricting her drinking failed. The fact that Pearl continued to drink after giving birth can be linked to her regular drinking (see extract 12) and also serves as a justification of her failure to restrict her drinking. Nevertheless, the achievement of not drinking on the day of giving birth is mentioned. A contradiction in Pearl's micro-narrative of her drinking becomes evident here. On the one hand (in extract 12), she indicates she is a drinker (justified through poverty); on the other (extract 14), she talks about struggling to stop.

In taking narratives about restricting drinking and drinking after the pregnancy further, some of the women said:

Extract 15

Pretty: *Now that the child was born then my drinking went down and I thought that this helped me a lot because I drank a lot back home*

Extract 16

Lucy: *I don't drink a lot now I've gone down [I've reduced my drinking] I used to drink a lot during the time when I was pregnant now I drink during parties and not too much*

After giving birth, Pretty (extract 15) and Lucy (extract 16) mention that their drinking patterns changed. Pretty says *my drinking went down* while Lucy says *I don't drink a lot now I've gone down*. Although she drank during her pregnancy, Pretty positions herself as a good mother once her child is born – the fact that her drinking has now gone down makes her a good mother dovetailing with the 'good mothering/appropriate pregnancies' discourse. Lucy further explains the change in her drinking patterns when she mentions that she now drinks at parties (i.e. at socially sanctioned times) and when she does so in this context, she does not drink too much. The changes in the

drinking patterns after pregnancy of these two women contrast those of Cindy and Pearl discussed in extracts 12 and 13 above.

Some of the women in this study gave reasons for restricting their drinking. Lola and Cindy said:

Extract 17

Lola: *I then stayed and thought to myself I'm taking a break I have had enough of drinking and during that time one week had passed and I had not drank alcohol and I started drinking the next week*

Extract 18

Cindy: *I then <u>though</u>t I should decrease my alcohol consumption and I stopped drinking and I continued [with my studies] as I was at school so I continued with school and I failed grade twelve last year and I had already stopped drinking by then.*

In extract 17, Lola indicates that she decided to take a break from alcohol as she *had enough of drinking*. As she explains, she was able to take a break from alcohol as she did not drink for one week but went back to drinking again the following week. This shows that restriction is not necessarily a once off effort as it may be followed by drinking again. In contrast, Cindy (extract 18) stopped drinking so that she could continue with her schooling. Interestingly, she mentions that she first *<u>thought</u>* about decreasing her alcohol consumption which could mean that she did not immediately stop drinking but started small by decreasing her consumption and then eventually stopped. Further, Cindy mentions that last year when she went back to school she failed grade twelve and *had already stopped drinking by then*. By mentioning this, Cindy evidences the fact that her failure cannot be attributed to alcohol use.

Nina spoke about how certain circumstances meant that she would not be able to drink. As such, it is evident that restriction is not the result of individual actions and decisions only (as shown by Lola and Cindy in the above extracts), but also circumstances. She said:

Extract 19

Sbosh: *Okay and then Sis'Nina during the time when you were pregnant were there things that helped you not to drink or decrease/limit your drinking?*

Nina: *There were*

Sbosh: *What things [helped you]?*

Nina: *When money was scarce and when there was no money [to buy alcohol to drink]*

When Nina did not have any money as she states in extract 19, she was unable to buy alcohol. This meant that she would drink less. Thus, in instances where alcohol is not available, changes in drinking patterns may be evident. It would be unsuitable in this case to argue that she did not drink at all when she did not have any money as in many contexts where drinking is a norm, some individuals make arrangements to get money to buy alcohol (e.g. by borrowing money) and friends may have money and then buy alcohol for the entire group.

3.3 <u>'I found alternative ways to continue drinking'</u>

While certain circumstances contributed to restricting drinking, one of the women who took part in this study spoke about how she ensured that she was able to continue drinking. As such, this micro-narrative did not feature prominently in the data. Lola said:

Extract 20

Lola: *I also used to take the children's grant money [social grant money] and run away with the card and use the money for alcohol*

As is evident in the above extract, Lola made use of her children's social grant funds to buy alcohol. In this instance, it could be argued that when circumstances (a lack of money) prevented Lola from drinking, these funds enabled her to drink. This is consistent with the findings of a study conducted by Khosa and Kaseke (2017) in the Limpopo province to explore how caregivers utilise the child support grant where it was found that some recipients of the grant do not use it in the best interest of the child but for personal interests such as drinking.

3.4 <u>'My drinking resulted in shame and stigma'</u>

The shame associated with drinking during pregnancy, as the women in this study highlighted, led to them being ostracised by various people. The women also spoke about shame going beyond them and affecting their families as was the case in the micro-narrative 'my pregnancy resulted in shame and stigma' discussed in the narrative category of stories about the pregnancy. Nonny and Nono in the extracts below draw upon the 'religious' discourse to show how shame is linked to ostracisation, both internal and external.

Extract 21

Nonny: *After what happened to my baby because of my drinking (4) I am still scared of going to church because I am worried about what people will say about me. I do go to church but not all the*

time. The people there don't speak to me like they used to (.) some people do not speak to me at all because of what happened and I think (.) I think it's (.) it's because they know what I did

Extract 22

Nono: *When I didn't go to church on a Sunday the next time I go everyone would be questioning me and asking if I had been drinking. Sometimes I feel like I must leave the community and go live somewhere else and start a new church where no one will question me*

The women in the above extracts highlight how they respond to the stigma associated with their drinking by deciding to find new social spaces because of the shame they experience or anticipate they will experience. Nonny (extract 21) shares that she feels so ashamed that going to church is something that she does not do often. In this case, Nonny engages in self-imposed ostracism. Nono (extract 22) talks to the stigma she feels when people within the church question her about her drinking when she does not go to church on a Sunday and how this often makes her think about moving to another community. In extracts 21 and 22, the church is regarded as one of the contexts a person is ostracised in. In the cases of both Nonny and Nono, the ostracisation is real.

Shame in some narratives is compounded by the actions of others (such as family members) if they found out that the women had been drinking during their pregnancies. Dineo said:

Extract 23

Dineo: *When my mother came back from work one day she said to me that she heard from one of the people in the community that I went to buy alcohol at the shebeen and I was drinking at the house with friends. She asked me if this was true and she searched the whole house and found the alcohol where I was hiding it. She beat me up so much. <u>Yho sisi she beat me up so much</u>. She did not even beat me up inside the house (.) she dragged me outside for everyone to see. Afterwards the people who saw me laughed and they still do. My mother and I were not good (.) she did not talk to me for a long long time because she told me not to drink during my pregnancy because it is not good for the baby*

Dineo in extract 23 talks about how her shame is extended to her mother who responded by beating her publicly. In the public beating, the mother potentially alleviates stigma accruing to her, as she is visibly opposing the drinking. Dineo highlights how the actions of other people which include laughing and remembering the beating compounds the shame. Dineo further talks about how shame disrupts family relationships as she and her mother were not on good terms when she found out about her drinking. She states *My mother and I were not good (.) she did not talk to me for a long*

long time because she told me not to drink during my pregnancy because it is not good for the baby. In a way, Dineo also justifies her mother's actions of beating/shaming her as she was told about the effects of drinking during pregnancy on the foetus but, as is apparent above, she did not listen to her.

The shame associated with drinking during pregnancy as Rosey shows does not only extend to the self but also to family members. She said:

Extract 24

Rosey: *Like I said (.) in our culture it has always been said that (.) a pregnant woman* <u>*cannot*</u> *drink. If they found out about my drinking (.) I would be embarrassed and my people (.) all my people [the Xhosa people] would be ashamed*

In extract 24, Rosey utilises the 'cultural' discourse to highlight how the shame associated with drinking during pregnancy is shared with her people. As such, Rosey sees herself as a representative of her people and her actions, which in her culture are constructed as shameful, do not only threaten her social position but also that of her people. Rosey thus in this instance speaks for herself and her family/her people as is already shown. In the above extract, Rosey shows the complex nature of stigma associated with drinking during pregnancy where it is not just her shame but that of her wider community or her people as well.

3.5 <u>'The drinking affected me badly'</u>

Out of all the other women who took part in this study, Khethiwe provided no justification story for drinking during her pregnancy. In her narrative, she spoke about how she regards drinking during pregnancy as something that is not right although she was not told. Khethiwe also emphasised the physiological effects of drinking excessively. She said:

Extract 25

Khethiwe: *When I was pregnant when I used to drink what happened is that I didn't feel alright when I had drank so when I had drank I mean when I drank I used to wake up in the morning with a hangover you understand? With a hangover and I didn't want to eat I wanted to drink again you understand*

Khethiwe in extract 25 speaks about how drinking excessively led her to have a hangover the next day. A hangover is often caused by drinking excessively. In addition, she mentions that she did not want to eat and craved more alcohol. These kinds of physiological consequences were, however,

not spoken to by other women suggesting, perhaps, that the social consequences (stigma, shame, ostracisation) may be felt more keenly.

4. Stories that justify/explain drinking

The women in this study were asked to tell the story of the journey of their pregnancy with reference to the events and experiences that were important to them during this time. In most of the narratives that the women produced, their drinking was justified/explained. That is, most of the women gave reasons for why they drank during their pregnancies. The narratives in this section all centre around the women justifying/explaining their drinking during the pregnancy.

4.1 'My partner was not there for me': Lack of partner support, partner unreliability, denial of paternity and infidelity

The majority of the women in this study (7 out of 13 women), indicated that they drank because of their partners being unsupportive and unreliable, denying the pregnancy, and cheating/being unfaithful. In these narratives, the women mainly drew upon the 'stress and coping' discourse including the 'male/masculine provider' discourse. Sharing her narrative, Morongwa said:

Extract 26

Morongwa: *The main main thing that made me drink that time [when I was pregnant] was not getting the truth from him [my partner] [about making the other woman pregnant] you see? Otherwise I did not mean to drink/I did not want to drink because I knew that it was not right for my baby but I decided to drink anyway. Every time I drank I was able to forget about what he had done (.) and I would not stress about it too much. Talking about it with my mother did not help me because the more I talked about it the more I thought about it but alcohol (.) the alcohol helped me (.) it made it easier for me to deal with what happened and to deal with him because when I brought this up and I was drunk he would get angry and want to hit me but when I drank I was not scared of saying what was on my mind*

In extract 26 above, Morongwa explains that she drank during her pregnancy because her partner betrayed her/was unfaithful as he impregnated someone else. She thus positions him as unfaithful and dishonest. Morongwa states that drinking, as opposed to talking to her mother about this unfaithfulness and dishonesty, made her *forget about what he had done* and that she *would not stress about it too much*. As such, Morongwa draws upon the 'stress and coping' discourse to highlight that her partner's unfaithfulness/act of betrayal caused her to stress and thus drinking helped her cope with this stress. In drawing upon this discourse, she positions herself as dependent on alcohol for forgetting, not stressing too much and making things easier. Further, she states that

the alcohol helped me (.) it made it easier for me to deal with what had happened and to deal with him because when I brought this up and I was drunk he would get angry and want to hit me. In this instance, Morongwa draws upon a 'hegemonic masculinities' discourse to highlight how her drinking caused some tension between her and her partner and possibly could lead to an incident of IPV. Although this was the case, she felt empowered to speak up about what was happening hence she says *but when I drank I was not scared of saying what was on my mind*. In this instance, Morongwa shows how when she had drunk, she was able to resist the unequal gender relations between her and her partner given the fact that she was able to speak up about things despite the violent threats her partner made. A similar incident was discussed in the previous chapter (see extract 5) when Nono mentioned that when she had been drinking with her partner and he became violent, she was able to fight back. Thus, drinking is justified in light of partner betrayal and violence.

Similar to Morongwa, Rosey said the following:

Extract 27

Rosey: *When I told [...] I was pregnant he said that the child was not his (3) he did not say anything. I called him and he did not take any of my calls then one day hayke I saw him walking with another woman then I realised that he does not love me and (.) and that he does not want me anymore. He kept calling me and calling and asking me to go there [to his place] and (.) and I also agreed because I still loved him (.) I would spend the night and it would be nice but the next day he was not saying the same thing [he said the previous day] (.) when I call him he wasn't saying what he said because [the previous day] it seemed like he was alright and then he was not saying what he said and he didn't even want to see me and <u>even when this happened I used to wait and wait and every time he came back to me I accepted him you see</u>? (.) because I loved him (.) he was the person that didn't want me so I ended up drinking like this sisi as I was stressed. He did not support me and the child when I was pregnant (.) he has not supported the child until now. I support the child (.) the guy I live with also supports the child because the guy I live with gives me money to buy the child [things] (.) <u>he [...] (.)has never</u> until now (.) he doesn't even want to see me. When I asked him about his child he didn't care at all. Things like this made me drink sisi. When I drank I felt like I did not have any problems and that all my stress about my partner not wanting me anymore and the other things I just told you about did not exist*

Rosey (extract 27) explains that her reasons for drinking during her pregnancy are threefold and are linked to her partner's actions who: 1) denied the pregnancy; 2) was unfaithful as he had a relationship with someone else while she was pregnant; and 3) was unsupportive as he did not

support her and her potential child during her pregnancy and is currently not doing so. In this instance, Rosey mainly draws upon the 'male/masculine provider' discourse to highlight how her partner failed to fulfil his gendered role of being a provider as he did not support both her and her potential child financially both during and after the pregnancy thus positioning him as irresponsible. While a male/masculine provider is present in her and her child's lives and is supporting both her and her child at the moment, Rosey indicates that she is also supporting her own child thus resisting the gendered expectation of men as providers and women as the primary caregivers of children. Rosey also draws upon a 'stress and coping' discourse. In her narrative she explained all the partner-related troubles she endured during her pregnancy which made her stress. In extract 27 above, she said *I ended up drinking like this sisi as I was stressed*. Through her drinking she was able to cope with the stress of partner infidelity and abandonment as she mentioned that she felt like she did not have any problems and that the stress associated with her problems did not exist. While she positions herself as dependent on alcohol similar to Morongwa, she does so to emphasise that drinking helped her cope with the emotional pain that was caused by her partner falling out of love with her and finding someone else which led to his failure to support her and her potential child.

For many of the women in this study, the disappearance of the man responsible for the pregnancy often resulted in them drinking as life without a financial provider made life difficult for the women. Rosey speaks to this in the extract below:

Extract 28

Rosey: *After I became pregnant (.) I got pregnant last year nhe so my partner disappeared and I never saw him again. We used to live together so one day (.) one day I came back from work and all his clothes were gone. I heard he was renting at another house but when I went to look for him there was no one there. When I told him I was pregnant he was very happy shame but I don't know what made him leave me. This is when I started drinking and sisi I drank a lot because of him. He was not there so no one was going to provide for me and my child. No one was going to support us. If he stayed and did not leave me I wouldn't be talking like this [participant crying] (15) I wouldn't have drank because alcohol was never my thing*

In the above extract, Rosey perceives her partner's role as providing for her and her potential child thus showing the gendered expectation of men as providers. The disappearance of her partner means that Rosey could not depend on him and this led her to drink. She, however, does some labour to show that drinking during her pregnancy was not something that she considered until her partner left and she realised that he was not going to be around to support and provide for her and her potential child both during and after her pregnancy.

Interestingly, the 'male/masculine provider' discourse was also drawn upon by some women in this study even though the man or partner was around. In these cases, the men are positioned as not pulling their weight. Sharing their experiences, Lucy and Nonny said the following:

Extract 29

Lucy: *After what happened I (.) I (.) I told my partner I was pregnant and he didn't say anything. He used to work but he never gave me money for baby things and he didn't even buy groceries (.) all he did was give money to his other girlfriends. I had to ask my mother for money to take care of everything in the house so she was the one that supported us.*

Extract 30

Nonny: *I was so* <u>*frustrated*</u> *when I got pregnant because my partner did not have a job and was not educated so (.) so (.) it was* <u>*very hard*</u> *for him to find a job. Sisi he never even made the effort to find a job. He never said anything when I told him I was pregnant so (.) I don't know sisi but you must know that I drank because I wanted to deal with the frustration*

The above extracts highlight that it is not only in instances where men have denied a pregnancy or disappeared that they fail to take up their gendered role of being the male provider. Lucy's (extract 29) pregnancy started off as unsupported as her partner did not give her money to buy baby things as well as groceries and so did not take up his role as masculine provider. Her pregnancy later becomes supported not by her partner but by her mother as Lucy took it upon herself to find someone who would support her and her potential child. For Nonny (extract 30), her partner does not possess the qualities of a male/masculine provider which include having, or at least seeking a job as well as an education/being educated in order to get a job and thus a salary or income that can ensure comfortable living. This led to her drinking during her pregnancy. By explaining that their drinking during pregnancy was because of the men/their partners not acting the way they were supposed to act, the women in this study are speaking in a socially sanctioned way.

As is seen in the extracts above, the implication is that in the absence of a male/masculine provider, child-rearing becomes the sole responsibility of a woman and this is something that none of the women in the above extracts challenged similarly to those in the study conducted by Eddy et al. (2013) discussed in the literature review in chapter two.

4.2 <u>'There were familial problems/problems at home'</u>

Two of the women who took part in this study located their drinking within problems in the home. Broadly speaking to her familial circumstances, Pearl said the following:

Extract 31

Pearl: *I am a person who generally drinks who also comes from a poor family that is not alright*

In her narrative, Pearl mentioned that she comes from a family "that is not alright". In explaining what she meant by this, she spoke to issues related to family conflict particularly between her and her grandmother, difficulties between different members of her family which led to them not getting along, and family poverty. Based on this, Pearl mentions why she drank during her pregnancy:

Extract 32

Pearl: *Because I was from a poor family (.) and we have no money and I did not know who the father of my child was (2) during my pregnancy I was always worried about where my child was going to get the things he/she needed like clothes and food and medicine when he/she was sick. When this worry became too much for me to handle I would drink and forget about all of this and I felt really nice*

Poverty, as is claimed by Pearl in extract 32, leads to drinking during pregnancy as the family situation results in a lot of worrying about whether the potential child will be taken care of. Pearl thus shows how, through worrying about the needs of her potential child she became stressed and therefore, she drank. In doing so she mentions that she would *forget about all of this* and she *felt really nice*, thus drawing upon a 'stress and coping' discourse to show how she was able to overcome the worrying, and to justify her drinking.

Similar to Pearl, Nono highlighted how problems in her home led to drinking:

Extract 33

Nono: *There was a lot going on bantasekhaya. I had a lot of problems which made me drink (.) [...]. I was worried about the kind of life my child would have when he/she was born so <u>drinking was my way of escaping</u>. I knew it was wrong [to drink while I was pregnant] but there was a lot stressing me and there was nothing I could do to help me make things better. I tried to look for a job (.) I was not lucky*

Nono in extract 33 positions herself as helpless and highlights how she was 'made' to drink during her pregnancy as there was nothing else she could do to help her *make things better* or rather change her situation. In doing so, she alludes to the 'stress and coping' discourse. In the above extract, she further talks about how a person's circumstances, due to various reasons, cause them to worry

during pregnancy and how this can make a pregnancy challenging thus leading to drinking which is then justified. As such, Nono also shows that circumstances can lead a person to disregard the risks of drinking during pregnancy due to the difficulty of the situation.

4.3 'I drank to abort'

Most of the literature (e.g. Chiodo et al., 2012; Kline, Stein, Shrout, Susser, & Warbuton, 1980) on alcohol use during pregnancy has shown how drinking during pregnancy is a risk factor for a miscarriage rather than an abortion. In a recent study conducted by Watt et al. (2014), discussed in the literature review in chapter two, it was found that some women continue to drink during their pregnancies with the intention to abort the foetus.

The women in this study spoke about drinking during their pregnancies to abort rather than to have a miscarriage. The language that they used in their narratives supported this. In isiXhosa, a significant difference exists when speaking about an abortion and a miscarriage. *Ukukhupha isisu*, which directly translates into "removing the tummy or taking the tummy out", refers to having an abortion while *ukuphuncuka kwesisu*, which directly translates into "the tummy falling or losing the tummy", refers to having a miscarriage. The three women who spoke about drinking to abort in this study used the former term and said:

Extract 34

Pretty: *When I got pregnant my father said that I must stop going to school because I had already embarrassed him in the community and now I was going to embarrass him at school. I told him I did not want to stop going to school and he said to me I must do something about the tummy. I spoke to a friend who was in a similar situation who told me that she drank alcohol (.) she said she drank shots of brandy so that she could take the tummy out [have an abortion] so I did this too but nothing happened*

Extract 35

Pearl: *I mean during my pregnancy I became used to alcohol and I was a person who was always drunk you understand? (.) And previously I was a person who used to work so I lost my job and I mean this wasn't a right thing for me (.) I mean before all of this I was a right person but things changed so when I found out that I was pregnant (.) I thought I wanted to take this tummy out [have an abortion] but this was not possible. I remember one day when I was sitting (.) I have a child who is my first born called [...] I remember that day I took all the pills I take for HIV [anti retrovirals] and drank a lot of alcohol but nothing happened you understand? (.) so everything continued and continued (.) another thing that made me think of taking this tummy out [having an abortion] is that*

I wasn't expecting this child she just happened so I didn't know who out of my three boyfriends (.) who exactly is the father of my child you understand

Extract 36

Nina: *Okay (.) during the time when I was pregnant (.) I found out that I was pregnant as I was vomiting bile nhe so my mother told me to go to the healthcare centre and my older sister accompanied me and at the clinic they discovered that (.) I was tested and they saw that I was pregnant and I asked them to please test me again because I didn't believe [that I was pregnant] and they tested me again and they discovered that I was pregnant. I came back home and when I came back my mother asked me what the outcome was and I asked her to send me somewhere and I told her that it can be anywhere even to the shop and she really sent me [to the shop] and she asked my sister because I was scared of telling her that I was pregnant as I was the most trusted person at home. So I told my boyfriend who I used to steal cause I used to steal the person that made me pregnant (.) I told him that I was pregnant and he said 'it can't be me that made you pregnant, look for the person that you were with [that made you pregnant]' yabo? Cause I told him that 'I would steal you because I already have someone [have a boyfriend]' and he said 'no look for your boyfriend' yabo? And then I thought I would like to take this baby out [abort] and I asked around in the community how a baby is taken out [aborted] and they said ha.a (.) you have to drink black coffee or drink (.) or take a shot of brandy and drink it so that the baby comes out of your stomach [the abortion happens] and I continued (.) I continued taking brandy daily (.) red brandy (.) it was Commando and I kept on taking the brandy and drinking and drinking the brandy and then the baby never came out [the abortion never happened]*

In Extract 34, as highlighted earlier in this chapter, Pretty shows how her pregnancy threatened her schooling. She shows that drinking to abort was a possible 'solution' for her to continue with her schooling. During her pregnancy, Pearl (extract 35) highlights how she lost her job due to her drinking and did not know the father of her child as she had multiple sexual partners. Pearl mentions that she drank to abort because her pregnancy was unexpected, that having a child would add to her existing financial problems and thus be a burden including her possible worry that her potential child will grow up fatherless.

In extract 36, Nina, as previously mentioned in this chapter shows how she did not expect to get pregnant. She draws upon a 'stress and coping' discourse in a different way compared to the way most of the women in this study did: Nina drew upon this discourse to only highlight the various issues that made her stress rather than highlighting that she drank to cope with stress. The fact that she was scared of telling her mother about her pregnancy given the fact that she has high hopes for

her may have lead Nina to stress. Another important experience during Nina's pregnancy is that her other partner, whom she used "to steal", impregnated her and denied the pregnancy although, it is assumed, there seems to have been an agreement (*cause I told him that 'I would steal you because I already have someone [have a boyfriend]*) between them that they would see each other even though she had a partner. This instance of paternity denial may have thus made Nina more stressed leading her to turn to alcohol in an attempt to abort. Nina's reasons for drinking to abort thus include her partner denying the pregnancy which may have made her worry about the possibility of raising her potential child alone with no support from her partner including parental displeasure (see extract 7 for more discussion). The fact that Nina's pregnancy was unexpected could also have been one of the reasons why she thought about drinking to abort especially given her mother's future hopes for her. Should the abortion have been successful, Nina would have 'made things right' which would mean that she continues with her schooling and furthers her education. Pretty and Nina, it is worth mentioning, drank to abort in a similar way as they took shots of brandy while Pearl took her anti-retrovirals with alcohol. All three women in the above narratives mention that although they drank to abort, their attempts were not successful. Pretty said *nothing happened*, Pearl said *this was not possible* and Nina said *the baby never came out*. This could be because the women drank at a later stage in their pregnancies.

In their narratives, Pretty, Pearl and Nina did not mention the possibility of presenting at a termination of pregnancy clinic. In extract 36, Nina mentioned that when she thought about drinking to abort, she asked around in her community and was given various suggestions which included drinking black coffee or a shot of brandy. We spoke more about this in her second interview (sub-session three):

Extract 37

Sbosh: *Okay (.) so uhm (.) the first question I would like to ask (.) [in your story] you said that after you found out that you were pregnant anhe uhm:: (.) fine you left and went to the clinic with your sister and then you asked around in the community cause you mentioned that you (.) you (.) you (.) you (.) thought about uhm taking the tummy out [having an abortion]*

Nina: *Yes*

Sbosh: *Okay so you asked around in the community how this could be done so I would like to ask (.) why did you not ask [about this] at the clinic and choose to ask people in the community?*

Nina: *It was because I knew that if I asked people in the community nhe they would give me easy solutions (.) at the clinic they would ask me questions [like] <u>why do</u> you want to take it [the tummy] out [have an abortion] you see [they would have asked] a lot of things*

In extract 37, Nina highlights how she avoided being questioned and possibly judged by the clinic staff for enquiring about an abortion and/or wanting to abort. This is the reason why she did not present or consider presenting at a termination of pregnancy clinic. The same is assumed for Pretty and Pearl. By positioning the clinic staff as curious and judgemental, she states why she chose to ask around in the community: *I knew that if I asked people in the community nhe they would give me easy solutions*. Unlike the clinic staff, community members would ask no questions thus making no judgements. As such, Nina positions the community members as non-judgemental and trustworthy which is why she decided not only to ask them for more information but also drink as they had suggested. In the above extract, Nina also (although not explicitly) speaks to the attitudes of healthcare providers and how they become a barrier to accessing abortion services as they may be opposed to providing the service (Harries, Stinson, & Orner, 2009) which in this case is evidenced through the questioning that Nina anticipates.

4.4 <u>'I drank to cope with an HIV diagnosis'</u>

Two of the women who took part in this study shared that they were diagnosed with HIV during their pregnancies. Below, Pretty and Hope share their experiences:

Extract 38

Pretty: *I was tested and I found out that I am HIV [positive] (.) that's where the drinking started and I drank for a <u>long</u> time because I thought about who I was going to tell about this and you know with such things you want to tell a person who will not go out and tell others and keep it to themselves then at this time I had no one to tell so it [the diagnosis] was always on my mind and it was nice when I drank for it [I drank to forget about it] as I didn't think about it at all.*

Extract 39

Hope: *At the clinic they don't test one thing (.) the fact that you are pregnant (.) they test a lot of things so (.) and it doesn't depend on whether you want to or you don't want to (.) it is a must that you are tested [for other things] when you find out that you are pregnant so I found out that I am HIV positive and then I couldn't (.) I couldn't (.) ((clears throat)) I couldn't stay and keep this [I couldn't handle] so I started drinking alcohol (.) okay (.) during my pregnancy. I couldn't believe that I was pregnant and HIV positive so the alcohol helped me forget about this sisi. I also didn't take my pills [antiretrovirals]*

In extract 38, Pretty shows that her stress stems from the fact that she has no one with whom to share her diagnosis. She says *I thought about who I was going to tell about this*. Given the fact that she had no one to tell, Pretty thought about her diagnosis a lot as she says *it was always on my mind* and this thus led her to stress. In contrast, Hope in extract 39 shows that her stress comes from the fact that she is pregnant and HIV positive. She says *I couldn't believe that I was pregnant and HIV positive*. Drawing upon a 'stress and coping' discourse Pretty and Hope talk about how alcohol helped them cope/deal with their diagnosis. Pretty says *it was nice when I drank for it [I drank to forget about it] as I didn't think about it at all* while Hope says *the alcohol helped me forget about this sisi*. In extract 38, Pretty also speaks to the stigma that exists around HIV and AIDS which often prevents people from speaking out about their diagnoses as they fear that those told will not *keep it to themselves*. While drinking alcohol for Pretty may have helped her forget about the diagnosis, it can also be argued that drinking provided her with some comfort regarding her diagnosis, something which she was not able to get from another person given her fear.

One of the women in this study, although she did not drink to cope/deal with an HIV diagnosis, spoke about how she wanted to commit suicide:

Extract 40

Rosey: *These things didn't sit well with me sisi at first especially the one about being [HIV] positive I also wanted to kill myself [commit suicide]*

In a study conducted by Giellen, McDonnell, O'Campo, and Burke (2005) in which data from Project WAVE was used to examine the association between a women's HIV status, IPV and risk of suicide, it was found that HIV positive women had thoughts about suicide frequently. This can be linked to the case of Rosey: she may have wanted to commit suicide when she found out about her HIV status due to the belief that HIV is a death sentence. Once a person is diagnosed with this disease, it is thought that they no longer have a life.

4.5 <u>'It was my decision'</u>

In the extracts below, Pearl and Lucy take up agentic positions; they own the fact that they drank to cope. This is quite different to taking up a victim position (e.g. victim of abandonment, violence, HIV diagnosis). The latter appears to be socially safe because it suggests that the women had no choice. The former, although not extensively used, is a socially uneasy position to take up and/or maintain which explains its limited use in this study. The women said:

Extract 41

Pearl: *When I did it [drank when I was pregnant] I used to think to myself 'is this the right thing to do'? (.) 'what will people say'? (.) I used to think about it a lot but (.) I told myself that I was drinking to solve what I wanted to solve and it was my decision*

Extract 42

Lucy: *I do not feel bad for drinking when I was pregnant (2) it really helped me deal with everything that was going on. Who was going to listen to me when I told them all my problems and about my situation? People have their own stress in life (.) I know a lot of people who drank when they were pregnant because of being in the same place [situation] like me*

In extracts 41 and 42, Pearl and Lucy assert their power to make the decision to drink during their pregnancies. In doing so, Pearl (extract 41) resists the stigma associated with drinking during pregnancy and shows that stigmatisation is a process that people who are vulnerable to the stigma can actively resist. Lucy in extract 42 positions herself as justified due to her circumstances. This justification is further emphasised by the fact that other previously pregnant women who were faced with the same situations drank during their pregnancies. Lucy shows that given the position she found herself in, drinking during pregnancy was not a bad thing as it allowed her to cope with the stress that she was experiencing.

5. Stories that condemn the drinking

Narratives of guilt/regret were evident in this study although the women justified/explained their drinking. This is consistent with findings in the studies conducted by Greaves and Poole (2005) and May and Gossage (2011) discussed in the literature review in chapter two.

5.1 'I feel guilty about drinking during my pregnancy'

In this micro narrative, the women draw on the 'good mothering/appropriate pregnancies' discourse to highlight how drinking during their pregnancies meant that they were not good mothers. This was closely linked to prioritising drinking over the needs of the foetus as well as the effects the drinking had on their children. Nono and Lola said:

Extract 43

Nono: *When I think back to the time when I was pregnant (.) it hurts me mntasekhaya because why? I almost ruined the future of this person who is bright [smart] cause he has been struggling a*

lot at school (.) all I cared about was the drinking and myself (.) I didn't think about him (.) I regret what I did mntasekhaya (.) I regret it

Extract 44

Lola: *When I think back to the time when I was pregnant and I drank (.) I feel very guilty (.) I really do (.) Even if I drank because of the problems I had I can tell that my drinking affected my child (.) I should have thought about her first and not myself (.) now she does not listen at all (.) it's my fault she is misbehaving*

In extracts 43 and 44, Nono and Lola touch on how guilt can come up due to the 'consequences' or effects of drinking during pregnancy. Both their guilt/regret comes from the fact that when they were pregnant they prioritised their drinking over the needs of their children. By touching on the prioritisation of needs, both women show the gendered expectation that comes with pregnancy where women are obligated and responsible for considering and placing the needs of the foetus as primary (Greaves & Poole, 2005; Jacques & Radtke, 2012). Their guilt/regret is thus compounded by drinking during their pregnancies and placing the needs of the foetus as secondary. Nono captures this when she says *all I cared about was the drinking and myself (.) I didn't think about him* while Lola says *I should have thought about her and not myself*. Furthermore, both Nono and Lola blame themselves for the challenges that their children are experiencing because of their drinking in addition to the guilt/regret they are feeling. Nono blames herself for the fact that her child is struggling at school while Lola, despite the fact that she justifies her drinking by saying *Even if I drank because of the problems I had*, blames herself for her child misbehaving and not listening. In this regard, it is clear that the women not only feel guilty, show regret for drinking during their pregnancies and blame themselves for the challenges that their children are experiencing, but also take responsibility for these challenges thus drawing on a discourse of responsibilisation. For Nono, this is evident when she says *I almost ruined the future of this person who is bright [smart] cause he has been struggling a lot at schoo*l while Lola says *it is my fault she is misbehaving*.

6. Stories about the women knowing the effects of drinking during pregnancy

Crawford-Williams et al. (2015), as discussed in the literature review in chapter two, have highlighted how pregnant women who drink often rely on various individuals such as their partners and/or family members for information about drinking during pregnancy. The women in this study also spoke about different people who provided them with information.

6.1 <u>'We knew about the effects of drinking'</u>

Various sources of knowledge about the effects of drinking during pregnancy were mentioned by the women. In the extracts below, Nina, Lucy, Pearl, and Nonny speak about how they came to know about the effects of drinking during pregnancy. The women said:

Extract 45

Nina: *When we [my sister and I] went to the clinic we arrived at the clinic and we were told to come on a Wednesday this is when I first booked so we were told about drinking [during pregnancy] we were also told to condomise and use a condom we were also told about our pills that we have to take our pills*

Extract 46

Sbosh: *I would like to know how going to the clinic was. How was it at the clinic? Did the nurses tell you [pregnant women] that (.) or did they tell you that you are not supposed to drink when you are pregnant and so on and so on?*

Lucy: *Yes they did speak about this [drinking during pregnancy]*

Sbosh: *What (.) what did they say maybe?*

Lucy: *They told us that a pregnant person should not drink*

Extract 47

Lucy: *(2) Yes [I know] just a little but I have heard people speak (.)*

Extract 48

Pearl: *I knew that it was not even right to smoke and drink when you are pregnant because the child gets affected by this. We are told this even at the clinic because they tell us that drinking [during pregnancy] is not right and so on*

Extract 49

Nonny: *She [my mother] told me that a pregnant person doesn't drink*

From the above extracts, it is evident that the women's knowledge about the effects of drinking during pregnancy in this study comes from others, a finding consistent with Crawford-Williams et al's. (2015) study. Nina (extract 45), Lucy (extract 46), and Pearl (extract 48) highlight how they were told about the effects of drinking during pregnancy at the clinic possibly by the nurses. Pearl

also mentions that she knew that drinking and smoking can affect a potential child. In their study, Watt et al. (2014) highlighted how women believed and understood messages about drinking during pregnancy that came from nurses. It is assumed that this was also the case for the women in this study. Nonny (extract 49) was told by her mother not to drink when she was pregnant and like Lucy (extract 47), she also heard about the effects of drinking from other people.

Some of the women in this study spoke about knowing the effects of drinking during pregnancy from 'culture'. Rosey, Pearl, and Khethiwe said:

Extract 50

Rosey: *In our culture it has always been said that (.) a pregnant woman* <u>*cannot*</u> *drink (.) I was told this a lot when I grew up.*

Extract 51

Pearl: *Our culture says that a pregnant woman should not drink.*

Extract 52

Khethiwe: *My children (.) in our culture it has always been said that drinking during pregnancy is not right because it harms the baby.*

As mentioned in the previous chapter, the women in this study refer to culture as a 'real thing' given their use of the term "in our culture". In the extracts above, the women draw upon the 'cultural' discourse to show that shared knowledge, beliefs, and norms exist in the Xhosa culture about drinking during pregnancy. This practice, as governed by culture is wrong and is one in which a pregnant woman should not engage. In emphasising this, the women say *a pregnant woman* <u>*cannot*</u> *drink* (Rosey, extract 50), *a pregnant woman should not drink* (Pearl, extract 51) and Khethiwe (extract 52) says *drinking during pregnancy is not right*.

6.2 <u>'We ignored our knowledge/what we were told'</u>

When they were told about some of the effects of drinking during pregnancy, some of the women in this study spoke about how they responded as well as what they did. Lucy, Dineo, and Cindy said:

Extract 53

Sbosh: *I would like to ask another question how did you respond when [...] told you about drinking when you are pregnant?*

Lucy: *I wasn't cheeky though but I would just laugh at her when she spoke*

Sbosh: *Why?*

Lucy: *Huh?*

Sbosh: *Why?*

Lucy: *I used to tell them that I wasn't the only person that drank (.)other people drink as well*

Extract 54

Sbosh: *Okay okay so you didn't have any knowledge (.) did your mother maybe know something or?*

Dineo: *I think so she usually saw me when I had <u>drunk</u>*

Sbosh: *Uh-huh uh-huh was (.) was there maybe something she used to say about your drinking maybe 'don't drink'?*

Dineo: *Yes she used to say I shouldn't drink but I kept on drinking*

Extract 55

Sbosh: *Okay and then here in your area what do people say maybe when they see a pregnant person drinking? So are there things that they maybe say (.) or do they just leave her [let her be]?*
Cindy: *They (.) there are things that they say but the pregnant people just ignore them but there are things that are always said*
Zamo[10]: *What things are said maybe?*
Cindy: *That we (.) a pregnant person must not drink because she does not go [to the clinic] to book and when she has to go book she does not go*
Zamo: *Yes*
Sbosh: *Do you think there is a reason (.) so you say they [pregnant women] ignore other people [when they tell them not to drink]*
Cindy: *Yes*
Sbosh: *So do you think there is a reason for ignoring other people when they say 'you should not drink when you are pregnant' and so on*
Cindy: *Maybe. I: I don't know if there is a reason but it could be because they like alcohol or they think that the other people are lying*

[10] This is the co-researcher.

In extract 53, Lucy mentions that when a relative of hers told her about drinking during pregnancy she used to laugh because she was not the only person who drank during her pregnancy. Implied here is that she may have continued drinking during her pregnancy although she was told not to. When she was told by her mother not to drink, Dineo (extract 54, see also extract 23) mentions that she did not stop doing so. It is assumed that this was not possible because of the stress her partner had caused her due to being unreliable. In extract 55, Cindy speaks to the responses of pregnant women in the community regarding drinking during pregnancy. She says *the pregnant people just ignore them* and in giving a reason for this she says *it could be because they like alcohol or they think that the other people are lying*. This could be linked to the fact that alcohol use in the context of these women is a norm thus anything that would prevent them from drinking is ignored. Lucy's reaction (that of laughter) can also be linked to this.

7. Summation

In this chapter, I looked at how the women who took part in this study utilised the discursive resources discussed in the previous chapter in their narratives. The narratives were divided into five categories in an attempt to draw attention to the five main features of the narratives of the women.

The first category focused on the stories about the pregnancy. In these narratives, the women reported feeling shocked and scared when they found out about their pregnancies. This was closely linked to the fact that the pregnancy went against the "appropriate pregnancies" norm and happened while still in school or was unexpected. As such, for some of the women, the pregnancy led to shame and stigma which resulted in exclusion particularly from school spaces. The stigma as shown by the women not only affected them but their families. Instances of parental displeasure were also reported by the women. Interestingly, while some of the parents of the women may have been displeased, they ended up accepting the pregnancy. The reactions of partners towards the pregnancy were also spoken about and while these reactions were positive, issues emerged as partners left the women or got annoyed by them.

The second category focused on stories about the drinking. Here, the women spoke about their drinking patterns during and after the pregnancy. Instances of drinking regularly were reported and some of the women in this study spoke about restricting their drinking. Reasons for restricting drinking were given by some women. These included wanting to take a break from alcohol and to continue with schooling. Some women spoke about the challenges they experienced in their attempts to restrict their drinking. Circumstances which prevented the women from drinking (thus possibly limiting their drinking) such as a lack of money were also highlighted while other women found alternative ways to continue with their drinking and/or get money to ensure that they drank.

Like the pregnancy which led to shame and stigma, the drinking, as some of the women in this study showed, resulted to shame and stigma. As such, the women reported being ostracised by others where the shame and stigma was compounded by the reactions of others to their drinking, thus not only affecting them, but their families.

In the third category, stories about justifying/explaining drinking were focused on. In this narrative category, it became evident that the drinking of many of the women in this study is a result of stress caused by partner related issues such as a lack of support, partners being unreliable, denying the pregnancy, and being unfaithful. The utilisation of the 'stress and coping' discourse as well as the 'male/masculine provider' discourse were dominant discourses that the women drew upon to highlight this. In addition, the women also spoke about issues within their families as well as between them and their partners that made them drink. Some of the women in this study reported drinking to abort and to cope with an HIV diagnosis. Two of the women who took part in this study highlighted that drinking during their pregnancies was a decision that they made so as to be able to cope with various problems they were experiencing. In taking up this agentic position, these women were also able to resist the stigma associated with drinking during pregnancy.

Stories that condemn the drinking were focused on in the fourth narrative category. In this category, the women constructed drinking during pregnancy as wrong and as such, emphasised that they felt guilty for engaging in this practice. Drawing on the 'good mothering/appropriate pregnancies' discourse, the women highlighted that drinking during their pregnancies meant that they were bad mothers as their drinking affected their children by causing behavioural and school related problems. In emphasising their guilt, the women blamed themselves and took responsibility for these problems.

Lastly, this chapter focused on stories about how the women knew the effects of drinking during pregnancy. Family members particularly mothers as well as nurses and other people were said to be the main sources of information when it comes to knowing about the effects of drinking during pregnancy. Some of the women spoke about knowing the effects of drinking during pregnancy from 'culture'. In these narratives, the norm that drinking during pregnancy should be avoided in the Xhosa culture was shared among the women. The ways in which the women responded to what they were told about the effects of drinking during pregnancy was also highlighted in this narrative category.

In the final chapter, I pull these findings together and discuss what has emerged from this study about the social and interpersonal circumstances under which drinking during pregnancy takes place and the implications of this for interventions.

Chapter Seven: Concluding Discussion

1. Introduction

In concluding this study, I revisit the research questions which I sought to answer. The main research question for this study was: How do women who have drunk alcohol narrate the journey of their pregnancy? The following sub-questions were formulated: 1) What social, cultural, gendered, religious, and socio-economic discourses are drawn upon in narrating these stories? 2) What subject positions are enabled in these narratives and discourses? 3) What gendered power relations are referred to in these narratives and discourses?

This study was conducted to explore women's narratives of the personal and interpersonal circumstances under which drinking during pregnancy takes place in an attempt to understand the practice of alcohol use during pregnancy within the social and cultural narratives, practices, and discourses around pregnancy in this particular context as well as gendered and social relations. Furthermore, this research was conducted to add to the growing body of research on alcohol use during pregnancy which aims to explore the contextual, cultural, economic, familial, psychological and social factors that contribute to drinking during pregnancy.

With regard to the theoretical framework, I used a feminist postructuralist approach together with Foucault's theory of power to highlight variability in the women's experiences of drinking during pregnancy as well as instances of resistance and oppression through analysing the narratives for gendered power relations. I collected the data for this study from thirteen women using narrative interviews and analysed it using Taylor and Littleton's (2006) iterative two step approach to data analysis. In employing these approaches, including the data collection method of narrative interviewing, an important and valuable contribution that this study has made is that it has given voice to a group of women who are marginalised and often stigmatised. Studies on alcohol use during pregnancy are mostly conducted quantitatively, concentrating either on drinking patterns or effects on foetal and child development. In this study, the voices of women who drank during their pregnancies were privileged and their experiences of alcohol use during this time were heard. In an attempt to answer the research questions, I separated the analysis and interpretation of the data/findings into two chapters. In chapter five, I discussed the discursive resources that the women in this study deployed in telling their stories while chapter six focused on the stories that the women shared to explore how they put the discursive resources identified in chapter five to work in their narratives.

In this chapter, I start off by providing a summary of the findings of this study then move to discuss the implications of these findings and make recommendations for interventions which aim to address alcohol use during pregnancy. Finally, I speak to the limitations of this study and make recommendations for future research.

2. Summary of findings

One of the main findings of this study is that women construct their environments as containing multiple severe stressors with which they needed to cope. As such, alcohol use during pregnancy was presented as a useful practice to engage in as drinking during this time helped the women cope with stressful circumstances. These stressful circumstances were thus constructed by the participants as compelling them to drink in order to cope. Further, alcohol was constructed as a remedy which makes coping with stressful circumstances possible as the women can forget and not think about problems they experience. Drinking then in this case is often justified/explained. In constructing alcohol as a coping mechanism, the discourse of 'stress and coping' is drawn upon and participants are positioned as dependent on alcohol and drinking to cope.

In line with the above argument, the women in this study spent time justifying/explaining their drinking. Their justifications included narratives concerning a lack of partner support, partner unreliability as well as infidelity and denial of paternity. These narratives pointed to the overpowering role of partners when it comes to drinking during pregnancy. The drinking of some of the women was located within problems in the home such as family of origin problems and poverty. Some of the women spoke about drinking to abort as a 'solution' to issues that the pregnancy raised such as the potential child growing up without a father and therefore no male/masculine provider to provide financially, the pregnancy being unexpected, leading to parental displeasure, or in an attempt to be able to continue with schooling as the pregnancy went against the "appropriate pregnancies" norm. Other women spoke about drinking to cope/deal with an HIV diagnosis. The micro-narrative 'It was my decision' saw some of the women in this study taking up an agentic position and owning up to the fact that they drank to cope. In doing so, they asserted their power to make the decision to drink during their pregnancies which further allowed them to resist the stigma associated with this practice. While the women justified/explained their drinking, narratives which condemned the drinking were also evident. In this narrative category, feelings of guilt and regret for drinking during their pregnancies were reported by the women. Such feelings were closely associated with the effects of drinking during pregnancy that they had noticed in their children as well as women placing the needs of the child as secondary, and prioritising drinking, which led to self-blame. Drinking during pregnancy in this narrative category was portrayed as an act that is wrong and thus leads to bad mothering.

In utilising a ‘hegemonic masculinities’ discourse, the women in this study were able to highlight that the context in which they live is highly gendered where women and men are positioned unequally – the women occupied a passive and subordinate position while the men occupied a dominant and powerful position. Given this positioning, male partners were violent towards the women due to drinking and non-drinking. Some women in this study reported drinking to cope with violence in intimate relationships and others drank to avoid conflict which would lead to violence. Although there was limited resistance to the ‘hegemonic masculinities’ discourse in this study and the patriarchal view that men are more powerful and dominant than women, two women who took part in this study did challenge unequal partner relations when they had drunk by fighting back and speaking up about the state of things despite violent threats. Agentic positions such as leaving a violent partner and deciding not to drink despite this leading to violence were also narrated by some of the women in this study. While such positions were taken up, it is important to highlight the fact that within a context of poverty, leaving a violent partner could, for example, render many women vulnerable to continued and/or further abuse and maltreatment at the hands of other men. Furthermore, many women are dependent on their violent partners. This may explain why the two women who narrated agentic positions in this study were unable to leave their partners.

The hegemony of men was taken further in the ‘male/masculine provider’ discourse where male partners were regarded as breadwinners and providers and the women were financially dependent on them. The women in this study constructed a male/masculine provider as a man who: 1) does not deny responsibility when there is a pregnancy or disappears once told about a pregnancy; 2) is able to take care of the potential child and the woman financially both during and after the pregnancy; 3) can make the necessary means and/or put in the effort to ensure that he is able to provide; 4) has an education/is educated in order to get a job and thus a salary or income that can ensure comfortable living; and 5) is truthful and honest. In this study, the partners/men that the women spoke about did not possess these qualities. While the absence of a male/masculine provider led to drinking as the women stressed about how the potential child would be provided for and/or supported, the presence of a male/masculine provider as some of the women in this study narrated also led them to drink during their pregnancies. In these cases, men/partners were regarded as not pulling their weight as they did not provide financially for the child even though they are employed or did not put in the effort to ensure that they would be able to provide.

The ‘hegemonic masculinities’ and the ‘male/masculine provider’ discourses that the women drew upon in narrating their stories are all based on gendered ideals of masculinity. The ‘male/masculine provider’ discourse, as argued by Tamale (2003), shows how domesticity operates. Women are expected to be dependent on their male partners while providing the necessities of reproductive

social life. The gendered understandings of the roles of males and females in this study point to the subtle operation of patriarchal power relations where the outcome is sexed and gendered bodies.

Parenting ideas were also seen in this study when the women drew upon the ‘good mothering/appropriate pregnancies’ discourse. The ideal here focused on how a good mother should act and behave. Non-drinking, caring and providing for a child were two qualities a good mother was said to possess. With regard to the timing of a pregnancy, focus was mainly on pregnancies that happened when a woman was young and still in school. Pregnancies which took place at this time were regarded as inappropriate by teachers and parents and, as such, met with negative attitudes. Women who got pregnant while young and still in school were positioned as irresponsible and teenage mothers were regarded as not being able to be good mothers and/or engage in good mothering. A good mother, in addition to the above two qualities, thus ensures that she gets pregnant at the ‘right time’ – after school, at an older age and when married as these circumstances enable good mothering.

The ‘good mothering/appropriate pregnancies’ discourse was mainly utilised by the women in sharing their stories about the pregnancy. In this narrative category, this discourse was used to highlight how they went against the “appropriate pregnancies” norm or rather how their pregnancies were problematic. In finding out they were pregnant, some of the women in this study indicated that they felt shocked and scared as they got pregnant while still in school and did not plan or expect the pregnancy. Instances of parental displeasure as parents were unhappy about the early pregnancies were also evident. Most importantly, going against the ‘good mothering/appropriate pregnancies’ discourse led to the pregnancy resulting in shame and stigma. In such instances, one of the women in this study reported hiding her pregnancy from her teachers by wearing a windbreaker to avoid any negative attitudes and being questioned. The shame and stigma which resulted because of an inappropriate pregnancy not only affected the women but also their families who avoided further stigma by restricting the movement of their daughters into spaces (particularly the school space) where stigma may operate.

In the ‘cultural’ discourse, the view of the good mother was taken further where marriage, based on cultural expectations was emphasised as the appropriate place for reproduction to occur. Reproduction that takes place outside of this union is problematised and regarded as disrupting the ‘good mothering/appropriate pregnancies’ discourse. In relating the ‘cultural’ discourse to drinking during pregnancy, participants spoke of the practice as culturally shameful. The social sanction of drinking during pregnancy in the Xhosa culture is due to its association with bad mothering. This results, according to the participants, in silence around drinking during pregnancy. While this was

the case, some women in this study, as mentioned previously in this chapter, highlighted that drinking during their pregnancies was a decision that they made. Relating this micro-narrative to the 'cultural' discourse, it can be said that these women did not regard their drinking as a shameful act.

A 'disablement and developmental delay' discourse was drawn upon to highlight the detrimental effects of drinking during pregnancy on the foetus. Here, the emphasis was on the realisation that when a woman drinks during her pregnancy, the potential child will be disabled, brain damaged or struggle at school. Although factually correct, the implication of this, as two of the women in this study showed, is that children born from mothers who drink during their pregnancies are stigmatised or rather constructed as abnormal and different. Information about the effects of drinking during pregnancy, as the women reported in the narrative category on stories about the women knowing the effects of engaging in this practice, comes from family members, nurses and other people in their communities. What was surprising both in this discourse and narrative category is that despite the fact that the women knew and were told about the effects of drinking during pregnancy, they drank.

In reflecting on the data, it is important to consider the broader context of the study: the context within which the narratives must be understood. As the women in this study live in a low resource setting, it is possible that they may have felt that drinking was the only possible way in which they could cope with their problems. In the context of the women who took part in this study, drinking, as evidenced in the 'peer pressure' discourse, is a norm. As such, peers actively encourage the use of alcohol during pregnancy and resistance to this pressure by some pregnant women is limited. Drinking amongst peers is a norm and resisting this norm can include being excluded from a peer group, being positioned negatively rather than positively or as a good mother. In the narrative category on stories about the drinking, the micro narrative 'I drank a lot', the challenges experienced by some of the women in restricting their drinking (including their failed attempts), and using social grant funds to ensure that drinking continues can thus be explained through the 'peer pressure' discourse. Even though the drinking as highlighted by one of the women in this study affected her badly by resulting in a hangover, in her narrative, she indicated that her drinking continued.

Within the 'religious' discourse, drinking during pregnancy was constructed as an act of killing and therefore a sinful practice. Some of the women in this study spoke about the church as a safe space where they could speak about the problems they experienced during their pregnancies without judgement while others highlighted how going to church helped with restricting drinking. Like the pregnancy, drinking as shown by some of the women in this study resulted in shame and stigma.

This shame and stigma led to ostracism particularly in the religious/church context and family members compounded the shame by responding negatively to the women's drinking resulting to changes in familial relationships. One of the women showed how the shame and stigma drinking during pregnancy results to does not only affect her but is shared with people in her cultural context.

In summarising the findings of this study a brief explanation can be made: drinking during pregnancy is a practice that is understood and made sense of in a variety of ways and is shaped by the broader discursive context in which it takes place. In this study, alcohol use during pregnancy was a practice that the women explained and/or justified and as such was mainly regarded as a coping mechanism, given stressful life circumstances. Further, the patriarchal nature of the relationships between the women and their partners meant instances of IPV were common which also led the women to further drink in order to cope with the violence they experienced in relationships. The absence (and presence) of a male/masculine provider meant that the women would have difficulty providing both for themselves and the potential child and this also often led the women to drink. Cultural views on drinking during pregnancy including the timing of a pregnancy which often influenced meanings of the 'good' and 'bad' mother at times necessitated drinking among some of the women in an attempt to 'make things right' or 'solve' problems that their drinking had caused especially between them and their parents. The influence of peers, as well as social norms around drinking were other factors in the women's context that also influenced drinking during pregnancy.

3. Recommendations for interventions

The findings of this study provide a number of useful insights into the context in which pregnant women live which could be of great value for interventions aimed at addressing alcohol use during pregnancy. A critical aspect of both interventions and substance abuse treatment services is that they do not individualise or decontextualize drinking during pregnancy as this further stigmatises this practice. Interventions and treatment services should rather adopt a supportive, non-judgemental approach that not only prioritises the health and well-being of the foetus but also the health and well-being of the pregnant woman, acknowledging the multiple factors that influence the drinking behaviour of pregnant women. In South Africa, the prevention (and treatment) of alcohol use during pregnancy needs to be appropriately framed both at a legislative and policy level in order to guarantee that women with alcohol misuse or abuse problems are not punished for their actions. In the paper by Young (1994) in which policy approaches to pregnant women who are addicts were discussed, there were instances where women who used alcohol (including drugs) have been arrested, detained and in other cases prosecuted. To prevent this from happening in the context of

the women in this study, the fact that drinking during pregnancy does not occur in isolation or rather the fact that pregnant women do not 'choose' to drink and that their drinking is located in a particular context and influenced by multiple socio-cultural, economic, and familial issues such as the culture or norm of heavy drinking, lack of partner support, and familial conflict should be acknowledged and addressed.

In line with the theoretical approach guiding this study, tackling social practices linked to particular discourses is central to improving the effectiveness of interventions. Such an effort can firstly be achieved by challenging the negative discourses that surround alcohol use during pregnancy such as the perception that drinking during pregnancy necessarily makes a woman a bad mother. Instead, discourses around mothering being powerful need to be encouraged to limit the effects that the discourse of 'good mothering/appropriate pregnancies' has. It is important to acknowledge mothering as a complex and variable task that relies on a number of social resources. Further, acknowledging that mothers deal with stress and ambivalence rather than portraying mothering as an inevitably positive and fulfilling experience is important. A focus on what is called the 'good enough' (Winnicott, 1953, as cited in Ratnapalan, 2009) mother may be useful. This idea acknowledges that there is no such thing as the 'perfect' or 'good' mother in real life and that mothering is a series of actions and decisions taken in everyday life – some of which are positive and some of which are negative, depending on the circumstances. It is a flexible and contradictory relationship that requires personal and interpersonal labour (Ratnapalan & Batty, 2009). Emphasising the 'good enough' notion can result in highlighting the positive aspects of their mothering and diminishing the negative ones, as well as in less stigma (that the label of bad mother promotes). The disputed idea that young women make bad mothers should also be addressed and interventions can incorporate a component where they work together with schools to ensure that support for young women to, firstly, return to school after a pregnancy and, secondly, be involved in childcare, is available.

The involvement of fathers or male partners during pregnancy has been shown as contributing positively to certain maternal behaviours particularly drinking during pregnancy (Gearing et al., 2005). As such, a component that works with both pregnant women and their partners may be beneficial for interventions aimed at reducing alcohol use during pregnancy. In such a component, male partners can be encouraged to support their partners during a pregnancy in a caring and compassionate way as they are able to play a role in helping their partners limit their drinking or not drink during their pregnancies. Further, both the women and their partners can be informed about what can be expected during a pregnancy as well as the best ways to ensure the health and well-being of both the pregnant woman and the foetus. In this way, the gender norms underpinning the

‘male/masculine provider’ discourse will be tackled or undermined as involving fathers and/or male partners will encourage equal responsibility for caring for the child rather than emphasising the gendered nature of child care where men are regarded as the providers and women the child rearers.

Importantly in the context of this study, women who are faced with stressful circumstances during their pregnancy should be provided with psychological/psychosocial services in an attempt to ensure that they do not feel that in order to cope, they should turn to alcohol (Watt et al., 2014). The women in this study have limited access to substance misuse services including mental health care services. The therapeutic and counselling services offered to pregnant women should focus on addressing the stressful circumstances that they face such as IPV and partner infidelity in order to help them develop effective coping strategies. Of importance here is that these services ensure women are not made to feel as though they are responsible for the violence because of their drinking or non-drinking. Rather, these services should also aim to empower pregnant women so that they are able to resist unequal power relations and also feel confident to make positive life choices such as standing up to their partners if they are being controlling or restrictive. In this way, the gender norms underlying the ‘hegemonic masculinities’ discourse can be undermined. Looking specifically at what is causing stress during pregnancy is also another way that interventions targeted at reducing alcohol use during pregnancy can become more effective. In this study for example, some women reported drinking to cope with an HIV diagnosis. A peer support/mentoring aspect to these interventions will also be beneficial to help with providing support to women living positively while at the same time providing support through the pregnancy journey. Ensuring access to resources (e.g. putting women in touch with representatives of the Department of Social Development (DSD) to get a child support grant and potential employers) for women who drink because of partners being absent and difficult familial and financial circumstances may also be beneficial for interventions.

An important aspect to mention is that interventions and campaigns focused on only providing information about alcohol use during pregnancy will in all likelihood fail. As was evident in the ‘disablement and developmental delay’ discourse and the narrative category of stories about the women knowing the effects of drinking during pregnancy, participants knew about the effects of drinking during pregnancy and indicated that they received information from a number of sources. Drinking during pregnancy, they indicated, is culturally prohibited, yet they drank. Addressing the social dynamics underpinning such drinking to challenge the ‘peer pressure’ discourse is therefore indicated. While interventions encourage a level of responsibility when it comes to abstaining or limiting alcohol use during pregnancy, it is important that this responsibility for change should not be portrayed as the sole responsibility of the pregnant woman. As such, interventions should rather

be implemented at a community level where attention to other alternative recreational opportunities (such as support groups in which women share their experiences of their pregnancy journey and give each other advice, reading clubs etc.) that do not involve the use of alcohol should be provided in low resourced communities such as the one in which I conducted this study. In doing so, women will be offered with an alternative option to socialise and de-stress rather than turning to alcohol, in an attempt to cope (Choi et al., 2014b). This will aid existing interventions on alcohol use during pregnancy including the NGO with which we were working to continue shifting the norms of heavy drinking (Branco & Kaskutas, 2001; Rosenthal, Christianson, & Cordero, 2005; Watt et al., 2014).

4. Limitations of the study and recommendations for future research

While yielding valuable results, this study does not come without any limitations. The first limitation revolves around the data that were collected for this study. All of the women who took part in this study were isiXhosa speaking 'Black' women who were mostly unemployed. Thus, there was limited diversity in the participants in terms of cultural, racial, and socio-economic identities. In recruiting participants, as mentioned in the methodology chapter in chapter four, I wanted to keep in line with poststructural feminism's emphasis on difference in terms of geographical location, race, and socio-economic circumstances. However, due to the fact that the participants were recruited from one geographical area, the sample was homogenous. The second limitation has to do with the possibility of the women's narratives being influenced by my being a student and an African woman. The women, because of this might have constructed particular narratives so as to not appear to contradict common, widely held experiences and views about drinking during pregnancy.

In closing, with regard to future research that can be conducted, it would be useful to expand the diversity in terms of culture, race, and socio-economic identities among participants so as to have a broader sense of experiences about drinking during pregnancy. It also be would be interesting to conduct research with: 1) women who are currently pregnant, drinking during their pregnancies, and part of an intervention or programme that aims to reduce alcohol use during pregnancy, and 2) healthcare providers. In conducting research with women who are currently pregnant, drinking, and part of an intervention or programme, a holistic understanding of this practice will be obtained. In other words, if the narratives come from women who are currently drinking during a pregnancy, they may be different as they would be first-hand and perhaps clearer. Further, in such a study, it would be useful to see whether or not the intervention or programme does or does not have an impact on the women's perceptions and understandings of drinking during pregnancy. Research with healthcare providers (e.g. nurses, doctors) may provide an opportunity to explore what

discourses they draw upon when speaking about drinking during pregnancy as well as what discursive constructions emerge when speaking about women who drink during their pregnancies.

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Appendices

Appendix A: Research Information Card

Dear Potential Participant

My name is Sibongile Matebese. I am a Masters by Thesis student in the Department of Psychology at Rhodes University. I am conducting research on women and asking them to tell me about the journey of their pregnancy from before they were pregnant until their children were born as well as the experiences and events that were important to them during this time. I want to hear **your** individual story which you will tell in a non-judgemental environment.

The information you share with me will be used to inform interventions to help women and their families address difficulties faced during their pregnancies, in particular alcohol use. I would really appreciate you sharing your story with me because what you have to say will help others. You will also receive a food voucher worth R200 as a token of appreciation for you time. If you would like to know more about the research, please fill in the section below, tear it out, and give it to the mentor or the research student.

Thank You

Sibongile Matebese

……………………………………………………………………………………………………..

Your Name ……………………………………………………….

Response (select one option):

☐ No, I don't give the social worker permission to give the researcher any information.

☐ Yes, I give the social worker permission to give the researcher the following:

☐ My contact details

Number ………………………………………….

IsiXhosa Research Information Card
Ikhadi leenkcukacha ngophando

Molo mthathi-nxaxheba

Igama lam nguSibongile Matebese. Ndingumfundi owenza ii*Masters* kwisebe lezifundo zeSayikholoji/lezenzuluwazi ngengqondo. Ndenza uphando ngabafazi apho ndibacela bandixelele ngohambo lwabo lokukhulelwa ukusukela ngexesha phambi kokuba bazi okanye bafumanise ukuba bakhulelwe ukuyokutsho kwixesha abantwana babo abazalwa ngalo kwakunye nezehlo okanye izenzeko ezazibalulekile kubo ngelixesha. Ndifuna ukuva **elakho** ibali ozakundixelela lona kwindawo ongazokugxekwa okanye ujongelwe phantsi kuyo.

Iinkcukacha ozakube undixelele zona zizakusetyenziswa ukuphucula amangenelelo anceda abafazi neentsapho zabo ukuze bazame ukulungisa ubunzima neengxaki abajongene nazo ngexesha besakhulelwe, ingakumbi ukusetyenziswa kobutywala. Ndingakuxabisa kakhulu ukuva bali lakho ngokuba ozakukuthetha kuzakunceda nabanye abantu. Uzakufumana isipho sevawutsha yokuthenga ukutya exabisa amakhulu amabini eerandi (R200) ukubulela ngokusinika ixesha lakho. Ukuba uyafuna ukwazi banzi ngoluphando, ndicela uzalise elicandelo lingezantsi, ulikrazule, uze ulinike umcebisi okanye abaphandi abafundayo.

Enkosi

NguSibongile Matebese
…………………………………………………………………………………………………..

Igama lakho ……………………………………………………….

Impedulo (Khetha ibenye):

☐ Hayi, andimniki unontlalontle imvume yokuba anike umphandi naziphi iinkcukacha ngam.

☐ Ewe, ndiyamnika unontlalontle imvume yokuba anike umphandi oku kulandelayo:

☐ Inombolo yam yefowni

Inombolo yefowni ………………………………………….

Appendix B: Study Information Sheet

Dear Potential Participant

Thank you for your interest in the research. This document serves to provide you with more information about the research. Please feel free to ask any questions once you have finished if you have any.

If you agree to participate in the research, you will be asked to take part in three sessions that will be recorded. You can withdraw from the session(s) at any time when you want to stop or feel uncomfortable. Sibongile Matebese and Nontozamo Tsetse will be present during the sessions and will help each other take notes and come up with questions to ask you. The first session will be divided into two sessions. In the first, we would like you to tell us your story. Everything you tell us is **confidential**. You can tell us your story in English or isiXhosa. After you have told your story, we will spend 15 minutes coming up with questions to ask you in the second session based on the story you told us. The first session will take approximately an hour to two hours. The final session will only take place after we have transcribed the recordings and read over the transcripts from the first and second sessions. We will ask you questions in this session about any missing information we have noted. We will store the recordings on our computers that are password protected for five years. When this period of time has passed, we will destroy both the recordings and transcripts. We will not use your name or the name of the ward in which you are in the research report and because of this no one will be able to identify you. Once we have completed the first two sessions, we will give you a questionnaire called the AUDIT-C. The questionnaire has three questions and will take between 3 and 5 minutes to complete. We will keep the questionnaire and no one else will have access to it. You will also receive a food voucher worth R200 that is not transferable for cash as a token of appreciation for your time. This will be given to you even if you withdraw from the study at any point during the sessions.

Taking part in this research is voluntary. Your participation or non-participation will in no way affect your relationship with the NGO. If you do not want to take part, you do not have to give a reason and no pressure will be put on you to try and change your mind. If you decide to participate, what you have to say is very important as it will help others better understand the circumstances of pregnancy and why women drink during pregnancy. If you are comfortable, we will proceed with the sessions. You may contact the researchers at any time during the research.

Yours Sincerely
Sibongile Matebese and Nontozamo Tsetse

IsiXhosa Study Information Sheet
Iphepha leenkcukacha ngophando

Molo mthathi-nxaxheba

Enkosi ngokubonakalisa umdla koluphando. Oluxwebhu lwenzelwe ukunika iinkcukacha ezithe vetshe ngoluphando. Nceda ukhululeke ukubuza nayiphi na imibuzo xa ugqibile ukulufunda oluxwebhu ukuba ikhona imibuzo onayo.

Ukuba uyavuma ukuthatha inxaxheba koluphando uzakucelwa ukuba uthathe inxaxheba kwiiseshini ezintathu ezizakurekhodishwa. Ungarhoxa kwiiseshini naninina xa ufuna ukuyeka okanye uziva ungakhululekanga. USibongile Matebese noNontozamo Tsetse bazakube bekhona ngexesha iiseshini zisenzeka kwaye bazakuncedisana ukuthatha amanqaku baqulunqe imibuzo yokubuza wena ngezinto ozakube uzithethile. Iseshini yokuqala izakwahlulwa ibe ziiseshini ezimbini. Kweyokuqala, sizakucela ukuba usibalisele elakho ibali. Yonke into ozakube usixelela yona **yimfihlo**. Ibali lakho ungalibalisa ngesiNgesi okanye ngesiXhosa. Emva kokuba usibalisele ibali lakho, sizakucela ukuba uphume egumbini imizuzu engamashumi anesihlanu (15) apho sizakuhlala siqulunqe imibuzo esizakubuza yona kwiseshini yesibini. Le mibuzo izakuxhomekeka kwibali lakho ozakube usele usibalisele. Iseshini yokuqala izakuthatha ixesha eliphakathi kweyure enye nezimbini. Iseshini yokugqibela izakwenzeka emva kokuba sesikubhale phantsi konke ebesikurekhodishile kwiseshini yokuqala neyesibini saza sakufunda. Sizakubuza imibuzo kule seshini yokugqibela ngeenkcukacha ezishotayo, ezingacacanga okanye esingaziqondiyo esithe sazibona. Oko sizakube sikurekhodishile sizakugcina iminyaka emihlanu kwiikhompyutha zethu ezineenombolo zokuvalwa ezaziwa sithi kuphela. Xa elithuba lidlulile, siyakutshabalalisa oko besikurekhodishile noko besikubhale phantsi. Asizokulisebenzisa igama lakho okanye igama lewadi okuyo kwingxelo esizakuyibhala ngoluphando kwaye ngenxa yoku, akukho mntu uzakuba nolwazi lokuba into ethile ibithethwe nguwe. Emva kokuba uzigqibile iiseshini ezimbini, sizakunika iphepha lemibuzo ebizwa ngokuba yi-*AUDIT-C*. Eliphepha linemibuzo emithathu kwaye lizakuthatha imizuzu emithathu ukuyokutsho kwemihlanu ukwenza. Sizakuligcina eliphepha lemibuzo kungabikho namnye umntu ngaphandle kwethu ozakubona iimpendulo zakho. Uzakufumana ivawutsha yokuthenga ukutya exabisa amakhulu amabini eerandi (R200) ukubonisa ukuba siyabulela kakhulu ngokusinika ixesha lakho. Le vawutsha awuzokukwazi ukuyitshintsha ibe yimali. Ukuba uyarhoxa kuphando okanye naninina kwiiseshini, uzakuyifumana levawutsha.

Uthatha inxaxheba koluphando ngokuzithandela. Ukuthatha kwakho inxaxheba okanye ukungathathi kwakho inxaxheba akuzokuphazamisa ulwalamano okanye unxulumano onalo ne*NGO*. Ukuba awufuni ukuthatha inxaxheba akunyanzelekanga ukuba unike isizathu kwaye akukho xinzelelo ozakuthi ubekwe phantsi kwalo ukuze utshintshe ingqondo yakho okanye isigqibo sakho. Ukuba ukhetha ukuthatha inxaxheba, oko uzakuthetha kubalulekile kakhulu njengoko kuzakunceda nabanye abantu baziqonde ngcono nabhetele iimeko zokukhulelwa nokuba kutheni abafazi besela ubutywala xa bekhulelwe. Ukuba ukhululekile, sizakuqhubeka neeseshini. Abaphandi ungabatsalela umxeba naninina ngexesha oluphando luqhubeka.

Abazithobileyo
NguSibongile Matebese noNontozamo Tsetse

Appendix C: Consent Form

RHODES UNIVERSITY
DEPARTMENT OF PSYCHOLOGY
AGREEMENT BETWEEN STUDENT RESEARCHER AND RESEARCH PARTICIPANT

Updated 26 January 2011

I (participant's name) ________________________ agree to participate in the research project of Sibongile Matebese on women's narratives about alcohol use during pregnancy.

I understand that:

1. The researcher is a student conducting the research as part of the requirements for a Masters degree at Rhodes University. The researcher may be contacted on 0746496628 (cell phone) or g13m2013@campus.ru.ac.za (email). The research project has been approved by the relevant ethics committee(s), and is under the supervision of Professor Catriona Macleod in the Psychology Department at Rhodes University, who may be contacted on 046 603 7328 (office) or C.Macleod@ru.ac.za (email).

2. The researcher is interested in the narratives of women about alcohol use during pregnancy so as to understand the interpersonal circumstances under which drinking during pregnancy takes place.

3. My participation will involve taking part in three sessions. The first session will be divided into two sessions. In the first, I will try my best to tell the researcher my story. After I have told my story, the researcher and her co-researcher will spend 15 minutes developing questions to ask me in the second session. Session three will take place after the researcher has transcribed the recordings from session one and two and I will be asked questions about any missing information. After these sessions are complete, I give the researcher permission to administer the AUDIT-C Questionnaire.

4. I may be asked to answer questions of a personal nature, but I can choose not to answer any questions about aspects of my life which I am not willing to disclose.

5. I am invited to voice to the researcher any concerns I have about my participation in the study, or consequences I may experience as a result of my participation, and to have these addressed to my satisfaction. *A counselling centre (Family and Marriage Society of South Africa or FAMSA) may be contacted for further support on 043 743 8277 (telephone).*

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

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

8. Data collected from participants may be used by CSSR researchers at a later stage as this is a requirement for all CSSR research.

Signed on (Date): ____________________
Participant: __________________________
Researcher: __________________________

IDYUNIVESITHI YASE RHODES
ISEBE LEZIFUNDO ZESAYIKHOLOJI/ISEBE LEZENZULULWAZI NGENGQONDO
ISIVUMELWANO PHAKATHI KOMPHANDI NOMTHATHI-NXAXHEBA
Ihlaziywe nge 26 EqoMqungu 2011

Mna (igama lomthathi-nxaxheba) __________________________ ndiyavuma ukuthatha inxaxheba kuphando luka Sibongile Matebese ngamabali abafazi angokusetyenziswa kobutywala ngexesha umntu ekhulelwe.

Ndiyaqonda ukuba:

1. Umphandi ngumfundi owenza uphando oluyinxalenye nemfuneko yedigri ye*Masters* kwiDyunivesithi yase Rhodes. Umphandi angatsalelwa umxeba ku 0746496628 (iinombolo yefowni) okanye ku g13m2013@campus.ru.ac.za (nge-imeyile). Oluphando luvunyiwe ziikomiti zemikhwa esesiskweni kwaye longanywelwe nguNjingalwazi uCatriona Macleod kwisebe lezifundo zeSayikholoji/lezenzululwazi ngengqondo kwiDyunivesithi yaseRhodes, ongatsalelwa umxeba ku 046 603 7328 (iinombolo ye-ofisi) okanye ku C.Macleod@ru.ac.za (nge-imeyile).

2. Umphandi unomdla kwamabali abafazi angokusetyenziswa kobutywala ngexesha umntu ekhulelwe ukuze aqonde iimeko apho ukusela ngexesha umntu ekhulelwe kuye kwenzeke.

3. Ukuthatha kwam inxaxheba kuzakuquka ukuba yinxalenye kwiiseshini ezintathu. Iseshini yokuqala izakwahlulwa ibe ziiseshini ezimbini. Kweyokuqala, ndizakuzama kangangoko ndinako ukuxelela umphandi ibali lam. Emva kokuba ndilibalisile ibali lam, umphandi nomphandi-omcedisayo bazakuchitha imizuzu engamashumi anesihlanu (15) bebhala phantsi imibuzo yokundibuza kwiseshini yesibini. Iseshini yesithathu izakwenzeka emva kokuba umphandi ekukhuphele oko bendikuthethile kwiseshini yokuqala neyesibini kwaye ndizakubuzwa imibuzo ngeenkcukacha ezingacacanga nezishotayo. Emva kweziseshini, ndinika umphandi imvume yokuba andinike iphepha lemibuzo i-*AUDIT-C*.

4. Ndingabuzwa imibuzo ngobomi bam, kodwa ndingakhetha ukungayiphenduli nayiphi imibuzo edibene nento ethile ngobomi bam endingafuni ukuyichaza okanye yaziwe.

5. Ndiyamenywa ukuba ndibuze imibuzo kumphandi nangantoni na enxulumene noluphando nangantoni na endikhathazayo ngokuthatha kwam inxaxheba koluphando, lemibuzo iphendulwe ngokweemfanelo zam ndaneliseke ziimpendulo endizinikwayo. Ukufumana inkxaso engaphezulu, iziko lengcebiso *(iFamily and Marriage Society of South Africa okanye iFAMSA) ingatsalelwa umxeba ku 043 743 8277 (iinombolo yefowni).*

6. Ndikhululekile kwaye ndivumelekile ukuba ndirhoxe koluphando nokuba kunini na – kodwa ndiyazinikela ukuba ndithathe inxaxheba ngokupheleleyo ngaphandle kokuba kwenzeke into endingayilindelanga okanye ndiye ndakhathazeka ngento okanye ndakhathazwa yinto ethi yenzeke ngenxa yokuthatha kwam inxaxheba ebendingayilindelanga.

7. Ingxelo ngoluphando lungaba neenkcukacha ngamava, izimvo, nokuziphatha kwam kodwa lengxelo izakubhalwa ngendlela ezakwenza abo bayifundayo bangabi nolwazi lokuba oko kubhaliweyo bekuthethwe ndim.

8. Onke amabali abathathi-nxaxheba angasetyenziswa ngabanye abaphandi abakwiyunithi i-*Critical Studies in Sexualities and Reproduction* (*CSSR*) kwixesha elizayo njengoko oku kuyimfuneko kuphando olwenziwa e-*CSSR*.

Isayiniwe ngo (Umhla): ______________________
Umthathi-nxaxheba: ____________________________
Umphandi: ____________________________

Appendix D: Tape Recording Consent Form

Rhodes University — Department of Psychology

USE OF TAPE RECORDINGS FOR RESEARCH PURPOSES
—
PERMISSION AND RELEASE FORM

Participant name & contacts (address, phone etc.)	
Name of researcher & level of research (Honours/Masters/PhD)	Sibongile Matebese; Masters Research
Brief title of project	Women's narratives about alcohol use during pregnancy: A narrative discursive study
Supervisor	Professor Catriona Macleod

Declaration *(Please initial/tick blocks next to the relevant statements)*		
1. *The nature of the research and the nature of my participation have been explained to me*	Verbally	
	in writing	
2. *I agree to take part in all three sessions and to allow tape-recordings to be made of the sessions*	Audiotape	
	Videotape	
3. *I agree to take part in and to allow tape-recordings to be made.*	Audiotape	
	Videotape	
4. *The tape recordings may be transcribed*	without conditions	
	only by the researcher	
	by one or more nominated third parties:	
5.1 *I have been informed by the researcher that the tape recordings will be kept for five years after the study is complete and the report has been written. I have also been informed that the recordings may be used at the CSSR for other research purposes.*		
5.2 *OR I give permission for the tape recordings to be retained after the study and for them to utilised for the following purposes and under the following conditions:*		

Signatures		
Signature of participant		*Date*
Witnessed by researcher		

IsiXhosa Tape Recording Consent Form

IDynuvesithi yase Rhodes — Isebe lezifundo zeSayikholoji/lezenzululwazi ngengqondo

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

Igama lomthathi-nxaxheba	
Iinkcukacha zonxibelelwano zomthathi-nxaxheba	
Igama lomphandi nezinga lophando (iiHonours/iiMasters/iPhD)	NguSibongile Matebese; Uphando lwenzelwa ii*Masters*
Isihloko esifutshane sophando	*Women's narratives about alcohol use during pregnancy: A narrative discursive study*
Umongameli	Ngunjingalwazi uCatriona Macleod

Isibhengezo *(Ndicela utikishe iibloko eziqulathe oko kufanelekileyo)*		
1. Isimo sophando nesothatha kwam inxaxheba ndisichazlwe kwaye ndisicaciselwe	ngokuthethiweyo	
	ngokubhaliweyo	
2. Ndiyavuma ukuthatha inxaxheba kuzo zonke iiseshini ezintathu kwaye eziseshini zirekhodiswe	urekhodisho lweteyipu	
	urekhodisho lwevidiyo	
3. Ndiyavuma ukuthatha inxaxheba kwaye kurekhodishwe	urekhodisho lweyetiphu	
	Urekhodisho lwevidiyo	
4. Oko kurekhodishiweyo ngeteyipu kungakhutshelwa	ngaphandle kweemfuneko	
	ngumphandi kuphela	
	ngumntu oqeqeshelwe noqeshiweyo okanye oqeshelwe ukukhuphela okuthethiweyo	
5. Ndixelelwe kwaye ndazisiwe ngumphandi ukuba iiteyipu zoko kurekhodishiweyo zizakugcinwa iminyaka emihlanu emva kokuba uphando lugqityiwe nengxelo ngoluphando ibhaliwe. Ndazisiwe/ndixelelwe kanajalo ukuba oko kurekhodishiweyo kuzakusetyenziswa e-CSSR kolunye uphando olunxulumene nolu.		
5.2 OKANYE ndinika imvume yokuba iiteyipu zoko kurekhodishiweyo zigcinwe emva kokuba uphando lugqityiwe zisetyenziswe kwezizinto zilandelayo nangaphantsi kwezimfuneko:		

Imisayino		
Isayiniwe ngumthathi-nxaxheba		***Umhla:***
Ingqiniwe ngumphandi		

Appendix E: Participant Demographic Form

Please provide a response for each of the questions below. Please do not write your name on this form. The information you provide here will allow us to provide an accurate description of the sample.

1. Age: _______

2. Race:
   □ African/Black
   □ Coloured
   □ White
   □ Indian

3. Are you in a relationship?
   □ Yes
   □ No
   If yes, please specify:
   □ Married
   □ Separated
   □ Widowed
   □ Single
   □ Other

4. Which languages do you speak?

   ____

5. Level of education:
   □ None
   □ Primary School
   □ High School
   □ Matric
   □ Higher Education

6. Are you employed?
   □ Yes
   □ No
   If yes, what do you do for a living?

   ____

7. How many people do you live with? _______

8. How many children do you have? _______

IsiXhosa Demographic Form

Ifomu yeenkcukacha zomthathi-nxaxheba

Ndicela unike impendulo kuyo yonke lemibuzo ingezantsi. Ndicela ungalibhali igama lakho kule fomu. Iinkcukacha osinika zona apha zizakusinceda sinke/sinikise inkcazelo echanekileyo yabathathi-nxaxheba.

1. Iminyaka: _______

2. Uhlanga:
   □ M'Afrika/Ntsundu
   □ Khaladi
   □ Mhlophe
   □ Indiya

3. Unalo iqabane?
   □ Ewe
   □ Hayi
   Ukuba ewe, ndicela ubalule:
   □ Nditshatile
   □ Sohlukene
   □ Ndingumhlolokazi
   □ Enye

4. Uthetha eziphi iilwimi?

   ____

5. Inqanaba lemfundo:
   □ Andizange ndifunde/Andinalo
   □ Isikolo esisezantsi (Ibanga 1-7)
   □ Isikolo esiphezulu (Ibanga 8-11)
   □ Imatriki
   □ Imfundo ephakamileyo

6. Uyaphangela?
   □ Ewe
   □ Hayi

   Ukuba ewe, ingaba wenza owuphi umsebenzi?

   ____

7. Uhlala nabantu abangaphi? _______

8. Unabantwana abangaphi? _______

Appendix F: AUDIT-C Questionnaire

		Today's date:	
For the following items, please read questions as they are written. Record answers carefully.			
1	In what YEAR and MONTH were you born?	Year:	Month:
2	What is your RACE:	☐ African ☐ Coloured	☐ White ☐ Indian
3	What is the highest level of EDUCATION that you have obtained?	☐ No formal schooling completed ☐ Primary School ☐ High School ☐ Matric ☐ Higher Education	
4	Are you employed?	☐ Yes	☐ No
ALCOHOL USE DISORDERS IDENTIFICATION TEST			
A1	How often did you have a drink containing alcohol during your pregnancy?	☐ Never (0) ☐ Monthly or less (1) ☐ 2 to 4 times a month (2) ☐ 2 to 3 times a week (3) ☐ 4 or more times a week (4)	
A2	How many drinks containing alcohol did you have on a typical day when you were drinking during your pregnancy?	☐ 1 or 2 (0) ☐ 3 or 4 (1) ☐ 5 or 6 (2) ☐ 7, 8, or 9 (3) ☐ 10 or more (4)	
A3	How often did you have six or more drinks on one occasion during your pregnancy?	☐ Never (0) ☐ Less than monthly (1) ☐ Monthly (2) ☐ Weekly (3) ☐ Daily or almost daily (4)	
Thank you for taking the time to complete this questionnaire.			

IsiXhosa AUDIT-C

Iphepha lemibuzo l-*AUDIT-C*

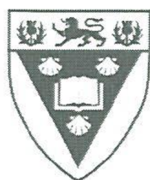
UKUSETYENZISWA KOTYWALA NGELI XESHA UMNTU AKHULELWEYO EMPUMA KOLONI

	Usuku lwanamhlanje:		
	Indawo:		
Kwezi zinto zilandelayo, nceda ufunde imibuzo njengokuba ibhaliwe. Bhala iimpendulo ngokucacileyo.			
1	WAZALWA ngowuphi UNYAKA NENYANGA?	Unyaka:	Inyanga:
2	Uloluphi UHLANGA:	☐ Ntsundu ☐ Khaladi	☐ Mhlophe ☐ Ndiya
3	Leliphi elona zinga liphezulu LEMFUNDO oyifumeneyo?	☐ Akukho sikolo esisesikweni esigqityiweyo ☐ Amabanga aphantsi (ibanga loku-1 ukuya kwele-7) ☐ Amabanga aphakamileyo (ibanga lesi-8 ukuya kwele-11) ☐ Imatriki (ibanga le-12) ☐ Imfundo ephakamileyo	
4	Ngaba uqeshiwe ?	☐ Ewe	☐ Hayi
UVAVANYO LOKUCHONGA IIMPAZAMISO ZOKUSETYENZISWA KOTYWALA			
A1	Kukaninzi kangakanani usela iziselo ezinxilisayo ngexesha wawukhulelwe?	☐ Zange(0) ☐ Qho ngenyanga okanye ngaphantsi (1) ☐ Ka-2 ukuya ka-4 ngenyanga (2) ☐ Ka-2 ukuya ka-3 ngeveki (3) ☐ Ka-4 okanye ngaphezulu ngeveki (4)	
A2	Zingaphi iziselo ezinxilisayo owawuzisela ngemini yesiqhelo xa wasela ngexesha wawukhulelwe?	☐ i-1 okanye zi-2 (0) ☐ zi-3 okanye zi-4 (1) ☐ zi-5 okanye zi-6 (2) ☐ zi-7, zi-8, okanye zili-9 (3) ☐ zili-10 okanye ngaphezulu (4)	
A3	Kukangakanani usela iziselo eziyi-6 okanye ngaphezulu ngexesha elinye ngexesha wawukhulelwe?	☐ Zange (0) ☐ Ngaphantsi kwenyanga (1) ☐ Qho ngenyanga (2) ☐ Qho ngeveki (3) ☐ Yonke imihla okanye phantse yonke imihla(4)	
Enkosi ngokuthatha ithuba lokuzalisa eliphepha lemibuzo.			

Appendix G: Ian Parker's (1992) Transcription Conventions (Adapted)

Symbol	**Meaning**
Round brackets ( )	Indicates doubts arising about the accuracy of material
Ellipses …	To show when material is omitted from the transcript
Square brackets	To clarify something for the reader
Forward slashes	Indicates noises, words of assents and others
Equals sign =	Indicates the absence of a gap between one speaker and another at the end of one utterance and the beginning of the next utterance
Round brackets with number inserted, e.g. (2)	Indicates pauses in speech with the number of seconds in round brackets
Round brackets with full stop (.)	Indicates pauses in speech that last less than a second
Colon ::	Indicates an extended sound in the speech
Underlining _______	Indicates emphasis in speech
Single inverted commas ' '	Indicates words or phrases which have been quoted; either the participants quoting themselves or quoting other people

Appendix H: RPERC Ethical Clearance Letter



RHODES UNIVERSITY
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Psychology Department
1 University Road, Grahamstown, 6139, South Africa
PO Box 94, Grahamstown, 6140, South Africa
T: +27 (0) 46 603 8500
T: +27 (0) 46 603 7614
E: psychology@ ru.ac.za

RESEARCH PROJECTS AND ETHICS REVIEW COMMITTEE

22 June 2017

Sibongile Matebese
Department of Psychology
RHODES UNIVERSITY
6140

Dear Sibongile,

SUPPORT FOR ETHICAL CLEARANCE OF PROJECT PSY2017/49

This letter confirms your research proposal with tracking number PSY2017/49 and title, *'Women's narratives about alcohol use during pregnancy: A narrative-discursive study'*, served at the Research Projects and Ethics Review Committee (RPERC) of the Psychology Department of Rhodes University on 21 June 2017. The RPERC notes that this project is supervised by Prof. Catriona Macleod. The RPERC supports ethical approval of your project. However, since the research is of a potentially sensitive nature and has been classified as High Risk research, you are referred to the Rhodes University Ethical Standards Committee (RUESC) for final ethical clearance.

Please note that should your project require consent from institutional gatekeepers, the RPERC requires that you submit written confirmation of this consent. Kindly also ensure that the RPERC is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators.

Yours sincerely

Mr. Werner Bohmke
CHAIRPERSON: RPERC

Appendix I: RUESC Ethical Clearance Letter

Rhodes University Ethical Standards Committee
PO Box 94, Grahamstown, 6140, South Africa
t: +27 (0) 46 603 8055
f: +27 (0) 46 603 8822
e: ethics-committee@ru.ac.za

www.ru.ac.za/research/research/ethics

8 June 2018

Sibongile Matebese
g13m2013@campus.ru.ac.za

Dear Sibongile Matebese,

Re: HUMAN SUBJECTS ETHICS APPLICATION
Women's narratives about alcohol use during pregnancy: A narrative-discursive study
Reference number: 8134591
Submitted: 7/6/2017

This letter confirms that the above research proposal has been reviewed by the Rhodes University Ethical Standards Committee (RUESC).

Thank you for receipt of the gatekeeper's permission. The committee decision is APPROVED.
Please ensure that the ethical standards committee is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators. Please also ensure that a brief report is submitted to the ethics committee on completion of the research. The purpose of this report is to indicate whether the research was conducted successfully, if any aspects could not be completed, or if any problems arose that the ethical standards committee should be aware of. If a thesis or dissertation arising from this research is submitted to the library's electronic theses and dissertations (ETD) repository, please notify the committee of the date of submission and/or any reference or cataloguing number allocated.

Sincerely,

Prof Jo Dames
Chair: Human Ethics sub-committee, RUESC- HE

Note:
1. The ethics committee cannot grant retrospective ethics clearance.