A formative evaluation and critical analysis of an alcohol and pregnancy intervention in the Eastern Cape of South Africa

Submitted in fulfilment of the requirements for the degree

DOCTORATE OF PHILOSOPHY

of

RHODES UNIVERSITY

Makhanda, South Africa

Nicola Jearey Graham

Orcid ID

0000-0003-0498-4521

December 2022

Supervisor: Distinguished Professor Catriona Macleod

Table of Contents

Abstract ix

Table of Contents i

Acronyms and definitions used in this thesis ix

Explanation of use of racial signifiers in this thesis xiii

Acknowledgements xiv

Chapter 1: Foetal Alcohol Spectrum Disorders, and overview of thesis 1

1. Introduction 1

2. Foetal Alcohol Spectrum Disorders 4

2.1. FASD features and incidence 4

Figure 1. Foetal Alcohol Spectrum Disorders 6

2.2. Maternal physiological factors 7

2.3. Maternal nutrition 8

2.4. Effects of low to moderate prenatal alcohol exposure 9

3. Alcohol use and FASD in South Africa 11

3.1. Alcohol use in South Africa 11

3.2. Historical underpinnings of alcohol use amongst poor people in South Africa 13

4. Factors that contribute to alcohol use during pregnancy 15

4.1. Social norms and identity 16

4.2. Alcohol consumption by male partners and family 17

4.3. Maternal stress levels and exposure to trauma 17

4.4. Lack of attachment to the pregnancy 18

4.5. Alcohol use disorders 19

5. Description of the intervention and the larger research project 20

5.1. The intervention 20

5.2. Description of the three projects making up the overall research project 22

6. Summary of studies looking at interventions to reduce alcohol exposed pregnancies 24

7. Rationale for this research, and methodology 25
8. Values underpinning recommendations: Introducing an ethics of care and justice 26
9. Methodological and theoretical concepts used in this thesis 28
9.1. Methodological dilemma 32
9.2. Research questions 34
10. Analytical findings and recommendations 34
Chapter 2: Quantitative studies - do interventions to reduce alcohol exposed pregnancies 'work'? 36
1. Introduction 36
2. Universal interventions 37
2.1. Components that enhance the persuasiveness of public health messages 40
3. Clinical interventions 43
3.1. The 'gold standard' of clinical approaches with clients with substance use difficulties: a harm reduction approach, using Motivational Interviewing 43
3.2. Clinical interventions with pregnant alcohol consuming women 45
3.3. Clinical interventions with non-pregnant women who drink at risky levels 47
3.4. Training levels for personnel delivering clinical interventions 52
4. Conclusion: Efficacy and effectiveness of interventions to reduce AEPs 53
Chapter 3: Qualitative and critical reviews of interventions to reduce alcohol exposed pregnancies 55
1. Introduction 55
2. Qualitative studies of FASD interventions 55
2.1. Perceptions of midwives regarding addressing alcohol use with pregnant women 56
2.2. Perceptions of women regarding advice on alcohol consumption during pregnancy 58
2.3. The importance of social support and integrated services 60
3. Critiques of FASD interventions: the re-inscription of unjust power relations 61
3.1. Individualisation, responsibilisation, and discourses of moral degeneracy 61
3.2. Separation of foetus from pregnant woman 64
3.3. Invisibilisation of male partners 65
3.4. Abstinence approaches 66

3.5. A lack of engagement with social motivators and the pleasures of drinking 67

3.6. On-going marginalisation of disadvantaged women 68

3.7. Conclusion to critiques: the management of 'risk' 68

4. Conclusion 69

Chapter 4: The person – what is it? Who is it? The constituted subject and the ethical subject 71

1. Introduction 71

2. Power relations 72

2.1. Knowledge, discourse and truth 74

3. Disciplinary power 76

3.2. Individualisation and ranking 77

3.2. Surveillance 78

3.3. Normalising judgement 78

3.4. The invisibility of disciplinary power and visibility of subjects 80

3.5. The spread of disciplinary mechanisms 80

4. Bio-power 81

4.1. Sex and reproduction 83

5. Power apparatuses 83

6. Governmentality, technologies of the self and subjectivities 87

6.1. Subject positions 89

7. Freedom and resistance 90

7.1. On the matter of agency 91

7.2. Positive and negative resistance, and violence 94

8. Ethics 95

9. Conclusion 99

Chapter 5: Methodology 101

1. Introduction 101

2. Discourse and subject positions 102

3. Research Questions 105

4. Data collection, informed consent and ethical clearance 105

Table 1: Data sources and analytical methods 106

4.1. Training materials 106

4.2. Training sessions and interviews 107

4.2.1. Community awareness training session and interviews – December 2017 109

Table 2: Demographics of interviewees from the community awareness training session 110

4.2.2. Mentoring programme training and interviews – March 2018 110

Table 3: Demographics of interviewees from the mentoring training session 111

4.2.3. Translation and transcription of recordings. 111

4.3. Mentoring sessions 112

Table 4: length of recordings of mentoring sessions 114

4.3.1. Translation and transcription of mentoring sessions 114

5. Ethical considerations 114

6. Formative feedback 117

6.1. Formative report on training manuals 118

6.2. Formative report on training sessions 120

6.3. Formative report on mentoring sessions 121

7. Reflexive discussion 123

8. Issues of credibility and trustworthiness 129

9. Foucauldian Discourse Analysis (FDA) 132

9.1. Critiques of FDA 132

9.2. FDA analytical steps 134

10. Conversation analysis (CA) 136

10.1. Theoretical assumptions of CA 138

10.2. Critiques of CA 140

10.3. Conducting a CA 142

10.4. Analysing institutional talk using CA 146

10.5. Analysing positioning using CA 148

10.6. CA analytical steps ... 150
11. Conclusion ... 151
Chapter 6: Knowledge and ignorance; saviours and sinners ... 153
1. Introduction ... 153
2. Coloniality: (Western) knowledge and (African) ignorance ... 154
2.1. Training materials ... 154
2.2. Training sessions and interviews ... 156
3. Pastoral power: Knowledgeable teachers and ignorant children ... 161
3.1. Resistance to the dominant positions ... 166
4. Pastoral power: saviours and sinners ... 170
4.1. Training materials ... 170
4.2. Training sessions ... 174
4.3. Interviews ... 176
4.4. Mentoring sessions: saviours, sinners, and silence ... 180
5. Conclusion: the pregnant/newly parenting woman as ignorant or sinful ... 186
Chapter 7: Precious “babies”, defiled Others, and Mommies ... 188
1. Introduction ... 188
2. Precious “babies” and invisible women ... 188
2.1. Constructions of “precious babies” in the training manuals ... 189
Image 1 ... 189
Image 2 ... 189
Image 3 ... 190
Images 4 and 5 ... 191
Image 6 ... 191
Image 7 ... 192
2.2. Constructions of “precious babies” in the training videos ... 193
2.3. Constructions of “precious babies” in the training sessions and interviews ... 197
2.4. Constructions of “precious babies” in the mentoring sessions ... 201

3. The defiled Other: the child with FAS 204
3.1. The defiled Other in the training manuals 204
3.2. The defiled Other in the training sessions and interviews 209
4. Mommies: visible only in their (ir)responsibility 212
4.1. Training materials: Patriarchy, risk and responsibilisation 213
4.1.1. Patriarchy in the manuals 214
Image 8 216
Image 9 217
4.1.2. Risk and responsibilisation in the manuals 217
4.2. Training sessions and interviews: Regulation, responsibilisation, and patriarchy 222
4.3. Mentoring sessions: regulation and conjugal idealism 225
4.3.1. Resistance to the Organisation's responsibilising thrust 229
6. Conclusion 233
Chapter 8: Towards an ethics of care and justice 235
1. Introduction 235
2. Positioning drinking pregnant women as affected by social injustices 236
2.1. The cultural hegemony of drinking 236
2.1.1. Training sessions: "We can no longer do anything without alcohol" 237
2.1.2. Interviews: "It's the only way we socialise nowadays" 239
2.2. Structural injustices: unemployment, poverty and boredom 243
2.3. Patriarchy 247
2.4. Ignorance 249
2.5. Conclusion: Positioning drinking pregnant women as affected by social injustices 251
3. Positioning drinking pregnant women as affected by lack of care 251
4. Women positioned within a relationship of care 253
5. Women as agentic 260
6. Conclusion 262

Chapter 9: Conclusion and recommendations: an ethics of care and justice, and decolonial psychology 264
1. Introduction 264
2. The inadequacy of FASD interventions in South Africa 264
3. Synopsis of the literature on FASD interventions 266
4. Rationale for this research and methodological approach 268
5. Theoretical paradigm 270
6. Positionings of pregnant and newly parenting women in the data 272
6.1. Ignorant children and reprobate sinners 272
6.2. Precious “babies”, defiled Others, and invisible Mommies 274
6.3. Positions within an ethics of justice and care 276
7. Unintended negative consequences of the dominant positionings 277
8. Recommendations for interventions 279
8.1. Recommendations for country-wide policies and interventions 280
8.2. Recommendations for specific FASD interventions: a feminist decolonial psychology approach 283
8.2.1. Focus on broad, social factors more than individual behaviours of women 285
8.2.2. Utilise harm reduction approaches with well-trained providers in clinical interventions 286
8.2.3. Focus on enlarging women’s ensemble of habitual subject positions 288
8.2.4. Intentionally focus on provision of care 289
Table 4: Practical suggestions for care 290
8.2.5. Take a feminist decolonising approach to FASD interventions 291
Table 5: A feminist decolonising approach to FASD interventions 291
9. Contributions and limitations of this research 293
10. Suggestions for future research 296
References 298
Appendix A: Ethical clearance for overarching project 323

Appendix B: Ethical approval for Project 3 324
Appendix C: Permission from Organisation to collect data 325
Appendix D: Information on the research into the training sessions 326
Appendix E: Agreement between researchers and participant 330
Appendix F: Use of video and audio recordings for research purposes 334
Appendix G: Use of audio recordings for research purposes 337
Appendix H: Semi structured interview schedule 339
Appendix I: Transcribers' confidentiality agreement 341
Appendix J: Information on research into mentoring programme (mentors) 342
Appendix K: Agreement between researcher and mentor 346
Appendix L: Use of audio recordings for research purposes 350
Appendix M: Information on research into mentoring programme (pregnant women) 352
Appendix N: Agreement between researcher and pregnant woman 355
Appendix O: Transcription notations 359

Abstract

Some communities in South Africa have the highest documented rates of Foetal Alcohol Spectrum Disorders (FASD) in the world. Interventions to reduce alcohol consumption during pregnancy are crucial, but evaluations of such interventions are sparse. Formative evaluations are indicated to assist in the development of interventions. Harmful alcohol consumption during pregnancy is undergirded by a range of social injustices, including those imposed by colonisation and patriarchy; a feminist, decolonial approach to evaluations is, therefore, important. A research project, consisting of three arms, examined alcohol use during pregnancy in an under-resourced urban area of the Eastern Cape, and this research was one of those arms. An intervention was being rolled out in this area and I gathered a range of data from it. I engaged in a formative evaluation of it, and I reflect on the difficulties that I encountered in this endeavour.

In the bulk of this thesis, I examine the power apparatuses and technologies that were used during the intervention to discursively position pregnant women. My analysis was guided by Foucauldian and post-Foucauldian theories, using Foucauldian Discourse Analysis and simplified Conversation Analysis (CA). Power apparatuses of coloniality, patriarchy, and pastoral power were used in the intervention to construct positions for pregnant women who drink alcohol as ignorant children, sinners, criminals, or “Mommies”. The foetus was constructed as a precious, vulnerable baby, while the person with FASD was constructed as the defiled Other, responsible for societal dissolution. The intervention used various disciplinary techniques to exhort women to follow their dictates. Women were generally compliant with being positioned as ignorant children, which absolved them from any blame for pre-natal drinking. However, some resistance was evident.

I then introduce an ethics of care and justice, and I argue that pregnant/newly parenting women need to be positioned within such an ethics, which acknowledges both the universal resources that they require for reproductive freedoms, as well as their particular care needs. I highlight the few

times when women were positioned in this way in the data, and I look at how the common positions could be altered or expanded to promote such an ethics.

I conclude by arguing that alcohol use during pregnancy cannot be separated from the larger context of the cultural hegemony of alcohol use in some communities, and the social injustices that potentiate this use. I provide suggestions for country-wide policies and interventions, as well as specific FASD prevention programmes, and I argue that a feminist decolonising approach, within an ethics of care and justice, should guide interventions at all levels.

Acronyms and definitions used in this thesis

ADH Alcohol dehydrogenase. This is an enzyme in the body that breaks down alcohol.

AEPs Alcohol exposed pregnancies

ARBD Alcohol Related Birth Defects. This is one of the conditions in Foetal Alcohol Spectrum Disorders, caused by prenatal alcohol injestion.

ARND Alcohol Related Neurodevelopment Disorder. This is another of the Foetal Alcohol Spectrum Disorders.

BAC Blood alcohol concentration

BMI Body Mass Index. This is a calculated with the following formula: weight (kg) divided by square of height (m). It is a rough indicator of body fat.

Binge drinking refers to heavy episodic drinking

DALYs – Disability Adjusted Life Years. These are calculated by combining weighted measures of years lived with disability and years of life lost for a specific condition (Solberg et al., 2020)

Dependent alcohol use – see under HHDA definition.

FAS Foetal Alcohol Syndrome. This is the most severe of the alcohol related harms caused to foetuses

FASD Foetal Alcohol Spectrum Disorders. This is a cluster of disorders caused by heavy prenatal alcohol ingestion. They include foetal alcohol syndrome, partial foetal alcohol syndrome, alcohol related birth defects, and alcohol related neurodevelopmental disorders.

Gravidity The number of times that a woman has been pregnant.

HHDA Harmful, hazardous or dependent alcohol use. The Department of Health Medical Research Council (2007) defined **harmful** levels of alcohol consumption as 4-5 drinks per day for men, and 2-3 drinks per day for women, and it defined **hazardous** levels as six or more drinks per day for men and four or more drinks per day for women. Peltzer and Ramlagan (2009) described hazardous drinking as indicated by behaviours such as "drinking first thing in the morning, drinking to intoxication, [and] drinking apart from meals." (p. 9). **Harmful** drinking may result in "adverse events (e.g. physical or psychological harm)" while **hazardous** drinking places consumers at risk for "adverse health events" (Peltzer & Ramlagan, 2009, p.

1). **Dependent** alcohol use is characterised by physical cravings for alcohol, and the need to drink more and more to get the same effect. There are physical withdrawal symptoms if the person stops drinking.

Harmful alcohol use – see under HHDA definition.

Hazardous alcohol use - see under HHDA definition.

MI Motivational Interviewing. This is a counselling technique that has been shown to be helpful when working with clients with substance use difficulties. It adopts a harm reduction approach, surfaces clients' own goals for their substance use, and supports them in achieving these goals. It is based on cognitive behavioural therapeutic techniques.

PAE Prenatal alcohol exposure

PFAS Partial Foetal Alcohol Syndrome

SGA Small for gestational age. This is a term applied to newborn babies.

SES Socio-economic status

Teratogenic A substance injested by a pregnant woman is teratogenic if it causes harm to the developing foetus.

Explanation of use of racial signifiers in this thesis

In this thesis I use the signifiers “Black”, “Coloured” and “White” to designate people of African, mixed race, or European descent respectively. I am aware that the term “People of Colour” is generally considered to be less racially offensive and more politically correct than “Black” or “Coloured”. However, I continue to use the latter terms due to the specific post-Apartheid context of South Africa, where Apartheid classifications of people’s groups, depending on their skin colour, continue to shape society and access to resources. Despite the formal legislation of employment equity, where companies are obliged to have a certain proportion of “Black” and “Coloured” senior staff, historical legacies of wealth and poverty mean that the vast majority of people living in poverty are people of Colour. Furthermore, “Coloured” people and “Black” people often occupy distinct cultural and social spaces, with different historical roots, and in South African academic literature, they are often identified separately. I place the racial signifiers in inverted commas to indicate that they are social constructions and over-determined in terms of their social effects.

Acknowledgements

I gratefully thank the following people and organisations for their assistance with this research project:

- The Organisation's board, funders, senior management team and CEO for permission to conduct this research and granting me access to their records, reports, training and mentoring sites;
- The Social Worker who was working at the Organisation from which I collected data, for her invaluable help with data collection;
- The participants who agreed to be recorded and those who recorded their mentoring sessions;
- As always, my supervisor, Prof. Catriona Macleod, for her superlative research skills, generous guidance, personal support, and friendship. Catriona, I could not have done any of this without you;
- The Critical Studies in Sexualities and Reproduction Research Unit at Rhodes University for funding for this research from 2016 – 2018;
- My wonderful family who give my life meaning and provide endless support: my husband Vic Graham, and children Aaron, Ruth-Anne and Nathan Graham.

Chapter 1: Foetal Alcohol Spectrum Disorders, and overview of thesis

1. Introduction

Foetal Alcohol Spectrum Disorders (FASD), arising from heavy pre-natal alcohol ingestion, are increasingly being identified as a critical public health concern. They are now recognised as the leading preventable cause of pre-natal developmental disorders worldwide (Jacobsen et al., 2022). FASD leads to a range of cognitive, neurological, and physical disabilities in people affected by this disorder, due to disrupted foetal development from the alcohol. Research indicates that certain communities in South Africa carry the highest recorded burdens of FASD in the world (May et al., 2017), and with this recognition, efforts are being made to intervene to reduce the FASD prevalence. However, studies that evaluate interventions, both in South Africa and elsewhere, are sparse and often lack methodological rigour (Crawford-Williams, Fielder, et al., 2015; Gilinsky et al., 2011; Jacobsen et al., 2022) which points to a need in the field of FASD research.

The few quantitative studies that have examined the effectiveness of universal or population-level public health messages, which aim to promote community-wide awareness of the harms of pre-natal drinking and reduce prenatal drinking, have shown increased knowledge of the harms, and non-significant reductions in drinking (Crawford-Williams, Fielder, et al., 2015). However, most of the populations studied were not drinking at high risk levels pre-intervention, and measurements were via self-report, which carries a strong risk of bias. There are suggestions that universal campaigns have no effect, or possibly even detrimental effects, on women who are most at risk of bearing a FASD child, as they could lead to shame in such women and avoidance of interventions and healthcare (Rutman et al., 2020; Salmon, 2011). Quantitative studies of clinical interventions, which target individuals, suggest that brief clinical interventions (one to four sessions) with episodic and non-dependant pregnant drinkers can reduce their drinking, but heavier drinkers need more intensive help (de Vries et al., 2016; Gilinsky et al., 2011; Marais et al., 2011). Some interventions have targeted non-pregnant women who are at risk of an alcohol-exposed pregnancy (AEP) due to their drinking behaviour and ineffective use of contraception, and studies have found that brief interventions can increase their contraceptive use. These studies will be discussed in more detail in Chapter 2.

Quantitative studies are necessary to answer the question "Do interventions aimed at reducing pre-natal drinking 'work'?" However, as they are quantitative, they necessarily use aggregated data and look at overall results. They are not able to examine which aspects of interventions are effective and which are not, and what aspects may detract from the helpfulness of interventions (Doi et al., 2015; Gaume et al., 2014). Furthermore, they are not able to assess the acceptability and contextual relevance of intervention components (Dr Zoe Duby, personal comm, March 2023). All of this information is crucial to inform the development of interventions and enhance the training of service providers (Doi et al., 2015; Gaume et al., 2014), and in this regard, qualitative studies are required. Again, there is a relative dearth of published studies in this area, and the majority that have been conducted concentrate on interventions that target low-risk women in well-resourced settings. It is well established that women most at risk for an alcohol exposed pregnancy (AEP) generally suffer from a range of negative psychosocial factors, including low socio-economic status, high alcohol consumption within their communities, high stress levels, and exposure to trauma (Choi et al., 2014; de Vries et al., 2016; Macleod, Matebese, et al., 2020; May et al., 2019; Russell et al., 2013; Watt et al., 2014); hence, research with these populations is required. Recent evidence from studies of interventions in Canada with women at high risk for an AEP highlight the importance of a non-judgemental and compassionate approach, with the provision of wrap-around services, where several maternal and infant health and social services are offered at one site in an integrated manner (Rutman & Hubberstey, 2019). The findings from qualitative studies into FASD interventions are unpacked in the first part of Chapter 3.

Most evaluations come from a positivist, public health paradigm, which may overlook unintended negative consequences arising from interventions, and the power dynamics that are at play within interventions. Critical scholars (Armstrong, 1998; Benoit et al., 2014; Boucher, 2004; Hunting & Browne, 2012; Hutton et al., 2013; Lupton, 2012; Rutman et al., 2000; Salmon, 2011) have provided cogent critiques of FASD interventions, claiming that they often re-inscribe unjust power relations through implicitly blaming drinking pregnant women for FASD, while the societal factors that potentiate pre-natal drinking in the first place are ignored. The responsibility for preventing FASD is placed almost entirely on the pregnant woman, with very little effort spent on addressing inequitable social structures. Those who are most disadvantaged in society continue to be marginalised as they do not have the means to take up the responsible, risk-averse identity of the "good mother" that is often promoted by FASD interventions. It is generally assumed that pregnant women want to be mothers, and "good mothers" at that; that they are ready and willing to take on this identity; and that is easy for them to sacrifice the social and psychological motivators for drinking. Furthermore, the foetus is constructed as a person in its own right, who is fragile yet

concomitantly of immense importance, thereby requiring a huge investment of care and protection. This potentially pits the needs and desires of the woman against those of the foetus. These critiques are addressed in the latter part of Chapter 3.

Given this paucity of evaluations of FASD interventions in general, and particularly from a critical feminist perspective, the research project that I present here is a critical evaluation of one such intervention in South Africa. I use the term "critical" in the manner conceptualised by Kincheloe and McLaren (2008), who understood critical social theory as "concerned in particular with issues of power and justice and the ways that the economy, matters of race, class, and gender, ideologies, discourses, education, religion, and other social institutions, and cultural dynamics interact to construct a social system." (p. 288). As such, my research is concerned with issues of power and justice, and the processes by which these operate, in the context of this particular intervention. Drawing from Foucauldian and post-Foucauldian theories (discussed in Chapter 4), I understand that there are multiple forms of power – discursive, material, and structural — operating simultaneously, fluidly, and often invisibly, in any social setting, and that power "is a basic constituent of human existence that works to shape the oppressive and productive nature of the human tradition." (Kincheloe & McLaren, 2008, p. 290).

My study is also a formative evaluation: as a critical feminist, I am mindful of trying to ensure that those I study benefit in some concrete way from my research. The intervention that I evaluated was being rolled out at a pilot site in a new province. Hence, my aim with the formative evaluation, and with agreement from the organisation that runs the intervention and their funders, was to evaluate aspects of the intervention as it was being rolled out, and to provide recommendations on how the intervention could be improved. The benefit of formative evaluations is that, by providing feedback as a programme is being rolled out, any recommended changes and improvements can be implemented before too much time and resources have been spent on establishing the programme in a less optimal manner (Babbie & Mouton, 2001; Duignan, 2009).

The intervention that I studied was established in the Western Cape and is now being implemented in an area of the Eastern Cape. The intervention is run by a Non-Governmental Organisation (NGO) which relies on funding from private donors in order to operate. Hereafter, I refer to this NGO as "the Organisation". My data are primarily linguistic, in the form of spoken and written words (although I also include some visual images from the Organisation's training manuals in my data set) and so my focus is on discursive forms of power that were in operation within the intervention. In particular, I analyse the subject positions that were made available by these power structures, using

both Foucauldian Discourse Analysis, and, for conversational data, also Conversation Analysis. My data collection and analytical methods are described in Chapter 5.

In the next section I provide an overview of FASD and its prevalence worldwide, and I review studies that examine maternal physiological factors that contribute to, or protect against, FASD. After discussing studies that try and tease out the effects of low to moderate prenatal alcohol consumption, I take a look at contextual factors that contribute to prenatal alcohol exposure. Drinking alcohol during pregnancy takes place within multifaceted contexts of generalised drinking cultures, socio-economic and emotional stressors, inequitable gendered norms, and historical patterns which often feature disempowerment. It is, thus, important to gain an in-depth knowledge of these contextual factors that contribute to prenatal alcohol consumption in order to effectively address the issue. In these sections, I discuss, first, alcohol usage in South Africa and its historical underpinnings, and I then proceed to examine proximal factors that contribute to alcohol use during pregnancy. Thereafter, I provide an overview of the Organisation which is providing the intervention that I evaluated, and the nature of its programmes. In the final sections of this chapter, I outline the key theoretical concepts used in this thesis, before providing the research questions upon which this study was based, and a synopsis of the chapters to follow.

2. Foetal Alcohol Spectrum Disorders

Foetal Alcohol Spectrum Disorders (FASD) are a collection of disabilities caused by prenatal alcohol use. While there is generally a dose-response effect in terms of the amount of alcohol a pregnant woman ingests, and the magnitude of disorder manifested in her foetus, the timing plays a critical role, with drinking in the earliest stages of pregnancy being more teratogenic than in later stages. However, many other modifying effects also play a role in the expression of FASD, in particular socio-economic status.

2.1. FASD features and incidence

The toxic effects of alcohol ingestion on a foetus were first systematically documented by medical professionals in 1973, and a new diagnostic category of Foetal Alcohol Syndrome (FAS) was constructed (Armstrong, 1998). Children with FAS exhibit various anomalies. Excessive drinking in the earliest stages of pregnancy can produce facial defects such as a smooth philtrum[1], small palpebral fissures[2], thin upper lip, and flattened mid face face (Calhoun & Warren, 2007; Hoyme et

[1] The philtrum is the groove between nose and the upper lip.
[2] The palpebral fissure is the area between the open eyelids. Small palpebral fissures make the eyes look small.

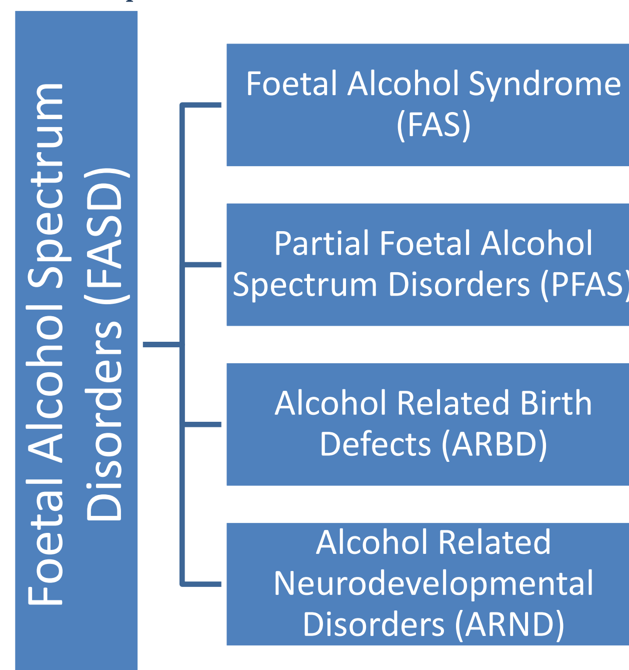
al., 2016). Other anomalies include microcephaly[3], delayed physical growth and development, lowered intelligence, reduced attention span, central nervous system problems, impaired affect regulation and behavioural problems (Cismaru et al., 2010; Flak et al., 2014; Jacobsen et al., 2022; May et al., 2000, 2008). Such impairments can lead to secondary disabilities such as academic failure, substance use disorders, unemployment, and law-breaking (Popova et al., 2017).

Since the initial introduction of the FAS diagnostic category, it has been extended and refined and an umbrella term, Foetal Alcohol Spectrum Disorders (FASD) has been introduced. This term now encompasses the diagnosis of FAS, as well as lesser impairments resulting from frequent and heavy drinking during pregnancy, namely, Partial Foetal Alcohol Syndrome (PFAS), Alcohol Related Birth Defects (ARBD) and Alcohol Related Neurodevelopmental Disorder (ARND) (see figure 1). These diagnoses fall on a continuum, from most to least impaired (Hoyme et al., 2016; May et al., 2017). As well as the risk for foetal abnormality, there is also an increasing risk of adverse birth outcomes with maternal alcohol use (spontaneous abortion, stillbirth, low birth weight, preterm birth, and babies being small for gestational age) (Popova et al., 2017).

Worldwide, FAS prevalence is estimated at 7.7 per 1000 people (Jacobsen et al., 2022), or 0.7% of the general population. Certain rural communities in South Africa carry the highest recorded burdens of FAS and FASD in the world; two studies, initiated in 2009 and 2011, of Grade One pupils in three rural towns in the Western Cape revealed estimated prevalence rates of FAS at 9 – 13 percent and FASD at 20 – 28 percent (May et al., 2017). Olivier et al. (2016), who surveyed Grade One pupils in 17 towns in three provinces of South Africa, found FASD prevalence rates of 29 -290 cases per 1000 live births, or 2.9 – 29 percent, and the authors caution that most cases of ARND and ARBD, and even some PFAS cases were likely to have been missed. Popova et al. (2017), who attempted to estimate national and global prevalences of FAS, suggested that the prevalence of FAS in South Africa as a whole to be 585 per 10,000 people, or 5.85 percent. The epidemic proportions of FAS and FASD in South Africa are, therefore, clear.

[3] Microcephaly refers to an abnormally small head, associated with reduced brain development.

Figure 1. Foetal Alcohol Spectrum Disorders



The brain development of a foetus is particularly vulnerable to alcoholic exposure in the earliest stages of pregnancy (Popova et al., 2017), which is often before a pregnancy is recognised. Alcohol is metabolised much more slowly by the foetus than the pregnant woman, meaning that it remains in the foetus and amniotic fluid for longer than in the woman (May et al., 2014). Binge drinking, or heavy episodic drinking, has been found to be the most harmful to the foetus, and in general, there is a dose-response effect in terms of the frequency and quantity of alcohol consumed during pregnancy and the severity of FASD (Flak et al., 2014; May et al., 2008; Patra et al., 2011). However, there is great variation in the severity and symptoms of FASD, which is not entirely explained by the quantity and frequency of drinking during pregnancy. May et al.(2008, p. 739) stated that "risk factors other than alcohol ...serve to mediate, moderate or otherwise alter the effects of alcohol on the foetus." Such risk factors appear to include metabolic and genetic factors of both the pregnant woman and the foetus, as well as environmental, social and behavioural factors such as maternal smoking, nutrition, and stress levels (Flak et al., 2014; May et al., 2008; May, Marais, et al., 2013; Popova et al., 2017). Heavy alcohol use during breastfeeding has also been shown to negatively affect child development, independent of whether alcohol was consumed during pregnancy (May, Hasken, et al., 2016).

Furthermore, there is some evidence that paternal chronic alcohol use alters gene expression in the sperm, which increases the risk of FASD (Gupta et al., 2016). Studies have shown that increasing alcohol use by the father prior to conception can lead to worsening sperm health and foetal health (lower conception rates, reduced live births, poorer infant health, and increased risk for FASD), even

when other confounders (such as maternal alcohol consumption) are controlled (Gupta et al., 2016; McBride & Johnson, 2016).

In the following three subsections, I discuss research on the effects of maternal physiological and nutritional factors that play a role in the expression of FASD, and then I look at studies on the effects of low to moderate alcohol use on the foetus. These aspects are important to understand from an interventional point of view.

2.2. Maternal physiological factors

A number of maternal physiological factors have been found to worsen the effects of prenatal alcohol consumption on the foetus. These include genetic factors, mothers who had alcohol exposure in utero, higher gravidity (the number of times a woman has been pregnant), higher birth order of index children, and early initiation of drinking (May et al., 2008). As the number of years over which a woman has been drinking increases, so there is diminished activity of her gastric mucosal alcohol dehydrogenase (ADH – an enzyme that breaks down ethanol), which leads to higher blood alcohol concentrations (May et al., 2008). This results in greater quantities of alcohol passing to the foetus. Smoking tobacco also appears to worsen the effects of prenatal alcohol exposure (May et al., 2008). It is well known that tobacco use on its own during pregnancy has been linked to low birth weight, preterm birth, and birth defects (Drake et al., 2018), and so, combined with alcohol, the effects are worsened.

One of the strongest associational factors that worsens outcomes when prenatal alcohol exposure is heavy is low socio-economic status (SES) (May et al., 2008; Patra et al., 2011). A study comparing mothers of varying SES levels who drank 12 units of alcohol daily was conducted in the United States, and it found that "(b)earing a FAS child was 45 times more common among births to low SES mothers" (Bingol et al, cited by May et al., 2008, p. 739). In South Africa, May et al. (2019) have found, in their ongoing studies of FASD in this country, that the prevalence is highest in rural areas surrounding small towns. Such areas are generally poverty-stricken, but their proximity to a town means that access to alcohol is easy. There are numerous adverse environmental, social and behavioural factors that are more prevalent in low SES settings, with one of them being food insecurity. Maternal nutritional status has been examined in some depth to ascertain whether poor nutrition leads to worsening effects of prenatal alcohol exposure. I discuss some of the other social and behavioural correlates with low SES and FASD in section 4 of this chapter, but in the next section I review studies that have examined maternal nutrition.

2.3. Maternal nutrition

Animal studies show that nutritional deficiencies can negatively impact offspring (May et al., 2014), and a combination of under-nutrition and alcohol consumption leads to a decrease in maternal growth hormone levels, resulting in reduced foetal weight (May et al., 2008). In humans, alcohol ingestion generally leads to reduced dietary intake, and May et al. (2008) found that mothers of PFAS and FAS children were significantly smaller and had a lower body mass index (BMI), on average, than controls from the same impoverished area. Smaller women produce higher blood alcohol concentrations (BAC) for the same amount of alcohol than larger women, leading to more alcohol passing through the placenta. Additionally, under-nourished women would be more likely to have an empty stomach when drinking, leading to higher BAC.

Eaton et al. (2014) recruited women from alcohol- serving establishments in a township in Cape Town. Amongst pregnant women, they found a significant positive relationship between elevated drinking (as assessed by the Alcohol Use Disorder Identification Test – AUDIT) and food insecurity (reduced availability, access, or nutritional content of food). These authors noted that alcohol is more easily accessible in some impoverished areas than food.

In their follow up studies of mothers of FASD children and controls, May et al. (2014) and May, Hamrick, et al. (2016) found that for all participants of two different samples in the impoverished study site, there was an overall inadequate intake of many micronutrients. However, the mothers of FASD children had lower BMI's than the mothers in the control group. Alcohol consumption and poor nutritional intake during breastfeeding is also likely to affect the newborn child due to alcohol exposure through the breastmilk, and reduced delivery of nutrients. Furthermore, even when dietary intake is adequate, chronic alcohol use can reduce the absorption of micronutrients (May et al., 2014; May, Hamrick, et al., 2016).

Studies of rats reveal promising results with nutritional supplementation in mitigating the effects of prenatal alcohol exposure (PAE). A recent study by Wang et al. (2021) found that an energy dense diet fed to pregnant rats who were given alcohol lessened the weight reducing effects of the alcohol on the rat pups. Prenatal supplementation with the micronutrient choline, given to pregnant rats who were ingesting alcohol, has been shown to improve the cognitive and behavioural outcomes of their offspring (Jacobson et al., 2018). This has led authors to conduct trials of nutrient supplementation in humans.

Coles et al. (2015) conducted a prospective cohort study in Western Ukraine to assess the effects of vitamin and mineral supplementation on the child outcomes of heavily drinking pregnant women.

Moderate to heavy drinking pregnant women were recruited (N = 301), as well as a comparison group of pregnant women who abstained or drank at low levels (N = 313). Half of each group received a daily multivitamin and mineral supplement, whilst the other half was given recommendations to use such supplements but they were not provided. Additionally, half of the group receiving the supplementations were given a daily dose of 750mg choline. Infants were assessed between the ages of 4.5 – 10 months with the Bayley Scales of Infant Development, which evaluate cognitive and psychomotor development. Results indicated that nutritional supplementation had a small but significant effect on measures of infant cognitive development in the alcohol-exposed group, but not on measures of psychomotor development. The addition of choline did not have a significant effect. Such results indicate that nutritional supplementation may ameliorate some of the effects of PAE on infant development. However, the authors cautioned that infant measurements of cognitive and psychomotor development are relatively insensitive, and longer-term follow-up is indicated.

Jacobson et al. (2018) looked at the effects of a daily dose of 2g of choline (compared to 750mg which was used in the Coles et al. (2015)study) on infant growth and cognitive outcomes in a group of heavy drinking and nutritionally deficient pregnant women in Cape Town. Sixty-two infants were assessed: 31 whose mothers received the choline supplement, and 31 in the placebo group. The researchers used more sensitive measures of infant cognitive development (a physiological eye blink conditioning response and a test of visual recognition memory) than used by Coles et al. (2015). No difference was found in incidence of FAS and PFAS between groups, which is to be expected as the craniofacial features upon which diagnosis was made develop in the earliest stages of foetal development, prior to the initiation of the supplements in the second trimester. However, the authors reported that there were large effect sizes for eye blink conditioning, visual recognition memory, and infant growth, and moderate effect sizes on measures of infants' processing speed (Jacobson et al., 2018). Although the sample size was small, these results are promising, and warrant further investigation.

Overall, these studies on maternal nutrition demonstrate a definite link between low maternal nutritional deficiency and worse outcomes for infants who had similar prenatal alcohol exposure. Furthermore, multivitamin, mineral, and choline supplementation shows promising results when taken regularly by heavily drinking pregnant women.

2.4. Effects of low to moderate prenatal alcohol exposure

Studies on the effects of low to moderate alcohol consumption on the foetus are inconclusive as yet. Whilst complete abstinence from alcohol during pregnancy is recommended, as there is no known

safe consumption amount, it cannot be stated conclusively that low amounts of alcohol adversely affect the foetus. Patra et al. (2011) performed a meta-analysis on studies looking at the relationship between maternal alcohol exposure and low birth weight, preterm birth and babies being small for gestational age (SGA). They found no apparent effects on these factors when mothers drank up to an average of about one drink a day (10g pure alcohol/day), but there was an increasing risk for these occurrences with increasing alcohol consumption, as well as the risk of ongoing, compromised postnatal development. Similarly, O'Keeffe et al. (2014) conducted a systematic review of the effects of low or moderate interuterine alcohol exposure (averaging less than 10g per day or 70g per week during pregnancy) on the speech and language outcomes of the children. Results suggested that there were no adverse effects from this level of alcohol exposure, although the authors caution that all the studies they reviewed had risks of bias.

Flak et al., (2014), in their meta-analysis of 34 studies, could find no consistent evidence that cognitive, visual or motor development were affected by mild or moderate (up to six drinks per week) pre-natal alcohol exposure, but their results suggest that moderate consumption (3-6 drinks per week) may affect child behaviour (social engagement, affect, and conduct). Unfortunately, these authors did not control for the timing of the weekly alcohol consumption, as three to six drinks consumed on one day of the week is more toxic than three to six drinks spread evenly over the week. Nor did they control for whether the alcohol was consumed with or without food. May, Blankenship, et al. (2013) found that there was a possibility of FASD occurring with binge drinking of as few as three drinks per episode twice a week.

Pfinder et al.(2013) theorised that the inconsistency in the results of studies of the effects of low to moderate prenatal alcohol consumption (PAE) may be due to differences in the socioeconomic characteristics of the studied populations, given that high prenatal alcohol exposure has been shown to have greater negative effects on the offspring of women of low socio-economic status (SES). These authors suggested that this association may be due to the interaction of the effects of alcohol with smoking and maternal distress, which are more prevalent in women of lower SES. Using data from two large Western European studies, Pfinder et al. (2013), therefore, examined the associations between low to moderate PAE and two perinatal outcomes (preterm birth and small for gestational age - SGA), and assessed whether levels of maternal education, mental distress, or smoking modified these outcomes. Contrary to expectations, the authors' findings suggested a decreased risk of preterm birth in offspring of women who drank 2-4 drinks per week. The authors noted that alcohol reduces the release of birth hormones, and this may account for these findings. They also suggested that women who continue to drink during pregnancy may be generally healthier

than abstainers, so there may be confounding effects contributing to these results. The positive effects of mild prenatal alcohol exposure (PAE) on preterm birth disappeared in women with high levels of mental distress. Regarding SGA, there was no association with low to moderate PAE. Pfinder et al. (2013) also found no interaction between low to moderate drinking during pregnancy and maternal education, and nor were the birth outcomes worse with lower educated women, or with women who both smoked and drank.

Mamluk et al. (2017) conducted a systematic review and meta-analysis of studies that looked at the effects of pre-natal alcohol consumption on pregnancy and offspring outcomes of up to two standard drinks up to twice a week (approximately 32g alcohol per week), compared to abstinence. They found a limited number of studies that addressed their question, and no clear evidence of detrimental effects of light alcohol consumption. However, there was some evidence that even light PAE may be associated with SGA.

There has, therefore, been no study that has conclusively shown adverse effects resulting from up to one alcoholic drink a day. However, medical advice is to abstain completely during pregnancy as the possibility of subtle neurological deficits arising from low consumption cannot be ruled out, especially in genetically susceptible woman-foetus dyads (Flak et al., 2014).

3. Alcohol use and FASD in South Africa

With some communities in South Africa having the highest recorded prevalence of FASD in the world, there is a clear need for interventions to address this. However, it is important to understand the broad context of alcohol use in South Africa and factors that contribute to heavy drinking during pregnancy in order to assist appropriately.

3.1. Alcohol use in South Africa

South Africa carries a higher than average burden of alcohol related difficulties compared to the rest of the world (Pengpid et al., 2021). Whilst the per capita consumption of alcohol in South Africa is unremarkable, this is due to a substantial proportion of the population who do not drink. The amount of alcohol consumed by those who do drink, however, is amongst the highest in the world (World Health Organisation, 2018), estimated to be close to 20 litres of pure alcohol per adult per year (Parry, 2005; Peltzer & Ramlagan, 2009). Across the world, estimates over the period from 2000 – 2016 have found that 5.3% of all deaths, and 5.0% of disability-adjusted life-years (DALYs)[4] are

[4] DALYs are calculated by combining weighted measures of years lived with disability and years of life lost for a specific condition (Solberg et al., 2020).

attributable to alcohol use, with these figures being higher in countries with lower human development index ratings (Shield et al., 2020). Comparable figures for South Africa in 2000 were 7.1% for alcohol-attributable deaths, and 7.0% for DALYs (Schneider et al., 2007).

A large national population-based self-report survey by Pengpid et al. (2021) looked at the prevalence of harmful, hazardous, or dependent alcohol (HHDA) use[5] in South Africa in 2017, and it revealed that 10.3% of the population engaged in HHDA use. This figure is higher than indicated by a comparable survey in 2008, which gave a figure of 9.0% HHDA use (Pengpid et al., 2021). The most recent South African Demographic and Health Survey (SADHS) (National Department of Health et al., 2019) indicated that 28% of men and 5% of women engage in risky drinking.[6] In line with previous surveys, these surveys indicated that, amongst women, those of mixed race had significantly higher HHDA use. Psychological distress and other substance use were also strongly associated with HHDA use (Pengpid et al., 2021). An earlier analysis by Peltzer and Ramlagan (2009) synthesised data from national and local surveys, and they found higher overall levels of binge drinking in urban areas (17% of men and 4% of women) than in rural areas (11% of men and 2% of women). However, amongst drinkers specifically, these trends were reversed for women, with more rural women binge drinking than urban women (26 - 39% vs 19 - 29%). Amongst drinking men, binge rates are more evenly distributed (rural men: 34 - 38%; urban men: 30 – 37%)

The South African Demographic and Health Survey (SADHS) (National Department of Health et al., 2019) found that, nationally, 3% of women who had a live birth in the last five years reported drinking during pregnancy (levels of drinking were, unfortunately, not recorded.) These figures were highest for the Western Cape (7%), followed by the Eastern Cape and Northern Cape (both at 6%). The review conducted by Peltzer and Ramlagan (2009) found that 2.5% of pregnant women in South Africa reported risky drinking. Provincial data from this review indicated hazardous or harmful drinking by pregnant women to be highest in the Northern Cape at 24.9%, followed by the Eastern Cape at 2.5 %, and the North West at 2.1%. Nationally, highest levels of harmful or hazardous drinking amongst pregnant women were recorded for "Coloured[7]"[8] women (11.6%) followed by

---

[5] The Department of Health Medical Research Council (2007) defined harmful levels of alcohol consumption as 4-5 drinks per day for men, and 2-3 drinks per day for women, and it defined hazardous levels as six or more drinks per day for men and four or more drinks per day for women. Peltzer and Ramlagan (2009) described hazardous drinking as indicated by behaviours such as "drinking first thing in the morning, drinking to intoxication, [and] drinking apart from meals." (p. 9). Harmful drinking may result in "adverse events (e.g. physical or psychological harm)" while hazardous drinking places consumers at risk for "adverse health events" (Peltzer & Ramlagan, 2009, p. 1)

[6] The SADHS (2019) defined risky drinking in this instance as drinking five or more standard drinks on a single occasion in the 30 days prior to the survey

[7] I place racial signifiers in inverted commas to indicate the socially constructed nature of such signifiers.

[8] "Coloured" is a term used in South Africa for people of mixed-race descent

"Black"[9] women (1.6%) (Peltzer & Ramlagan, 2009). However, Peltzer and Ramlagan cautioned that, given the traditionally low cut off points used in the screening questionnaires of the surveys from which these data were gleaned, the actual rates of harmful and hazardous drinking could be much higher than recorded. A recent Eastern Cape study (Macleod et al., 2021) did, indeed, reveal much higher levels of risky drinking by pregnant women. Macleod et al. (2021) looked at alcohol use during pregnancy in a low-resource urban setting in the Eastern Cape. These authors found that one third of a sample of 1028 pregnant women reported current drinking, with 17 – 20% indicating risky drinking, and 6.6% reporting heavy episodic drinking.

3.2. Historical underpinnings of alcohol use amongst poor people in South Africa

In this section I review some of the historical roots of heavy alcohol use amongst disadvantaged people in South Africa. "White" people and economically advantaged people also struggle with heavy alcohol use, but I focus on disadvantaged people groups as they are the ones targeted by the intervention that I evaluated.

From the start of colonisation, as the Cape Colony was being settled by colonial farmers in the 17th and 18th centuries, indigenous people were induced to provide labour through the payment of tobacco, bread and wine (London, 1999). The practice of using alcohol as payment for work, known as the *dop*[10] system, became institutionalised, and also served as a means of social control over indigenous people, enabling "recruitment, retention and reproduction of agricultural labour as well as providing an important market for low grade alcohol products" (London, 1999, p. 1409). In 1928 the Liquor Act curtailed the *dop* system, but alcohol as part of a wage package was only legally outlawed in 1961 (London, 1999). However, the provision of free alcohol as an employment "perk" was not outlawed, and some farms, particularly wine farms in the Western Cape, provided alcohol to workers on credit (London, 2000). With no other recreational outlets, and harsh working and living conditions, alcohol consumption became the primary social occupation of farm workers, creating both alcohol dependence and a widespread "alcohol culture" (London, 1999).

London (2000) defined the modern day *dop* system as "one where workers may expect to be provided with alcohol as part of their farm work" (p. 200). He reported on a 1993 survey of 113 fruit farms in the Western Cape which found that 19.4% of the sampled workers reported current exposure to the *dop* system, and 47.8% had past experience of it. The alcohol supplied as *dop* was

[9] "Black" is a term used in South Africa for people of African descent
[10] *Dop* means "alcoholic beverage" in Afrikaans, the predominant home language of "Coloured" people

not usually directly from the farm but was reject wine sold back cheaply to farmers by producers. Those workers who had experienced the *dop* system were ten times less likely to abstain from alcohol than those who had not (London, 2000).

Although there have been recent moves by some farm owners to improve living and working conditions for farm workers and to assist with reducing risky drinking (Gossage et al., 2014), the legacy of the *dop* system lives on. Farm workers continue to be amongst the most poorly paid and least educated of the national workforce, and a 2011 cluster randomised survey indicated that Western Cape farm workers who drink consume, on average, almost twice the amount of alcohol that drinkers in other occupations consume (Gossage et al., 2014). This survey indicated that between a quarter and half of the surveyed farm workers in this area drank at risky levels. The authors suggested that on-going poverty and stress, as well as historical drinking norms, contribute to current hazardous drinking patterns amongst farm workers.

Away from the farms, the dangerous nature of mining required a sober workforce, and selective prohibition was deployed in the late 19th and early 20th century to restrict access to "European liquor" by "Black" labourers. Even after such prohibitions were lifted, "Black" people were banned from owning bottle stores and pubs, which inevitably led to the proliferation of illegal liquor outlets (*shebeens*) in African townships[11] and a defiant drinking culture (Mager, 2004). Within mining compounds, the heavy consumption of alcohol (usually poor-quality state-brewed sorghum beer) in mine hostel bars became the norm through the 20th century. Families of "Black" miners were prevented from living with them, due to Apartheid segregation laws, and the lack of other recreational activities and home responsibilities, as well as the alienation caused by migrant conditions and the stress of a harsh working environment, led to heavy alcohol consumption (Mager, 2004). As stated by Mager (2004), "Compound bars were a far cry from communal beer drinking environments that reinscribed regulated meanings of beer drinking and connected different households in rural communities." (p. 739).

The establishment of the "Bantu homelands" in the 1970s led to the massive, forced relocation of "Black" people out of designated "White" areas (which constituted most of the country's productive land) into cramped and impoverished "bantustans". The fracturing of communities and families, and removal of economic opportunities, resulted in trauma that can be directly connected to heavy alcohol use (Hunting & Browne, 2012). There was also a sudden increase in the income of a few people newly employed as bureaucrats within these rural areas, resulting in new drinking cultures and the consumption of high alcohol content "European" liquor as a sign of status (Mager, 2004).

[11] These are areas of towns that were previously designated under Apartheid for occupation by "Black" people.

Outside the homelands, the Apartheid laws denied “Coloured” and “African” people access to leisure venues such as cinemas, parks and sporting facilities, and the combined effects of boredom and oppression contributed to heavy alcohol use (Mager, 2004; Watt et al., 2014).

Following the 1976 student uprisings, with its surge of youthful infiltration into traditionally adult arenas of political activity, a concomitant uptake of alcoholic consumption by youth occurred, abetted by aggressive marketing by South African Breweries (SAB) in an attempt to capture the African market due to fierce competition from other beer producers (Mager, 2004). In the late 1980s, as segregationalist laws began to be dismantled, informal shack settlements sprang up around cities due to a mass influx of rural dwellers seeking work. Alcohol consumption became endemic, and it is reported that the number of *shebeens* in the Western Cape Province doubled over the period from 1990-2000 (Mager, 2004).

Currently, the legacies of the *dop* system and political oppression, combined with the lack of economic and social self-determination in poverty stricken areas, as well as endemic community-wide and personal trauma, all contribute to excessive alcohol use (Cloete, 2012; Watt et al., 2014). One of the many ill effects of high alcohol consumption is Foetal Alcohol Spectrum Disorders, which may be seen as “a symptom of an array of underlying social, economic and political problems” (Cloete, 2012, p. 2).

In Chapter 2 of this thesis, I review studies of alcohol use and FASD in South Africa. I discuss the strong culture of risky drinking among disadvantaged people in this country, with roots in its apartheid and colonial past. Whilst a substantial proportion of South Africans abstain from alcohol completely, there is a pattern of harmful, hazardous or dependent alcohol use (HHDA use) among those people who do drink (Parry, 2005; Peltzer & Ramlagan, 2009). Research into factors that contribute to alcohol use during pregnancy among South African women indicate that the stresses associated with poverty, a history of trauma, intimate partner violence, social norms and identity, alcohol consumption by male partners and family members, a lack of attachment to the pregnancy, and alcohol use disorders all play a part in risky prenatal alcohol consumption.

4. Factors that contribute to alcohol use during pregnancy

In order to intervene in the area of FASD, it is important to understand factors that contribute to alcohol use during pregnancy. A number of authors have examined this question, and the following themes have emerged from their research with women who consumed large quantities of alcohol while pregnant: amongst women who drink, drinking is normative in their contexts, even during pregnancy, and is part of their identity; male partners and other family members drink heavily;

alcohol is used as a strategy to cope with stressors and negative emotions; women lack attachment to their pregnancies; and they are alcohol dependant or addicted. I now examine each of these themes in more detail.

4.1. Social norms and identity

Qualitative studies with women who drank during pregnancy in impoverished South African settings reveal a pervasive sense amongst participants that it is normal to drink during pregnancy, and their narratives indicated that drinking is embedded in the societal fabric of their contexts (Cloete, 2012; Kelly & Ward, 2018; Macleod, Matebese, et al., 2020; Watt et al., 2014, 2016). Whilst most participants in these studies had received some general exhortations to cease drinking, they were also given pro-drinking messages from friends and peer groups, which were more influential and trusted than those received from older women and clinics (Watt et al., 2016). To not drink meant excluding themselves from social activities. With few opportunities for recreation or employment in impoverished settings, visiting a *shebeen* or drinking at a friend's house is often the only means of socialising, of relaxing, of occupying one's time, and of retaining connections during the life-changing pregnancy period (Cloete, 2012; de Vries et al., 2016; Watt et al., 2014, 2016). As de Vries et al. (2016) stated, "To give up drinking is to give up their whole social life, their circle of friends and sometimes the only way of coping with hardship" (p.6).

If social practices are organised around drinking, and being drunk is the norm, then getting drunk is one of the primary ways of being a "normal" young woman in some contexts. There is a collective drinking identity that legitimises alcohol use (Kelly & Ward, 2018), and participation in normative activities contributes to personal identity formation. Participants in a study by Cloete (2012) identified the occupation of drinking as a core aspect of who they are, stating "*Ek is 'n drinker en klaar*." ("I am a drinker and that's it.") (p.2). An Australian study by Meurk et al. (2014) likewise found that alcohol consumption is an important part of the identity of women who continued to drink through their pregnancies. By claiming the identity of a drinker, women can deflect the blame that accrues to women who drink — if you are a drinker by nature, then you cannot be expected to abstain, even when pregnant.

The fact that alcohol use is such a normative practice, and that binge drinking is an integral part of many social events in some contexts, indicates how important it is to focus not only on pregnant women, but also on society's use of alcohol when intervening. The World Health Organisation (2018) has identified a link between problematic alcohol use and reduced socio-economic development. They have recommended a range of policies to address such problematic use, including legislation and enforcement of drink-driving laws, limiting the availability of alcohol sales (so long as this policy

is implemented across wide geographical locations), increasing taxation on alcohol, and using well designed mass media campaigns. All of these measures have been shown to reduce alcohol consumption. With many people earning income from informal and unregulated alcohol serving establishments, the provision of alternative employment avenues would be necessary, though difficult, if such establishments are closed in order to regulate and limit alcohol availability.

4.2. Alcohol consumption by male partners and family

Studies from the United States, Europe and Australia as well as South Africa have highlighted the association of the partner's and family's alcohol use with maternal alcohol consumption during pregnancy (May et al., 2008; McBride & Johnson, 2016; van der Wulp et al., 2015). Furthermore, van der Wulp et al. (2015), in their survey of Dutch pregnant women and their partners, found that a woman was more likely to drink if her partner did not consider that it was important for her to abstain from alcohol. Significantly, authors have also found that high alcohol use by the male partner prior to conception can lead to poor sperm health and foetal health (lower conception rates, reduced live births, poorer infant health, and increased risk for FASD), even when other confounders (such as maternal alcohol consumption) are controlled (Gupta et al., 2016; McBride & Johnson, 2016).

McBride and Johnson (2016), in their systematic review of eleven studies on the role of the partner in alcohol-exposed pregnancies, found that women who were less satisfied with their relationship were more likely to continue drinking through pregnancy. There is also the issue of intimate partner violence, which increases when a male partner is drunk (Yüksel-Kaptanoğlu & Adalı, 2021). The trauma arising from this is a significant predictor of drinking by the female partner. This will be discussed further in the next sub-section.

Whilst some clinical FASD interventions try to include partners in their treatment targets, community wide interventions tend to focus exclusively on the alcohol consumption of pregnant women. The results of these above studies suggest that such an exclusive focus is not adequate.

4.3. Maternal stress levels and exposure to trauma

A third factor associated with heavy drinking is experiencing highly stressful events, including intimate partner violence (IPV), during pregnancy (Choi et al., 2014; May et al., 2008). Russell et al. (2013) discussed the term "syndemic", which acknowledges the interactive and compounding effects of various contextual, social, physical, and mental/emotional conditions in producing adverse health outcomes. They considered the intersection of three epidemics – alcohol use, interpersonal violence, and HIV infection (sometimes referred to as SAVA – Substance Abuse, Violence and AIDS) –

which commonly affect pregnant women in South Africa. Alcohol use significantly predicts the perpetration of violence, and an HIV positive status increases the chances of suffering from IPV (Russell et al., 2013), just as IPV increases the chances of contracting HIV (Jewkes et al., 2010). Other common stressors during pregnancy in low resource settings include poverty, a new HIV diagnosis (as HIV testing is part of antenatal care), partner abandonment due to the pregnancy, and relational difficulties. Participants in studies by Kelly and Ward (2018), Macleod, Matebese, et al. (2020) and Watt et al. (2014) linked all of these stressors to increased pre-natal drinking, and drinking was commonly understood as a temporary panacea for all emotional struggles.

Whilst alcohol consuming women in general tend to decrease their consumption upon discovering that they are pregnant, Choi et al. (2014) found that women with a history of trauma (either recently or during childhood) were less likely to reduce their alcohol intake, and may even increase it, upon pregnancy recognition. The authors stated that "(r)ecognition of pregnancy may act as an additional stressor that interacts with the woman's trauma history to increase distress and related drinking behaviour." (p. 7). Relatedly, these authors found that such women also have higher levels of unintended pregnancies than those without such a history. An unintended pregnancy can be a significant stressor, causing shame and anxiety: as one drinking, recently pregnant woman stated, "I was scared because it's my first child, and I don't have parents, so I don't know what to do. So every time I think of that I will go and drink" (Watt et al., 2014, p. 122).

Chronic anxiety and high stress levels invariably lead to depression, which is associated with drinking (Penberthy et al., 2013) and with bearing a child with FASD (Chersich et al., 2012; de Vries et al., 2016). Tomlinson et al. (2014) surveyed 1,145 pregnant Xhosa speaking women in 24 separate townships around Cape Town. They found that 37% of the women's scores on the Edinburgh Postnatal Depression Scale indicated depressed mood, and depressed mood was significantly associated with alcohol use. Initiatives to reduce gender-based violence, to alleviate poverty, and to provide psycho-social support and counselling to trauma victims are, therefore, all indicated to reduce FASD prevalence.

4.4. Lack of attachment to the pregnancy

Lack of attachment to the pregnancy is another factor associated with higher alcohol consumption. Watt et al. (2014) suggested that drinking "may represent resistance to transitioning to a life of motherhood that is more laden with responsibilities." (p. 122). In their interviews with 24 pregnant or recently post-partum drinking women, these authors found that only two women (both of whom had reduced or ceased their drinking on pregnancy recognition) verbalised protective feelings towards their unborn child. The remainder did not express attachment to their foetus, and rather

expressed their disconnection from or rejection of the pregnancy. Two women attempted to abort their pregnancies through excessive drinking. Similar themes have been found in Canadian Aboriginal contexts: Walker et al., (2011) found that women who were unhappy about being pregnant were two and a half times more likely to drink than their counterparts who were happy about being pregnant, while Rutman et al. (2000) reported that some women use substances excessively as a way of inducing a miscarriage, despite the legality of abortion in Canada. This suggests that women lack both the knowledge and support to access legal termination of pregnancy services, both in South Africa and elsewhere, as well as difficulties in accessing and/or using consistent and reliable contraception.

A parent's relationship with their child begins during pregnancy, and a positive parent-child relationship, in which a parent is attuned to their child's needs, is critical for the mental health and development of the child (Pajulo et al., 2006). Depression and/or negative experiences such as being the victim of recent or past trauma, neglect, or abuse, can significantly disrupt a parent's ability to respond positively to their child (Santona et al., 2015; Schechter et al., 2005). As Belt et al. (2012) pointed out, "early traumatic attachment patterns are easily activated in the perinatal period and transferred to the mother-child relationship." (p. 521). There is some evidence that interventions to enhance the mother-child relationship with women with problematic substance use, starting in pregnancy, can assist the women to invest in their child rather than a substance, and that this leads to greater maternal abstinence (Belt et al., 2012; Pajulo et al., 2006).

4.5. Alcohol use disorders

The final reason that is addressed in the literature as a contributing factor to alcohol use during pregnancy is an alcohol use disorder in the pregnant woman. Alcohol addiction was not admitted by the women in the studies by Cloete (2012) and Watt et al. (2014) (who interviewed a combined total of 38 women who drank during pregnancy), as this term was considered to apply only to those who were intoxicated daily. However, it was clear that the majority were dependent on alcohol. The Diagnostic and Statistical Manual of Mental Disorders (5th edition) defines an alcohol use disorder as "A problematic pattern of alcohol use leading to clinically significant impairment or distress" (American Psychiatric Association, 2013, p. 490), and women in the study by Watt et al. (2014) talked about "choosing to drink alcohol instead of eating; experiencing hangovers; having a drink first thing in the morning; begging in order to get money for alcohol; experiencing guilt about their drinking; and going into labour intoxicated." (p. 123). This points to a need for better community wide recognition of alcohol use disorders, and for much greater provision of government funded treatment units and outpatient psychological care for substance use disorders.

With the increasing concern over the prevalence of FASD worldwide, interventions to reduce drinking during pregnancy are being established. In South Africa, interventions are provided by Non-Governmental Organisations (NGOs) which raise funds from private and public entities to operate. One such NGO is the Foundation for Alcohol Related Research (FARR). FARR, founded in 1997, focuses on conducting research, offering support services, and intervening in the form of community awareness campaigns, education and training of service providers, and support of pregnant women. They operate primarily in the Western and Northern Cape provinces in areas with a high prevalence of FASD (FARR, 2016). Another intervention is provided by another NGO, and it is this intervention that was evaluated by this current research.

5. Description of the intervention and the larger research project

This current study was part of a larger research project undertaken to investigate alcohol consumption by pregnant women in a region of the Eastern Cape, in support of an NGO (Non-Governmental Organisation) intervention. Hereafter, this particular NGO will be referred to as "the Organisation". The research was conducted by researchers from the Rhodes University Critical Studies in Sexualities and Reproduction (CSSR) research unit. It incorporated three specific projects: Project One was a quantitative survey of drinking patterns of pregnant women attending clinics in selected wards of the target municipality; Project Two was a qualitative investigation of the narratives of women who drank heavily during pregnancy, and of their family members; Project Three (this research) was a critical formative evaluation of the Organisation's pilot intervention in three wards of the target municipality. I will describe Projects One and Two in more detail after describing the interventions provided by the Organisation. Three to four meetings a year were held between mid-2016 and the end of 2019, attended by representatives from the funders of the research, the Organisation CEO and staff, and all the Rhodes researchers involved in the projects.

5.1. The intervention

The intervention studied is run by an Organisation which aims to reduce the incidence of FASD. The Organisation was established two decades ago in a region in the Western Cape, and it runs programmes in selected sites in the Western and Northern Cape, and now the Eastern Cape. It has three inter-related programmes:

a) A **Community Awareness Programme** trains community members about FASD and in basic presentation skills, and then tasks each trained community member (hereafter referred to as a trainer) to educate 500 other people per year about FASD. Talks are held in clinics, schools, and other community locations.

b) A **Mentoring Programme** trains community members in FASD and basic mentoring skills. These members (hereafter called mentors) are then tasked with identifying three alcohol-consuming pregnant women in their neighbourhood and developing a mentoring relationship with them, aimed at helping the women to reduce or eliminate alcohol consumption. This mentoring relationship starts during the woman's pregnancy and aims to continue for 12 months. Mentors are asked to visit the woman in her home weekly, and pay a surprise monthly visit to the woman over a weekend, which is when she may be more likely to be tempted to drink. Mentors are also tasked with developing a mentoring relationship with the partners of drinking pregnant women, although this has proven to be difficult, and it has not been an emphasis in the Eastern Cape intervention. Mentors are provided with a monthly stipend of R500[12]. A social worker runs the programme in each region, with the assistance of a community worker. The social worker provides approximately 4 – 6 psycho-social support sessions to the pregnant/newly parenting women in the programme. Monthly training programmes are also provided to the women and mentors in the programme. These programmes are usually educational in nature, and cover topics such as HIV prevention, nutrition, exercise, and domestic violence. Participants are transported to the venues by the Organisation, and receive a main meal.

c) A **School Programme** targets Grade 6-7 school learners to motivate them to commit to alcohol-free pregnancies.

In 2017 the Organisation rolled out two of their programmes (the community awareness programme and the mentoring programme) as a pilot intervention in two geographically separate areas of an Eastern Cape municipality, and it is this intervention that was formatively evaluated in this study. These implementation areas were chosen as they displayed the riskiest antenatal drinking patterns of the surveyed wards, according to the results from Project One. In one area, the intervention was conducted in two neighbouring wards, and in the other area, about 40km away, the intervention was established in one ward. A social worker was appointed by the Organisation in August 2017 to establish the community awareness and mentoring programmes, and she was trained in the Western Cape by attending a mentoring training session herself. She started implementing the intervention by recruiting trainers for the community awareness programme, the training for which is identical to the mentoring training except it gives input on delivering information in public settings rather than on mentoring. She trained these recruits and supported in their community awareness efforts (for which they do not get a stipend), then she recruited some of them to be trained as mentors for the mentoring programme.

[12] For context, the minimum daily wage in 2018 when data was gathered was approximately R120.

The Organisation's CEO claimed that its theoretical model is based on the Theory of Change, but the particular theory of change that they follow is not articulated. However, judging from the programme content, they appear to work from the theory that imparting knowledge about the harms of alcohol consumption during pregnancy, and urging abstinence, will lead to a reduction in FASD.

Two mixed-methods summative evaluations of the Organisation's intervention were carried out in the Western Cape in 2011 and 2015 (references withheld to maintain confidentiality) which suggested that the intervention was increasing knowledge about FAS and was assisting some pregnant and lactating women to reduce or cease their alcohol consumption. Mentors of pregnant women were identified as significant beneficiaries of the programme, as many of them reported their own reduction or cessation of drinking. However, these studies were not robust, and more rigorous research is indicated.

A policy brief was written in 2014 for the Organisation by a qualitative researcher in the field of alcohol consumption during pregnancy, and who is also one of the Organisation's directors (reference withheld to maintain confidentiality). She advised that health promotion should shift from a "lifestyle approach", which focuses on educating individuals regarding healthier lifestyle choices, to a "developmental approach", which emphasizes the empowerment and consciousness raising of individuals and communities, in line with Freirian principles of dialogical pedagogy for adult education (Freire, 1993). Dialogical pedagogy theorises that true adult education can only happen through a process of dialogue, where teachers and students are considered equal, and all participants are considered "teacher-learners". Parties need to express and name their own realities in an atmosphere of mutual trust and respect, discuss problems, and collectively arrive at an actionable solution. My research shows how far from that ideal the Organisation was at the time of data collection (2017 – 2018), and how the "lifestyle approach" was the mainstay of its interventions.

5.2. Description of the three projects making up the overall research project

Project One was quantitative, involving two arms. The first was a baseline survey of drinking patterns by pregnant women attending government antenatal clinics in 16 wards of low resource settings of the target municipality. Data were collected by clinic nurses after receiving training in data collection by the researchers. These data were collected in 2016 and 2017, and from these data, three wards with the highest drinking prevalence were chosen for the Organisation's intervention. The second arm of the study was conducted two years after the intervention

commenced, and end term data were collected in 2019 from the three intervention sites and two non-intervention sites, which served as control sites. The survey instrument was the AUDIT scale, translated into isiXhosa and Afrikaans, and with some additional questions added to survey experiences of domestic violence.

Results of the baseline study indicated very high levels of risky drinking in the sample of 1028 pregnant women. 16.8 – 20.1% (depending on whether results of the total AUDIT or AUDIT-C) of the full sample, and 81% of those who reported drinking, were measured as drinking at risky levels. This is in line with drinking patterns in the general population, where those who drink tend to do so at risky levels (Parry, 2005). In the baseline study, six or more drinks per occasion were reported by 6.6% of the whole sample, or 31% of those who reported drinking (Macleod et al., 2021). The end term study indicated that, overall, there was a statistically significant *increase* in reported drinking at the three intervention sites compared to the control sites. However, the average levels of drinking reported by those who drank at the intervention sites did not rise. As there was no increase in reported drinking at the control sites, the changes measured at the intervention sites can be assumed to arise from the intervention and not wider social changes that may have affected reported drinking behaviour between the baseline and end-term data collection.

Three explanations were offered for these results: (1) in the intervention sites, women may have become more aware of the issue of alcohol use during pregnancy and become more willing to acknowledge their drinking with the nurse who was collecting data; (2) pregnant women who were reached by the intervention may indeed have engaged in more drinking than those who weren't, as the women may have come to view ante-natal drinking as widespread and normal; (3) at one intervention site, a new service provider collected the end-term data, and participants may have been more willing to report their drinking behaviour to her. How much of the effect is explained by each of these possible scenarios is impossible to know.

Project Two was a qualitative project, involving interviews with women who drank heavily during a previous pregnancy. Family members or partners of the women were also interviewed. All participants were asked to narrate the journey of the index pregnancy. The aim of this project was to ascertain micro- and macro- level factors that promote alcohol use during pregnancy. A total of 25 interviews were conducted with 24 participants in May 2018: 13 previously pregnant women; five partners; and eight family members (one participant was interviewed about both her own pregnancy and also that of a family member who drank heavily during pregnancy.) Narrative themes that emerged from the data (Macleod, Matebese, et al., 2020) were similar to themes from other studies with drinking pregnant women, and I report on these in the next chapter.

Project Three (this project) was a qualitative project aimed at providing a critical formative evaluation of the intervention in the Eastern Cape. Before describing the rationale for my particular approach to this research, I give a synopsis, below, of research into interventions aiming to reduce the incidence of FASD, and an outline of the theoretical paradigm of this research.

6. Summary of studies looking at interventions to reduce alcohol exposed pregnancies

In Chapters 2 and 3 of this thesis, I provide an in-depth literature review of both quantitative and qualitative studies of interventions, as well as looking at critiques that highlight ways in which interventions may inadvertently have negative effects. I provide a summary of that review here.

FASD Interventions take two general forms: broad-based educational campaigns (referred to as universal or public health interventions) which aim to increase knowledge of the teratogenic effects of alcohol, and to shift drinking norms; and clinical interventions which target at-risk women. In Chapter 3, I review quantitative studies that were conducted to ascertain whether a particular intervention, or a range of interventions, were successful in increasing knowledge of the teratogenic effects of alcohol, reducing drinking during pregnancy, or reducing FASD incidence. Methodological complexity abounds when attempting to indicate the efficacy of an intervention, as drinking during pregnancy is influenced by multiple factors, and FASD can be hard to diagnose during infancy. Studies that have been conducted to date, as outlined in Chapter 2, lack methodological rigour, such as short follow-up times, risks of social desirability and selection bias, or small sample sizes. Nevertheless, they suggest that both universal and brief clinical interventions that are well designed and implemented may reduce episodic and non-dependant drinking in pregnant women and increase contraceptive use in non-pregnant drinking women. Heavier or dependant drinkers require more intensive clinical interventions.

Quantitative studies are necessary to ascertain whether an intervention is having a significant effect on the targeted outcome, but they are less sensitive to the specifics of which aspects of an intervention are beneficial and which are not. They are also not attuned to power dynamics within interventions. With FASD being primarily potentiated by unjust societal factors, such as poverty, food insecurity, gender-based violence, trauma, and negative social norms, it is crucial that interventions to reduce FASD do not unintentionally re-inscribe unjust power relations and culture-specific values that are unhelpful. In Chapter 3, therefore, I examine qualitative studies and critiques of interventions. There is a relative dearth of such studies, and many of the ones that have been conducted have been in middle class settings with women who do not drink at risky levels. Results

from qualitative studies point to the importance of quality training for people delivering interventions, the importance of social support in reducing drinking, and the benefits of integrated social and health services at one site for women at risk of an alcohol exposed pregnancy (AEP). Critiques of FASD interventions centre around their attempts to manage the risk of AEPs through efforts to make individual women responsible for the ills of FASD, and in the process, they inadvertently reinscribe gendered, raced, colonial, and classed injustices.

In the next sections I discuss my rationale for this research, the theoretical paradigm within which this research is located, the methodological approach that I take, and the methodological dilemma that I seek to address.

7. Rationale for this research, and methodology

The above synopsis of my review of the literature shows the importance of qualitative and critical studies of FASD interventions in South Africa to assist with teasing out the multiple power relations that underpin all attempts to bring about change in other people, and to highlight unjust or uncaring effects that may inadvertently occur. Formative evaluations of interventions are indicated to ensure that social and reproductive injustice is not unintentionally perpetuated by them, and to help them more effectively address the root causes of binge drinking during pregnancy. With a new arm of an intervention being implemented in the Eastern Cape, a formative evaluation was indicated to assist with enhancing the design and delivery of the programmes.

Data were collected from the Organisation between 2016 and 2018. These data consisted of all training materials used by the Organisation when training trainers and mentors (training manuals, videos, powerpoint presentations), video and audio recordings of two three-day training sessions, 12 interviews with trainees and Organisational personnel, and 32 audio recordings of mentoring sessions, recorded by the mentors. Three separate formative reports were provided verbally and in writing to the Organisational personnel and funders on the training materials, the training sessions, and the mentoring sessions. Additionally, once data had been collected, a colleague and I substantially revised the training manuals in line with our recommendations, as the Organisation had not managed to find another suitable curriculum developer.

As well as providing our partner Organisation and funders with a formative report on their interventions, this research also critically analysed the interventions. For this analysis, I chose to use a discursive approach within a social constructionist paradigm to highlight the manners in which pregnant women are regulated through various discursive technologies. I engaged in a specific subject positioning analysis, using both a Foucauldian Discourse Analysis and a simplified

Conversation Analysis, to indicate which discursive subject positions for pregnant women were provided/taken up/resisted during the intervention, and which positions enhanced or detracted from what I call an ethics of care and justice, which I describe next. This positioning analysis enabled recommendations to be made regarding ways in which the Organisation could promote such an ethics.

8. Values underpinning recommendations: Introducing an ethics of care and justice

There have been recent calls to locate reproductive interventions within a framework of reproductive justice. Such calls have come from researchers working in fields where the notion of reproductive rights has been widely taken up, but where such a notion has been shown to be inadequate to fully promote the needs of disadvantaged people. These fields include abortion (Chiweshe et al., 2017; Cook & Dickens, 2009; Macleod et al., 2017), maternal surrogacy (Bailey, 2011), minority sexualities (Morison & Lynch, 2016) and family planning and contraception (Gilliam et al., 2009). Reproductive justice considers the intersecting "social, economic, cultural and healthcare possibilities and challenges that serve to either enhance or hinder women's reproductive freedoms" (Macleod et al., 2017, p. 602).

Situated within a social justice framework, reproductive justice incorporates notions of reproductive rights, but also moves beyond a rights-based approach. Discourses of "rights" have several problematic aspects. Firstly, such discourses assume agency on the part of individual women, and the capacity to "choose" which rights they would like to take up (Bailey, 2011; Macleod et al., 2017). However, rights-based discourses are often irrelevant for women mired in inequitable social systems which strip them of agency. Secondly, a rights-based approach may lead to "the creation of a hierarchy of rights and the pitting of various rights against one another" (Morison & Lynch, 2016, p. 17). This is often seen in abortion debates, where the rights of the foetus are pitted against the rights of the pregnant woman. Thirdly, rights discourses promote individualism and self-interest which conflicts with social solidarity and cohesion (Morison & Lynch, 2016). Such solidarity is necessary to fight injustices. Finally, notions of rights presume a universal set of common human values, arising from humanist and essentialist ontological understandings of personhood. However, as well as running counter to the social constructionist perspective of this thesis, which views subjects as discursively constructed by the varying socialities within which they are situated, such "universal" human values tend, in fact, to be implicitly Western and middle-class (Mckenzie & Macleod, 2012).

The notion of reproductive justice is fundamentally social, addressing factors which contribute to negative reproductive health consequences, such as discrimination, poverty, gendered inequalities, sexual violence, and restricted access to quality healthcare (Gilliam et al., 2009). It is, therefore, a crucial anchor point which FASD interventions need to incorporate. However, it, too, has limitations. The signifier “reproductive/reproduction” links with medical, biological and demographic discourses. The term “justice” is a legal one, speaking to issues of fairness and moral correctness. It is also equated with redress or punishment when a crime has been committed. Such notions of reproduction and justice tend not to be naturally taken up when women speak about their own childbearing. Chiweshe et al. (2017) analysed the narratives of Zimbabwean and South African women regarding their decision to terminate a pregnancy. No justice or rights discourses were drawn on in their accounts. Instead, the women drew off familial and relational discourses to justify their decisions. Researchers who have interviewed South African women who drank during pregnancy have found themes of stress, trauma, shame, relational difficulties, and a culture of drinking in the women’s narratives (Macleod, Matebese, et al., 2020; Matebese et al., 2021; Watt et al., 2014). As well as injustices and social norms, these themes speak to issues of relationality. Indeed, familial and relational discourses cohere far more strongly around pregnancy and childbearing than the impersonal and universalising discourses of reproduction or justice. Regarding FASD interventions, therefore, an overarching framework that guides interventions needs to incorporate reproductive justice issues, but I argue that it also needs to include more personal and relational notions.

Fundamental to relationships is the notion of care. An ethics of care moves beyond the competing claims that can arise out of rights based arguments, and foregrounds the fundamentally interdependent nature of all of humanity (Mckenzie & Macleod, 2012). Rather than conceptualising people as rational and independent actors, an ethics of care upholds the idea that we are all “constantly enmeshed in relationships of care” (Tronto, 1995, p. 142) and it views the care of others as a core value (Postow, 2008). While universal principles of fairness inhere in the concept of justice, the notion of care is situated and specific to the lives of individuals (Tronto, 1995). Thus, while the application of justice would ideally afford all people the same benefits and rights, the application of care should provide people with what they most need at a particular point in order to thrive.

Care can be conceptualised as having four interdependent phases, namely: “caring about, attentiveness; taking care of, responsibility; care-giving, competence; and care-receiving, responsiveness.” (Tronto, 1995, p. 142). An ethics of care, therefore, incorporates the need for responsibility, which is the primary impetus of most FASD interventions, but it also provides much

richer and more ethical principles to guide interventions. In the context of pregnancy and alcohol, "caring about, attentiveness" points to maternal bonding processes and reflective functioning, which are important motivational factors in assisting pregnant/parenting women to resist alcohol and invest, rather, in their child or future child (Pajulo et al., 2012). It also highlights the requirements of interventions to be attentive to the specifics of women's lives, through deep listening and addressing the needs and pain that women express. "Care-giving, competence" speaks to the empowerment of women which is necessary for them to be able to effectively take care of themselves and their children, and for interventions, it highlights the training requirements and mentoring competencies that personnel require. "Care-receiving, responsiveness" points to the needs that pregnant and newly parenting women have for support, and, for the personnel delivering interventions, it indicates the need they have for ongoing supervision and debriefing as they engage in intense and often stressful work.

Using an ethics of care as a guiding framework when working with pregnant women who use substances dovetails with an approach used by Rutman et al. (2000). These authors discussed a case study of one Canadian Aboriginal community's efforts to address substance use during pregnancy. The framework that guided their approach included the factors of respect, hope, understanding and compassion. These are all elements that intersect with the concept of care.

I am aware of two dangers that exist, however, with notions of care. Firstly, paternalistic and moralising processes can enter under the guise of care where power differentials exist; and secondly, as Tronto (1995) pointed out, a care perspective runs the risk of becoming too narrow and blinkered to wider perspectives. Thus, marrying an ethics of care with an ethics of justice may be the best way forward, as a justice perspective would highlight power differentials and guard against parochialist tendencies. Such a combination would allow due cognisance of partial and particular care needs (Postow, 2008) within the ambit of impartial and universalising justice principles.

9. Methodological and theoretical concepts used in this thesis

This research is situated within a social constructionist paradigm, which takes the view that social and psychological realities are constructed through social processes. Social constructionism is a broad and sometimes disparate school of thought, but Cromby and Nightingale (1999) outlined four general principles of psychological theory which can be termed "social constructionist". Firstly, social processes are deemed to be primary. "It is the social reproduction and transformation of structures of meaning, conventions, morals and discursive practices that principally constitutes both our relationships and ourselves."(Cromby & Nightingale, 1999, p. 5). With language being one of the

dominant media through which social processes occur, language is a central location for the study of such processes. Secondly, ways of talking and interacting vary across time and contexts: social constructionism acknowledges that social processes, and the resultant subjectivities of people, are historically and culturally specific. Thirdly, social constructionism asserts that knowledge and activity are fundamentally related to one another. "(K)nowledge is inextricably linked to, and emerges as a product of, activity and purpose." (Cromby & Nightingale, 1999, p. 5). This indicates that what is taken to be "truth" may be variable and specific, depending on what activities have produced the knowledge that is taken to be true. There is debate about whether some "truths" are more universal and unchanging than others, but there is consensus that social and psychological "truths" are intertwined with, and contingent upon, social processes and activities, and which activities are dominant or more powerful in a particular social setting. Fourthly, arising out of this understanding of the relativity of knowledge, social constructionism takes a critical stance towards positivism and the belief that science advances through neutral observation and study (Cromby & Nightingale, 1999).

Regarding this critical stance, the field of critical psychology, in alignment with the fourth principle of social constructionism outlined above, critiques the broad field of psychology in general: its methods (too experimental/quantitative); its epistemology (largely positivist or postpositivist); its samples (skewed towards young Western students); its choice of research areas (often driven by funding); its gendered and raced bias[13]; and its frequent failure to examine the broad socio-political implications of the practice of psychology (Eagly & Riger, 2014; Sampson, 2001). There is also a second aspect to critical psychology, captured in the quote below:

> [There is a] concern with human betterment, with the social transformations needed to achieve such betterment, and with [a] belief that helping provide voice for those persons and groups heretofore denied such voice is an essential element in bringing about the societal transformations needed to achieve human betterment. (Sampson, 2000, p. 1)

Likewise, I aimed to be critical in this research: I used qualitative methods which allowed the voices and views of the participants to be heard, within a social constructionist epistemology; my sample largely consisted of disadvantaged women; I aimed to privilege the voices of women and people of Colour; I attempted to examine the socio-political implications of the intervention provided by the

---

[13] Although psychology's androcentric bias has improved considerably over the past 40 years, Eagly and Riger (2014) found that women have still not achieved parity with men in psychology in terms of earnings, number of full professors and psychology chairs in the USA, editors of influential journals, number of female first authors, and citation counts. The same is true for people of Colour.

Organisation and the messages they conveyed; and I was (and am) concerned with the betterment of pregnant women who consume alcohol. However, I need to acknowledge that my choice of this area to research was, in part, driven by the availability of funding; even critical researchers are subject to the power inherent in money.

Within a social constructionist paradigm, I locate myself within critical realism which acknowledges extra-discursive material and embodied factors. Embodiment and materiality refer to biological bodies and the material and physical world within which we are embedded, and which are not reducible to social processes and language (Cromby & Nightingale, 1999). However, my focus in this thesis is on the socially constituted power relations that shaped the intervention in question. I draw specifically from Foucauldian theories of power relations, their links with knowledge production, and the manners in which subjects come into being through the mechanisms of **bio-power** and **norms**. Bio-power refers to the multitudinous techniques and mechanisms through which subjects are exhorted to manage their bodies and minds to keep them healthy and economically productive. Norms, or normative judgements, refer to the ranking of the population along pre-defined and measurable axes, with those falling outside of the so-called normal distribution being subject to censure. This is a powerful method of ensuring that people manage themselves and "produce" themselves in ways sanctioned by the prevailing power structures.

With regards to power relations, Foucault discussed apparatuses of security, or what I prefer to call **power apparatuses.** These refer to the broad networks that structure relationships between subjects, objects, and institutions. While bio-power and norms can be understood as the micro-technologies, or techniques, through which power exhorts subjects to manage themselves in line with its aims, apparatuses are the broad and loose assemblages, the macro-networks that extend state power to regulate the population. I identified three power apparatuses that were strongly at work in my data: pastoral power, coloniality, and patriarchy. These concepts are discussed further in section 5 of chapter 4.

A key theoretical concept within the field of social constructionism is **discourse**. The term "discourse" broadly has to do with language use, or representations of meaning, but it is used in a variety of ways. It may be used to refer to the interactional elements of language in use, or to the way that sentences link together to convey specific meanings (Potter, 2004). These uses draw from the field of linguistics. Coming out of the work of Foucault, a much broader focus was conceptualised, with "discourse" being understood as a set of statements, or a system of meanings, which constitute objects and subjects (Parker, 1992; Potter, 2004). This Foucauldian understanding of discourse is the one that I employ in this thesis. It acknowledges that discourses arise and

circulate within specific socio-historical contexts, so while there is coherence and regularity to discourses, there is also variability and instability, leading to mutations over time and across contexts (Macleod, 2011). A crucial aspect of discourses is that they reproduce power relations (Parker, 1992) and truth. Truth is contingent upon the dominant discourses of the moment, meaning that there is no universal or absolute truths or ethical positions in social and psychological spheres (Wetherell, 2001). Expressions of discourses are realised wherever meaning is reproduced; we can never find a complete and full expression of a particular discourse in a particular text of meaning (Parker, 1992), but instead any text is made up of multiple pieces of different discourses. Foucault's theorising on the concepts of discourse and discursive practices is discussed further in Chapter 4.

A central analytical tool that is used in discursive studies, and which I employ in this study, is the concept of **subject positions.** Parker (1992) stated that "(a) discourse makes available a space for particular types of self to step in." (p. 9). It is this discursive space that is now generally termed a subject position. Subject positions locate a person within the structure of concepts, rights and story lines made relevant by the particular constituting discursive practices (Davies & Harré, 1990). Given that a multiplicity of discourses is in operation at any particular time and place, there is a range of available subject positions into which a person may be placed, or which a person may take up. Mouffe (1992) stated that "the social agent [is] constituted by an ensemble of 'subject positions' ..., constructed by a diversity of discourses". (p. 372). Given this diversity of discourses, the subject has some agency to take up a particular position and refuse another. However, that agency is constrained by which subject positions are available. I discuss this notion of subject positions in more depth in Chapter 4. I extend my understanding of the subject with a look at some post-Foucauldian theories in the latter part of Chapter 4, examining the question of human agency and resistance in a manner that is compatible with Foucault's ideas. From this I posit, in line with Guilfoyle (2014), that the subject is both constituted by prevailing power structures, but is also ethical, in that it does have some freedom to agentively resist some subject positions and take up others.

Given this understanding of discourse and subject positions, then it follows that a woman who drinks alcohol during pregnancy is likely to continue to do so if she remains within positions that promote drinking. If a reduction in FASD is the aim, then positions that enable abstinence or a reduction in drinking need to be brought to prominence in people's lives. These positions need to be "thickened", both in dialogue with others, and experientially. This is necessary for drinking positions that dominate a person's life to be displaced. An analysis of the subject positions within my data was, therefore, important as it showed how the Organisation positioned drinking pregnant women and

how women positioned themselves within mentoring sessions. From this information, and drawing from the literature, I was able to infer which positions were helpful or unhelpful in reducing drinking, and draw out recommendations on how the Organisation could promote discourses and subject positions that may assist women in reducing their alcohol consumption. My recommendations were guided values informed by an ethics of care and justice.

9.1. Methodological dilemma

Given my desire to foreground broad issues of justice, as well as particular issues of care, for drinking pregnant women, I needed to find analytical tools that would reveal these notions (or the lack thereof) in the data, within the ambit of a positioning analysis. Methodologically, there are disparate ways of analysing subject positions, arising from different theoretical views of the topic. Stemming from the theories of Foucault, a Foucauldian Discourse Analysis (FDA) looks at the broad power dynamics and power relations that are encoded discursively, and which construct objects and open up positions for subjects to inhabit. This can be understood as an analysis of the "top-down" construction of subject positions, where the subject is viewed somewhat passively, as made and remade by prevailing discourses. Conversation Analysis (CA), on the other hand, arose from the field of linguistics which analyses, amongst other things, the universal structures that govern speech and language use. CA analyses how language interaction is used agentively by speakers during in-the-moment engagements. It is a fine grained, close-up look at the underlying, instinctive rules that govern conversations, and how speakers use these verbal and non-verbal rules fluidly to achieve certain interactional and social ends, such as agreement, refusal, and social alignment. Using CA, an analyst can assess how a person uses their freedom to agentively present, take up, refuse, or modify subject positions within the interactional milieu of the conversation (Kitzinger, 2000). CA also gives insight into a speaker's emotional tone, as it pays close attention to pauses, changes of voice pitch and volume, sighs, and other non-verbal elements in a conversation. CA is sometimes termed a "bottom-up" approach to analysing subject positions, with the subject viewed as active and agentic in positioning themselves and others. Both FDA and CA are discussed further in Chapter 5.

Other ways of analysing subject positions are through hybrid methodologies known as discursive psychological analyses (Wetherell, 1998), or narrative discursive analyses (Taylor & Littleton, 2006). These methodologies incorporate an analysis of both the top-down positioning of subjects by prevailing discourses as well as the bottom-up positioning in which subjects engage agentively to position themselves and others, utilising the positions made available by the prevailing discourses. Here, the insights from a broad, critical discursive analytical method and a more fine-grained, non-critical, interactional analytical method are combined, with the one read in terms of the other

(Wetherell, 1998). Discursive psychological analyses look at what people do with the discursive resources at their disposal (Willig, 2013). These are useful analytical methods and have been used widely, for example, by Morison and Macleod (2013); Taylor and Littleton (2006); and Wetherell (1998). However, a synthesis of methods necessarily loses some of the depth that a purer method provides, and I chose to engage in two separate analyses, using first FDA and then a simplified CA, for the reasons cited below.

Given the ethics of justice and care that I wished to incorporate, it was necessary to do an in-depth analysis of the power apparatuses (such as patriarchy, colonialism, and pastoral power, which are discussed in Chapter 4) that were operating in my data. This was to understand how injustices may be unwittingly perpetuated by the Organisation, which discourses promoted or detracted from care, and which power apparatuses and discursive practices needed to shift. For this, I needed the emphasis on power relations provided by Foucauldian theorising. Furthermore, some of my data were not interactive (namely, the training materials and some training sessions) so did not lend themselves to analyses that look at interaction, such as hybrid or bottom-up methods. Therefore, FDA fitted my aims for part of the analysis. However, I also wanted to understand how pregnant women who were being mentored responded agentively to the top-down imposition of the discursive practices and subject positions by the Organisation, what they did with these imposed positions, and what emotions may have been aroused by these subject positions. Therefore, I used a simplified CA to illuminate the fluid and in-the-moment uptake, resistance to, or modification of available subject positions within the mentoring sessions. I also used CA to shine a light on some of the emotional content of the mentoring sessions through looking at emotional markers like sighs, pauses, and changes in pitch and volume of voice. Using this tool enabled me to show how interactional care was being provided, or not, and how reproductive justice was being promoted, or not, within mentoring sessions. This provided insight into women's responses to the Organisation's intervention, and how the intervention may be enhanced to promote care and reproductive justice for drinking pregnant women.

Procedurally, I first used FDA to indicate how varying power apparatuses worked through the Organisation to construct subject positions for the Organisation, their personnel, pregnant women and their clients, and then I used a simplified CA to analyse how participants in the mentoring sessions engaged with these subject positions in an agentic way. In this manner, I was able to show how drinking pregnant and newly parenting women were both discursively constituted and discursively agentic. From these insights, I was then able to provide recommendations on how discursive practices and interactions provided by the Organisation could be modified or changed to

provide justice and care, and to enhance women's agency to reduce drinking. The research questions that I formulated to animate this study are as follows:

9.2. Research questions

The overarching question was: **What power apparatuses and technologies were used to discursely position pregnant women during the intervention, and how may these positionings be altered or expanded to promote an ethics of care and justice?** Specific questions were as follows:

1. What discursive subject positions were evident during a FASD prevention intervention?
2. What power apparatuses and technologies innervated the construction of these positions?
3. What power relations were evident in the conversational practices used in the mentoring sessions of the intervention, and what positions did this lead to?
4. How may these positions and conversational practices be altered or expanded to promote an ethics of care and justice for pregnant and newly parenting women?

10. Analytical findings and recommendations

I provide three analytical chapters to discuss the positionings of pregnant and newly parenting women by the Organisation. The first, Chapter 6, shows how women were positioned either as ignorant children in need of the Westernised knowledge that the Organisation provided, or as sinners who needed redemption from their reprobate lifestyle. Apparatuses of coloniality and pastoral power were used in these constructions. In Chapter 7, I discuss how foetuses were constructed as "precious babies" and women as invisible "mommies" who need to need to sacrifice all for the sake of their foetuses and babies. There was also a construction of the person with FASD, and women who continued to drink during pregnancy, despite knowing better, as the "defiled Others" who threaten the wellbeing of society. These constructions were innervated by apparatuses of patriarchy and coloniality. In my final analytical chapter, Chapter 8, I highlight the few times when women were positioned within an ethics of care or reproductive justice.

Drawing together these findings and insights from the literature, I provide recommendations, in my concluding chapter, on ways in which FASD may be tackled. I argue that FASD prevention needs to be addressed along with other alcohol related harms at all social ecological levels (macro, meso, and micro) in an integrated manner, and I provide suggestions for countrywide policies and interventions, as well as specific FASD interventions. At all times, I situate these suggestions within an ethics of care and justice, where pre-pregnant, pregnant and newly parenting women are positioned in manners that provide care and enhance their reproductive freedoms. I suggest in my

conclusion that a feminist decolonial approach may usefully be drawn on in order to deliberately undermine the colonialities of power, knowledge and being that have contributed to alcohol related harms in South Africa.

Chapter 2: Quantitative studies - do interventions to reduce alcohol exposed pregnancies 'work'?

1. Introduction

Increasing political and civic awareness of FASD over the past two decades has led to different forms of interventions aimed at reducing alcohol exposed pregnancies (AEPs). As noted in the previous chapter, these may be divided into clinical approaches, which target individuals, and universal approaches (also known as population-level or public health approaches), which focus on prevention at a community-wide level and generally aim to increase knowledge of the teratogenic effects of alcohol, and to shift drinking norms (Chersich et al., 2012; Crawford-Williams, Fielder, et al., 2015). Quantitative studies are necessary to evaluate whether such interventions achieve their aim in reducing AEPs, and I review some such studies in this chapter. While such evaluation evidence is not yet strong enough to identify prevention and intervention best practices with certainty (Pei et al., 2017), there are indicators which point to some of the intervention strategies that are necessary for success.

The kinds of messages that universal interventions deliver and the manners in which they are communicated need to be guided by research into how to enhance the persuasiveness of their messages, and I examine this research in some depth. The studies of clinical interventions that I review also suggest that brief clinical interventions with episodic and non-dependent drinking pregnant women can reduce their drinking, while heavier and dependent drinkers require more intensive clinical help. Some interventions with non-pregnant drinking women who did not use contraception reliably showed increases in contraceptive use, and small but significant decreases in alcohol consumption. It is important to note that the personnel who delivered the interventions that were studied appeared to be well trained and educated.

In this chapter I review quantitative studies of interventions aiming to reduce AEPs. The interventions that I review were quite varied in their approach, so I provide descriptions of them before presenting the study results.

2. Universal interventions

Surprisingly few studies that evaluate the effectiveness of universal interventions targeting alcohol use in pregnant women have been published. Systematic reviews of such studies have found that they lack methodological rigour, so conclusions about their effectiveness are tentative. Nevertheless, they indicate that well designed and well implemented universal interventions can increase knowledge about the effects of pre-natal drinking, and lead to small reductions in alcohol consumption by pregnant women.

Crawford-Williams et al. (2015) engaged in a critical review of such studies and were able to identify only seven research articles which met their inclusion criteria and reported on studies conducted between 1994 and 2014 (five from the USA, one from Canada and one from South Africa). The authors' inclusion criteria were: that the sample population needed to be women between the ages of 18 – 45 who were not health professionals and did not have alcohol use disorders; that a clearly defined universal/public health intervention was used; that outcome measures included levels of knowledge about drinking in pregnancy or maternal alcohol consumption; that the report be written in English; and that the intervention was not a clinical one.

The interventions that were selected by Crawford-Williams et al. (2015) focussed on increasing knowledge of the effects of alcohol on the foetus through multi-media educational campaigns. Improvements in knowledge were demonstrated in six studies, and the four studies which reported alcohol consumption during pregnancy (including the South African one, conducted by Chersich et al. (2012)) were able to demonstrate a non-significant reduction post-intervention. However, the authors pointed out that in three of these four studies, the targeted women were generally not drinking at high risk levels pre-intervention, and so the impact of the interventions in reducing harm is uncertain. The authors also cautioned that none of the reported studies were highly rigorous and all had risks of bias. Alcohol consumption was measured via self-report measures, and there is a strong risk of social-desirability bias post-intervention, when women are more aware of the harms of maternal drinking (Chersich et al., 2012). Crawford-Williams et al. (2015) concluded that there is insufficient evidence at this stage regarding the effectiveness of public health interventions which aim to reduce drinking amongst pregnant women.

Likewise, Jacobsen et al. (2022), in their systematic review of prevention programmes which were peer reviewed, conducted in Western countries, and published between 2010 and 2020, found only four studies of universal programmes that targeted women who were not health professionals. The studies assessed the odds of prenatal alcohol consumption and/or knowledge of FASD. All studies

showed a significant improvement in the outcomes measured, but again, none of the studies were highly rigorous.

Nevertheless, Chersich et al.'s (2012) South African study (which was one of the studies reviewed by Crawford-Williams et al. (2015)) did provide some promising results. As well as assessing maternal knowledge and self reported drinking behaviour pre- and post-intervention, this study also examined FASD prevalence before and after the intervention. It was conducted in two towns with predominantly mixed-race populations with low SES in the Northern Cape. Both towns had amongst the highest ever reported rates of FASD (Chersich et al., 2012). Cohorts of infants born within a one-year period were identified both pre- and post-intervention. Anthropometric assessments (weight, length and head circumference measures), facial dysmorphology assessments, and neurodevelopmental assessments were conducted on the infants at the age of nine and 18 months, and a structured questionnaire and Beck's Depression Inventory was administered to their mothers. The intervention consisted of the distribution of different forms of media (pamphlets, posters, newspaper articles, radio advertisements, and drama productions) highlighting FASD to the community, as well as talks by community health workers at health and community facilities, and training on FASD for health providers and social workers. Women identified as high risk were referred to existing clinical interventions.

As well as finding substantial increases in maternal knowledge of alcohol harms and self-reported drops in the amount of drinking by mothers of FAS/PFAS children post intervention (statistically significant for PFAS mothers but not significant for FAS mothers), Chersich et al. (2012) also found a significant drop in PFAS prevalence (from 4.9% to 2.4%; $P = 0.008$). There was no significant reduction in FAS prevalence. These results suggest that universal intervention programmes may assist with decreasing maternal drinking, particularly occasional episodic drinking, and the concomitant prevalence of PFAS. However, they also indicated that such interventions are less successful with women with entrenched heavy drinking patterns and/or depression, who require more individualised (clinical) interventions (Chersich et al., 2012).

Another study included in Crawford-Williams et al.'s (2015) review was conducted by Evans et al. (2012). They conducted a randomised control trial to evaluate a text messaging campaign, *Text4baby,* targeting low-income pregnant women in Virginia, USA. The aim of this campaign was to increase women's self-efficacy for healthy behaviours, such as attending antenatal clinics, eating healthily, taking vitamin and folic acid supplements, and avoiding smoking and alcohol. On follow up, they found that women in the intervention arm were almost three times more likely to agree with the statement "I am prepared to be a new mother". They also found that women in the

intervention arm who were High School graduates were significantly more likely to agree that drinking alcohol will harm a foetus, than those with lesser education. This suggests that better educated women may have been more able to process the messages in the campaign. In terms of reducing drinking, more women in the intervention arm who drank at baseline had ceased drinking at follow-up, compared to women in the control group. However, the difference was not significant, and the numbers of women who reported drinking at baseline were low.

An formative evaluation of an innovative study by Driscoll et al. (2018) (which was one of the studies reviewed by Jacobsen et al. (2022)) involved placing a prevention message in women's restrooms at alcohol serving establishments in Alaska, USA, and the Yukon Territory, a Canadian territory which borders Alaska. These areas have higher-than-average rates of FASD compared to other areas of North America. Eight intervention communities with 14 intervention sites were chosen. Four intervention communities with eight sites had a FASD prevention message attached to a pregnancy test dispenser, while the other four intervention communities, with six sites, had the same prevention message displayed on a poster. The test dispenser sites were matched with the poster sites, and condom dispensers were made available in all the sites. The message was developed by an expert advisory panel and piloted with women of childbearing age who consumed alcohol. Assessment was via a self-report survey, completed either via text messaging or online, at baseline and six months later. Results indicated that the dispenser group had better knowledge and beliefs about FASD than the poster group, both at baseline and at follow-up, and the authors suggested that the message on the dispenser had greater immediate impact than the poster alone. Fewer pregnant participants reported drinking within the past 30 days at follow up (10%) than at baseline (17%), and 43 women (out of 2132 participants at baseline) reported learning that they were pregnant from the pregnancy tests made available.

While this study lacked a control site, the results are encouraging, not least because the intervention enabled 43 women to learn of their pregnancy earlier than they would otherwise have, which would hopefully have led to earlier reduction or cessation of drinking. Providing accessible pregnancy tests is an important intervention in itself (Driscoll et al., 2018). Another strength of the study was that the health message was designed by an expert panel and piloted with women of childbearing age who drank.

Given that universal interventions have the potential to reach wide numbers of people, and are relatively cost effective, there is an urgent need for more rigorous research into the efficacy of such programmes. Whilst there is a paucity of such efficacy studies, there have been a significant number of studies that examine the persuasiveness of public health messages under experimental

conditions. The insights gleaned from such studies need to be harnessed when designing messages to lessen the prevalence of FASD. Some of these studies are reviewed below.

2.1. Components that enhance the persuasiveness of public health messages

It is well established that public health messages that have strong fear appeals, or threat-based messages, produce higher levels of perceived severity and susceptibility to harm than messages with weak fear appeals (Witte & Allen, 2000). Perceived threat involves the degree to which a person feels at risk of the threat, and the magnitude of harm that is expected from the threat (Witte & Allen, 2000). For example, a FASD prevention message that states that alcohol consumption during pregnancy can lead to irreparable brain damage to the foetus is likely to have a strong fear appeal to pregnant women who drink. Furthermore, such threat-based messages can be effective in motivating behaviour change (France et al., 2014; Witte & Allen, 2000). However, there is also a risk that fear appeals trigger defensive avoidance of the messages and of the promoted behaviour, and can lead to the perception that such messages are sensationalising or over-stating the consequences (France et al., 2014; Witte & Allen, 2000).

Witte and Allen's (2000) meta-analysis of literature on fear appeals found that as defensive resistance to a recommendation increases, so appropriate behavioural changes decrease. However, resistance can be reduced by introducing an efficacy-promoting appeal, which is one that promotes the belief in the audience that they are able to perform the recommended response (like avoiding alcohol), and that the recommended response will work to avoid the threat. Witte and Allen (2000) found that messages that combine strong fear appeals with efficacy-promoting appeals lead to the greatest intention to change behaviour positively, while the greatest levels of defensive responses arise to strong fear appeals with low-efficacy messages. In order to increase perceptions of efficacy, Witte and Allen (2000) recommended that common barriers to the audience's perceived ability to engage in the recommended behaviour be identified and directly addressed in the message. For example, in FASD prevention messages, a perceived inability to abstain from alcohol may be due to a belief that abstainers will be socially isolated. Hence, community support for abstention before and during pregnancy needs to be encouraged, and ways of socialising without alcohol could be promoted.

In a similar vein, Cismaru et al. (2010) claimed that public health messages should incorporate a number of factors as well as threat variables. They described Protection Motivation Theory (PMT), which is commonly used as a theoretical framework to examine the persuasiveness of public health

communication. Protection Motivation Theory posits that motivation to protect oneself from the harms associated with a particular behaviour is maximised when:

> (a) the threat to health is perceived as being severe; (b) the individual feels vulnerable to the threat; (c) the adaptive response is believed to be an effective means of averting the threat (high response efficacy); (d) the costs associated with the adaptive response are small; and (e) the person is confident in her abilities to successfully complete the adaptive response (high self-efficacy)... Among the factors that play a role in behaviour change according to PMT, self-efficacy is believed to have the most significant impact. (Cismaru et al., 2010, p. 71)

Cismaru et al. (2010) conducted a qualitative content analysis of the communication materials of 20 different social marketing (universal) FASD prevention campaigns from Western countries that targeted pregnant women or women planning to become pregnant. While most of the campaigns focused on threat variables, that is, the severity of the harms caused by alcohol, and the vulnerability of foetuses to the harms, fewer focussed on other Protection Motivation Theory variables. Cismaru et al. (2010) asserted that campaigns would be enhanced if they also aimed to boost the self-efficacy of women to refuse alcohol, and the low costs of doing so (for example, by offering advice as to how to avoid alcohol, and indicating that abstaining from alcohol does not lead to social exclusion). They also recommended that social marketing programmes should be created to promote an alcohol-free environment for pregnant women.

France et al. (2014) assessed the responses of women of childbearing age who drank alcohol, and pregnant women, to four variations of an advertising message. The first focussed on enhancing a woman's self-efficacy to abstain from alcohol when pregnant, and encouraging social support for this behaviour: a scene showed a newly pregnant woman choosing a non-alcoholic drink at a party, and, when challenged by her host, her friend stated that they were on a health kick, and she also asked for a non-alcoholic drink. The second variation was threat based, and showed an obstetrician stating "We just don't know how much alcohol it takes to do damage. It is different for different women and different babies. No amount has been proven safe. That is why I say no alcohol is the safest choice." (France et al., 2014, p. 4). The third variation showed both the self-efficacy and the threat components. The fourth variation was the control, using a similar scene as the self-efficacy one, but the focus was on reducing alcohol consumption for general health benefits.

All three experimental variations led to a significant increase in women's intentions to abstain from alcoholic beverages during a pregnancy, compared to the control condition. Positive emotional responses of relief and happiness were generated by the self-efficacy messages. However, threat-based messages led to greater intention and confidence to modify drinking behaviour. France et al. (2014) stated that "provided the promoted response is under volitional control, the negative motivation of avoiding the threat is a powerful instigator of behaviour change." (p. 10). These authors did not address the question of how women respond when they feel that the promoted response (alcohol abstinence) is not under their volitional control, for example, women who are addicted to alcohol, or who feel that they cannot socialise without alcohol.

In order to reduce the risks of defensive reactions and message rejection, France et al. (2014) recommended that messages about the risks of alcohol consumption should be honest and factual, delivered in a supportive manner, and should acknowledge the current medical uncertainty regarding the risk of low to moderate alcohol consumption. In line with the findings of Witte and Allen (2000), they further recommended that threat and self-efficacy messages be combined as this provides the greatest persuasive potential whilst reducing the possibility of arousing negative emotions and message rejection. Self-efficacy messages could focus on giving practical advice on how to reduce/abstain from alcohol, and could also give personal narratives of others who have succeeded in abstaining (France et al., 2014; Smith & Bonfiglioli, 2015). Such messages arouse positive emotional responses (France et al., 2014), which are important when aiming for behaviour change. It is also important that media campaigns be formatively developed in conjunction with members from the target community, and that they incorporate local languages and images in order to ensure that they are culturally appropriate for the target community (Hanson et al., 2012).

A limitation of the study by France et al. (2014) was that participants were generally educated and middle class, and the advertisements were designed to reach those who drink but not excessively. A further limitation of both France et al.'s study and of Witte and Allen's (2000) meta-analysis is that the studies were conducted under controlled conditions, where participants were forced to process the experimental messages. In natural settings, where people can simply avoid public health messages, results may be different. Furthermore, Kaskutas (2000) found that lower proportions of women who drank at risky levels during their pregnancies (compared to those who drank at non-risky levels) reported that alcohol health warnings influenced their decisions about drinking. Additionally, pregnant drinkers were more likely to ignore warning messages than pregnant abstainers. This supports the recommendation of Chersich et al. (2012) that women with more entrenched drinking habits require clinical interventions.

3. Clinical interventions

Clinical interventions may target drinking women who are either pregnant or non-pregnant. Non-pregnant women who drink at risky levels and are ineffective contraception users are considered to be at risk of an alcohol exposed pregnancy (AEP), and interventions have, thus, also been implemented with this target group. The harm reduction approach, using motivational interviewing techniques, is currently viewed as the best approach to use with substance using clients, and I discuss this approach in the next sub-section. Thereafter, I review clinical interventions, first looking at those that target pregnant alcohol consuming women, and then at non-pregnant women who are at risk of an alcohol exposed pregnancy (AEP). Finally, I look at the training levels of personnel who deliver such interventions, as this is an important factor in the success of an intervention but is largely overlooked in the literature.

3.1. The 'gold standard' of clinical approaches with clients with substance use difficulties: a harm reduction approach, using Motivational Interviewing

Whilst traditional approaches to intervening in high-risk activities have been to advocate complete abstinence from the activity, more recent approaches have tended to focus on harm reduction. The key tenets of harm reduction models are as follows (Gaume et al., 2014; Logan & Marlatt, 2010; Marlatt & Witkiewitz, 2010):

- Any step in the right direction is supported. Abstinence is not insisted upon, although that may be the ultimate goal.
- The harmful behaviour is neither ignored nor condemned. A non-judgemental attitude is crucial.
- The intervention is individualised according to the needs of the client and their community.
- It aims to meet individuals and communities "where they are at".
- It relies heavily on motivational interviewing (MI), which is a counselling model that includes the following elements:
  - Exploration of, and empathy for current realities;
  - Surfacing the *client's* ultimate goals regarding substance use, and respecting decisions both for and against change;
  - Looking at the discrepancy between what the client wants and where they are currently;
  - Accepting resistance to change;
  - Collaboratively setting achievable, stepwise goals;

- Building self-efficacy – identifying and building on client's strengths, and enhancing their confidence to change;
- Identifying supportive people/structures within the client's community, and discussing ways of accessing that support;
- Identifying alternative behaviours to the substance use;
- Practicing refusal skills;
- Making contingency plans for when relapse occurs.

A harm reduction approach enables users to achieve success in modifying some of their behaviours, which raises self-efficacy for future change. Ultimately, this can lead users to abstinence (Marlatt & Witkiewitz, 2010). It has a strong commitment to an amoral approach to substance use, which may be "a powerful rhetorical intervention in the highly moralised landscape" of substance use (Keane, 2003, p. 227). Harm reduction approaches may incorporate normative education on populations' usage of the substance in question (Marlatt & Witkiewitz, 2010), as it has been shown that heavy drinkers generally over-estimate the amount that their peers drink, and assume that their own usage is within the norm (Neighbors et al., 2016). Education about the normative usage of peers can influence heavy drinkers to reduce their drinking in line with these norms (Neighbors et al., 2016). Whilst the normative alcohol use may be at risky levels within some pregnant women's contexts, it may be valuable to provide the norms of drinking in the wider population.

It has been shown that the provision of information alone, particularly with young people, is not generally sufficient to lead to behavioural change (Logan & Marlatt, 2010; Stockings et al., 2016), and those interventions that incorporate skills training are more likely to be effective (Stockings et al., 2016). Skills training can include training in social skills, resistance and coping skills, stress reduction, and collaborative identification of less risky drinking habits (Marlatt & Witkiewitz, 2010). Skills training strengthens the clients' own resources to assist them with modifying their behaviour.

As yet, there have been no identified iatrogenic effects from harm reduction interventions (i.e., they don't lead to increased use or more harmful use), whilst some abstinence based interventions have been shown to have negative effects (Logan & Marlatt, 2010; Marlatt & Witkiewitz, 2010). Whilst harm reduction approaches have not yet been found to reduce long-term prevalence of substance use, a number of interventions based on harm reduction principles have demonstrated significant short term reductions in harmful use (Logan & Marlatt, 2010). Additionally, harm reduction , approaches are able to recruit more substance abusers, and demonstrate less client attrition, than abstinence-based programmes (Logan & Marlatt, 2010).

It is important during any intervention to try and ensure that shame or guilt is not induced in the target population, as these feelings promote defensive reactions, and may lead to increases of substance use to cope with feelings of shame (Du Plessis et al., 2017). Hence, the deliberately amoral stance of harm reduction (Keane, 2003) and the emphasis in motivational interviewing on empathy, rolling with client resistance, and supporting self-efficacy is crucial.

3.2. Clinical interventions with pregnant alcohol consuming women

Gilinsky et al. (2011) conducted a systematic literature review of studies of clinical interventions with pregnant women in Western countries which aimed to reduce alcohol consumption. They included both randomised controlled trials (RCTs) and non-RCTs, and they identified eight published studies (five from the USA, two from the UK, and one from Norway) that assessed short- and long-term alcohol consumption during pregnancy. Most interventions were delivered by the study investigator or by trained health professionals. There was some evidence of a reduction in drinking arising from single session face-to-face interventions, and partner participation improved results. There were also suggestions that multi-session brief interventions and motivational interviewing reduced alcohol consumption for those women who continued to drink in the early stages of their pregnancies. However, lack of methodological rigour in the reviewed studies limits the generalisability of these findings.

One of the studies reviewed by Gilinsky et al. (2011) was conducted by O'Connor and Whaley (2007) in the USA. They conducted a study of the effects of brief monthly interventions by antenatal nutritionists with women who were identified as non-dependant drinkers in their first trimester of pregnancy. A control group consisted of standard nutritional advice and assessment of drinking patterns. Results indicated that women in the treatment arm of the study were five times more likely to report that they were abstaining from alcohol by their third trimester than women in the control arm ($p < 0.04$; OR = 5.9). These results were via self report, which has risk of bias. However, the birth weight and length of infants born to women who had been consuming three or more drinks per drinking occasion at the start of the study were also significantly greater for women in the treatment arm than in the control arm. This is a more robust indicator of significance for brief interventions.

In South Africa, Marais et al. (2011) conducted a cluster randomised trial of the effect of brief interventions with pregnant women in a high-risk rural district of the Western Cape. The brief interventions were delivered by trained field workers (educational levels and extent of training was not provided) and consisted of four individual counselling sessions of approximately 20 minutes, focusing on setting goals to reduce/eliminate drinking and reinforcement of behaviour change. The

control condition consisted of an alcohol use assessment plus information. Declines in drinking behaviour were reported via self-report questionnaires for both the control and intervention groups, but the intervention group reported significantly greater reductions.

De Vries et al. (2016) and May, Marais, et al. (2013) described a South African Case Management approach for pregnant women who drink at risky levels. Case Management (CM) incorporates motivational interviewing techniques, education about foetal growth and development, general life management and coaching, and a community reinforcement approach, which helps family members and friends reinforce healthier choices by the woman with the goal of making sobriety more rewarding for the woman. The aim of Case Management (CM) is to help women access both their own inner strengths and also external resources in order to reduce drinking (de Vries et al., 2016; May, Marais, et al., 2013). De Vries et al. (2016) conducted a prospective study of CM, looking at change over time. They enrolled a total of 67 high risk pregnant women from a rural area of the Western Cape, and 51 women (76%) completed their 18-month course. Most women began the programme in their second trimester of pregnancy, due to generally late pregnancy recognition in this population. The CM model involved monthly or twice monthly visits and monthly or twice monthly phone calls by social workers or nurses (case managers) who had been specifically trained, and who received professional mentoring throughout their time of engaging with the pregnant/newly parenting women. The women could also contact their case manager when in need of support. Assessment at baseline and six, 12 and 18 months after initiation of CM was via interview by the case manager. Measures included rates of alcohol consumption, measured by the self-report Alcohol Use Disorders Identification Test (AUDIT) and a seven-day recall of alcohol consumption, and also levels of well-being/contentment, assessed via the adult Happiness Scale. Unfortunately, the use of the women's case manager to collect data would have resulted in significant risk of social desirability bias in the women's reporting of their alcohol consumption, due to their relationship with their case manager.

While pregnancy recognition in itself led to a self-reported reduction in drinking (from a mean of 16.9 drinks per weekend to 8.6 drinks per weekend), enrolment in CM correlated with further reductions in drinking for the remainder of the pregnancy (from a mean of 4.1 drinks per weekend at baseline, to 3.3. drinks per weekend six months after CM initiation). However, after giving birth, alcohol consumption rose again to a mean of seven drinks per weekend at 18 months (de Vries et al., 2016). AUDIT scores, which give a more comprehensive indicator of problematic drinking, decreased significantly from baseline to six months into CM, and while they did rise again after giving birth, they remained significantly lower than at baseline. This suggests that enrolment in CM may have led

to a reduction in problematic drinking (de Vries et al., 2016), although methodological weaknesses in this study limit the robustness of these findings.

Happiness levels were significantly inversely correlated with weekend drinking, with women with the lowest levels of happiness drinking the most at baseline and all follow-up points (de Vries et al., 2016). Overall, results indicated that women's happiness scores increased significantly from baseline to six and twelve months after CM initiation, returning to near baseline levels at the termination of CM at 18 months. Those with the lowest levels of happiness at baseline increased their happiness scores the most, and whilst there was some drop-off in their scores at 18 months, their scores at termination were significantly higher than at baseline (de Vries et al., 2016). Hence, CM appeared to be of greatest benefit to those who were the most unhappy, which would likely have led to a positive reduction of drinking.

Overall, these reviewed studies indicate that brief interventions consisting of one to four sessions of MI and psycho-education, delivered by well trained personnel, may assist alcohol consuming pregnant women to reduce or eliminate drinking, and more intensive Case Management interventions by trained nurses or social workers appear to be effective, to some degree, with pregnant women who drink at risky levels. However, the effectiveness of such strategies with pregnant women is hampered by the fact that the foetus is most vulnerable to alcohol in the earliest stages of pregnancy, prior to pregnancy recognition (Popova et al., 2017). Furthermore, pregnancy recognition tends to occur very late (often only in the second trimester) for South African women in impoverished settings, where the majority of pregnancies are unplanned (de Vries et al., 2016). Authors have therefore been calling for interventions to reduce AEPs to begin pre-conceptually (Floyd et al., 2008; Hanson et al., 2013; Ingersoll et al., 2013).

3.3. Clinical interventions with non-pregnant women who drink at risky levels

Whilst the majority of drinking women reduce or cease their drinking when planning on becoming pregnant or on pregnancy recognition, the large number of unplanned pregnancies means that such pregnancies are often not recognised for a substantial period of time after conception, resulting in an AEP in women who drink (Ingersoll et al., 2013). Some interventions that focus on helping women who drink and are of child bearing age to prevent unintended pregnancies and/or reduce drinking have therefore been implemented in the United States (Floyd et al., 2007; Hanson et al., 2013, 2017; Ingersoll et al., 2013, 2018) and South Africa (Rendall-Mkosi et al., 2013).

One such intervention was called project CHOICES (Changing High-risk alcOhol use and Increasing Contraception Effectiveness Study) (Hanson et al., 2013). This intervention provided a contraceptive session, up to four individual MI sessions to increase participants' commitments to reduce drinking and/or consistently use contraception, informational pamphlets, and personalised feedback regarding a woman's risk of an AEP compared to other women of childbearing age (Floyd et al., 2007).

Floyd et al. (2007) reported on a two-group parallel randomised controlled trial of project CHOICES with 830 participants. The study targeted women with the following characteristics: sexually active with men; non-pregnant; aged 18-44; no confirmed infertility; no plans to become pregnant within the following nine months; ineffective contraception use; and engagement in risky drinking (defined as five or more standard drinks in a day, or eight or more drinks in a week). Recruitment was from jails, drug and alcohol treatment centres, primary care practices, a gynaecology clinic, a private healthcare organisation, and a media-recruited sample. All participants had a baseline interview. The intervention arm provided the following to participants: informational pamphlets; four MI counselling sessions of 45-60 minutes, delivered by trained counsellors with at least a master's level qualification; one contraception session, delivered by a healthcare provider; and personalised feedback regarding the participant's risk of an AEP compared to other women of childbearing age. Participants were asked to record daily drinking behaviour, sexual activity and contraception use (Floyd et al., 2007). The control group received information pamphlets and a referral guide to local resources. The intervention was delivered over 14 weeks, and participants were followed up at three, six- and nine-months post intervention. At all follow-up periods, the intervention provided an approximately twofold greater reduction in risk for an AEP than the control condition, according to self-report measures. Nevertheless, there were also significant risk reductions in the control group, which suggests that merely being interviewed, followed up at three month intervals, and recording daily drinking behaviour, assisted women to reduce drinking and/or improve their contraception use (Floyd et al., 2007).

The CHOICES intervention is relatively resource intensive, which reduces the scale at which it can be implemented. Ingersoll et al. (2013), therefore, analysed a similar intervention (called EARLY) which provided only one MI session to women at risk of an AEP, and referred the participants to clinics for contraceptive access. The counsellors all had at least master's level education. They also included two other arms in their study: a group receiving information from a counsellor on FASD, plus information pamphlets on contraception and a list of community women's health resources; and a group that, in addition to receiving the above information, also watched three informational videos

(totalling 45 minutes viewing time) and had a 5-minute conversation with a counsellor about the videos. These control arms were used to provide (1) equivalent time and attention to participants via the video control condition as in the intervention condition, and (2) to enable analysis of potential assessment reactivity plus minimal information via the informational pamphlet condition. Results were gathered via self-report measures.

All three arms reduced the participants' drinks per drinking day (small effect size), ineffective contraception (small to medium effect size), and AEP risk across time. A slight advantage accrued to the counselling (MI) arm in that it showed improved contraceptive use and therefore reduced AEP risk, but not a decrease in drinks per drinking day, compared to the other two arms. Ingersoll et al. (2013) compared their data to that obtained in the study on the CHOICES intervention (described above, by Floyd et al. (2007)) and also to a one session MI intervention with college women at risk of an AEP, called BALANCE, which achieved reduced risk for AEPs. The risk reductions in the EARLY intervention were smaller in magnitude than in these other two interventions. EARLY did not outperform the control groups for reducing drinking or overall AEP, unlike the other two interventions. Although BALANCE was also a one-session intervention, like EARLY, its target group of college women were less likely to have other psychosocial risk factors for AEP (such as older age, other substance use, mental illness, or recent physical abuse) than general community women. The authors stated that "It is possible that the brief EARLY intervention with community women was not powerful enough to influence both behaviours that compose AEP risk among community women, beyond the risk reduction achieved by the consciousness raising impact of assessment that all participants received regardless of condition assignment." (Ingersoll et al., 2013, p. 414)

Based on these results, Ingersoll et al. (2013) suggested that there is a role for one-session interventions where more intensive ones are not feasible. They also pointed out that the awareness-raising that accrues through detailed assessment and information alone can have a significant effect on the behaviour of many women at risk of an AEP. However, where possible, a multi-session intervention such as CHOICES is preferable, especially for those women who don't respond to briefer interventions.

Hanson et al. (2013) evaluated a phone-based intervention, modified from project CHOICES, for use with a group of non-pregnant Aboriginal American women in rural and remote reserves. Inclusion criteria were the same as for the study conducted by Floyd et al.(2007). Assessment and intervention was via telephone at baseline, and three-monthly for a year (five phone calls in total), by personnel trained in MI techniques (the educational level of the personnel was not provided). Intervention materials (including a workbook based on MI constructs and daily behaviour logs) and

personalised feedback about the participants' risk for an AEP compared with other women were posted to participants after each telephone call. Self-report surveys about alcohol consumption and contraceptive use were conducted at baseline and at three monthly intervals up to a year. Hanson et al. (2013) reported that the intervention significantly reduced alcohol consumption and significantly increased contraception use. However, Symons et al. (2018), who reviewed this study, pointed out that 76.1% of participants were lost to follow up by 12 months, indicating a high risk for selection bias. Another limitation of this study was that participants called a designated hotline to participate in the study after an in-depth media campaign was conducted to advertise the study. Assessments of their motivation to change indicated that it was high (Hanson et al., 2013). Less motivated women are likely to respond less well to such an intervention.

Wilton et al. (2013) conducted a randomised trial in Wisconsin, United States, of a two-session brief intervention to reduce AEPs, in which they compared telephone versus in-person administration of the intervention. Participants were of child-bearing age, heterosexually active, not using effective contraception, and drinking more than seven drinks a week or more than three a day. The sessions used MI and cognitive techniques, with workbooks (posted to telephone participants) and between-session activities for participants to complete. The counsellors were either licenced professional counsellors or rehabilitation psychologists. 73% of participants completed both intervention sessions, and of those who completed the sessions, 93% completed the six-month follow up. Those who were lost to follow up were more likely to have reported a current mood disorder, biological parent with an alcohol use problem, or physical abuse.

At the six-month follow up point, no significant differences were found between the two methods of intervention delivery. Overall, the interventions reduced the risk of an AEP from 100% to 52%. The risk of pregnancy was reduced from 100% to 56%. There were also small but significant reductions in risky drinking, from 100% to 89% (Wilton et al., 2013). The loss to follow up of participants with multiple risk factors indicates the difficulty of retaining women with a very high risk of an AEP in intervention programmes.

The use of telephonic interventions are usually more cost effective, particularly for the client, due to reduced travel costs and reduced time loss from work (Wilton et al., 2013). This may be a useful model in South Africa. However, the poor postal service and low levels of literacy in impoverished settings may make the use of posted workbooks impractical. Research is indicated to investigate whether telephonic interventions remain effective without the use of workbooks. For women with smart phones and WiFi access or mobile data, electronic workbooks or apps could be developed.

In South Africa, Rendall-Mkosi et al. (2013) conducted a randomised controlled trial to evaluate the efficacy of MI to reduce AEP's in non-pregnant high-risk women in a rural Western Cape area. They modelled their intervention on the CHOICES project described above (Floyd et al., 2007), providing five MI sessions in the intervention arm. The MI sessions were provided by trained lay counsellors, but the authors did not provide the counsellors' educational levels. Results indicated that MI was more than twice as likely to lower the risk of an AEP compared to the control condition at twelve months follow-up. These results were similar to those of Floyd et al. (2007). The lowered AEP risk resulted primarily from improved contraception use rather than reduced alcohol consumption.

The final study that I review of an intervention designed to reduce d to reduce AEPs was of an internet-based programme in the USA called CARRII (Contraception and Alcohol Risk Reduction Internet Intervention) which was based on the CHOICES intervention (Ingersoll et al., 2018). Internet programmes may increase the reach of AEP reduction programmes and reduce the reliance on skilled counsellors. Ingersoll et al. (2018) conducted a pilot RTC of this programme, comparing it to a static patient education website for its effect on AEP risk. The authors stated that "CARRII is a fully automated Internet intervention that incorporated dynamic, interactive, and feedback elements designed to mirror the therapist-patient interaction in face-to-face interventions." (p. 6). A key element of the programme was the completion of diaries of drinking, sex, and contraception use for at least seven of 14-day periods. Graphical feedback of participants' progress was provided each week.

There was a high rate of completion of the CARRII programme. Participants in the CARRII group sustained significant improvements in reported contraceptive use, up to six months post treatment, and displayed short term reported reduction in risky drinking (significant at the post-treatment point, but not significant at the six-month follow-up.) Those in the static patient education group showed no significant impact on contraception use or drinking behaviour, although there was a non-significant drop in risky drinking at six months. Higher programme logins in the CARRII group led to greater positive changes in behaviours of interest. The authors claim that their data indicate that CARRII may have a similar impact as well designed and implemented face-to-face interventions (Ingersoll et al., 2018).

While these results are encouraging, it was a pilot study with a small sample size, short follow-up time, and self-selected volunteers as participants, the majority of whom had a college education. Assessment was also via self-report, rather than any biomarker data, which has high risks of bias. Nevertheless, the fact that assessment was through a phone call may have reduced social desirability bias compared to face-to-face assessment in in-person programmes. An internet

programme can provide anonymity which may be more attractive to those at risk of AEPs than face-to-face programmes, especially where people live in close quarters, and confidentiality is difficult to ensure.

Overall, these studies provide some evidence for the use of brief interventions (generally of the order of two to five individual MI sessions) with non-pregnant women at risk of an AEP. Telephone and interactive internet programmes showed similar results to face-to-face programmes, which increases the reach of such interventions. However, it must be noted that participants in the above studies were paid for their participation, which is likely to have increased their commitment to the aims of the interventions (even for participants in control conditions). The effects of such interventions without monetary incentives are unknown.

3.4. Training levels for personnel delivering clinical interventions

There is a paucity of studies that look at the levels of training required for the personnel who deliver brief clinical interventions. Holmqvist and Nilsen (2010) found that Swedish midwives with three or more days of continuing professional education in managing risky alcohol use during pregnancy were more likely to adequately assess women's pre-pregnancy alcohol intake (which predicts alcohol intake during pregnancy), and were also more likely to engage in counselling with a woman who had risky pre-conception alcohol use, than those who had participated in two days or less. Gaume et al. (2014) reported on two studies in the general population which indicated that the personnel's competence in counselling skills is important: one study of alcohol brief interventions with college students found that participants who perceived a greater sense of empathy from the counsellor had better outcomes; and another study with participants from emergency departments found that better outcomes were achieved by counsellors with better motivational interviewing skills. The authors suggested that counsellors need to have an accepting and optimistic attitude, avoid confrontations and warnings, use complex reflective listening techniques, and focus more on reflecting than asking (Gaume et al., 2014). These studies from the general population indicate the importance of counselling skills, which often require in-depth training to master.

Many of the international studies reviewed above used healthcare professionals such as doctors, nurses, nutritionists, psychologists, professional counsellors, or the study researcher to deliver the interventions. Hence, the educational levels of the personnel were high. Some of the reviewed South African studies used personnel with presumably lower educational levels (for example, "trained lay counsellors" (Rendall-Mkosi et al., 2013) or "trained field workers" (Marais et al., 2011)) but it is unfortunate that their educational levels and the extent of their training was not specified. It is important to know what level of education and training is needed to effectively equip counsellors. Of

relevance to my current evaluation of the Organisation is that the community educators and mentors that it trains to deliver interventions often have low levels of education (either matric level or below), and the counselling training provided by the Organisation is minimal.

4. Conclusion: Efficacy and effectiveness of interventions to reduce AEPs

The studies reviewed above lack methodological rigour, such as short follow-up times, high risks of social desirability bias, and some had small sample sizes. Nevertheless, they suggest that both universal and brief clinical interventions may be efficacious[14] in reducing episodic and non-dependent drinking by pregnant women. Heavier or dependent drinkers require more intensive clinical interventions. Furthermore, brief clinical interventions have been shown to be efficacious in increasing contraceptive use with non-pregnant heterosexually active drinking women who are ineffective contraceptive users. Such interventions have also been shown to reduce alcohol consumption by these non-pregnant women to a small but significant degree. In studies where there was a control group, there were often self-reported drops in alcohol consumption, or increases in effective contraception use in non-pregnant women within the control groups, although not of the same magnitude as within the intervention groups. This suggests that the mere act of surveying the behaviour of interest (alcohol consumption and/or contraception use) leads to more healthy behaviours. This may be because women are asked to consciously review and quantify their behaviour, which may lead to increased self-reflection and conscientisation. It also promotes the message that AEPs are not only undesirable, but are also the subject of public surveillance, possibly leading to social pressure on women to reduce drinking and/or increase effective contraception use.

It is important to note that these reviewed studies demonstrate the efficacy of interventions to reduce the risk of AEPs under controlled conditions. Such conditions include incentives in the form of monetary remuneration or food parcels for participants, which may increase participants' motivation to comply with the aims of the intervention, and monitoring and supervision of the personnel delivering the interventions in order to ensure programme compliance. The effectiveness of such interventions in general public health settings is not known. Kaner et al. (2007), in their review of randomised controlled trials of brief interventions to reduce alcohol consumption in the general population, found that the benefits were similar in both normal clinical settings (general medical practice or emergency setting) and in research settings where greater resources were

[14] Efficacy refers to the degree to which an intervention works on the targeted outcome, as measured under controlled, research conditions. Effectiveness refers to how well an intervention performs in real world, non-research conditions.

available. In other words, there were no significant differences between trials of efficacy and trials of effectiveness. Such research needs to be repeated with brief interventions to reduce AEPs to ascertain if there is similar equivalency between efficacy studies and effectiveness studies. Possible methods to assess effectiveness could include using levels of drinking or rates of FASD in a community before and after the roll-out of interventions in routine settings.

While there is some evidence of positive outcomes from interventions to reduce AEPs, Gaume et al. (2014) asserted that knowledge on *how* brief interventions achieve positive results in randomised trials is lacking. It is important to understand which elements of brief interventions are helpful in achieving positive outcomes, in order to inform the training of practitioners to deliver interventions. Whilst questions of efficacy and effectiveness need to be answered through quantitative studies, qualitative studies can unpack factors that enhance or detract from interventions. They can provide nuanced accounts of how interventions work, and investigate whether they have any unintended consequences (Doi et al., 2015). Critical studies are necessary to tease out the multiple power relations and complexities that underpin pregnancy, alcohol use, and interventions to reduce AEPs. I examine such studies in the next chapter.

Chapter 3: Qualitative and critical reviews of interventions to reduce alcohol exposed pregnancies

1. Introduction

The previous chapter reviewed quantitative studies of interventions to reduce AEPs (alcohol exposed pregnancies). Results suggested that well designed and implemented universal and brief clinical interventions may help to reduce AEPs in non-dependant woman drinkers. More intensive clinical interventions are required to change the drinking behaviours of dependant drinkers or women suffering from depression. However, such studies necessarily looked at averaged results of certain pre-defined indicators; they were unable to assess factors that enhance or detract from individual interventions in any level of depth, or shed light on the processes of change embedded within interventions (Doi et al., 2015). Indeed, with regard to research on alcohol brief interventions in the general population, Gaume et al. (2014) lamented that most research "has been conducted as if the intervention could be treated as a black box, without regard for detailed content." (p.2).

In order to inform the development of effective interventions, qualitative studies are needed to assess their "detailed content" in order to understand factors and processes that enhance or detract from effectiveness. Furthermore, critique is needed to uncover taken-for-granted power vectors within interventions, and to highlight the manners in which they may inadvertently reproduce injustices. Given that interventions and messages about alcohol risk on the foetus are not only based on scientific evidence, but are also "bound up with social and cultural values and ideas about what it means to be a 'good' or 'bad' mother" (Holland et al., 2016, p.38), critical qualitative studies are required to tease out the cultural assumptions and discourses upon which they are based, in order to point to equitable and just ways of intervening.

2. Qualitative studies of FASD interventions

There is a relative dearth of literature on qualitative studies of FASD interventions. The majority of reported studies have looked at the perceptions of midwives and pregnant women in middle-class settings regarding alcohol advice given during pregnancy, and I review these below. Voices from

under-resourced locations are lacking. One exception is a study by Hanson and colleagues (Hanson et al., 2015, 2017; Hanson & Jensen, 2015) which garnered perceptions of American Aboriginal community members towards the CHOICES intervention. Another exception is a recent evaluation of integrated, or holistic programmes serving women at high risk of an AEP in Canada (Hubberstey et al., 2021; Rutman & Hubberstey, 2019). I review these studies in the third sub-section, below.

2.1. Perceptions of midwives regarding addressing alcohol use with pregnant women

Midwives are a logical source of advice for pregnant women, and a number of researchers conducting qualitative studies have interviewed midwives about their views regarding addressing alcohol consumption with pregnant women. Findings from studies in Australia and the Netherlands suggested that midwives need structured training in how to effectively screen for alcohol related risks, and how to communicate about alcohol use during pregnancy with their patients (Jones et al., 2011; Loxton et al., 2013; Van der Wulp et al., 2013). There was also a perception amongst some midwives that smoking is a bigger problem during pregnancy than drinking (Crawford-Williams, Steen, et al., 2015; van der Wulp et al., 2014): Crawford-Williams, Steen, et al. (2015) found that Australian health professionals screened more thoroughly for smoking, had a better understanding of the consequences of smoking on a pregnancy, and provided more information to clients who smoked than to women who may be using alcohol. Loxton et al. (2013), reported that Australian midwives are less inclined to ask questions about alcohol use if they feel unsure of how to respond when a woman admits alcohol use, or if they lack referral pathways. All of this suggests that midwives need comprehensive training on how to address alcohol use in pregnancy.

Doi et al. (2015) in their Scottish study, found that delivery of alcohol brief interventions (ABIs) by midwives was often undercut when a client had other health or social challenges that the midwife needed to address. Midwives have also noted that there is so much information to cover with pregnant women that alcohol consumption is often not adequately addressed (Crawford-Williams et al., 2015).

However, there are issues beyond training and time constraints that studies have uncovered. Doi et al. (2015) found that the emotive nature of drinking in pregnancy meant that addressing this during the first antenatal visit, before a strong relationship had been established, could be challenging. In a similar vein, Loxton et al.'s (2013) Australian study reported findings that suggest that some midwives felt conflicted about the dichotomous splitting of the rights of the woman and the rights of the foetus; some felt that a pregnant woman's alcohol consumption was "none of our business", and they raised the question "At what point do you say, 'It's no longer your body, this body belongs to

your baby...” (p. 527). (This point will be discussed further in the next section.) Midwives in Loxton et al's (2013) study were far more inclined to address alcohol use with women who were considered to be at risk for heavy drinking. This point requires critique, as it is not clear how these midwives assessed who was “at risk”; their lack of structured training in screening for alcohol risks had already been reported on in the study. There is a danger that stereotypical ideas of the typical “bad mother” (such as poor, single, teenaged, or person of Colour) inform such “risk assessments”.

In response to studies indicating that midwives need more structured training in delivering ABIs, a Dutch intervention was conducted in which midwives were given training and a structured protocol to follow (van der Wulp et al., 2014). Midwives received three hours of training, a manual which explained the intervention protocol, and a card on which to record progress. The intervention advocated abstinence from alcohol during pregnancy and breastfeeding. Three intervention sessions were structured: the first session incorporated an assessment of alcohol use and motivational techniques to assist with ceasing alcohol use; the second session, six weeks later, involved a reassessment of alcohol use and further abstinence support; the final session six weeks after that involved a discussion of the impact of alcohol when breastfeeding (van der Wulp et al., 2014). The experiences of 14 midwives in implementing this programme with 135 pregnant women were gleaned (van der Wulp et al., 2014). While the midwives appreciated the training, the majority did not provide alcohol counselling beyond the first consultation as they felt that their clients did not need or want the repetition of information. The intervention was felt to be too extensive with women who stated that they wanted to abstain from alcohol in the first session, and some midwives felt that the decision to drink was the responsibility of the client.

The only conclusion that Van der Wulp et al. (2014) provided regarding the above findings was to assert that “the importance of alcohol advice needs to be stressed in midwives’ training” (p.3288). They appeared to conflate the giving of advice with counselling, and the advice they advocated was abstinence. They did not address the midwives’ sense of discomfort with repetition of information and intrusion on clients’ autonomy in making their own decisions regarding drinking. Nor did the authors give credence to the midwives’ capacity and relational ability to assess which women required more in-depth counselling and which women did not. Instead, they recommended repetition of information in midwives’ training (stressing “the importance of alcohol advice”) – a re-inscription of the blunt methods they advocated with pregnant women. Likewise, Crawford-Williams, Steen, et al. (2015), in their study with antenatal healthcare professionals, were concerned that professionals who sanctioned low levels of alcohol consumption during pregnancy for special occasions may be providing “confusing and conflicting messages for women” (p. 335). Such

paternalistic and risk-averse concerns undermine the competencies of both pregnant women and healthcare professionals.

However, some authors provided more nuanced suggestions. Loxton et al. (2013) argued that "service providers have a clear responsibility to explain to pregnant women that although heavy drinking will harm their foetuses, light drinking may or may not. Providing all the available information allows the pregnant woman to make her own informed choice." (p. 527). In order to assist with making informed choices, Doi et al. (2015) suggested that, through educating women on how to estimate units of alcohol, those women who still wished to drink could make informed decisions on the quantity they consumed.

These studies were all conducted in the global North with midwives who were working in middle class settings where rates of FASD are generally low. To my knowledge, there is a dearth of studies that examine the experiences of midwives working in the global South or with women who drink at risky levels during their pregnancies.

2.2. Perceptions of women regarding advice on alcohol consumption during pregnancy

Some authors have examined the perceptions of women on the advice regarding alcohol consumption that they received during pregnancy. Balachova et al. (2013) found that women perceived doctors to be the most influential source of health-related information, suggesting that advice from a doctor to reduce or abstain from alcohol would be more likely to be acted on than advice from other sources.

Anderson et al. (2014) and Loxton et al. (2013) interviewed Australian women who had recently been pregnant (up to three to four years earlier). Women reported abstention or low alcohol consumption during their pregnancies, although some were heavy drinkers prior to pregnancy. Most women reported that they were overwhelmed with the general amount of information that they were given from a variety of sources during their pregnancy, particularly with their first child. Regarding alcohol consumption, the provision of information was considered to be patchy and sometimes contradictory (generally around sanctioning low levels of consumption versus promoting abstinence). Some healthcare professionals did provide such information, but not generally at the beginning of the pregnancy. Whilst women were aware that heavy alcohol consumption was risky for the foetus, there was some confusion around whether light drinking was harmful. Participants believed that a clear, consistent message should be provided early in the pregnancy journey by a healthcare provider, as such providers were considered to be reliable sources of healthcare

information. In the intervention that I evaluated, information is provided by community members with variable educational levels, ranging from qualified social workers to people who have not completed high school. Their perceived reliability by their target community should, therefore, be ascertained in future studies.

Authors have discussed how perceptions of risk are only one of a range of factors that influence people's responses to health messages; other considerations such as social wellbeing, freedom and pleasure also figure in shaping people's responses (Holland et al., 2016). In their interviews with pregnant or newly parenting women in Australia, both Loxton et al. (2013) and Holland et al. (2016) described how some women who engaged in light drinking drew off notions of the health benefits of being relaxed or receiving the anti-oxidants in red wine during pregnancy in order to justify low levels of alcohol consumption. Some used social justifications such as using alcohol on celebratory occasions, or the general drinking culture around them. Others discussed how other women they knew had not caused harm to their offspring through low levels of consumption, and they distinguished between "the odd glass of wine" and "getting drunk" (Holland et al., 2016; Loxton et al., 2013). An internal bargaining process was also noted, whereby some women justified drinking in the third trimester, or felt that "light drinks" such as beer or wine were safer than spirits or recreational drugs, and therefore justifiable (Loxton et al., 2013). As with the perceptions of midwives, pregnant and newly parenting women in Loxton et al.'s (2013) study perceived a general hierarchy of substances, whereby smoking was clearly perceived as not acceptable, whereas drinking was viewed ambiguously. This is likely to be due to the fact that in Australia, alcohol consumption is a socially acceptable and even normative practice, whereas smoking is not (Loxton et al., 2013). Holland et al. (2016) discussed how women resisted being positioned as "at risk" or engaging in "risky behaviours" by creating alternative positions for themselves, such as being a "responsible drinker".

Some of the (highly educated) participants in Holland et al's. (2016) study justified the abstinence-only approach of public health messages as a means to try and pull the general public towards a more conservative attitude to alcohol consumption during pregnancy, and not leave scope for interpretation and confusion. However, others felt that such a conservative approach was an example of the policing of pregnant women, and that it led to unnecessary guilt and negative judgement of women who consume small amounts of alcohol.

These studies are limited in that all the participants were either abstainers or drank at low levels during their pregnancies. The responses of women who consume high levels of alcohol during pregnancy to Alcohol Brief Interventions are seemingly absent, and this is a critical gap in the

literature. Indeed, the on-going focus in current research on whether to provide abstinence-only advice or provide honest appraisals of the uncertainty regarding risks of low consumption shifts attention away from examining what high consuming women need in terms of interventions.

2.3. The importance of social support and integrated services

Social relationships fundamentally shape both drinking behaviours (Hanson & Jensen, 2015; May et al., 2008; McBride & Johnson, 2016) and contraceptive use (Hanson & Jensen, 2015). In evaluating the CHOICES intervention (described in the previous chapter in section 3.2) with non-pregnant American Aboriginal women to reduce AEPs, community members in a study by Hanson and Jensen (2015) felt that inclusion of older female relatives, peers, and male sexual partners in the programmes would be beneficial. They also felt that group delivery of AEP prevention programmes would provide necessary social support to participants. Unfortunately, the authors did not garner suggestions from women who were the target of the intervention (i.e., those at risk for an AEP).

The suggestion for group delivery was taken up, and the intervention was expanded and delivered in a group setting (Hanson et al., 2015). Qualitative ratings of groups by the researchers indicated that members engaged positively, there was little tension between members, and members had average avoidance levels of personal responsibility. Qualitative feedback from the trained facilitators indicated that they felt that younger women (under 35 years of age) were more engaged and responsive within the groups than older women. However, the quality of the Motivational Interviewing skills and group leadership skills of the facilitators was not always optimal, indicating the need for on-going training and supervision (Hanson et al., 2015). Again, no feedback was gleaned from the women participating in the groups, which limits this study.

Along with social relationships, social and practical support are crucial for women to reduce problematic substance use. Studies have shown that combining non-judgemental, harm reduction programmes with efforts to remove barriers to participation, such as transportation costs, childcare, meals and stigma, are the most effective approaches in reaching pregnant and parenting women struggling with substance use (Rutman & Hubberstey, 2019). Studies are now beginning to emerge as to how interventions can optimally leverage relationships and also integrate support services to assist high-risk pre-pregnant and pregnant women. Rutman, Hubberstey, and colleagues, working in Canada, formed partnerships with eight multi-service FASD prevention programmes (also called wraparound programmes), and engaged in a mixed-methods evaluation of the programmes (Hubberstey et al., 2021; Rutman et al., 2020; Rutman & Hubberstey, 2019). As well as using a non-judgemental, harm reduction approach, the programmes acknowledged that women with substance use difficulties were often victims of multiple forms of past and present trauma and mental health

difficulties, and that substance use was their means to try and manage the feelings associated with these factors. The programmes aimed to provide outreach as well as a "one-stop" service where mental health, physical health, and social services, as well as peer support for pregnant and parenting women and their children could be accessed on-site or through a network of integrated services. Preliminary qualitative findings indicated that the programmes were reaching pregnant or parenting women who faced a range of complex psycho-social difficulties. Clients reported that they appreciated the supportive and non-judgemental approach of the staff; the sense of community that developed in the programmes; having multiple services in one location; and practical assistance with child protection services (Rutman & Hubberstey, 2019). Other findings indicated increased prenatal visits, better birth outcomes and reduced substance use, with the key factor being the positive attachment that women were able to make with one or more health care providers (Rutman et al., 2020). Such programmes require partnerships with several different agencies for their operation, for example, health, child welfare, and mental health services, and these partnerships require ongoing dialogue and collaboration for their success (Hubberstey et al., 2021).

3. Critiques of FASD interventions: the re-inscription of unjust power relations

The overarching critique of FASD interventions is that they commonly re-inscribe unjust social power relations. This occurs through a number of different mechanisms, many of which reflect current broader societal impulses towards individualisation and risk management, marginalisation of disadvantaged women, and patriarchal concerns around the nature of the "good mother". I discuss these mechanisms in the sections below.

3.1. Individualisation, responsibilisation, and discourses of moral degeneracy

Critical scholars are concerned that many intervention efforts to reduce FASD are massively skewed towards exhorting women to individually "take responsibility" for the health of their unborn children. This comes with a concomitant neglect of the social, economic, political, colonial, gendered and raced power inequities that potentiate alcohol abuse in the first place (Hunting & Browne, 2012; Salmon, 2011), and which also predispose some women to be more susceptible to the effects of alcohol (Armstrong, 1998). Salmon (2011) warned that such campaigns "may inadvertently increase risks to maternal and child health by discouraging women from disclosing their substance use and pregnancies and seeking timely care." (p. 168).

The very term "foetal alcohol syndrome" focuses attention on a single causative factor – maternal alcohol consumption – whilst neglecting the contextual and social factors which heighten susceptibility to bearing a FASD child, such as poverty, malnutrition, low BMI, smoking and trauma (Armstrong, 1998). The diagnosis of a FASD in a child, therefore, conveys a concomitant diagnosis of moral degeneracy on the mother (Armstrong, 1998), who is considered either sick, or deviant, or both (Benoit et al., 2014; Rutman et al., 2000). The notions of sickness and deviance both locate aberrance within individuals, and depoliticise the issue of FASD (Armstrong, 1998) by obscuring broader environmental and contextual causalities. The prevention of FASD is, therefore, predicated entirely on convincing individual women to change their behaviour (Armstrong, 1998). Hunting and Browne (2012) referred to such individualising tendencies as the "responsibilisation paradigm", upon which most health care policies are based. They stated that "responsibilisation discourses tend to stigmatize those who face barriers to health or healthcare as individual failures, overlooking the systemic barriers that shape peoples' experiences of inequity within social and health contexts." (p.41).

The notions of deviance and sickness also have other effects beyond individualisation. Constructing substance users as deviant results in an impetus to punish, and there were moves in the United States and Canada at one point to prosecute and incarcerate pregnant and early mothering women who are affected by substance abuse[15] (Armstrong, 1998; Rutman et al., 2000): alcohol use during pregnancy thus becomes not only a risk, but a crime (Bell et al., 2009). Discourses of choice are invoked, with the implication that such women "choose to abuse" substances and "are breaching their ethical responsibilities to themselves and the foetus" (Benoit et al., 2014, p. 253). The idea that women affected by substance abuse are sick leads to interventions aiming to "treat" such women (Rutman et al., 2000), which singles them out as different from the general population.

The discourses of responsibilisation, individualisation, and moral degeneracy that cohere around FASD lead to interventions that easily take up a stance of what Armstrong (1998) referred to as moral entrepreneurship: the evils of drinking during pregnancy are expounded, a change in individual lifestyle is advocated, and the progenitors and service providers of such interventions are positioned as morally superior to the women they try to reach. Such moralising reinforces the sense that women who use substances when pregnant carry sole responsibility for harming their foetuses and that they have the capacity to behave differently (Rutman et al., 2000). The resulting stigma and

[15] A 2001 Auditor General report indicated that 94 percent of the Canadian government's budget for substance use strategy was spent on enforcement practices, while only six percent was allocated to prevention and treatment initiatives (Hunting & Browne, 2012).

shame can lead to the avoidance of health and intervention services by substance using women (Benoit et al., 2014).

Shaming of pregnant and parenting women who use substances also arises through the historical construction of women's primary value as being intimately linked with their childbearing and child-rearing capacities. This leads to heightened stigma against women affected by substance abuse, and the sense that women are more deviant than men with similar difficulties (Rutman et al., 2000). An example of this heightened stigma was shown in a discourse analysis by Day et al. (2004) of British newspaper reports relating to women and drinking. They report on two articles that appeared in *The Daily Mail:* in November 1999, there was a minor column on one of the inside pages of the newspaper entitled "Alcohol is killing more men"; shortly afterwards, in January 2000, the paper carried a front page headline stating "Pregnant women warned: avoid all alcohol" (p.173). The message was clear: female drinking poses more threats to society than male drinking. Another example was provided by Kukla (2010), who pointed out that the United States Surgeon General's warning on alcoholic beverages read "1. Women should not drink alcoholic beverages during pregnancy because of the risk of birth defects. 2. Consumption of alcoholic beverages impairs your ability to drive a car or operate machinery, and may cause health problems." (p.134). A prescriptive instruction is issued to pregnant women, whilst those who drive are merely provided with information, despite the huge dangers of drunk driving (Kukla, 2010).

Most intervention policies include an educational component, premised on the assumption that alcohol use during pregnancy arises from a lack of knowledge of the harms that alcohol can cause to the foetus. The messages used in educational campaigns draw primarily off individualising and responsibilising discourses, such as "don't drink when pregnant" and "make healthy choices for you and your baby" (Hunting & Browne, 2012). As Wolanski (2005, quoted by Hunting and Browne, 2012) pointed out, "it is a very short step from personal responsibility to blame." (p. 42). The harms caused to the foetus from broader social injustices such as poverty and violence towards women are ignored, and the implications are that the foetus needs to be protected from the pregnant woman's behaviour (Hunting & Browne, 2012).

Interventions generally frame the pregnant woman as a "mother", thereby invoking prevailing ideologies of what motherhood ought to look like, for example, protective, self-sacrificing, and so on (Rutman et al., 2000). A "mother" who uses substances which can harm her foetus is, by implication, a "bad mother" (Leppo et al., 2014). Such shaming can lead to an increase in substance use (Rutman et al., 2000).

The on-going concern in the literature regarding whether low consumption of alcohol during pregnancy causes any harm to the foetus, and the heavy emphasis on researching women who consume any alcohol during pregnancy, regardless of quantity, have the hallmarks of moral panic (Bell et al., 2009; Salmon, 2004) around alcohol use during pregnancy. Salmon (2004) defined moral panic as when "an identifiable, usually marginalized, group or behaviour comes to stand as a signifier of generalized social crisis and is represented by hegemonic institutions as threatening or antagonistic to the morals, values, or interests of 'society as a whole.'" (p.112). It is well established that significant foetal effects only occur with substantial drinking, and yet the major focus in the qualitative studies reviewed in the previous section was with women who drink at low levels and with midwives and other personnel who work with them. Such a focus contributes to constructing women who consume alcohol at any level during pregnancy as morally deviant.

3.2. Separation of foetus from pregnant woman

Benoit et al. (2014) analysed the conceptualisations of problematic substance use by service providers and stakeholders who served pregnant and early parenting women affected by substance abuse in Canada. They found that the primary focus was on the wellbeing of the foetus and infant child, with the woman's own wellbeing subordinate to this. This focus arises from a separating out the foetus from the pregnant woman. Authors have discussed how the advent of ultrasonography and foetal photography, which became widespread in the 1970s, rendered the foetus visible for the first time (Armstrong, 1998; Boucher, 2004; Rutman et al., 2000). Although developed for medical purposes, photo-shopped foetal images have been taken up widely in non-medical settings, and are now used in advertisements, media, education, pregnancy advice books, and by anti-abortion lobbies and FASD prevention initiatives[16] (Boucher, 2004). As such, the foetus has become a public commodity and is constructed as a person in its own right, a "baby", separate from the woman (Armstrong, 1998; Boucher, 2004). This construction of foetal personhood has rendered it as representing the origins of human life, with its own personality: "It is a gentle, peaceful creature embodying innocence." (Boucher, 2004, p. 70). The foetus is also continually constructed as extremely vulnerable and precious, with media articles and pregnancy advice books advising a plethora of "risk-aversive" behaviours in which pregnant women should engage to protect their "precious cargo" (Lupton, 2012, p. 329) and to enhance optimal development. Such discourses of foetal vulnerability and preciousness abet societal moral panic about foetal welfare.

[16] Boucher (2004) pointed out that most foetal photographs are of dead foetuses that have been "elaborately and dramatically colourised" (p.74) in order to present an image that is alive and beautiful.

In this process of foetal illumination, publication, and personification, its embeddedness within the woman has been erased (Armstrong, 1998; Boucher, 2004). The result of this erasure and separation, coupled with women's increasing control over reproduction through contraceptives and the legalisation of abortion in some countries, has led to "an increasing tendency to see the pregnant woman and the foetus as being at odds, their individual welfares as oppositional rather than mutual." (Armstrong, 1998, p. 2037). This tendency further promotes societal moral panic, as the welfare of "our precious children" is seen to be jeopardised by sick or deviant women. The social ills caused by FASD are perceived to arise from the misbehaviour of individual women: causality is reversed, and society is absolved of responsibility.

Lupton (2012) pointed out that the pregnant body is in an "anomalous ontological state of containing the Other within the Self" (p. 333), and she suggested that the anxieties generated by such ambiguities and blurring of boundaries lead to imperatives to control, protect and separate. A dichotomous separation of the foetus from the pregnant woman is an ideology that underpins many interventions, and Rutman et al. (2000) claimed that such thinking hampers the creative identification of effective solutions. Women and foetuses are positioned adversarially against one another, rather than being seen as a unit (Rutman et al., 2000). This can lead to a shaming of the pregnant woman, which can result in intervention or treatment avoidance, and a dampening of the woman's creative and agentic ability to tackle the social issue of substance abuse in her life.

3.3. Invisibilisation of male partners

Research, media reports, and interventions all tend to link FASD directly to maternal "lifestyle choices", with scant attention paid to the adverse effects of paternal "lifestyle choices" or the impact that paternal substance abuse may have on sperm health or maternal health (Rutman et al., 2000). As discussed in the previous chapter, not only does heavy drinking by men affect sperm health and increase a future foetus's susceptibility to FASD, but male drinking also directly or indirectly contributes to alcohol consumption by women. Violence by male partners against female partners is eight times higher when a man is consuming alcohol, and yet there are no warnings against drinking for expectant fathers (Kukla, 2010). Whilst some FASD interventions attempt to include the partners of drinking women, women are still the primary target. The fact that specific interventions to reduce AEPs focus primarily or solely on women leads to the ongoing invisibilisation of men in the pregnancy journey.

The overarching research project of which this current evaluation was a part reinforced the invisibilisation of male partners. Project One surveyed the drinking behaviour of pregnant women in antenatal clinics, and Project Two interviewed pregnant women who drank during pregnancy, and

family members. The researchers in Project Two wished to interview male partners, but only five partners of the twelve women interviewed were forthcoming, and the remainder were women's family members. In this project (Project Three), a formative evaluation and critical analysis of an intervention, part of the data were recordings of mentoring sessions with pregnant and newly parenting women. The Organisation's aim is to recruit male partners for mentoring as well, but they did not succeed in this task in the Eastern Cape site when data were being gathered. Women are easier to recruit as participants in psychological and health related research projects and interventions, probably due to gendered norms around talking to psychologists and mentors, attending clinics and interventions, helping researchers, and so on. South Africa also has a well-documented phenomenon of "absent fathers" (a father who is neither physically living with his child, nor involved in his child's life) (Van den Berg et al., 2018), meaning that they are harder to access. However, merely taking part in qualitative research interviews can be a form of intervention for participants, as they tell their experiences to a receptive listener, or engage in focus groups about pertinent topics.

3.4. Abstinence approaches

Salmon (2011) pointed out that, in the prior decade in the United States, more pregnant women who were considered "low risk" were abstaining completely from alcohol than in earlier decades (which may account for the "success" of public health campaigns), whereas the incidence of binge drinking during pregnancy had remained relatively stable. This suggests that many interventions are not impacting women who are most at risk of bearing a FASD child. Rutman et al. (2000) critiqued approaches that exhort women to "just say no" to alcohol use, as they are not appropriate for women who lack self-esteem, who have spent their lives saying "yes" to dominant others, and who have little hope for the future. Such abstinence approaches do not recognise the complexities of the lives of women who use substances; the reasons for using substances and the purposes that substance use may serve in a woman's life are not adequately addressed. Additionally, abstinence models generally do not take cognisance of the considerable time, effort, and frequent relapses that typically go into recovery from substance abuse, which may mean that women's attempts to reduce consumption are not acknowledged, and relapse can lead to discouragement and treatment drop-out (Rutman et al., 2000). Rutman et al. (2000) therefore recommended that a harm reduction philosophy guides interventions, rather than an abstinence philosophy. The harm reduction approach was outlined in the previous chapter.

Whilst current health policies recommend total abstinence from alcohol during pregnancy and the pre-conception period, research has consistently failed to demonstrate adverse effects from alcohol

on the foetus from consumption of up to one standard drink a day (Flak et al., 2014; O'Keeffe et al., 2014; Patra et al., 2011; Pfinder et al., 2013). This lack of evidence of the harmful effects of low consumption is generally not communicated in health messages to the public, and Leppo et al. (2014) stated that "the diffusion of the total abstinence advice should be understood as a symbolic struggle to protect the purity of the foetus and to construct the ideal of the perfect mother." (p. 526).The paternalistic withholding of information that would allow pre-pregnant or pregnant women to make their own informed choices about how much alcohol they feel would be safe for them to consume may backfire, leading to a rejection of messages from health authorities (Leppo et al., 2014). Furthermore, health messages exhorting abstinence generally do not provide advice on how pregnant women who drink can reduce their alcohol intake (Leppo et al., 2014).

3.5. A lack of engagement with social motivators and the pleasures of drinking

In critiquing interventions that target drinking women in general, Hutton et al. (2013) pointed out that

> campaigns routinely talk past the pursuit of pleasure and the purposeful engagement with excess that are characteristic of cultures of intoxication, as well as the social and peer interactions that have been found to be core elements of how young women drink (p. 455-456).

These authors, who explored the drinking cultures of young New Zealand women, found that alcohol use was connected with all of the following social motivators: to "let loose, catch up, network, celebrate, do something nice, clock off, and hang out." (p. 462). The pursuit of drunkenness was tied up with seeking out a sense of belonging and positive emotional connections in specific locations (Hutton et al., 2013). Brown and Gregg (2012) found that the pleasures and social bonding that arise out of excessive drinking are both anticipated beforehand, and extended and celebrated after the event, as narratives of drunken exploits and the "risky" consequences (such as "killer hangovers" and embarrassing faux pas) are circulated and retold, both in person and on social media sites. Performances of pleasure and fun construct identities of hedonism, freedom and liberation (Brown & Gregg, 2012), and with many other avenues to such currently celebrated feminine identities denied to poorer women, alcoholic excesses may be one of the few means of performing such identities.

Given these social and identity motivators to drink excessively, a focus on individual responsibility in drinking interventions misses the primarily social nature of young women's drinking. Interventions

that focus on the risks of drinking may unintentionally glamorize drunkenness (Brown & Gregg, 2012), as pleasure is often bound up with risk-taking. Suggesting that young women give up such pleasurably social pursuits and identity performances without engaging with constructions of pleasure and providing social alternatives is unlikely to gain much traction.

3.6. On-going marginalisation of disadvantaged women

Policies and interventions concerning substance use during pregnancy and the prevention of FASD are generally formulated by those in positions of power. The voices of poor and marginalised women, who are predominantly the ones affected by such policies and interventions, are overwhelmingly absent from such decision making processes (Rutman et al., 2000). Furthermore, the "responsibilisation paradigm" within which interventions and policies are situated favour advantaged women, who have more resources that enable them to take up the prescribed behaviours. For example, Lupton (2011) found that middle-class Australian women took up "risk-aversive/responsible" discourses regarding their pregnancies in a manner that Australian working-class women did not.

Themes that emerge to explain ongoing drinking during pregnancy in low resource settings in South Africa include a drinking culture within the community, lack of partner support, and the stresses arising from poverty, an HIV diagnosis, trauma, and unwanted pregnancies (Macleod, Matebese, et al., 2020). Women facing such adverse circumstances are further marginalised by exhortations to "take responsibility" for their foetus when they are emotionally and physically incapable of doing so.

3.7. Conclusion to critiques: the management of 'risk'

In this section I have traced how FASD interventions take up the current neo-liberal impetus towards individualisation and responsibilisation for healthcare, placing responsibility for the societal burdens of FASD on individual pregnant women. There is also a conceptual separation of the foetus from the pregnant woman and a concomitant personification of the foetus as innocent, precious and vulnerable. Those women who do not, or cannot, follow the risk-aversive dictates of the "responsibilisation paradigm" (who are usually from disadvantaged social groups) are positioned adversarially against their foetus (Rutman et al., 2000) and are subject to societal moral censure for not protecting their "precious and vulnerable baby". This leads to the on-going marginalisation of disadvantaged women.

FASD interventions have also been criticised for a lack of focus on male partners, which ties in with the impetus to hold individual women solely responsible. A further critique is the emphasis on abstinence approaches rather than harm reduction approaches. Not only is abstinence an unrealistic

goal for some heavy-drinking women, but such an approach also marks *all* pre-pregnant, pregnant, and breastfeeding women who consume alcohol, even at low levels, as morally degenerate. A lack of engagement with the social motivations to drink heavily, and the on-going marginalisation of disadvantaged women, are further critiques of FASD interventions.

The issues discussed above may be understood as arising out of a societal impetus that: firstly, increasingly attempts to manage "risk" through responsibilising individual subjects; secondly, views reproductive risks as being greater than other health risks; and thirdly, holds individual pregnant, pre-pregnant and parenting women solely responsible for managing those risks (Kukla, 2010; Lupton, 2012). In each case, injustice is perpetuated.

4. Conclusion

In this chapter I reviewed qualitative and critical literature on FASD interventions. Qualitative studies with midwives make it clear that sufficient training to deliver interventions is essential. While personnel who deliver interventions need to know the facts about alcohol's effects on foetuses, it is far more important that they are trained in techniques that enable them to address such an emotive issue with women who may be ashamed of their drinking. They also need to be sensitized to implicit injustices that may be reproduced through interventions. There is debate about whether only abstinence should be recommended, or whether the uncertainty about the risks of low consumption be acknowledged, but I feel that the approach taken by Doi et al. (2015) and Loxton et al. (2013) is the most respectful to drinking women: they advocate providing all the available facts so that women can make their own informed choice, and assisting them to accurately estimate how much they drink if they choose to continue.

Qualitative studies of the perceptions of recently pregnant women to the alcohol advice they received are limited to well-educated women in middle class contexts, who generally abstained or only consumed low levels of alcohol during pregnancy. Results indicated that women who drank resisted being positioned as "at risk" and drew on other socially acceptable subject positions to justify their behaviours, such as being a "responsible drinker" or "social drinker". The perceptions of women from disadvantaged contexts, and from women who consumed alcohol at risky levels during pregnancy, about the alcohol advice they received during pregnancy are lacking.

The importance of social support for heavy drinking women to assist them to reduce consumption has been identified, and preliminary evidence from a group delivery format for an intervention (Hanson et al., 2015) suggested that this may be a helpful mode of delivery. Additionally, programmes that provide integrated, or "wrap-around" services which target broad health and

social concerns for women affected by negative psychosocial factors and their children is likely to be a more effective approach than targeting individual factors in a silo-like manner.

There are a number of critiques of FASD interventions, with the overarching one being that they generally buy into the moral panic that surrounds pregnant women who drink, and they then attempt to manage this risk through a process of responsibilisation of individual women. In the process, they are at risk themselves of re-inscribing unjust patriarchal, classed, and raced power relations and ignoring the societal drivers of FASD. Other specific critiques involve the conceptual separation of the foetus from the pregnant woman, the invisibilisation of male partners, and a lack of engagement with social motivations to drink.

In order to reduce the imposition of unjust power relations in interventions it is important to understand how implicit and normative power structures operate, and in the next chapter I use Foucauldian and some post-Foucauldian theorising to illuminate such factors. I unpack some of Michel Foucault's key theories around power and knowledge, and how power operates through discourse to constitute subjects. I also harness the thinking of some more recent scholars to discuss the nature of the person from a critical, social constructionist perspective.

Chapter 4: The person – what is it? Who is it? The constituted subject and the ethical subject

1. Introduction

In this thesis I use Foucauldian and post-Foucauldian theorising to understand how pregnant women are discursively positioned, or constituted, during the Organisation's interventions, and how they agentively take up or resist these positions. I conducted what is known as a Foucauldian discourse analysis (FDA) on the data to indicate the constitution of pregnant women through discursive positioning. This is my first analytical lens. On data gleaned from mentoring sessions I utilised Conversation Analysis techniques to unpack how the women comply with or resist this positioning, and this is my second analytical lens. Throughout my analysis, I foreground the underlying power structures that are at play in the data, and then I combine the insights from both analytical lenses to provide recommendations for interventions.

Foucault has been a primary theorist regarding power. He stated, towards the end of his life, that the goal of his work was to analyse the modes through which humans are made into subjects, rather than to analyse power. Nevertheless, he engaged deeply with the question of power in order to study "the objectivizing of the subject" (Foucault, 1982, p. 209). Dreyfus and Rabinow (1982) believed that Foucault's unique contribution lay in his analysis of the ways that macro-processes of organisational power link up with micro-practices located in the body, while Bevir (1999) pointed to Foucault's unmasking of the illusions of modernity (including objective knowledge and autonomous subjects) as his principle critical thrust. Guilfoyle (2014) highlighted how Foucault's theorising implicates historical processes of power and social organisation as accounting for individuals' locations in disadvantaged positions, rather than individual culpability arising from poor choices or defective character traits. This understanding allows us to take an entirely non-blaming approach to women who drink heavily during pregnancy.

Arribas-Ayllon and Walkerdine (2008) discussed three dimensions of a Foucauldian discourse analysis: a historical enquiry (genealogy); an analysis of power; and an analysis of subjectification. My analysis focuses on the latter two strands of an FDA. As such, an explication of Foucault's theorising of power, and its links with knowledge is required, as well as a description of his theories

of subjectification. Foucault provided in-depth theorising regarding how power dynamics come to play on individual bodies, through the mechanisms of bio-power and norms, leading to the production of subjects. The bulk of this chapter is devoted to discussing these theories. In answer to the question “What is the person?” he showed how “(t)he subject is not so much a ‘thing’ but a *position* maintained within relations of force.” (Arribas-Ayllon & Walkerdine, 2008, p. 94).

However, Foucault’s theories regarding “Who is the person?”, in other words, who is it that takes up and sometimes resists the positions into which power presses it, were less well developed. Foucault (1982, 1986) did make reference to a subject having freedom and the ability to resist some of the dictates of power relations, and some post-Foucauldian scholars have extended this notion to flesh out some answers to the question “Who is the person?” They did this by addressing the issue of agency. Bevir (1999) made a distinction between an autonomous subject, who could, in principle, exist outside of regimes of power/knowledge (as presupposed by liberalism), and which Foucault rejected as an illusion, and an agentive subject, who necessarily exists within power/knowledge regimes, but is not determined by them. Guilfoyle (2014) discussed how the multiple constituting discourses within any social situation gives people some freedom to choose one way of being over another, although this freedom is heavily constrained by prevailing power/knowledge regimes. Fundamentally, and although he explicated a discursively constituted subject, Guilfoyle (2014) believed that there is an *a priori* essence of humanity that exists outside of power-knowledge, and that this essence is the innate drive for meaning and structure, which propels a person into subjectification. I explicate these ideas later in this chapter to discuss how the person is someone who has a pre-discursive drive to be captured by discourse, and has the agency, to a greater or lesser extent, to exert some limited choice over which discourses they inhabit.

I end the chapter with an analysis of ethics from a Foucauldian perspective, which views ethics as referring to a person’s relationship with themselves. It is out of this reflexive consciousness of who they are and who they want to be that people can actively take up certain positions and resist others.

2. Power relations

Traditional understandings of social power are that it is an external, restrictive force, possessed and exerted by some, and from which others can, at least in theory, be liberated (Foucault, 1977/1995). However, Foucault (1978, 1982, 1997c) understood power as relational, and as fundamentally constitutive of all things, including any liberatory desires. He stated that “there is no escaping from power…it is always-already present, constituting the very thing which one attempts to counter it

with" (Foucault, 1978, p. 82). If this is so, and if it is not possible for society to exist without power relations, then one may be tempted to wonder whether attempts to counteract power are futile. But Foucault (1982) pointed out that this fact makes the analysis of power relations all the more important, so that unnecessary ones may be abolished, and others transformed.

Foucault (1982) distinguished between three types of power. There is a power that stems from aptitudes that inhere in the body, or is relayed through external instruments, and enables the use, modification, consumption or destruction of things; Foucault referred to this kind of power as a question of capacity, objective ability, or physical determination. Then there is a power within relationships of communication, or symbolic systems which transmit information and meaning. I discuss this linguistic form of power in the next chapter, when I explicate my second analytical lens, Conversation Analysis. Finally, there is a power that "brings into play relations between individuals (or between groups)" (Foucault, 1982, p. 217). Foucault referred to this last form as 'power relations', and it was this kind of power in which he was interested. These three types of power are not separate domains, but overlap and support one another. Although one or other type may be dominant in a particular setting, all three types may also come together into a concerted block, or discipline, to bring about a regulated system, for example, an educational or medical institution (Foucault, 1982).

Foucault (1978) characterised power relations as the multiple and localised force relations that operate within any particular relational sphere. He wrote that

> Power's condition of possibility...must not be sought in the primary existence of a central point...it is the moving substrate of force relations which, by virtue of their inequality, constantly engender states of power, but the latter are always local and unstable. The omnipresence of power: not because it has the privilege of consolidating everything under its invincible unity, but because it is produced from one moment to the next, at every point, or rather in every relation from one point to another. Power is everywhere; not because it embraces everything, but because it comes from everywhere. And "Power", insofar as it is permanent, repetitious, inert, and self-reproducing, is simply the over-all effect that emerges from all these mobilities, the concatenation that rests on each of them and seeks in turn to arrest their movement. (p.93).

Power, therefore, inheres in action and mobilities. Any permanent and unified appearance of power is merely an effect of the multiple and disparate flows of force relations which constantly produce power differentials from innumerable different points. These force relations are both the instigators, and also the effects of inequalities and disequilibriums within relationships. Rather than being imposed by rulers, "(p)ower comes from below" (Foucault, 1978, p. 94), arising from everywhere, yet authored and formulated by no one. The rulers and dominators are as much in the grip of power relations as are those that are dominated. Power tactics attract and propagate one another, and so at a local level they can appear synchronised and comprehensive, despite the lack of foundational authorial intention. This synchronicity manifests as socially coordinated human activity, where social actors hold one another accountable to particular positions and behaviours in a mutually compliant manner (Guilfoyle, 2014). Local actors within power relations may be aware of what they are doing, and why they are doing it, but the eventual outcomes and effects of their actions escapes their intentions (Dreyfus & Rabinow, 1982).

Despite its omnipresence, power operates largely in secret: it is only tolerable if the dominated understand it as an external force which sets a limit on freedom, rather than constituting the very freedom that they seek (Foucault, 1978). This portrayal of power as an external force (the repressive hypothesis), with truth, or knowledge being outside of the grip of power is, in fact, one of the tactics of power to remain invisible (Dreyfus & Rabinow, 1982). The hidden nature of power enables it to operate untrammelled, and the quest for "freedom" and resistance to "power", are in actuality constituted by the very power relations that are operating within a specified force field. Power tends to masquerade as "neutral knowledge" or "natural ways of being": Guilfoyle (2014) referred to power as "knowledge's invisible partner." (p.28).

2.1. Knowledge, discourse and truth

Power relations are enabled through "techniques of knowledge and procedures of discourse" (Foucault, 1978, p. 98), and conversely, such techniques and procedures can only operate where power relations have established a possible object. There is, thus, a reciprocal relationship between power and knowledge – it is not possible for the one to exist without the other – and Foucault stated that power and knowledge are joined through discourse. Indeed, it is the "circuits of communication" and "the play of signs" that "defines the anchorages of power" (Foucault, 1977/1995, p. 217). A heightened node of discursive activity signals an area of intense power interventions, as discourse is the means of exercising power (Foucault, 1978). In *The will to knowledge,* Foucault (1997d) described discursive practices as "characterized by the demarcation of a field of objects, by the definition of a legitimate perspective for a subject of knowledge, by the setting of norms for elaborating concepts and theories." (p.11). Thus, discursive practices establish

objects, provide a perspective or position for subjects to know about these objects, and set norms regarding such objects. Objects also include us, as people. We are objects established and constituted by discursive practices, and we are also made into knowing subjects through the operations of the same discourses.

Discursive practices are systematic, but the systematicity depends neither on logic nor on linguistic codes, even though discursive practices are typically realised through language. A discursive practice leads to the realisation and selection of some objects, and the exclusion of others (Foucault, 1997d). It does not necessarily coincide with a particular science or discipline, but more often "passes through a number of them and gathers several of their areas into a sometimes inconspicuous cluster." (Foucault, 1997d, p. 11-12) Nevertheless, Foucault was clear that discursive practices, and social institutions and their related non-discursive activities, are strongly imbricated in one another, and influence one another: "discourse is both dependent upon and yet feeds back and influences the nondiscursive practices it 'serves'." (Dreyfus & Rabinow, 1982. p. 67)

With language being one of the primary means through which discourse is expressed, passing experiences through "the endless mill of speech" (Foucault, 1978, p. 21) renders them manageable, useful, and ultimately serviceable. Through the encoding of experiences into discourses, power is able to capture such experiences. Discourses may be reproduced explicitly through speech or other symbolic means, but discourses also administer silences, which impose censorship. Foucault (1978) stated that

> Silence itself – the things one declines to say, or is forbidden to name, the discretion that is required between different speakers – is less the absolute limit of discourse, the other side from which it is separated by a strict boundary, than an element that functions alongside the things said, with them and in relation to them within over-all strategies. There is no binary division to be made between what one says and what one does not say; …There is not one but many silences, and they are an integral part of the strategies that underlie and permeate discourses. (p.27).

What is not spoken, therefore, is as constitutive of objects as what is spoken. Power generates both that which it sanctions and that which it prohibits, or silences.

Although discourse enables the operation of power, it is not always subservient to power. Foucault (1978) stated that "(d)iscourse transmits and produces power: it reinforces it, but also undermines

and exposes it, renders it fragile and makes it possible to thwart it." (p.101). There is not one discourse of power and another that resists such power. Discourses are, rather, "tactical elements or blocks operating in the field of force relations; there can exist different and even contradictory discourses within the same strategy; they can, on the contrary, circulate without changing their form from one strategy to another, opposing strategy." (Foucault, 1978, p. 101-2). For example, in my data, a discourse of women being ignorant and uneducated was used by the Organisation in its strategy of paternalistically "educating" women about the effects of alcohol on the foetus. However, women then used this same discourse in mentoring sessions as a strategy to avoid blame for drinking during pregnancy. The discourse did not change form but was used to bolster a different strategy.

On the question of "truth", Foucault preferred to talk about "games of truth" to indicate that truth is produced via certain sets of rules and procedures, which are established by power relations. Truth and power are, therefore, interconnected; there is no objective, unchanging "truth" that opposes oppressive power practices and can play a liberating role (Dreyfus & Rabinow, 1982). Rather, some procedures are considered valid means for truth production, whilst others are deemed invalid, and a very wide range of coordinated social activities come together, often over a long period of time, to privilege some procedures and disqualify others (Guilfoyle, 2014). Nevertheless, certain rules, or even an entire game of truth, may be modified in response to something that the particular game of truth has discovered (Foucault, 1997c).

3. Disciplinary power

In his seminal work, *Discipline and Punish: The birth of the prison*, Foucault (1977/1995) provided an in-depth historical analysis of changes in penal codes in Europe from the 17th century though to the present times, and the rise of disciplinary power as a means to control the population. As public executions and torture were replaced by the prison system, disciplinary power arose as a significant force to control the behaviour of individuals, replacing much of the top-down, sovereign power of earlier times. As an example, Foucault (1977/1995) discussed how, in the early 17th century in Europe, the ideal soldier was sought out, through looking for bodily signs that would indicate that a man was already suited to being a soldier. However, by the late 18th century, it was understood that a soldier could be made, or developed, through various disciplinary techniques applied to the body. The body gradually became an object of attention and a target of power. Institutions such as schools, hospitals, the military, and factories arose in response to particular needs, and functioned to control, correct, and develop bodily, and body-mind operations. The "docile body" was produced: "A body is docile that may be subjected, used, transformed and improved." (Foucault, 1977/1995, p.

136). Although disciplinary methods had existed for centuries, such as in monasteries, this new disciplinary power differed from monastic discipline, which aimed to obtain bodily renunciations by the monks. Disciplinary power functions to increase the economic utility of the body, and also its obedience, and aims to ensure that each individual has mastery over their own body. It seeks to multiply and harness bodily forces. Through meticulous, often minute, and seemingly innocent techniques (which I will discuss next), such power infiltrates ever broader domains: "Discipline is a political anatomy of detail." (Foucault, 1977/1995, p. 139).

3.2. Individualisation and ranking

Disciplinary power functions through individualisation: it partitions the collective into individual bodies, each with its own space, in order to ensure that individuals do not disappear into an "unusable and dangerous coagulation." (Foucault, 1977/1995, p. 143). The rise of disciplinary power meant that individualisation moved from being ascendant to being descendant. Under feudal or sovereign regimes, being marked as an individual came only with power and privilege (usually as a result of ancestry), and such individualisation was marked by rituals or visual representations of power. It was an "ascending" individualisation, which increased with status. However, in a disciplinary regime, individualisation is "descending", as surveillance and normative judgements (discussed below) individualise the common person, particularly those considered abnormal (Foucault, 1977/1995). This gave rise to the human, or social sciences.

Individualisation enables the tracking, supervision, assessment, and judgement of each individual. Foucault (1977/1995) went so far as to say that "(d)iscipline 'makes' individuals." (p.170). Not just the population, but also the spread of diseases and the production of goods were individualised and partitioned throughout the classical age, leading to tremendous gains medically and industrially: each patient or worker, each disease process or labour operation, could be assessed, compared to others, and supervised. Politics too, modelled on the military, sought to prevent civil disorder through the control and discipline of bodies.

Disciplinary power not only individualises, but also ranks; an element is defined by its place in a series, and by the distance between it and other elements (Foucault, 1977/1995). Discipline "individualizes bodies by a location that does not give them a fixed position, but distributes them and circulates them in a network of relations." (Foucault, 1977/1995, p. 146). In the 18th century, the ranking of pupils became increasingly dominant in educational circles, as did the division of learning into individual subjects, each graduated by levels of difficulty. The examination became a central tool in this endeavour as it fixed individual differences to a particular rank.

Such individualisation and ranking ensure that disciplinary techniques maximise the obedience, as well as the efficiency and productivity of individuals, as time segments are matched with tasks. This has resulted in a dramatic increase in wealth over the past two centuries. It has also led to the training and measuring of "progress" of an individual over time, comparing it to an imaginary ideal (Foucault, 1977/1995). Such individualisation and ranking leads to a homogenisation of the population. Individuals are ranked according to a certain, pre-defined measure and dimension, which causes them to strive to move up the rank along that unitary dimension, and to discard other ways of being or behaving that are not ranked or measured.

3.2. Surveillance

In order to ensure such discipline, it is important that individuals are observed. The layout of military camps, and the architecture of hospitals, boarding schools and factories developed to ensure hierarchized surveillance. Surveillance by superiors of inferiors was enabled, at the same time as breaking down horizontal visibility – individuals on the same level were partitioned off from one another. This prevented the formation of collectives, which could foment unrest. Health, education and labour were divided into ever more specialised segments, each with a certain number of patients, pupils or workers, and each with its own supervisor, who were in turn supervised. The outbreaks of plagues in the 17th Century added impetus to surveillance efforts, as towns where the plague appeared were partitioned into quarters, then streets, each with its own syndic to ensure compliance with quarantine measures; each individual was registered and quarantined in their house (Foucault, 1977/1995).

By using surveillance as a means of exercising power, discipline has less need of the use of mass physical force in order to ensure compliance. Supervisors apply minor penal mechanisms, or punishments, to individuals who are falling short in some manner, which means that brute force does not need to be applied to the corporate body. Surveillance also fixes through documentation: individuals, behaviours, and movements are captured and frozen in written texts which are carefully filed for judgements at a future time (Foucault, 1977/1995).

3.3. Normalising judgement

Rules for punishment of non-conformity are established throughout institutions, and detailed rulebooks are devised. However, punishment can only be one pole of a disciplinary function; the other needs to be reward, or gratification (Foucault, 1977/1995). Hence, behaviour and performance, and ultimately individuals, are graded between positive and negative poles. Simply by ranking individuals publicly in relation to one another already punishes those lower down and

rewards those higher up the rank. This leads to conformity, sets optimum standards towards which one should strive, and establishes minimum thresholds below which one must not fall. If one does, one is expelled from the body corporate. The population is, thus, *normalised.* Part of the normalising technique is to trace “the limit that will define difference in relation to all other differences, the external frontier of the abnormal.” (Foucault, 1977/1995, p. 183). Disciplinary techniques, therefore, produce both docility and delinquency, or normality and abnormality, through the same mechanisms. Such normalising judgements are ubiquitous in medical, educational, and social sciences.

Foucault (1984) traced the birth of the “other”, or the abnormal, in *Madness and civilisation*. He discussed how houses of confinement were set up across Europe from the 16th century to deal with the “problem” of those who were unemployed or unable to work. Idleness was considered the root of all evil, and the poor, the sick, the unemployed, the criminals, the mad, indeed all those considered economically useless, were segregated and placed in another world. At the cost of their liberty, they were fed and given labour to do. The moral injunction to be “useful to society” was made visible and concrete by ejecting those who were not useful, under the guise of correcting and rehabilitating them. Religion was seen as one of the principle curative means, and was used as a tool to establish a sense of *individual responsibility* within the confined, through stoking a sense of conscience, and in this manner, the state took on the task of moral rehabilitation. Conscience requires that the subject treat itself as an object, and studies its own failings in order to be released from them[17].

This othering, or defining of the abnormal, is part of the normalising project. In FASD prevention campaigns, the child with FASD, and the pregnant woman who drinks, are established as the abnormal, the “external frontier”, the other against which the normal, the good, and the healthy are defined. Such normalising judgements stand in opposition to penal judgements, which simply judge according to what is permitted and what is forbidden, based on a corpus of laws. Disciplinary power, however, makes use of normalising judgements to classify, homogenise, hierarchise, and coerce individuals to behave in “healthy”, “productive” or “educable” ways. Foucault (1977/1995) stated that, by the end of the classical age, “the marks that once indicated status, privilege and affiliation were increasingly replaced – or at least supplemented – by a whole range of degrees of normality indicating membership of a homogenous social body.” (p.184). Normalisation homogenises, but it also individualises by measuring gaps and, thereby, ranking and highlighting differences. But these

[17] This treatment of the self as an object links with technologies of the self, which will be discussed in section 6 of this chapter.

"differences" are merely ranks within the same plane of homogeneity, rather than an expression of variety or diversity. As Mazzei (2007) said, "normalcy does not allow for difference." (p.4).

3.4. The invisibility of disciplinary power and visibility of subjects

Disciplinary power generally operates invisibly. The need to impose external, physical force to get individuals to comply is greatly reduced, as disciplinary power functions internally on both the individual body and the body corporate. Therefore, it does not need to display itself, but instead it visibilises those whom it subjects. Examinations, tests, and reviews present subjects as objects to the gaze of power, to be ranked and subjected to normalising judgements (Foucault, 1977/1995). Architecturally, the design of the panopticon, with its central observation tower and outer ring of individual cells, each with a window facing the tower, served as a physical portrayal of disciplinary power. The observer, unseen in their tower, could view any inmate of any cell at any time. "It is the fact … of being able always to be seen, that maintains the disciplined individual in his (sic) subjection." (Foucault, 1977/1995, p. 187). By knowing that they may always be observed, individuals then subject themselves to disciplinary power, resulting in a great victory for discipline as it becomes internalised.

3.5. The spread of disciplinary mechanisms

Particular disciplinary establishments, such as schools, training institutions, medical and social organisations, and so on, have increased dramatically since the 18th Century, but their disciplinary mechanisms have also spread beyond them, circulating freely as flexible and adaptable methods of control (Foucault, 1977/1995). Techniques for disciplining pupils have spread into the home as parents are held accountable for their children's behaviour, and medical disciplinary techniques move beyond the patient to encompass the general population. The state has now taken over control of many mechanisms of discipline, through the police service, health, and social development/welfare departments. Social media has recently become a powerful vector of discipline. Through such mechanisms, disciplinary power can be exerted on the smallest act of behaviour.

Foucault was entirely Eurocentric in his focus and did not consider the European colonial project, and for this he has been criticised (Stoler, 1995). Nevertheless, Mungwini, (2012) pointed out that pre-colonial African societies had their own panopticism which functioned to normalise the population and exert social control: community forms of surveillance; a belief that if there was social disharmony the ancestors would withdraw their protection from the community; norms around respect for elders, social ownership and reverence for nature; and so on. However, these mechanisms have been largely displaced, often violently, through the colonisation, as missionaries

and colonial rulers established formal schooling, hospitals, and other European forms of disciplinarity.

Disciplinary power is productive, as it gives rise to individuals, and it also maximises the forces of those individuals, harnessing them towards a specified goal through surveillance and normalising judgements. Through its ability to disperse, unseen, throughout the general population, it is also able to affect "the most minute and distant elements" (Foucault, 1977/1995, p. 216) in a most efficient manner. Foucault went on to closely examine the productive effects of disciplinary power on the human body – both the individual body and the collective – in his *History of sexuality* volumes, and he referred to this power as "bio-power".

4. Bio-power

In the last part of *History of sexuality: Volume 1,* Foucault (1978) discussed the historical shift of mechanisms of power over the last few centuries in the West. In earlier times, power manifested primarily through a right to decide life and death. A sovereign had the power to require that his subjects expose themselves to possible death through defending him from enemies, and he could also put to death anyone who rose against him or disobeyed his laws. His power manifested through killing or refraining from killing: "The right…was in reality the right to *take* life or *let* live" (p. 136, emphasis in original). Whilst this form of power is still extant, it was largely supplanted by disciplinary power over the last few centuries. Advances in knowledge ensured that death from natural causes (such as famine and disease) was no longer always imminent, and this allowed space for methods of power and knowledge to exert control over modes of life. Current forms of power inhere more broadly in the social body rather than one powerful ruler and manifest as an emphasis to develop life. Modern power is "bent on generating forces, making them grow, and ordering them, rather than one dedicated to impeding them, making them submit, or destroying them." (p. 136). Hence, "the right to take life or let live" has inverted to where power now has the right to "*foster* life or *disallow* it to the point of death." (p. 138, emphasis in original.) As a case in point, those who don't follow the dictates of "healthy living" regimes are, ultimately, left to die. Wars are now fought, not so much to defend a particular sovereign, but on the pretext of ensuring the existence, or fostering the life of a certain population, political group, society, or race.

This power over life is organised around two poles: the disciplining, training, and regulating of the body in order to optimise its capabilities ("an anatomo-politics of the human body" (Foucault, 1978, p. 139)); and the regulation of the population through the management of its procreative capabilities, modes of living, and health ("a bio-politics of the population" (p. 139)). These

techniques contributed substantially to the rise of capitalism, and they serve to enhance the power of the state, although they are couched in terms of contributing to the welfare of individuals (Dreyfus & Rabinow, 1982). Collectively, Foucault (1978) termed these two techniques "bio-power". He defined bio-power thus: "bio-power…designate(s) what brought life and its mechanisms into the realm of explicit calculations and made knowledge-power an agent of transformation of human life." (p. 143). Dreyfus and Rabinow (1982) gave the following definition:

> Bio-power is the increasing ordering in all realms under the guise of improving the welfare of the individual and the population...this order reveals itself to be a strategy, with no one directing it and everyone increasingly enmeshed in it, whose only end is the increase of power and order itself. (p.xxii).

Arising out of bio-power is the importance of normalising judgements (previously discussed in section 3.3.) The power to take life or let live is innervated through the law and the sovereign's orders. However, a power that manages and fosters life needs mechanisms that continuously regulate and correct the populace, rather than only being applied sporadically, as when juridical power is applied. This new mechanism comes about through effecting distributions around the norm (Foucault, 1978). It has to "qualify, measure, appraise, and hierarchize, rather than display itself in murderous splendour" (p. 144), and it does this through the endless apparatuses and surveillances employed by medicine, psychology, education, leisure, employment, and numerous other industries. Behaviours, bodies, and even attitudes are individualised and graded between the two extreme poles of "good" and "bad", and from this, "the norm of conformity is drawn." (Dreyfus & Rabinow, 1982, p. 158). There has been an explosion of classifications of "abnormality" in the modern era, as more and more aspects of human existence and behaviour are surveyed, examined, and graded, and "normality" is defined in opposition to "abnormality". The lure of this activity is the promise that, once identified, an "abnormality" can be normalised through the application of bio-power. "By identifying the anomalies scientifically, the techniques of bio-power are in a perfect position to supervise and administer them." (Dreyfus & Rabinow, 1982, p. 196).

The particular brilliance of bio-power as a technique for control comes through its ability to convince people to regulate and manage *themselves* in accordance with its dictates. Through a proliferation of knowledges about the human condition, generated by human sciences (what Foucault referred to as "dubious sciences" (Dreyfus & Rabinow, 1982)), and disseminated almost universally through educational and media outlets, incitement to self-surveillance, self-knowledge and self-control is widespread. This is a highly efficient means of exercising power (Guilfoyle, 2014).

FASD interventions are prime examples of the operation of bio-power: Concern over the creation of unemployable and economically dependent subjects (people with FASD, who are identified through comparing their features and abilities against the "norm") at the population level operates locally through the incitement of women to discipline their bodies in accordance to prevailing ideals in order to ensure the health of future generations.

4.1. Sex and reproduction

Sex and reproduction have been particularly fecund sites for the operation of bio-power over the last two centuries in Western civilizations, as they fit both poles of bio-power: the disciplining of the body and the regulation of populations. An "immense verbosity" (Foucault, 1978, p. 33) has encapsulated all facets and every peculiarity of sexuality, with the impetus behind such discursive subjectification being the maximisation of life and productivity. Reproductive research and interventions (including the Organisation and my research) can, in a Foucauldian economy, be seen as techniques of state power to enfold every aspect of pregnancy into a managerial web in the service of disciplining the body and producing a productive population. The acts of observing, specifying, classifying, and measuring all aspects of sex and reproduction produce norms, which then enable "disorders" to be realised, become visible and permanent. Thus, objects such as "FASD", "binge drinkers", "abstainers", "responsible/irresponsible mothers" and so on are created through the technologies of reproductive research and interventions.

In discussing the prohibitions around childhood masturbation (onanism) in the nineteenth century, Foucault (1978) pointed out that the identification of such a "vice", and attempts to eliminate it, paradoxically led to the perseverance, subdivision and proliferation of such practices. Such expansion allowed power to advance in its pursuit of the "vice". It is possible that efforts to control women's alcohol intake during pregnancy, as an exercise of power, may lead to a fracturing, dispersal, and ultimate proliferation of "risky" behaviours during pregnancy.

5. Power apparatuses

One of the impetuses of Foucault's work was to uncover the rationality or logic of state control. Hook (2007) understood Foucault's view of technologies (discussed below) to be the minute mechanisms of power that institutions exert on individuals, while apparatuses refer to broader political logics. Apparatuses are:

> Heterogeneous ensembles consisting of discourses, institutions, architectural arrangements, policy decisions, laws, administrative measures, scientific statements, philosophical, moral and

> philanthropic propositions; in sum, the said and the not said… The apparatus itself is the network that can be established between these elements. (Foucault, quoted in Hook, 2007, p. 232).

Apparatuses are disparate and under-coordinated combinations of power effects which enable state regulation of the population (Gough, 2008). This loose assemblage provides a hinge, or joiner, between macro- and micro-modalities of power, and the unconventional ensemble of power relations means that it is difficult to predict or resist (Gough, 2008). "The apparatus's conductions of power through the social body may thus be characterised as *under-determined in its co-ordinations,* although *over-determining in effects, in efficacy."* (Hook, 2007, p. 233-4, italics in original).

Foucault used the term "apparatuses of security", as he understood them as means of state control. I prefer to use the term "power apparatuses", as this clarifies the meaning better for me. Foucault discussed **the police** as a key apparatus of state. This is not just the institution of the police service, but anything that could be interpreted as "protecting and serving" the population – maintenance and promotion of health, safety, amenities, trade and so on. Hook (2007) stated that the different portfolios of a State's parliament are equivalent to the Foucauldian notion of policing.

Pastoral power is another apparatus, or rationality, that Foucault discussed. Modelled on the role of the shepherd, who needed to carefully watch over their flock, guide them to nourishing pastures, and care for them in order to maximise their health and productivity, so, too, the Christian pastor or priest needs to survey their congregation, guide them spiritually, and care for them in order to ensure their spiritual salvation. The confessional was a key aspect of pastoral power (Foucault, 1982) with the imperative to examine one's life and confess one's transgressions to a priest, who would then guide one towards spiritual redemption. Pastoral power is now exerted far more widely than by the Church, and families, NGOs, teachers, schools, and welfare departments of the state are vehicles for disciplining groups of people through the exercise of pastoral power (Gough, 2008). With the modern emphasis being on how to achieve personal "redemption" (or "health, wealth and happiness") in this life rather than in the after-life, psychotherapy, counselling, life coaching, and mentoring have proliferated as modern iterations of pastoral power; clients confess their inmost thoughts to a therapist, who guides them towards redemption through varying technologies of the self (discussed in the next section).

The discipline of psychology has been widely critiqued for, until recently, upholding white supremacist views of race and intelligence, being complicit in apartheid and colonising projects,

being uncritically heteronormative, being dominated by knowledge produced in the global North, and being at the forefront of classifying mental and behavioural states into "normal" and "abnormal" (Kessi & Boonzaier, 2018). As Kessi & Boonzaier (2018) stated, "(t)he role of the discipline in regulating behaviour and constructing what is considered 'normal' and what is not cannot be overstated." (p. 300). As such, psychology fits within the apparatus of pastoral power to extend the reach of the state to produce productive and compliant citizens.

Hook (2007) explicated four aspects of pastoral power: firstly, its mode of transmission is through the provision of kindness and love; secondly, there is an unquestioning authority that the pastor holds, in their position as intermediary between the flock and God, which requires obedience on the part of the flock; thirdly, the pastor bears responsibility for their flock's wellbeing; and lastly, "the pastoral relationship should result in a developed form of conscience in its subjects" (Hook, 2007, p. 238). The modern educational apparatus is innervated by pastoral power, as teachers, through kindness, instruct and discipline their flock in order to educate them. Pastoral power is one of the key apparatuses that FASD prevention interventions use in their attempts to discipline drinking pregnant women.

Coloniality may also be usefully understood as an apparatus, although Foucault did not turn his attention to this subject. Lugones (2010) understood coloniality as "the process of active reduction of people, the dehumanisation that fits them for the classification, the process of subjectification, the attempt to turn the colonised into less than human beings." (p. 745). The dividing strategy of marking out different populations according to racial or cultural differences, then discursive stereotyping the different populations as superior and inferior, justified the conquest, colonisation, and administration of "inferior" people groups (Gough, 2008). Hook (2007) explained that "multiple (formal and informal) types of power combine in a network of diverse elements, whose various forces – no matter how seemingly haphazard – nevertheless maintain the general ascendance of colonial rule" (p. 240). This helps to explain how coloniality still holds sway in South Africa, despite the transition to majority rule and the dismantling of formal racist legislation. Although legislation has changed, racist discourses, classifications, spatial divisions, inequalities, and colonial "knowledges" remain, imprinted in our subjectivities, leading to a racialization of our experiences and identities – a coloniality of being (Ndlovu-Gatsheni, 2018). Given such diverse, heterogeneous, and multiple vectors of power, the colonial apparatus resists attempts to uproot it, and underpins power differentials between the global North and South (Hook, 2007; Macleod, Bhatia, et al., 2020).

Ndlovu-Gatsheni (2018) discussed three analytics of coloniality: a coloniality of power; a coloniality of knowledge; and a coloniality of being. The coloniality of power was initially visible in the creation

of physical empires through the conquest of people and the exploitation of their resources. Whilst political decolonization and the dismantling of empires has now been achieved, the coloniality of power is alive and well in the asymmetries of military and economic power between the Global North and South. The coloniality of knowledge refers to the systematic repression of the beliefs, indigenous knowledges, cultures, histories and languages of colonised people, replacing them with the epistemes, educational systems and curricula, and languages of the colonisers. In the current post-colonial context of South Africa, the coloniality of knowledge persists, with "Westernised" and scientific epistemes considered superior to indigenous African ones. An example of this was starkly illustrated when we collected data: the training facilitator told us that if she conducted training only in isiXhosa (the indigenous language of the region) it would not be held in as high regard as if she conducts it in English with Xhosa translations where necessary.

The coloniality of being arose from the "consistent and systematic denial of humanity of those who became targets of enslavement and colonisation" (Ndlovu-Gatsheni, 2018, p. 61). This placed them as sub-human Others and justified their brutal exploitation. It also turned colonised people against themselves (Lugones, 2010). The colonised were/are judged, through the Western lens of modernism, individualism, capitalism, and Christianity, as deficient, and in need of civilising and conversion to Christianity (Lugones, 2010). This civilising mission links with pastoral apparatuses, indicating how different apparatuses of power support and reinforce one another.

Central to the notion of coloniality is the idea of "whiteness". Hook (2007) defined "whiteness" as "the implicit and undisclosed norm, … a discursive force-field of unspoken values and commitments, against which a variety of cultural differences, indeed cultural 'deviances' are measured and assessed." (p. 251). "Whiteness", and all the Western, scientific, capitalistic and individualistic notions of "progress" and "development" that accompany it, is the ideal, the taken-for-granted standard against which people groups, cultures and nations are measured. Lugones (2010) understood coloniality as being tied up with dichotomous hierarchies, with "white" men at the top, who were the only ones who were fit to rule. "White" women were constructed as the "white" men's passive aid in reproducing the race (Lugones, 2010), and tropes of these constructions persist today, despite decades of feminist work. Hence, the unspoken dominance and implied superiority of whiteness coheres easily with **patriarchy**, another power apparatus, which is the taken-for-granted hegemony of heterosexual masculinity. This leads to intersectional power relationships which disproportionately disadvantage women and gendered minorities of Colour. Coloniality intertwines with gendered power relations, sexualities, and families (Boonzaier, 2017; Macleod, Bhatia, et al., 2020), with African women constructed as "primitively hypersexualised and irresponsible" (Macleod,

Bhatia, et al., 2020, p.295). Such constructions legitimate the control of women of Colour, and in particular, the control of their sexuality and reproduction.

In this sub-section, I have discussed Foucault's notion of power apparatuses, and I have looked particularly at the apparatuses of pastoral power, coloniality, and patriarchy. My analytical chapters illustrate how these apparatuses underpinned the Organisational interventions to police the sexual and reproductive lives of the women of Colour who were the Organisation's targets.

6. Governmentality, technologies of the self and subjectivities

While Foucault provided an in-depth analysis of power, he stated that his primary objective was to create a history of the manners in which humans are transformed into subjects within the field of possibilities created by power relations (Foucault, 1982). He referred to these different manners or modes of transformation as "technologies" or "techniques", and he divided them into four categories, although they rarely function separately. These are: technologies of production; technologies of sign systems; technologies of power; and technologies of the self (Foucault, 1997b). Technologies, for Foucault, focus on the "micro-physics", or capilliary functioning of power relations (Gough, 2008), while apparatuses, as discussed above, are loose but powerful networks between assemblies of technologies that cohere to exert far-reaching control over populations. The first two technologies (of production and sign systems) manifest strongly through the disciplines of science and linguistics. An interaction between the third and fourth technologies, the technology of power/domination and technologies of the self, leads to what Foucault called **governmentality** (Foucault, 1997b). This refers to the manners in which power relations exert control over people's conduct through multitudinous normalising practices, bound up in the institutions that govern our lives – medical, educational, juridical, business, familial and so on. Hook (2007) pointed out that governmentality, for Foucault, was the linkage of micro-, or individualising aspects of power, with macro-, or totalising aspects of power, with each aspect of power being dependant on the other for its effects. Governmentality is "any calculated direction of human conduct" (Hook, 2007, p.224), and it is a matter of exerting influence over people's minds, rather than controlling bodies through the threat of violence (Bevir, 1999). Individuals are made, in a disciplinary manner, to extend the powers of the state, and the state requires a free-play of individuality and freedom, "an acting of self upon self" (Hook, 2007, p. 243, emphasis removed) in order to function.

The "acting of self upon self" was something that Foucault referred to as technologies of the self, or "arts of existence" (Foucault, 1985, p. 11). These are procedures through which individuals determine their identity, and transform it according to certain prescribed ends (Foucault, 1997a). All

social interventions, counselling, and educational endeavours, as prime examples of governmentality in action, attempt to instil technologies of the self in the objects of their focus. Foucault defined these technologies as "reflection on modes of living, on choices of existence, on the way to regulate one's behaviour, to attach oneself to ends and means" (Foucault, 1997a, p. 89). And of course, these "ends and means" are socially constructed according to prevailing codes of normality, morality and ethics. It is a matter of "governing oneself" through putting in place "relations with oneself" in order to "take care of oneself" (Foucault, 1997a). As such, these are practices through which people treat themselves as objects (Dreyfus & Rabinow, 1982). Given that these objectifying practices are part of the power-knowledge nexus within which people are situated, people can be seen as the by-products of such a nexus (Guilfoyle, 2014). Power-knowledge is realised through discourse, and it is important to reiterate that multiple discourses are implicated in the construction of an individual at any particular time. This paves the way for resistance (discussed further in the next section): a person may be constructed by the dominant power dynamics in a highly disadvantaging manner, but there are always other, subjugated discourses implicated in their construction, which have the potential to be harnessed to construct the person in less disadvantaging ways.

According to Foucault (1997b), in the first five centuries AD, Greco-Roman philosophy and Christian spirituality gave injunctions to "know yourself" and "take care of yourself" (the latter referring to care of one's inner self, or soul, rather than body), and various techniques evolved to achieve these ends. These included reflection on one's daily actions at the end of the day, obedience to a spiritual master, confession of sins, penitence, and denial of bodily pleasures, such as food and sex (Foucault, 1997b). Out of these early techniques, the confession evolved to become central to the technology of the modern self. Dreyfus and Rabinow (1982, p. 175) stated that "(t)he key to the technology of the self is the belief that one can, with the help of experts, tell the truth about oneself." Telling the "truth" about oneself, whether in the context of Christian confession or in the more modern confessional contexts such as counselling/mentoring, is understood to be necessary for redemption or healing through unlocking the "inner self". Such confessional techniques are also internalised, as individuals learn to police themselves by regulating their own thoughts and behaviours according to certain societal norms (Bevir, 1999). This exercise of power through the confessional is known as pastoral power (discussed in the previous section). Through these technologies of the self and power apparatuses, society defines who and what the subject is (Bevir, 1999). The mentoring of alcohol consuming pregnant women uses this confessional technology: as they "confess" the "truth" of their lives to their mentors, power relations are enacted to subjectify the women according to the idealised forms which are reproduced by the Organisation's intervention.

Arising out of these technologies of the self is the subject. Foucault's view was that, rather than being a substance with a pre-given essence or nature, the self or subject is a form, and this form is not always identical to itself. It takes different forms in different relationships and contexts. These forms are constituted according to the practices of power and games of truth in which the subject engages. These various constituting practices precede the individual, and are models that are available to them within their culture (Foucault, 1997c). Such practices refer to "the methods, techniques, and exercises directed at forming the self within a nexus of relationships." (Rabinow, 1997, p. xxvii). Subjectivity may, therefore, be understood as arising out of the multidimensional relationships that we have with others, with things, and with ourselves (Rabinow, 1997).

6.1. Subject positions

The concept of a subject position has arisen out of Foucauldian thought. Foucault (1977) asked his readers to consider what positions a subject occupies in the order of discourse, and what functions this position exhibits. Subsequent authors have extended the concept of subject positions, which has been taken up widely in critical discursive work (Davies & Harré, 1990; Guilfoyle, 2014; Mouffe, 1992; Taylor & Littleton, 2006; Törrönen, 2001; Wetherell, 1998). Practices of power and games of truth (what discursive psychological theorising usually refers to as "discourses") provide pre-defined forms, or subject positions, into which subjects are pressed (Guilfoyle, 2014). For example, a medical discourse requires subjects to take up the forms of doctor, nurse, patient, pharmacist and so on in order for the discourse to operate. And such forms, or subject positions, are further differentiated, such that doctors can be knowledgeable, rude, kind, and so on. But when a subject (for example, one who has taken up a subject position as patient) is situated in a different relational context (for example, their home context), they will take up different subject positions (such as loving parent, reluctant cook, or eager social media consumer). Their subjectivity, or sense of self, is made up of a collage of the subject positions in which they are habitually situated, and these different subject positions "have no predetermined relation to each another and ... cannot be fixed into any kind of stable unity." (Törrönen, 2001, p. 314).

Subject positions are always relational in that they obtain their salience and meaning in relation to other subject positions (Törrönen, 2001). For example, I cannot take up a subject position as a kind person without there being a recipient of that kindness, and without there being the potential for someone (myself or another) to inhabit a position as an unkind person. Each subject is positioned, both in relation to the overarching discourse, and also in relation to other subjects who are called into the same discourse. "Such a network of positions enables mutually coordinated activity, whose alignment ...makes up the primary force of power." (Guilfoyle, 2014, p. 59). Such alignments also hold subjects to their respective positions, leading to more-or-less stable social engagements.

Furthermore, these alignments transmit and reproduce the power relations inherent in the discursive formulation, leading to on-going iterations of the discourse. This relationality of subject positions means that for a subject to move out of a dominant subject position into a new, less dominant one, support needs to be provided in the form of a discursive community. This community needs to uphold and provide space and recognition for the new position (Guilfoyle, 2014). From this perspective, it is clear that merely exhorting drinking women to desist from drinking is not sufficient for them to move into a non-drinking position; there needs to be a discursive community that will recognise and relate to them in a non-drinking subject position. This relationality of being is something that is important for interventions to recognise and leverage: establishment of non-drinking communities for people affected by alcohol use is the foundation that people need to move away from problematic alcohol use.

While subject positions are provided by discursive practices, suggesting that discourse is the overarching concept, subject positions can also be anchors for several different discourses. This latter conception sees subject positions in the super-ordinate place. For example, a medical discourse can provide the positions of, *inter alia,* doctor, nurse and patient, but any one of those positions can be an anchor for a number of disparate discourses. So a nurse subject position can express discourses of medicine, service, employment, gender (where nurses are generally assumed to be female) and so on. There is, thus, reciprocity between the concepts of discourse and subject position. Furthermore, this multiplicity of discursive expressions within a subject position leads to dynamism and the potential for movement; a subject is never entirely captured by one discourse (Guilfoyle, 2014). It is this multiplicity that paves the way for resistance.

7. Freedom and resistance

If power relations manifest within actions, then they can only operate where there is a possibility for action and movement, or where there is freedom. Foucault (1982) stated that "(p)ower is exercised only over free subjects, and only insofar as they are free." (p.221). Subjects need the possibility of behaving in several different ways, or resisting, in order for power relations to manifest. Without the possibility of resistance (Foucault (1982) gave the example of a slave in chains), then such power is merely the imposition of physical restraint, and there is no element of power relations. Freedom is, therefore, a precondition for the exercise of power relations, and resistance is never in a position of exteriority to power relations, but instead is an "irreducible opposite" (Foucault, 1978, p. 96) to relations of power.

Resistance is not only constituted by power relations, but it is also one of the fundamental conditions for the operation of power (Dreyfus & Rabinow, 1982). Power is exercised within relationships of power through acting upon the actions of a subject who is nevertheless capable of acting in a variety of different ways (in other words, the subject is free and capable of resisting). “The exercise of power...incites, it induces, it seduces, it makes easier or more difficult... it is nevertheless always a way of acting upon an acting subject...” (Foucault, 1982, p. 220).

If power is fragmented and disparate, arising from multiple conflicting force relations, then the imposition of a particular power relation on subjects is necessarily incomplete, making space for resistance. Like power, there is no single locus of resistance to power. Instead, there are multiple points of resistance distributed irregularly within the field of power relations. Such resistances may occasionally align and mobilise groups in order to effect a revolution, but more often they manifest as mobile and transitory, leading to localised regroupings and fracturings (Foucault, 1978). Power generally operates invisibly, whereas resistance is sometimes more visible and obvious. Therefore, analysis of resistance can bring to light the mechanisms and locations of power relations (Foucault, 1982). Dreyfus and Rabinow (1982) stated that “(r)esistance is both an element of the functioning of power and a source of its perpetual disorder.” (p.147). There is, therefore, always a troubled relationship between power and its subjects (Guilfoyle, 2014). Whilst resistance can operate to disrupt dominant power relations, power relations can also incorporate resistances into new power strategies, leading to advancement of that particular power nexus reach rather than disruption (Guilfoyle, 2014).

Foucault (1982) discussed three types of struggles or resistances: “against forms of domination (ethnic, social, and religious); against forms of exploitation which separate individuals from what they produce; or against that which ties the individual to himself and submits him to others…(struggles against subjection, against forms of subjectivity and submission).” (p. 212). The lattermost struggle is becoming more prevalent in today’s world and is seen in resistances against such things as patriarchy and racism. In my data, I analysed resistances to manners in which pregnant women were subjectified to highlight the subjectifying power relations within which they were situated.

7.1. On the matter of agency

The concept of resistance leads me to the question of agency, which is a contested notion in post-structural thought. The concept of a socially constructed subject suggests one who is passive and lacks agency. Indeed, Foucault’s earlier works have been criticised by many for suggesting that the person is merely a docile puppet of power with no agentive ability to resist (Guilfoyle, 2014).

However, Bevir (1999) distinguished between the notions of autonomy and agency. He stated that an autonomous subject would be one that could, in principle, exist outside of, or prior to, social contexts and regimes of power/knowledge. This is the subject that is presupposed by liberalism and modernity, where universal, objective knowledge and individual freedom are championed. Such a subject was rejected by Foucault, who argued that notions of objective, neutral knowledge and an autonomous subject are illusions. However, in contrast to an autonomous subject, Bevir (1999) stated that an agentive subject can only exist within specific social contexts, but it is not determined by these contexts. He claimed the following:

> Although agents necessarily exist within regimes of power/knowledge, these regimes do not determine the experiences they can have, the ways they can exercise their reason, the beliefs they can adopt, or the actions they can attempt to perform. Agents are creative beings; it is just that their creativity occurs in a given social context that influences it. (p. 67)

Although Bevir (1999) pointed out that Foucault had a "characteristic elision of the distinction between autonomy and agency" (p.68), he believed that such an agentive (though not autonomous) subject is compatible with the general tenor of Foucault's latter works (even though Foucault did not ever use the word "agency", but referred instead to "resistance" and "freedom to act".) For example, Foucault (1986) talked about "constitut[ing] oneself as the subject of one's acts" (p.41), which suggests a decidedly agentive subject. Indeed, if the impetus of governmentality and modern pastoral power is to incite subjects to govern themselves according to certain pre-determined norms, then the subject must have the agency to either act accordingly, or to resist and choose non-sanctioned behaviours. If the Foucauldian subject is "not merely a product but also a vehicle of power" (Guilfoyle, 2014, p. 77), then it can use the power that rests on it to behave in a number of different ways.

While the existence of multiple constituting discourses in any social situation theoretically allows a person to resist a sanctioned way of being, or identity, in favour of another, Guilfoyle (2014) pointed out that, in practice, such freedom is often highly restricted. Firstly, dominant power relationships determine which identities are valid and which are not, and the consequences of inhabiting an unsanctioned identity can be dire. People are then naturally pushed to take up socially desirable identities and practices, and denigrate undesirable ones, both in themselves and others. Secondly, because technologies of the self dictate that we "know ourselves", we need to attach ourselves to a specific self-understanding, and this necessarily limits our freedom to roam within the multiplicities of ways of being: "The individual should 'be something': something recognisable, consistent,

predicable even; something people can count on." (Guilfoyle, 2014, p. 22). Through repeated citations of certain ways of being and knowing, these identities develop an "experiential thickness" (Guilfoyle, 2014, p. 24) within the lives of individuals and communities, leading to them becoming increasingly dominant and powerful. And finally, as one of power's tactics is to illuminate the person and invisibilise itself, it is difficult to recognise the social forces that constitute people; such social forces are generally masked and constructed as "innate" and "natural" aspects of ourselves and others (Guilfoyle, 2014).

The second point, above, relating to the need to "know ourselves", requires further unpacking. Foucault believed that this will to truth about ourselves is socially constructed and a product of our culture (Guilfoyle, 2014), but Guilfoyle, drawing from Nietzschian theorising, suggested that the need to believe and know who we are is more fundamental than that, and is essential for life itself. He stated that "if we do not believe in some truth we are at risk of being swept passively away in a sea of discourse; plunged into a world of fluid, unstructured, chaotic relativism." (Guilfoyle, 2014, p. 48-49) He went on to say "the need to hold something as true already lies 'within us'. So central is this compulsion to 'infer' truth that Nietzsche says not only that it is 'part of us', but that 'we almost *are* this instinct.'" (p. 49-50).

Guilfoyle(2014) was, therefore, suggesting that there is an *a priori* essence of humanity that exists outside of power-knowledge, and that this essence is the drive to be captured by power-knowledge in order to provide structure and meaning. He furthermore believed that this essence is inherent in our embodiment as human beings: we have agency because we have active, alive bodies. It is worth quoting Guilfoyle (2014) further on this point:

> First, power can only work if its subjects are already prediscursive, embodied, active beings, corporeally endowed with their own capacities and energies. Second, the energies and actions of this embodied being resist, exceed, and overflow the impositions of power. And third, in order to avoid being dissolved into chaos, meaninglessness, and nothingness, the person must direct these resistances into further, perhaps new, forms of subjection. (p. 107-8)

We are, therefore, inherently, prediscursively programmed to search for meaning as human beings, but it is the contents of that meaning that are socially constructed. Behind our inbuilt search for meaning, there is no informed subject who can freely select which discourses, or sets of meaning,

with which we would like to identify. Rather, "it is discourse that selects and fashions the person. We have no choice but to comply" (Guilfoyle, 2014, p. 50). Thus, it is a fundamental condition of life that we become subjects of discourse (which, as I discussed above, is the conduit for power-knowledge dynamics and meaning). Our agency lies in the relative flexibility that we have to take up or lay down discourses, and we can only resist one discourse through the taking up of another. This final point has important practical ramifications. If interventions wish to assist women to resist discourses that they deem to be problematic (such as the need to drink to be socially recognisable), then the interventions need to strengthen other, less problematic discourses in women's lives.

7.2. Positive and negative resistance, and violence

Guilfoyle (2014) engaged deeply with the question of agency from a post-structural, Foucauldian perspective, and expanded on concepts that were only implicit, or were not developed in Foucault's writings. He discussed how resistance to power can be understood as having both negative, or bodily aspects, and positive, or discursive aspects. Negative resistance can be seen to arise from our corporeal bodies which consist of multiple flows of energies, and which can never be entirely captured by any one power-knowledge complex. Along similar lines, Dreyfus & Rabinow (1982) suggested that resistance to bio-power may be situated in the body, due to the fact that the body can never be completely transformed through disciplinary techniques. Thus, a person can never be fully subjected to a discourse of, say, hegemonic masculinity, no matter how hard they or others try. There will always be corporeal aspects of that person that exceed, fail, or otherwise slip out from under the dictates of that discourse. Guilfoyle referred to this as a bodily resistance, but not yet a discursive one. However, such bodily resistances and slippages produce a discursive vacuum, and so there is always a corresponding positive resistance which strives towards further discursive subjectification. This new subjectification may take the form of positioning within a new discursive field, or it may be that the subject is simply recuperated back into the existing subject positions, possibly with some subtle adjustments to the constituting discourses. Nevertheless, there is always movement; the subject cannot solidify into a static, entirely stable entity. If there is anything essential about the subject, it is, firstly, this constant (although often unnoticed) flux, multiplicity, and lack of innate or stable meaning, character, or nature; and secondly, it is the drive towards meaning, and attempts at stability through discursive subjectification – there is a constant yin-yang of order and simplicity versus chaos and multiplicity.

Relating to the notion of agency is the concept of violent relationships. Bevir (1999) saw the essence of violent relationships as those in which one party denies the agency of the other by pre-defining the actions in which the other must engage. This is different from violence, where physical force is

exerted, and is merely a matter of physical capacity. Bevir stated that power relations, in contrast to violent relations, exert influence but are not determining. In a similar vein, Guilfoyle (2014) believed in the importance of facilitating "the dialogical rather than the monological possibilities of power, so that people are always able to find different ways of being" (p.99). This is important in the field of FASD interventions: it suggests that violent relationships ensue if ways of behaving are dictated to pregnant women without engaging in respectful and dialogical conversations with them, honouring their own knowledges, desires, and agency, and their own ways of being. An ethical relationship requires that the agency of both parties be upheld, and this opens the way for resistance to dominant social constructions and norms.

8. Ethics

Foucault (1997c) defined ethics as "the conscious practice of freedom" (p.284), and he went on to say that "(f)reedom is the ontological condition of ethics. But ethics is the considered form that freedom takes when it is informed by reflection" (p. 284). Hook (2007) distinguished between discipline, as an institutional system of control, and ethics, as a form of self-control. Guilfoyle (2014) summed up Foucault's position by saying that "the notion of ethics ... refer(s) to the relationship the person has with him or herself, as opposed to the constitutive relationship the person has with knowledge or discourse." (p.170). Out of this reflexive relationship with herself, a person can then take an active and ethical stand for or against varying constituting discourses. She actively becomes subject to certain discourses, and also positions others in these discourses, whilst agentively resisting other discourses (Guilfoyle, 2014).

Freedom and ethics exist in a reciprocal relationship with one another. While liberation may be necessary where there has been complete domination of one subject or group by another and where power relations have become blocked and immobilised, such liberation is not sufficient to ensure freedom, where people can enjoy full and satisfying relationships with themselves and others (Foucault, 1997c). Once liberation has occurred, the ethical mandate is to establish "practices of freedom" which control power relations and ensure that future domination doesn't occur.

Foucault distinguished between morality and ethics, or practices of freedom, with morals being a set of rigidly defined rules, whereas ethics refers to the manners in which individuals or groups conduct themselves considerately with respect to such rules. Ethics, or practices of freedom, may be seen as an orientation towards a set of rules or morals, or a personal style, rather than the rules as such (Bevir, 1999). Foucault examined the development of ethical thought in ancient Greece in his second and third volumes of *The history of sexuality* (Foucault, 1985, 1986).

In his second volume, *The use of pleasure*, Foucault (1985) discussed his interpretation of ancient Greek philosophical thought (from approximately the fifth to third centuries BC). This examined how elite free men (not women, servants or slaves, who were deemed inferior) should live ethically, and as individuals suitable to rule, or govern. Foucault divided these "arts of self conduct" or "techniques of the self" (p. 251) into three broad domains where moderation was exhorted: dietetics, concerned with how to manage one's body in a healthy manner, encompassing diet, exercise, massages, baths and so on, and the correct timing of such ministrations; economics, relating to how one managed one's work and household, including wife, children, servants and slaves, in a just manner; and erotics, relating to the management of one's sexual impulses, particularly in so far as attraction to young males was concerned[18]. These were not binding and universal codes of conduct, or morals; they were "principle(s) of stylization of conduct for those who wished to give their existence the most graceful and accomplished form possible." (p. 250-251).

Continuing this trend, Foucault's (1986) third volume, *The care of the self,* discussed how subsequent centuries (approximately the last two centuries BC and the first two centuries AD) evidenced an "increasing mistrust of the pleasures" (p. 39) in Greek and Greco-Roman philosophical and medical circles, despite general society being largely promiscuous. Such thought was highly influential on the early Christian writers. However, this increasing emphasis on austerity was not legislated through laws and institutions; rather, an on-going vigilance and attention directed at one's own body and mind was urged for individuals who wished to be different from "the masses", and who were part of the cultural elite. This took the form of "an intensification of the relation to oneself by which one constituted oneself as the subject of one's acts." (Foucault, 1986, p. 41). It was a "cultivation of the self", or a "care of the soul" that was exalted as the highest means of ensuring a noble life, through turning one's attention from the external world and onto the self. However, this was not a solitary activity but a social practice: schools and institutions for spiritual direction emerged; reading and letter writing were encouraged; more advanced philosophers offered tutoring, guidance and counselling to initiates; trusted friends and family members called on one another for guidance in times of need – there was an interplay of the care of the self and helping others. Social relations and reciprocal obligations were thus intensified. Here are the seeds of pastoral power, as self-

[18] Foucault (1985) asserted that in the Greek thought of the time, sexual attraction to the same sex was not seen as different or separate from opposite-sex attraction, or as something "unnatural"; it was taken as a given that men would be attracted to beautiful younger males. The concern, rather, was how such attractions and resulting relationships should be managed in a fitting way. The philosophical tendency was towards an ideal of renunciation of such relations (instead of a blanket prohibition, as was installed in later eras), and this arose out of concern for the freedom and masculinity of the male youth, for whom passive penetration, like a woman, was considered un-manly.

examination and confession to an authority figure were techniques used to influence a person to conduct themselves in a particular manner.

Philosophy and medicine were strongly linked in this care of the self, as ills of both the body and the soul were thought to have the same causes and need the same cures. It was also considered important to recognise one's own ills, especially "soul ills", which are harder to detect than bodily ones. Thus, self-knowledge was promoted, through processes of testing oneself, examining oneself, and monitoring oneself, to determine the truth of oneself in order to become a master of the self (Foucault, 1986). But it was not only mastery of bodily and mental desires that was sought; such self-knowledge and care also enabled one to take pleasure in oneself, and find joy within oneself rather than in external, and ultimately impermanent, objects.

During this period and in this elite Greco-Roman context, Foucault (1986) saw a shift in emphasis regarding marital relations: increasing value was placed on the personal and affective bond between husband and wife, rather than only on how one should "manage" one's wife in a just manner. Reciprocity and erotic love began to be seen as important, and as an integral part of the care of the self, and hence renunciation of extra-marital sexual relations by the man (this had always been demanded of the woman) was upheld as a way of preserving the conjugal bond. There was an important difference between this ethics and early Christian morality: in Greco-Roman thought, the pleasures arising from sexual relations were not deemed to be wrong in themselves, but rather something that needed to be moderated carefully; early Christian thought, however, cast sexual relations as arising from the Fall, and as being inherently evil, with matrimony being the only context that could provide some legitimacy to such relations (Foucault, 1986). Along with the elevation of the emotional and sexual bond between husband and wife, pederastic attachments (between older and younger males) began to be disqualified as a legitimate means of enjoying sexual pleasure (Foucault, 1986).

Thus, care of the self, involving self-formation and mastery of bodily appetites, was the ethical imperative of the time and was necessary in order to conduct oneself and one's relationships with others properly (Foucault, 1997b, 1997c). It also ensured one's freedom – freedom from domination both by others and by one's own passions (Foucault, 1997b, 1997c). Indeed, slavery to one's own bodily passions was considered by Socrates to be the worst kind of bondage (Foucault, 1985). The self-care necessary for such freedom required two things: knowledge of the self through turning one's gaze upon oneself, often with the help of a guide or counsellor; and knowledge of how to conduct oneself acceptably: it required knowing certain "truths" (Foucault, 1997c) in order to conduct oneself according to certain stylized principles (Foucault, 1985). This care of the self

resulted automatically in the ethical management of the power that exists in all relationships: "it is the power over oneself that thus regulates one's power over others." (Foucault, 1997c, p. 288). These regulated power relationships lead to care of others, with as little domination as possible (Foucault, 1997c).

However, with the rise of Christianity in the West, care of the self was seen by some as a form of selfishness; renunciation of the self in order to obtain salvation after life was rather what was required. Foucault (1997c) believed that this led to an imbalance in terms of the care of the self as it ties in with the care of others. Likewise, post-Greco-Roman philosophy in the first three centuries AD emphasised the imperative to "know yourself" at the expense of "take care of yourself": there was a gradual uncoupling of the former imperative from the latter, leading to the latter's relative eclipse (Rabinow, 1997). As care of the self entails relationships with others, this disproportionate emphasis on knowledge has been detrimental at a relational level (Rabinow, 1997). Furthermore, there was a gradual replacement of the ethical mandates given to elite men with stern moral laws that were applied universally: "The individual lost any real latitude of interpretation with respect to codes of conduct." (Bevir, 1999, p. 76). Thus, violent relationships began to hold sway and freedom regarding the individual's own interpretation and application of moral codes was constrained.

Drawing these strands together, and referring back to Bevir's (1999) and Guilfoyle's (2014) understandings of the agentic Foucauldian subject, an ethical society, therefore, needs to (1) actively promote relationships of care (which includes care of both the self and of others) and (2) recognise people as agentic, or free, which necessarily involves encouraging resistance and promoting and celebrating differences. Foucault's (1985) concept of "arts of self conduct" (p. 251) is useful here: "arts" implies creativity, consideration, and variety, as opposed to the uniform imposition of moral codes or social norms. Guilfoyle (2014) brought in the notion of values, and he understood personal ethics, or "ethical subjectivity" (p. 171) to be informed by what is of importance and of value to a person. Ethical conduct, therefore, involves conducting oneself consciously in accordance with certain pre-existing principles and values, and orientating to the other in a manner that provides space for their agency (Guilfoyle, 2014).

Foucault argued that modern individuals tend to use their agency to comply with social norms, rather than resist them (Bevir, 1999) and so Bevir (1999) understood ethical conduct to be "the form of agency that resists normalization." (p.76). This leads to a relation to self that promotes questioning of inherited norms and enhances one's beauty and pleasure in life. Of course, the questioning we need to engage in necessarily draws from societal resources; as constituted and non-autonomous beings we are not capable of inventing our own unique practices free from all social

influences. Bevir (1999) stated that "(w)e escape the normalizing effects of modern power by exploring limits to authorised forms of subjectivity – by questioning our inheritance – and thus developing an ethics of conduct informed by our personal style." (p.77). Norms, identities, and codes of living, therefore, need to be presented to others as flexible frameworks to be explored and questioned rather than as rigid and unchanging rules (Bevir, 1999). However, such free questioning and stylization necessarily needs to be conducted within an ethics of care for others, where one's own agentic pursuits enhance the agency and freedom of others.

While I have shown, in earlier sections, how the question "What is the person?" is answered by illuminating the discourses that constitute the person, these latter sections on resistance and ethics point to answers regarding "Who is the person?": the person is someone who has the freedom to agentively act within the field of possibilities constructed by social power relations; the person is someone who relates to themselves, and has the corporeal capacity to resist a current constituting discourse in favour of another; the person is someone who is never fixed in static positions, but is always moving and adjusting.

9. Conclusion

In this chapter I have traced some of Foucault's theories regarding power relations and the manners in which subjects are constituted. Rather than seeing power as an external, repressive force that is wielded by those in authority, Foucault understood power, or power relations, to be fundamentally constitutive of all subjects: subjects arise within fields of force relations, and those relations determine what kind of subject they should be. Through power relations that purport to maximise the life and well-being of a subject (bio-power), a subject is exhorted to discipline their body and conduct themselves according to societal norms. Societal norms are constructed by varying power apparatuses, such as coloniality, patriarchy, and pastoral power. These apparatuses, which are loose assemblages of discursive and physical power effects, link macro-modalities of power, such as laws and institutions, with micro-modalities of power, such as technologies of the self. Such apparatuses develop to advance the reach of the state to ensure healthy and productive citizens. Such is the constituted subject.

However, a constituted subject is not all that a person is, according to post-Foucauldian theorists such as Bevir (1999) and Guilfoyle (2014). Power is never able to entirely subjectify the corporeality, or bodily energies, of the human being, and so a person is constantly exceeding, failing, or otherwise slipping out from under the dictates of constituting power relations. Nevertheless, there is an inbuilt search for meaning and subjectification by the human being, so as it slips out from the dictates of

one power nexus, it is immediately caught up in, or drawn to, another. The subject is, therefore, in a constant state of (often unnoticed) flux as it flows between differing subject positions. Ethics arises as the person reflects on their differing subject positions and agentively chooses how they would like to behave, whilst at the same time affording others the same freedom. Such is the ethical subject.

In order to analyse the constitution of pregnant women by the Organisation, and to uncover ways in which the Organisation can better assist them in an ethical journey, I analysed the subject positions that were constructed by the Organisation, and how these positions were provided, taken up, resisted, or modified. In the next chapter, I explicate my methodology for this process in detail, and describe the two differing analytical methods that I used, namely a Foucauldian Discourse Analysis (FDA) and a simplified Conversation Analysis (CA). The FDA illuminated how pregnant women were constituted by the Organisation, and the CA uncovered how subjects were able to exercise their freedom in either taking up or resisting the constitutional forms to which they were being subjected.

Chapter 5: Methodology

1. Introduction

In this chapter I first revisit the concepts of discourse and subject positions, given their centrality in my analysis. Then I present the research questions again, first given in the introductory chapter, as these are the fulcrum on which this project rests. I go on to I describe my data collection, the sources of which were the Organisation's training manuals, video and audio recordings of two three-day training sessions, 12 interviews with training participants, and 35 audio recordings of mentoring sessions by the mentors. I discuss the ethical considerations of which I needed to be cognisant, and I then outline the formative feedback that we as a research team provided to the Organisation. Thereafter, I reflexively analyse my own positions and conflicts that were prominent for me throughout my engagement with the Organisation. Given that a formative evaluation necessarily involves forming a partnership with the target organisation, and the Organisation and I came from very different world views, this was an area of great struggle for me throughout my involvement with them. After reflexively discussing my own positions and conflicts, I move into a discussion about issues of credibility and trustworthiness in my analysis.

In the last part of this chapter, I provide an in-depth discussion of the two data analytical techniques that I employed: Foucauldian Discourse Analysis (FDA) and Conversation Analysis (CA). An FDA analyses the broad discourses that are circulating within a certain context, and these discourses provide a lens through which to understand which technologies of power are being utilised to uphold certain power apparatuses, and which are present but marginalised. These discourses provide subject positions into which people are pressed, thereby contributing to the construction of subjects. By illuminating these power apparatuses, technologies, and subject positions, the potential is provided to advise on how to bolster just and caring techniques which may be suppressed, and how to counteract unjust and uncaring techniques. Conversation Analysis, on the other hand, is a fine-grained analytical method that looks at the here-and-now usage of interactional conversational practices within talk, and how these practices are used to achieve certain ends. One of the things that conversation achieves is positioning of subjects: the talker; the listener; and, possibly, third parties. CA enables a study of how people agentively take up or resist certain subject positions in the immediacy of a conversation, and how they recruit others into pre-defined subject positions. Given that talk is "somewhat pre-formed by ...[cultural] discourses and it is somewhat improvised on the basis of what is actually taking place within the conversational interaction" (Strong, 2005, p. 526),

the use of these two analytical procedures provided a well-rounded analysis of the discursive constitution as well as the discursive agency of participants in mentoring sessions. It enabled me to show how the women (both the mentors and the clients) in the mentoring sessions were constituted by, and held to certain subject positions, dictated by prevailing discourses, but, through the use of conversational practices, they did have some agency to resist or comply with the uptake of these subject positions. Furthermore, the top-down analysis provided by the FDA, coupled with the bottom-up, interactional analysis provided by the CA, gave rich insights to assist with the development of the intervention towards something that would incorporate both an ethics of justice and an ethics of care.

2. Discourse and subject positions

The concepts of discourse and subject positions were introduced in the last chapter, but given their centrality in this thesis, I revisit and elaborate on them here. Power and knowledge are joined through discourse, and discursive practices are therefore a means of exercising power (Foucault, 1978). Foucault rarely used the term "discourse", but instead talked of "discursive practices"; this distinction is important as it foregrounds the fact that discourses are not autonomous "things", but relations, procedures, and practices (Arribas-Ayllon & Walkerdine, 2008) that enable some "truth games" and constrain others. Foucault (1997) described **discursive practices** as "**characterised by the demarcation of a field of objects, by the definition of a legitimate perspective for a subject of knowledge, by the setting of norms for elaborating concepts and theories.**" (p.11). There are, therefore, pre-defined perspectives, forms, or **subject positions** that are created by discursive activity. From the subject positions opened up by discursive practices, a subject can know about and relate to the discursively established objects (which include other subjects). Subject positions are "historical delimitations of what is sayable, thinkable and practicable." (Arribas-Ayllon & Walkerdene, 2017, p.111).

The concept of subject positioning has become a prominent one in discursive theorising and has been taken up and extended by post-Foucauldian scholars. Mouffe (1992) stated that

> We can ... conceive the social agent as constituted by an ensemble of "subject positions" that can never be totally fixed in a closed system of differences, constructed by a diversity of discourses among which there is no necessary relation, but a constant movement of overdetermination and displacement... It is therefore impossible to speak of the social agent as if we were dealing with a unified, homogeneous entity. We have rather to approach it as

> a plurality, dependent on the various subject positions through which it is constituted within various discursive formations. ... this plurality does not involve the *coexistence,* one by one, of a plurality of subject positions but rather the constant subversion and overdetermination of one by the others, which make possible the generation of "totalizing effects" within a field characterized by open and indeterminate frontiers. (p. 372, emphasis in original)

It is this "ensemble", or "collage" (Törrönen, 2001) of subject positions that constitute the social agent, and such an ensemble arises from multiple and disparate discourses. However, Mouffe's (1992) observation that one subject position can subvert the others, leading to "totalizing effects" is an important one. Cloete (2012) discussed how some participants in her study of drinking women described themselves thus: "*Ek is n' drinker en klaar"* ("I'm a drinker and that's it") (p.2). The subject position of "drinker" had thus subverted other positions within the women's lives, leading to that position becoming totalizing. Nevertheless, as Guilfoyle (2014) pointed out, due to the multiplicity of discursive formations that constitute a subject, a subject is never entirely captured by one discourse, despite the appearance of totality. There are always other subject positions lurking in the shadows, waiting to move into a position of prominence. Drawing from Narrative Therapy theory (in particular as espoused by White (2007) and Guilfoyle (2014)) I, therefore, believe that for any intervention to be successful, subjugated yet agency promoting subject positions need to be "thickened" and brought to prominence in people's lives in order for unhelpful, totalizing positions to be displaced.

Whilst Foucault's earlier works have been criticised for suggesting that the person lacks agency, and is merely a docile puppet of power (Guilfoyle, 2014), passively swept up into whatever discursive formations are operating in their contexts, Foucault's latter works (Foucault, 1978, 1982, 1986) suggested a decidedly agentive subject: he refered to subjects' resistance to power, to their freedom to act, and to "constitute[ing] oneself as the subject of one's acts" (1986, p.41). There is an inherent tension in conceiving of a subject as both constituted and agentive. Subsequent scholars understand subject positions as both "conferred from above" in a top-down fashion by available discursive resources, and also agentively taken up or resisted in a bottom-up fashion by individual subjects (Davies & Harré, 1990; Taylor & Littleton, 2006; Wetherell, 1998), thus making allowances for both passivity and agency in subject constitution. While the top-down conferring of subject positions can be analytically captured through a discursive analysis, it takes a fine-grained approach such as Conversation Analysis to unlock the agentive, moment-by-moment uptake of subject positions during conversations.

The interactional contexts within which people are positioned/position themselves helps to determine the values attached to particular subject positions, which then fuels the uptake of favoured positions (Wetherell, 1998). The uptake or identification by a person with a particular, available subject position is not an automatic process, but is dependent upon situated "intensities and mechanisms" (Törrönen, 2001, p. 315) which drive positional uptake, meaning that the identification is often momentary.

With subject positions being locations within discursive practices, their uptake is imbricated in the power and truth games that are played out by the operation of constituting discourses. Indeed, it is through positional uptake that people socially construct their world through their talk (Wilkinson & Kitzinger, 2003). Törrönen (2001) explained this concept as follows:

> As we identify with and use subject positions we take part in the (implicit) meaning struggle on what kinds of identity forms and world views should be considered as natural and truthful in particular situations. The increase in knowledge, as attached to specific subject positions with which one identifies, does not mean solely that one becomes more enlightened but also that one becomes subordinate to the discourses' expectations on what is normal, permitted and serviceable. (p. 315-316).

Törrönen (2001) went on to explain that the knowledge that comes through being positioned within discourses "both subjugates and makes possible." (p. 316). Such positions guide our choice of behaviours in varying situations.

Inherent in the concept of subject positions are the notions of rights and duties (Davies & Harré, 1990; Warren & Moghaddam, 2018). These are related to notions of justice, but are also intimately tied to a person's subject position within prevailing discursive practices and the normative systems that such practices institute (Warren & Moghaddam, 2018). For example, positioning a pregnant woman as "mother" and her foetus as "baby" confers a duty to care for the foetus upon the woman, and the right to receive care upon the foetus. These duties and rights arise from normative constructions of a mother being sacrificially caring towards her baby. Tied up with duties are moral injunctions (Warren & Moghaddam, 2018). Those who do not perform their normatively defined duties adequately are subject to moral censure.

Subject positions not only confer rights and duties and guide behaviour, but they also enable emotions. For example, within a "mother" position, a woman may feel guilt and shame if she drinks,

or pride and accomplishment if she succeeds in fulfilling her normatively defined mothering duties. Subject positions are also relational: they gain their salience and meaning in relation to other possible subject positions.

Although in some ways similar to a role (for example, “mother”, “mentor”), subject positions are multiple, situation-specific, and fluid, unlike the static and pre-determined nature of roles. Whilst roles are frequently uncontested (“mother”, “social worker”), a subject position, and its associated rights and duties, are constantly negotiated within social interaction (Warren & Moghaddam, 2018). For example, the Organisation positioned pregnant women as mothers who have a duty not to drink whilst pregnant. A drinking pregnant woman may resist this “dutiful mother” position by claiming a position that has a right to drink because of the stress to which she is subjected.

Given this understanding that the subject positions which people habitually inhabit are fundamental in determining their subjectivity – their behaviours, duties, rights, knowledge, and affectivity – an analysis of subject positions should provide rich insights into the effects that an intervention has on the people it targets. Hence, I formulated the research questions which guided this enquiry as follows:

3. Research Questions

The overarching question was: **What power apparatuses and technologies were used to discursively position pregnant women during the intervention, and how may these positionings be altered or expanded to promote an ethics of care and justice?** Specific questions were as follows:

1. What discursive subject positions were evident during a FASD prevention intervention?
2. What power apparatuses and technologies innervated the construction of these positions?
3. What power relations were evident in the conversational practices used in the mentoring sessions of the intervention, and what positions did this lead to?
4. How may these positions and conversational practices be altered or expanded to promote an ethics of care and justice for pregnant and newly parenting women?

4. Data collection, informed consent and ethical clearance

The overarching project, which included this project, received ethical clearance from the Rhodes University Ethical Standards Committee (RUESC) on 11 July 2016 with tracking number RU-HSD-16-05-0001 (Appendix A). I received ethical clearance for this specific project from the Rhodes University Psychology Department Research Projects and Ethical Review Committee (RPERC) on 16

November 2016 with tracking number PSY2016/63 (Appendix B). Before any data gathering occurred, I requested a letter from the Organisation granting me and assistant researchers permission to gather the specific data that we wished to collect, which they duly provided (Appendix C).

Four different types of data were collected from the Organisation and the interventions that it provided, as shown in the table below:

Table 1: Data sources and analytical methods

Data	People involved	Analytical method
1. All educational manuals, power points and videos	Used to train community members to be community educators and mentors. Manuals used by mentors in mentoring sessions with women	FDA
2. Audio and video recordings of two 3-day training sessions	a. One training session (hereafter referred to as the first training session) to train community educators, involving training facilitator[19] and community members; b. One training session (hereafter referred to as the second training session) to train mentors, involving training facilitator and community members who had previously been trained as community educators	FDA
3. Audio recordings of 12 interviews	a. Six interviews conducted with people from first training session: five trainees and training facilitator b. Six interviews conducted with people from the second training session: five trainees who had not previously been interviewed, and the Organisation's Community Worker	FDA, with elements of CA when indicated
4. Audio recordings of 33 mentoring sessions	Mentors and their clients	Simplified CA

4.1. Training materials

The training manual used to train community members for the community awareness programme consisted of three modules, covering information on Foetal Alcohol Syndrome, alcohol and drugs, and pregnancy. The training manual used to train mentors was identical, but it had a fourth module on the role of the mentor. This same manual was used by mentors to educate the women they were

[19] The social worker was also the training facilitator. I refer to her sometimes as the social worker and sometimes as the training facilitator, depending on the role she was fulfilling

mentoring. I was provided with hard and soft copies of this manual in 2016. The three-day training courses made use of power point slides based on the manual, and videos. These videos were on the following topics: foetal development during pregnancy; the effects of alcohol on the foetus; a pro-life animated video on how precious the foetus is; a rap song in Afrikaans using the words "*As die ma drink, soos die baba saam*" ("as the mom drinks, so does the baby"); and a drama about a man who falls into alcohol abuse, and the effect this has on his family. Electronic copies of the videos and power point presentations were given to me in December 2017 for analysis. All the training materials were imported into an Nvivo 11 software package and subjected to analysis based on Foucauldian Discourse Analysis procedures.

4.2. Training sessions and interviews

The Social Worker conducted regular training sessions for community volunteers who agreed to be trained to become community educators for the community awareness intervention. Each training session lasted three days. From the trained community educators, she later recruited people to become mentors, and they received further training of three days. This consisted of a revision of the material covered in the community educator training, and a short module on the characteristics necessary to be a mentor. Training manuals, power points, and videos were all in English (except for one video clip in Afrikaans), but the Social Worker spoke in a mixture of English, isiXhosa and isiZulu (as her home language is isiZulu, whilst the predominant language in the municipality is isiXhosa.)

Two assistant researchers[20] helped me to collect data from the first training session and interviews, and one helped me with the second training session and interviews. At the start of the first days of the training sessions that we recorded, one assistant researcher described the nature and purpose of this research to the attendees in isiXhosa (this information had already been shared with the social worker/training facilitator). They were also provided with this information in written form via an information document, written in both isiXhosa and English (Appendix D). We were committed to using isiXhosa rather than English as much as possible to privilege the indigenous language over the colonial language. The assistant researcher emphasised the fact that the formative evaluation was of the programme, not of attendees or the training facilitator, and that if any of their talk was used in the data analysis, it would be anonymised. She requested their permission to audio- and video-record the training sessions. She explained the voluntary nature of the research, and that if anyone did not want to take part, any comments that they made during the training sessions would be deleted and not used in the data analysis. Attendees were informed that if they did not wish to

[20] Both of the assistant researchers were students doing post-graduate Masters degrees. One was working on Project Two and is fluent in isiXhosa and English. The other was working with me on this project (Project Three). She is fluent in isiZulu and English, with adequate proficiency in isiXhosa.

participate, they could indicate this on the consent form, or speak to one of the researchers privately. However, all attendees agreed to participate, and they and the training facilitator signed participant consent forms, and audio- and video-recording consent forms, also written in both languages (Appendices E and F).

We handed out the forms with the Xhosa side uppermost, and it was interesting to note that some participants loudly requested English forms, being unaware that English was on the reverse side. Although the home language of all participants was isiXhosa, some of them may have been more comfortable reading and writing in English. Furthermore, it appeared that English tends to enjoy a higher status in that community, being seen as the language of privilege and education. Indeed, the training facilitator stated that if she conducted training only in isiXhosa, it would not be held in as high regard as if she conducts it in English, with isiXhosa translations.

Since the Organisation had agreed to the formative evaluation, the training facilitator and community worker could not voluntarily consent to take part, as they were employees of the Organisation. Hence, there are limits here to the extent that this research could follow standard ethical procedures with regards to these employees. I stressed to them both that the evaluation was of the Organisation, not of them, or the training facilitator's specific skills as a trainer. However, despite this, I was mindful of how threatening it could be for the training facilitator to have her training recorded, especially as she was new to the Organisation. I reflected this to her and thanked her for her participation. I also made a concerted effort to affirm her skills as a training facilitator when I later gave feedback at team meetings, which I was able to do wholeheartedly. Indeed, in our experience as researchers, we found that she was always willing to engage in reflexive discussions on the training and appeared to be grateful for feedback regarding improvements that could be made in the training.

Informed consent for the interviews was part of the initial consent form (Appendix E), but interviewees signed separate audio recording consent forms (Appendix G). All participants in both the community awareness training session and the mentoring training session were given a grocery voucher worth R50 at the end of the training to thank them for agreeing to have their training session recorded. Interviewees were given an additional voucher worth R100. The social worker/training facilitator was taken out to dinner prior the start of the community awareness training session and given a gift at the end to thank her. Both the social worker and the community worker (who was only employed just prior to the first mentoring training session) were taken out to dinner before the mentoring training session, and the social worker was given another gift at the end to thank her.

4.2.1. Community awareness training session and interviews – December 2017

In December 2017, the two assistant researchers and I gathered data from one of the community awareness training sessions, which was taking place at the premises of a local NGO. There were 13 women and one man participating. Six of the participants were social workers, one was a community development worker, and the rest were unemployed. Some of the unemployed people earned a small stipend as community volunteers or generated some income through informal trading or service provision. The male participant was 22, but the rest were between the ages of 32 and 53.

Audio- and video-recording equipment was set up in the training venue, but we did not sit in on the training, to try and reduce the influence of our presence. Nevertheless, we took part in the ice-breaker activities, tea breaks, and lunch breaks with the participants. The training facilitator reflected afterwards that our presence at these breaks was appreciated by the trainees, and that it would have made them more comfortable when being interviewed by us. Training time (excluding breaks) was approximately 4.5 hours on the first day, 3.5 hours on the second day, and 2 hours on the third day.

Five participants and the training facilitator were recruited for individual interviews, which took place at the end of each day's training: one interview on the first day, two on the second, and three on the third day, with the training facilitator being interviewed on the third day. The interviews aimed to glean participants' reflections on the training sessions. We had to do one interview at the end of the first day, even though the participant would have to reflect on less than half of the complete training, as we couldn't fit them all in at the end of the second and third days. Given that we lived two hours' drive away from the training venue, and some participants also lived some distance away, it was not practical to interview them in the days following the training. Participants were recruited by asking for volunteers; thus, they were self-selected. They were interviewed in isiXhosa by the assistant researcher who was using the interview data for her own project, but the other assistant researcher was also present in each participant interview. This was because the first researcher was not completely fluent in isiXhosa and she requested the assistance of the second one who is a home language isiXhosa speaker. The training facilitator was interviewed by me in English.

Interviews were audio recorded. A semi-structured interview schedule was followed (Appendix H). After asking the participants to describe themselves, they were asked about how they got involved in the Organisation, what they felt were the strengths and weaknesses of the training, the language used in training, what they had learnt through their involvement, what they thought led to alcohol use in pregnancy, and how they felt the Organisation can reduce alcohol use during pregnancy. They

were then shown two pictures from the training manuals (described/reproduced in appendix H) and asked to reflect on them. Interview time ranged from 20 minutes to over an hour. Four of the six interviews took between 20 and 25 minutes.

The table below presents the demographics of the interviewees. I provide their employment status as this is a proxy for their socio-economic status and educational levels. I state the number of children they have as their experience of pregnancy is assumed to give them some insight into the condition of being pregnant.

Table 2: Demographics of interviewees from the community awareness training session

Interviewee	Age	Employment	Number of children
1	32	Unemployed	4
2	35	Unemployed	2
3	33	Unemployed	2
4	53	Unemployed	3 (2 deceased); 1 Grandchild
5	28	Social Worker with Department of Social Development	2
6	29	Training facilitator with the Organisation being evaluated.	0

4.2.2. Mentoring programme training and interviews – March 2018

In March 2018, one assistant researcher and I gathered data from one of the training sessions that the training facilitator held to train people as mentors. This was held at a community centre. The majority of participants had already taken part in community awareness training, and all were women. 20 people participated. The age range was from 21 to 57, with a fairly even spread of ages. The training consisted of a revision of the community awareness material, but with increased participant discussion, and then a short exhortation by the training facilitator on the qualities needed by a mentor. Practical details of how the mentoring was to be conducted (recruitment of women, number of visits, session records and so on) were also discussed. Length of training (excluding breaks) was approximately 2.5 hours per day.

We took part in icebreakers and tea/lunch breaks, but sat in a separate room during training. Video- and audio-recordings of the training sessions were made, and the assistant researcher recruited five volunteers for individual interviews. These were participants who had not been interviewed during the December round of data gathering. The second assistant researcher, from Project Two, could not

be present for this round of data gathering, so interviews were conducted in isiXhosa/isiZulu by only one researcher.

A community worker had recently been appointed by the Organisation to assist the social worker/training facilitator, and I interviewed her in English. The same interview schedule was used as in the December 2017 round of data gathering. Interviews lasted between 17 and 30 minutes.

Table 3: Demographics of interviewees from the mentoring training session

Interviewee	Age	Employment	Number of children
7	49	Unemployed	3
8	55	On local ward committee	3
9	50	Unemployed (but husband has a job).	3
10	28	Unemployed	1
11	40	Unemployed	3
12	36	Community worker	1

4.2.3. Translation and transcription of recordings.

Three independent transcribers/translators who were fluent in isiXhosa and English were recruited and they signed confidentiality agreements (Appendix I). They worked through all the recordings of both the training sessions and the interviews, translating the material in their heads, and transcribing the translations verbatim. I did not require that they transcribe the isiXhosa words, as I was not doing a fine-grained analysis on these data. However, I requested that they write transcriptions of translated speech in italics, while transcriptions of English speech were written in normal text. This was so that I could check if some speech stood out due to being in a different language compared to the surrounding speech, which would indicate some kind of interactional emphasis. An independent Xhosa/English speaking researcher checked the quality of about 10% of the transcription and translation of the training sessions and found it to be good. I, therefore, decided that checks of the remaining transcription and translation of the training sessions was not necessary. The assistant researcher checked the quality of the transcription and translation of the isiXhosa interview data and found it to be adequate. She made corrections where necessary. I checked the quality of transcription of the English interviews and made corrections where necessary. I conducted an initial evaluation of these data and wrote a formative feedback report on the training sessions, which I presented in writing and verbally at our quarterly team meeting in August 2018. It is described in the next section. Data were then imported into an Nvivo 11 software package and subjected to in-depth analysis.

4.3. Mentoring sessions

After each mentoring training, the social worker, community worker, and the trained mentors would recruit drinking pregnant women into the mentoring programme. Informal networks and antenatal clinics were used as referral sources. Each mentor was assigned three women (referred to as clients) and was tasked with visiting each client once a week, and also once a month over the weekend. This mentoring relationship ideally lasted for a year in order to continue providing support to the woman once she had given birth. The social worker also provided between four and six psycho-social counselling sessions with each woman. When mentors and women dropped out of the programme, the social worker and community worker recruited replacements.

At the end of July 2018, the social worker organised a meeting of all the mentors, from both intervention sites, and I addressed them regarding making recordings of their mentoring sessions. Seventeen mentors attended. They had all attended the mentoring training from which I had gathered data, so they had some familiarity of me, the nature of the research, and issues of confidentiality and anonymity from that session. All the mentors spoke English, but the community worker translated what I said into isiXhosa in order to ensure that the information was clear, as I had no assistant researcher with me this time. I again explained the nature and purpose of my research and I gave them information sheets on which the same information was provided in English and isiXhosa (Appendix J). Ethical safeguards regarding the voluntary and confidential nature of their participation and that of their clients was emphasised. I explained that I would give a report to the Organisation on how they may make the mentoring programme even better, but I stressed that no individual names or details regarding their mentoring would be divulged to any of the Organisation's personnel, or in the research report. I asked those who wished to, to assist me by recording three of their mentoring sessions, and I stressed that their participation was voluntary. All the mentors who were present agreed to record their mentoring sessions, and they signed research consent forms (Appendix K) and audio-recording consent forms (Appendix L). I then trained them to provide the same information to their clients, both verbally and in writing (Appendix M), and to seek voluntary verbal and written consent from their clients to take part in the research (Appendix N) and to be recorded (Appendix L). I emphasised that they should not pressurise clients to take part if the client was in any way reluctant. Two mentors then role played a scenario where one was a mentor providing the information and requesting voluntary consent, and the other was a client. This was to ensure that the whole process was clear.

A group of four mentors were each given an audio recorder and trained how to use it. They were provided with three envelopes each. Each envelope contained an information form for the client to keep (Appendix M), a consent form to participate in the research (Appendix N) and a recording

consent form (Appendix L). Clients were to fill in the latter two forms, to be returned to me. I arranged to return in a week's time to collect the recorders and completed consent forms, download the recordings onto my hard drive, delete the recordings from the recorders, and then pass the recorders on to the next group of mentors. This was repeated four times over intervals of one or two weeks. Mentors were grouped according to where they lived, and convenient meeting points close to their homes were arranged. Some mentors who lived near to one another shared a recorder. Each time I met with a new group of mentors to give them the consent forms and recorders, I reviewed the instructions. The community worker accompanied me each time to direct me to the various meeting points. I phoned or texted each mentor a few days' prior to collecting the recorders to ask if there were any difficulties and to remind them of the meeting time and venue. Mentors who were to receive the recorders were texted a reminder the day before.

Two mentors did not gather any recordings, but the remaining 15 gathered between one and three recordings, providing a total of 35 recordings. One recording was only nine seconds in length, and it appeared to be from a client who did not wish to participate, even though that client had signed consent forms. This suggests that voluntary participation may not always have been negotiated appropriately. The importance of voluntary consent may not have been clear to the mentors. It is also possible that the mentors felt some obligation to me or the Organisation to obtain recordings. They may also have anticipated receiving a token of thanks, as they had during the training sessions, even though I didn't mention this to them beforehand, and so there may have been a perverse incentive for them to gather recordings. Two of the recordings appeared to be of a "staged" mentoring session: it sounded like a person (in one case, a child) was reading answers from a sheet of paper, and being prompted to talk at the appropriate time, so I deleted these two staged recordings from the data set. However, I kept the recording of only nine seconds, as it provided interesting insights into resistance to the Organisation's intervention. I ultimately had 33 mentoring recordings in my data set.

Mentors were given shopping vouchers of between R50 – R200, depending on the number and length of recordings they gathered, to thank them for their participation. Each client who was recorded was given a R50 shopping voucher. The community worker distributed the vouchers to the clients.

The table below shows that the majority of sessions were between two and ten minutes in length. All the sessions that lasted more than 40 minutes were from a single mentor.

Table 4: length of recordings of mentoring sessions

Length of sessions	0 – 1 minute	1-2 minutes	2–5 minutes	5–10 minutes	10–20 minutes	20–30 minutes	30-40 minutes	40–50 minutes
Number of sessions	1	3	8	10	6	1	1	3

Total number of sessions – 33

Nine of the 15 mentors who provided recordings had been interview participants in the first and second rounds of data collection. Only one of the 15 mentors provided recordings of sessions with their clients that could reasonably be called mentoring. The others appeared to be copying the interview format that they had taken part in, by asking the women to evaluate the Organisation, and/or they simply retold information about FASD and pregnancy that they had learnt. I had really emphasised to the mentors that my evaluation was of the Organisation, not of them, but they possibly felt that I was asking them to glean evaluations from their clients, rather than engage in mentoring. However, given that their training to be a mentor consisted of teaching them about FASD and pregnancy, and extremely short input on the necessary characteristics of a mentor (to be sober, responsible, upstanding, and so on), it is not surprising if they did not understand what mentoring involved.

4.3.1. Translation and transcription of mentoring sessions

One of the three translators/transcribers who had transcribed the previous data was engaged. Because I was doing a fine-grained, CA analysis on the mentoring data, I needed a more detailed transcription of the mentoring data than of other data. I requested that the speech be transcribed verbatim in isiXhosa, including transcription notations to indicate pauses, pitch, volume, sighs, and so on (see Appendix O for transcription notations.) Then a translation into English, as direct as possible, was provided under each conversational turn. An independent researcher, fluent in both isiXhosa and English, listened to approximately 10% of the recordings and rated the transcription-translations, which she found to be excellent.

5. Ethical considerations

In line with Roth and von Unger (2018), I understand ethics in research to be concerned with an ethical relationship between the researcher and the participants, rather than with a set of rules to be followed. Rules can be broken, or merely paid lip-service, whereas an ethical relationship requires that the researcher at all times, and to the best of their ability, upholds ethical principles throughout the research process, not just when participants are being recruited. Foundational ethical principles are those of beneficence, nonmaleficence, justice, and autonomy and respect for the dignity of participants, which is most often upheld through voluntary informed consent and confidentiality

(Wassenaar, 2006). However, the notion of "relationship" speaks to more than just principles; it suggests ongoing engagements and moral commitments over time, both with participants and with the data that they provide. Bijloos (2017) referred to the ethical project as a "complex interplay of moral considerations" (p.220), and this requires ongoing reflexivity and a continual weighing of risks versus benefits to individuals, organisations and communities. I discussed how I upheld my university's ethical rules in the section above (ethical clearance; written, "informed", "voluntary" consent; and confidentiality agreements), and I provide a reflexive discussion in section 7 of this chapter. This section looks at some of the ethical dilemmas I faced, particularly around confidentiality, informed and voluntary consent, and possible unintended harms.

While we are committed to concealing the identity of the Organisation in order to maintain confidentiality, there are limits to this. Anyone who reads this thesis who has knowledge of NGOs working in the field of FASD prevention in South Africa is likely to be able to identify the Organisation, due to descriptions I have given and some of the discussions in which I have engaged. Reputational harm may then occur as some of my findings do not place the Organisation in a very favourable light. However, in weighing the possible harms of this compared to the benefits I hope have accrued through this research by improving the Organisation's interventions and reducing their blaming stance and stigmatising messages, I trust that the balance is in favour of beneficence overall.

Through our ongoing relationship with the Organisation and funders over four and a half years, where we gave feedback regularly to both the Organisation and the funders, there was always the dilemma of presenting accurate findings and holding the Organisation accountable, yet not undermining them in front of one of their primary funders. Fortunately for them, this funder had partnered with them over a number of years, and the company representative of this funder appeared to hold the same conservative Christian views as the Organisation, which aligned her strongly with the Organisation. From our side, we took pains to highlight the positive aspects of the interventions. Due to the fact that the Organisation had agreed to the formative evaluation, the training facilitator/social worker and community worker could not voluntarily consent to take part. I endeavoured to mitigate any harms that may have befallen them, as discussed in section 4.2, particularly around anxiety that the facilitator may have felt at having her training recorded.

Bijloos (2017) suggested that trust between researchers and participants is a necessary precondition for ethical research, particularly if issues of confidentiality and voluntary consent may be at stake. Trust can only be built over time and with ongoing engagements. We hope that the relationship that we built with the Organisational and funder representatives, and the engagements that I had when

collecting data with the Organisation's social worker and community worker, kept us ethical in terms of not causing harm to the Organisation, social worker, or community worker.

In terms of risks and benefits to participants other than the Organisation and their staff, minimal risks were likely to have accrued to trainees who agreed to be recorded during their training sessions, and to be interviewed. Interviews are often a place of validation and a chance to have one's story and views heard, so I hope that interview participants benefitted personally from the interviews. One interviewee spoke personally about her emotional pain when her husband went drinking, leaving her alone at home with their children; this is likely to have been helpful to her, given the well documented benefits of verbalising emotional pain to an empathic listener.

The issue of social desirability, and the power dynamics involved, with the Organisation and I holding more power than participants, means that some participants may have volunteered to be part of the research when they would not have if their participation had been negotiated anonymously. This is likely to have been especially true for participation in making recordings of mentoring sessions. Mentors gathered for a special information and training session with me, and it would have been socially awkward for one of them to refuse to participate in front of their colleagues and the Organisation's community worker. As well as issues of social desirability and power dynamics, cultural norms around compliance with authority figures may have meant that the mentors did not feel that they had the freedom to refuse to participate. However, two of the mentors did not make any recordings, either because they were unable to access their clients, or because they did not want to participate, and in this way, they may have exerted their agency in refusing to take part.

Negotiating of informed consent and voluntary participation with clients was done by the clients' mentors. Therefore, how well these factors were negotiated is unclear, even though all clients signed consent forms. One recording was only of nine seconds and was with a client who was clearly reluctant to speak. It, thus, seems likely that voluntary participation was not negotiated properly with this client. This may have been true for other clients too. The possibility that participation was not entirely voluntary, especially for the clients, is an ethical limitation of this research. The fact that all clients signed consent forms stating that their participation was informed and voluntary, yet there are questions about how voluntary, or informed, the consent was, highlights the limits of traditional ethical safeguards around these factors.

I feel the possibility of risks may also have accrued to clients due to them being subjected to quite difficult interactions with the mentors. Many of the mentors seemed to be at pains to prove to me that they were upholding the mandate of the Organisation by inciting their clients to be responsible

mothers, and by giving them much information that they had clearly given before. This led to very stilted conversations, with many examples of “violent relationships” where the mentor did not grant any agency to the client. This suggests that some harm may have accrued to the clients through the recording process. This is not something that I anticipated prior to obtaining the recordings. If such research is to be repeated, I believe that consent needs to be negotiated by someone from outside the Organisation and the women’s communities, but who is socially closer to the clients than me or an assistant researcher.

The issue of perverse incentives may, paradoxically, have increased the risk of harm to clients. We gave shopping vouchers to trainees and interviewees after gathering data from them, and although we did not tell them this beforehand, it is likely that the mentors (who had also been trainees, and, in some instances, interviewees) anticipated (rightly so) receiving them again after obtaining recordings. This may have encouraged them to insist that their clients agreed to be recorded, even if they did not want to. While clients also received shopping vouchers if their session was recorded, this factor, as well as compromising their voluntary participation, would also have affected the trustworthiness of the data. The ethical dilemma of perverse incentives when doing research in resource-deprived communities is a common one. It is important to acknowledge poor people’s time and knowledge as precious and compensate them in some way for their efforts in participating; however, where resources are scarce, it is understandable that people participate solely for the money. In projects such as mine, where poor people were tasked with negotiating consent with other poor people, the risk that the autonomy and dignity of potential participants may not be respected is much higher.

6. Formative feedback

As this research was a formative evaluation of the pilot intervention, we were committed to providing feedback to the Organisation throughout the process of our engagement with them, and to give recommendations on how the intervention may be improved. I, therefore, provided the Organisation and the funders with three formative reports[21], presented in writing and verbally at three different quarterly meetings. The reports addressed the training manuals, the training sessions, and the mentoring interventions, and I presented them as soon as possible after gathering the necessary data on each of these aspects of the intervention. The plan was that the Organisation may incorporate some of our recommendations, and we could then assess whether they did, in fact, enhance the intervention. Unfortunately, for various reasons that will be discussed below, our

[21] Not included in appendices to protect the Organisation’s identity

recommendations regarding improving the training manuals were only implemented after I had completed all my data collection, and the entire intervention was based on these manuals.

6.1. Formative report on training manuals

I received hard and soft copies of the training manuals used for the community awareness and mentoring programme in 2016 from the Organisation, and subjected it to an initial thematic analysis (Braun et al., 2015), using a critical pedagogical lens. Critical pedagogy seeks to uncover and challenge power dynamics, and to act against processes that reproduce oppression in educational settings (Apple et al., 2009). I then wrote a formative evaluation report on the manual for the Organisation and research funders. I presented this report to the Organisation's CEO, Social Workers, and other Organisational staff, as well as representatives of the funders, verbally and in writing in March 2017 at one of our quarterly meetings. Electronic copies were also emailed to all the parties. I had hoped that this feedback could be used to improve the intervention prior to its implementation in the Eastern Cape. This 24-page report consisted of a literature review of pertinent research findings, a discussion of what I perceived to be the strengths of the manuals, and suggestions for ways that they could be improved. I based the latter two areas on insights from the literature, critical pedagogy, and an empowerment approach. The empowerment exercises that I suggested were based on a combination of Freire's (1993) approach to dialogical pedagogy and White's (2007) approach to narrative therapy.

The literature review included in this report addressed the following issues: evidence for using a harm reduction rather than abstinence approach; factors that contribute to alcohol consumption during pregnancy; whether low alcohol consumption affects the foetus; the effects of maternal nutritional status on the foetus; evidence for the positive effects of early interventions with prenatally alcohol exposed children and their carers; the importance of the mother-child relationship; media reception studies; and the success of Motivational Interviewing techniques in assisting people who abuse substances. I chose this literature as it addressed what I perceived to be deficits in the manuals.

I identified strengths of the manual as the following:

a. The use of video clips and coloured pictures;
b. Provision of information on foetal development, pregnancy, and labour;
c. Attempts to include male partners;
d. Provision of information on alcohol and drugs.

I then highlighted five possible areas for change and provided suggestions for how these changes may be effected. The first two areas referred to factors that could have unintended negative effects; the second two to areas of lack; and the final one to the style of information presentation. The section headings for these possible areas of change are presented below:

1. Reduce the potential for blame and shame-induction
    1.1. Move from an abstinence-based approach to a harm reduction approach
    1.2. Promote empathy for women who drink while pregnant
    1.3. Eliminate blaming or stigmatising language
2. Try not to stigmatise people with FASD
3. Attempt to build up strengths and promote empowerment
    3.1. Positive messaging
    3.2. Ways to shift identities and promote empowerment
4. Improve training in the skills of mentoring
5. Ensure information is contextually relevant and accurate.

In sections 1, 2, and 5, I provided examples from the existing manuals, highlighted the challenges or difficulties that these examples posed, and provided possible alternative wording or information that could be used. In section 3, I gave possible ways of providing positive messages, shifting identities, and promoting empowerment. In section 4, I suggested that mentors be trained in basic listening skills and motivational interviewing, as there was barely any training in the skills of mentoring.

Later in 2017, the Organisational CEO engaged a curriculum developer, on the recommendation of my supervisor and me, to improve the manuals in line with the suggestions I had given. Unfortunately, the drafts that she produced required quite high levels of literacy. Given the fact that many of the people recruited by the Organisation to provide community awareness or mentoring are not well educated, both the CEO and I felt that her drafts were unsuitable. I provided several rounds of feedback to her and the CEO from September 2017 to January 2018, giving suggestions on how to improve the drafts, but the final product still had overly high literacy levels. I suggested that her draft would be useful to inform the Organisation's staff, to which the CEO agreed. The Organisation decided to pay her only half her fee and engage a different curriculum developer. The CEO requested that I update the manuals, but I felt that this would be a blurring of my roles and I refused. However, as of January 2019, no new curriculum developer had been engaged, and my data collection and formative reports were complete. My research unit then offered to update the manuals, and I and the other researcher who worked on this project re-designed and re-rewrote the

manuals according to my original recommendations. We sent the final draft to them in May 2019. I am not sure when the Organisation rolled out these new manuals, and we struggled to get feedback on the manuals. Eventually, in August 2021, the social worker emailed us the following feedback that she had sourced from some mentors: "We have been loving the manuals"; "They are relatable and realistic"; "It has new important information, i.e. stats of unintended pregnancies"; "The suggested topics for brainstorming and those questions that make the audience think, while allowing them to participate, share views and interact with the facilitator are very helpful". Unfortunately, there was no reference to improved mentor training, which was a major addition to the manual, and which would have required significantly more training time. Therefore, I do not know whether this part of our updated training manual has been rolled out or not.

I had hoped that my feedback report on the original manuals would be used to inform the training that commenced in October 2017, despite the lack of updated manuals. Unfortunately, this was not the case and training in 2017 and 2018 proceeded according to the original manuals.

6.2. Formative report on training sessions

Once the recordings from the training sessions and interviews had been translated and transcribed, I imported the transcriptions into an NVivo 11 data analysis software package and subjected them to an initial thematic analysis (Braun et al., 2015), using a critical pedagogical lens (Apple et al., 2009). I then wrote a formative evaluation report on the training sessions for the Organisation and their funders. I presented this report verbally and in writing in August 2018 at one of our quarterly meetings, and electronic copies were emailed to all the parties. This 10-page report was shorter than the previous (2017) one as it did not include a literature review. However, it made frequent reference to the 2017 report, and to the literature cited there.

I identified the following areas of strength in the training:

1. It is conducted in a manner that is pitched at the right level for the participants;
2. It uses a good variety of interactive teaching methods;
3. It uses helpful visual aids and videos;
4. It is encouraging and supportive of the participants;
5. The participants generally find it enjoyable.

The areas that I felt needed to change or be included were as follows (the first four points were identified as the most important):

1. Bring in a strong emphasis on not blaming drinking pregnant women;

2. Focus more on larger societal issues that drive drinking;
3. Greatly expand mentoring training, including basic listening skills and motivational interviewing techniques;
4. Reduce the emphasis on the disabilities associated with FASD as this is stigmatising, and participants were leaving the training assuming that the majority of childhood difficulties were due to FAS;
5. Draw off participants' inherent knowledge in a more deliberate way during discussions;
6. Include harm reduction as well as abstinence messages;
7. Avoid the assumption that pregnant women are married or have a partner who is present;
8. Ensure that the information provided is accurate;
9. Streamline the material, as there is some unnecessary repetition, and information is not always presented logically;
10. Translate the training materials into isiXhosa.

I also presented a role play of a mentoring session (with myself as the mentor and a colleague working on Project Two as the pregnant woman) at our quarterly meeting in August 2018. The whole research team (from all three projects) gave input on trial runs of this role play the day before it was presented. It was presented in order to demonstrate to the Organisation and funders the kinds of mentoring that we were suggesting, and also to point out that role playing is necessary in order to train mentors.

6.3. Formative report on mentoring sessions

Once the mentoring sessions had been transcribed and translated, I listened to the recordings with the transcriptions and translations in front of me. Unfortunately, I cannot speak isiXhosa, but having the translated transcriptions in front of me whilst listening to the recordings gave me an understanding of both the auditory non-verbal[22] as well as verbal aspects of each recorded mentoring session. Auditory non-verbal aspects included silences, sighs, background noises and changes in pitch, volume or pace of speech. Based on this exercise and drawing off my knowledge and experience as a Counselling Psychologist, I then wrote a formative evaluation report on the mentoring sessions which I presented at our quarterly meeting in November 2018. Due to delays in transcribing and translating the material, and deadlines for presentation of the report, I only had transcriptions of 21 of the 33 recordings when I wrote the formative report.

[22] Without video-recording, I could not assess body language or facial expresssions

The report was much briefer than the others (only three pages). After describing the data gathering procedures and the nature of the data upon which the report was based, I presented what I perceived to be the strengths and the weaknesses of the mentoring programme.

Areas of perceived strength:

1. Some clients expressed appreciation for what they had learnt, and most claimed that they were no longer drinking (although the influence of social desirability on their responses was pointed out);
2. Some mentors had a warm and encouraging manner with their clients. It is likely that the mere fact of having an older woman visit regularly can be a source of psychosocial support;
3. The Organisation's Social Worker and Community Worker provide regular workshops for mentors and also for clients. I did not gather data from these workshops, but it is likely that they would not only provide both mentors and clients with knowledge on various health matters, but would also be a source of social support and encouragement for both mentors and clients.

I only had one major suggestion for change, and that is the one that I raised in both previous reports and at previous meetings: namely, that mentors were not actually trained how to mentor but were merely provided with information on FASD, and appeared to see their mandate as teaching rather then mentoring. Although I had tried to stress to mentors that they were not being assessed individually, and no feedback on their individual performance or mentoring style would be provided to the Organisation, it is likely that some of them may still have felt anxious when recording their sessions. This anxiety may have masked some of their own natural empathic abilities (this point was mentioned in the report.) Nevertheless, their lack of training in mentoring skills was very clear in the recordings, as discussed below and presented in the report:

1. Most of the recording time was taken up with mentors giving a great deal of unrequested information to their clients, which was frustrating for some clients;
2. Mentors would sometimes ask their clients questions, but these were closed-ended and did not encourage the women to express themselves freely;
3. Mentors displayed very few actual mentoring skills such as empathic and active listening, the use of open-ended questions, or motivational interviewing techniques. The only way they appeared to know how to assist women was through providing information;
4. Some blaming language was used at times.

7. Reflexive discussion

In conducting this research and writing this thesis, I was, and am, situated within two broad categories of subject positions: what I call "distal" positions, encompassing my demographic characteristics, and "proximal" positions, which have to do with my personal belief systems which I take up in a more agentic manner than my demographic positions.

In terms of distal positions, I am a "white", middle-aged, middle-class naturalised South African female who is unable to speak any indigenous language, and who is married with three young adult children and a professional post-graduate degree and registration as a counselling psychologist. My appearance and speech reveal many of these positions immediately – white, aging skin; decent car; wedding band on one hand and diamond on the other; woeful lack of fluency in any language apart from English. The participants who were recruited to become community educators and mentors were poor "Black" females with limited education. We were, therefore, automatically "other" to one another in terms of race, socio-economic status, language and education, despite my attempts to position myself closer to them by taking part in ice-breaker activities and joining them at mealtimes. How did the participants position me? As a member of the Colonial, racist class? As someone there to "educate" and "evaluate" them? As someone from whom resources could be gleaned (like the shopping vouchers we gave them)? As someone to whom they needed to pander, appease, and prove their worth? As someone who was so far removed from their daily life and struggles that I could not possibly understand them? As someone seeking a further qualification through using them as participants? I do not know. The assistant researchers were young, "Black", well-educated females working on Masters degrees, who were fluent in English and isiXhosa/isiZulu. However the participants positioned us as researchers, it would have shaped the data that they provided for us in fundamental ways (Berger, 2015).

In terms of my proximal positioning, I hold two common beliefs within the field of FASD. Firstly, I believe that helping women to desist from drinking heavily during pregnancy and in the post-partum period (and at other times) is a creditable thing to do, and a duty that the whole of society carries. This belief positions me as an ally in the fight against FASD. Secondly and relatedly, I hold the view that risky drinking is generally potentiated by multiple adverse societal factors (de Vries et al., 2016; Eaton et al., 2014; Macleod, Matebese, et al., 2020; May et al., 2019; Watt et al., 2014, 2016), and that addressing these factors above the behaviours of individual women holds the most potential for success in achieving a reduction in FASD. This view stems from social justice and feminist discourses, in which I position myself as a critical feminist researcher. I also hold a third belief, originating from my studies in Narrative Therapy (Guilfoyle, 2014; White, 2007) and my positioning as a narrative therapist: I believe that, in order for an individual to shift from an undesirable dominant position,

other more desirable and socially acceptable positions need to be viable and available for the individual to inhabit. As Guilfoyle pointed out (personal communication, 2014), we can't ask people to say "no" to a particular position without giving them viable alternative positions to which to say "yes".

As a practicing counselling psychologist, I am situated squarely within a psychological apparatus. The discipline of psychology has been widely critiqued for, until recently, upholding white supremacist views of race and intelligence, being complicit in apartheid and colonising projects, being uncritically heteronormative, being dominated by knowledge produced in the global North, and being at the forefront of classifying mental and behavioural states into "normal" and "abnormal" (Kessi & Boonzaier, 2018). As Kessi and Boonzaier (2018) stated, "(t)he role of the discipline in regulating behaviour and constructing what is considered 'normal' and what is not cannot be overstated." (p. 300). As such, psychology fits the definition of a power apparatus that extends the reach of the state to produce productive and compliant citizens. I attempt to position myself as a decolonial feminist psychologist which seeks to: undermine patriarchal and heteronormative practices; foreground knowledge production in the Global South; highlight and work against unjust and unequal power differentials between dominant and subordinated people groups; work relentlessly towards social justice; embrace an understanding of intersectionality; and to challenge what is taken as "normal" (Boonzaier & van Niekerk, 2019). As a researcher, I hope that I succeed in this, to some degree. However, as a practitioner, my income is generated through my practice as a mainstream psychologist with primarily economically privileged individuals; I attempt to assist them to overcome mental health difficulties, defined normatively by the DSM 5, and to live more "successfully" as neo-liberal, capitalist citizens, through drawing on Euro-American therapeutic knowledges. I worked hard to be admitted as a practitioner of this psychological apparatus, and I uphold it during my economic labour.

I also inhabit a personal position as a progressive Christian. As such, I believe in a Creator God/deity; in an unseen but real spiritual realm; in the sacredness and interconnectedness of all aspects of life; in the importance of social justice; and in a progressive interpretation of the life and teachings of Jesus and the books of the Bible. Thus, I inhabited the following positions (that I am aware of) to various degrees throughout my research: an ally in the fight against FASD; a feminist decolonial researcher and psychologist; a "mainstream" psychologist; and a progressive Christian. To a greater or lesser degree, all of these positions determined the design of this research; the types of literature that I reviewed; the nature of the data that I collected; the themes, discourses and subject positions

that I identified in the data; the kinds of feedback that I provided to the Organisation; and, of course, the analysis, findings, recommendations, and conclusions that I present in this thesis (Berger, 2015).

Apart from my belief in the importance of assisting drinking pregnant and parenting people to cease or reduce drinking, which I held in common with the Organisation, my other positions made my four years of engagement with them often frustrating and difficult for me. I perceived the Organisation to be conservative and paternalistic; I was frustrated that, despite our ongoing formative input, they continually emphasised the need for individual women to take responsibility for their behaviour and did not take societal drivers of drinking into consideration; they did not appear to have any conception of what effective mentoring entailed; and they placed barely any emphasis on building up positive skills and identities in the women. The Organisation was also overtly conservatively Christian, using quotes from the Bible in its manuals, and taking a strongly pro-life, anti-abortion stance. Having moved from that position myself many years ago, I was at times patient, and at times frustrated and angry with what I perceived to be their narrow and rigid religious stance that was covertly stigmatising, paternalistic, and judgemental.

However, I also situate myself within therapeutic and Christian discourses that emphasise the importance of understanding a client's subject positions, developing empathy for them, and striving to be radically non-judgemental. Viewing the Organisation as a client led me to take up a more empathic position towards them as I became aware of their concerted and sacrificial efforts to intervene in a difficult social situation.

All of these subject positions are ones that I value. Sometimes, I hope that I was able to hold them in creative tension and be affirming and empathic towards the Organisation whilst also providing critique. For example, when collecting data, I would tell participants that our goal was to assist the Organisation to be "even better". When giving feedback to the Organisation, I tried hard to affirm their strengths as well as point out aspects that I felt undermined care and justice, and how these aspects may be addressed. However, at other times I would bounce rather haphazardly between my positions, alternating between frustration, anger, and judgement when Organisational messages were perpetuated that I felt were implicitly or explicitly blaming of women, or were stigmatising of people with FASD, then feeling empathy and even admiration for some of the Organisation's employees when I saw their difficult working circumstances and sacrificial engagement with women.

Sometimes I would enter another position, and one that I value less (and therefore probably pay it less heed.) It was this position that led to the most difficulty for me. This was a position as someone who wants recognition for their efforts, and for their work to have an impact and make a difference.

When the Organisation did not act on my suggestions, or on my very carefully written reports, I found it frustrating and discouraging, and I would feel angry towards them. Blaming or stigmatising messages that they perpetuated were particularly hard for me, as we had highlighted these faults from the start of our engagement with the Organisation. I, in turn, would blame and stigmatize them in my mind (and to others) as a moralistic enterprise, out of touch with the lives of women they were purportedly helping. At these points I was most grateful to be working in a larger team, and with a supportive supervisor, both of whom provided encouragement and validation of my critical insights. My supervisor was able to take up a more detached and pragmatic position than me, and she pointed out that, even if the Organisation does not change much, forthcoming papers from my work may still advance the field of interventions into FASD.

The updating of the manuals that we did in the first quarter of 2019 was perhaps the aspect of our work that may have had the most impact, although again, this was saturated with frustration: we agreed with the Organisation that the updating process would be an iterative one, where they would review each module and provide feedback; we would adjust them based on their feedback; they would use the modules in training and provide further feedback, and then we would make final adjustments. However, we did not get any feedback during our updating process. Finally, two years after we had completed the updates, when I was wondering if they had even printed and started to use the new manuals, we requested feedback once again, and the social worker sent some snippets of comments from mentors who commented very positively on the updated manuals.

There were two periods of particular difficulty for me with this project. The first was in the first half of 2016 when I went through the training manuals and realised how far my own views and positions were from those of the Organisation. I wondered how we could possibly work together, and I even approached my supervisor to discuss working on a different project within the field of FASD. Pragmatic reasons, including funding, were part of what kept me within this project at that point. However, there was also an ethical mandate: having seen the gendered coloniality that was being perpetuated in the manuals, and knowing that the intervention would continue, regardless of our involvement, behoved us to do what we could to reduce the harms that we saw being perpetuated. The second period was in August and September 2018. By this stage I had collected the data from the mentoring programme, could see how short many of the recordings were, and had received some translated transcriptions. It was already clear that, rather than mentoring, most of the mentors were advising or lecturing their clients. This was difficult for me, as I place high value on listening. At the end of August 2018, I presented my formative report on the training sessions (with an effort to affirm some of the positive aspects) at our quarterly meeting with the Organisation and

funders, and, as I had pointed out previously, highlighted the lack of training in mentoring skills. We also presented a role-play, to demonstrate the kind of mentoring session that we envisaged. However, there still seemed to be no acknowledgement of the importance of training in mentoring skills. One of the aspects that the Organisation appeared to struggle with was our suggestion of incorporating harm reduction messages as well as abstinence messages. The CEO said that if a woman was affirmed for reducing her drinking from 12 glasses to 8 glasses of alcohol a day, the message would be given that 8 glasses is acceptable.

However, at the final quarterly meeting that I attended at the end of November 2018, I left feeling more encouraged. Before I presented my formative report on the mentoring sessions, a colleague working on Project One presented some quantitative data. Part of his data collection involved the administration of a modified isiXhosa version of the T-ACE and AUDIT questionnaires[23] to pregnant women before they engaged in the mentoring programme, and six months afterwards. Unfortunately, pre- and post-data from only five mentored women had been collected by the time of our meeting. Nevertheless, it indicated that three of the five women were drinking at risky levels six months after enrolling in the mentoring programme, and two women, whose drinking had reduced, were not heavy drinkers at the start. My formative report then pointed out the lack of mentoring skills of the mentors. Both these reports seemed to make an impact on the CEO, and he commented that some "red flags" were being raised. This is a practical example of the importance of data triangulation when attempting to effect change.

Another discouraging aspect for me was when I read back over some of the documents that the Organisation had provided to me at the start of the study. Included in this was a policy brief from one of its directors, who had done a PhD on developing appropriate FASD prevention initiatives. This director wrote the policy brief in April 2014, specifically for the Organisation. Drawing from Freire's (1993) pedagogical methods for promoting critical consciousness, she stated the following:

> (U)nless mothers are enabled to name their realities in an attempt to identify the underlying determinants that perpetuate prenatal alcohol consumption, health promoters will remain at a loss for addressing and reducing FASD prevalence...the individual [needs to be] viewed in

---

[23] Part of the initial stages of Project One, in 2016, was to combine two commonly used and well validated alcohol use questionnaires, the 4 item T-ACE (the acronym refers to what the questions assess – Tolerance, Annoyance, Cut-down, and Eye-opener (need to drink in the morning)) and the 10 item Alcohol Use Disorders Identification Test (AUDIT). The combined instrument also gleaned demographic information at the beginning, and at the end it asked about intimate partner violence during the pregnancy, and whether anyone else in the home drinks. This instrument was translated into Afrikaans and isiXhosa according to a rigorous method of forward and backward translation, and a focus group meeting to discuss the translation process. This was to ensure that the translated versions were as semantically close to the original version as possible.

> relation to the contextual factors...the focus [needs to] shift from having to make lifestyle choices to conscientizing community members on limiting social, economic and political factors that contribute to and perpetuate health problems. (Reference withheld to maintain confidentiality.)

These views are in line with my own, and I made extensive reference to this director's PhD thesis (from which the above recommendations are drawn, a copy of which the CEO has) in my first formative report for the Organisation. I remained discouraged that, four and a half years after this policy brief was provided to the Organisation by one of its own directors, there was no evidence that any of the recommendations had been implemented. What was the point, then, of providing yet more reports to the Organisation if they did not act on them?

There were, however, both encouraging and humbling times. Seeing how the participants enjoyed the training, and hearing in the interviews how much they valued being "educated" (as a number of them stated that they were "not educated"), was humbling for me, as I had been particularly critical of the training manuals. Observing the social worker's superb organisational skills as she managed all aspects of running the training programmes (organising participants, venues, participant transport, catering, and many other details, as well as presenting the training) and yet also took time to assist us with data gathering was also humbling. Some of the participants whom we interviewed had a very genuine desire to assist their community and were so delighted to be given tools that they felt would help reduce the incidence of FASD. My co-researcher and I were left with a sense that, even if the Organisation does not have a significant impact on FASD incidence, the trainers and mentors that it engages greatly benefit from its programmes.

In retrospect, and from a psychoanalytic counter-transferential perspective, I can see that, just as I struggled with the Organisation's positioning of drinking pregnant women as ignorant children, needing to be redeemed by the magnanimous education and guidance that the Organisation was offering, so I would position the Organisation as ignorant of ways to assist drinking pregnant women, and needing to be redeemed by the erudite insights that we, as researchers, offered them. As a social constructionist, I needed to hold my own truths lightly, knowing that they were (and are) as socially constructed as the truths that guided the Organisation. I also needed to understand that if I wanted the Organisation to move to a position of empathy and understanding of a drinking woman's reality, then I, too, needed to have empathy and understanding of the Organisation's worldview and reality, and stop blaming them for their methods. It was necessary for me to look for the grace involved in what they did and to value the sacrifice and commitment that they demonstrated,

however imperfectly, in service of their cause. Romaioli and McNamee (2021) stated that "(t)he aim of social construction is not to pursue agreement among different perspectives, but to engage them in order to reach some form of understanding and to generate ways to 'go on together' through the co-construction of these new understandings." (p.321). Our best work came when we looked for ways to "go on together" with the Organisation.

8. Issues of credibility and trustworthiness

In my reflexive discussion above, I have outlined all my own subject positions of which I am aware and that were prominent throughout this research process. It was from these vantage points that I engaged in the formative feedback to the Organisation and all other aspects of this research. Therefore, my analyses need to be read in the light of these positions. However, it wasn't only my positions that came to bear on this thesis, but also that of my supervisor, the team working on the other two projects of the larger research project looking at alcohol use by pregnant women, and the larger team of students and post-doctoral researchers within the Critical Studies in Sexualities and Reproduction (CSSR) research unit for which my supervisor holds a Research Chair. The CSSR has a specifically critical feminist stance, so this was the overarching paradigm within which we operated. The alcohol use research team interacted with me and my thoughts about the Organisation informally on our two-hour drives to and from our quarterly meetings, and we also met formally at times to discuss relevant issues. The larger CSSR research unit interacted with me formally twice a year, at our yearly colloquiums and research retreats, when we would each present aspects of our research. My supervisor, naturally, met with me regularly and gave me feedback on my formative reports for the Organisation, and on each chapter of this thesis. Kvale and Brinkman (2009) refered to these interactions as a process of dialogical intersubjectivity, which is a kind of validity that refers to "agreement through a rational discourse and reciprocal criticism between those interpreting a phenomenon." (p. 243).

Kvale and Brinkman (2009) suggested that "allowing the object [of study] to object" (p. 243) to the researcher's preconceived ideas about its nature, and to be "fully involved in what is said about themselves by others" (p, 244, quoting Latour, 2000) add to the trustworthiness of generated data. However, these authors noted that research participants are generally very compliant, so it is important to seek out those rare situations where participants raise questions on their own terms and protest against what a researcher may say about them. In this study, with the object being the Organisation, opportunities for members of the Organisation to dispute our evaluations were theoretically present at our quarterly meetings when I presented feedback reports. The CEO of the Organisation and the Eastern Cape social worker (once she was appointed) were always present. A

representative from the Organisation's Western Cape branch would also be present (either the office manager or the Western Cape social worker). On one occasion, during the August 2018 meeting, the CEO and the Western Cape social worker did disagree with our report. As noted above, this disagreement was about our promotion of a Harm Reduction approach as opposed to their "abstinence only" approach (which was to teach that even small amounts of alcohol can cause "serious, lifelong brain damage" to the developing foetus). The Western Cape social worker once noted, in response to our discussions about these differing approaches, that seeing a child with FAS was "not nice", and it appeared that the Organisation felt that we were minimising the risks and damage caused by alcohol consumption during pregnancy. The Organisation's members also made the point that women "take risks", meaning that if they sanctioned, for example, the consumption of one glass of alcohol during pregnancy, this limit would be pushed up much higher. The disagreement distressed me, as I felt that I had been misunderstood regarding the Harm Reduction approach (which accepts that abstinence may be the ultimate goal). However, I also had to acknowledge that I haven't worked directly with alcohol consuming pregnant women, who may indeed frequently push up sanctioned limits much higher to justify their continued drinking.

Another facet that made me re-evaluate my suggestions was seeing how messages given during training were sometimes incorrectly remembered or interpreted by trainees. For example, some of them stated in interviews that children with FAS had "big heads" and "couldn't walk", even though the training mentioned "small heads", and discussed difficulties with coordination and sport, not that children with FAS could not walk. This made me realise how a simple, negatively phrased message (e.g. "Don't drink when pregnant") may ultimately be easier to transmit than a more complex, positively phrased one (e.g. "the less you drink in pregnancy, the better it is for your unborn child"), which we had suggested in our evaluative reports on the manuals.

In retrospect, I wouldn't have revised suggestions about using the Harm Reduction approach (which seems to have more positive research findings), but I would acknowledge the above difficulties with it in my formative reports. I would also acknowledge the sense of urgency that comes when working with a pregnant drinker, as opposed to a non-pregnant drinker, as every week of continued heavy drinking by a pregnant woman causes more foetal damage. Again, I would not change the suggestion for using a Harm Reduction approach, but I would try to assist the Organisation to be more reflexive about whether they have an undue sense of urgency which may lead to unhelpfully strident messages about abstinence.

Apart from their objection to the Harm Reduction approach, the Organisation made no other overt objection to our suggestions. On the contrary, the Eastern Cape social worker regularly thanked us,

saying that our input was assisting them to improve. However, not acting on our suggestions was far more frequent. Whether this indicates a passive objection to our suggestions or was merely a reflection of the difficulties in instituting organisational change, I am not sure; it may be a combination of both.

Related to the difficulty in bypassing participants' natural compliance with researchers was the socially desirable responses we received to interview questions when trainees were interviewed about the training they received. They were generally overwhelmingly positive about the training, offering very little criticism or suggestions for improvement. This may have been because they genuinely enjoyed the training and had not been exposed to much in the way of interactive training or education in the past. However, it may also have been because of a reluctance to criticise the Organisation, despite our assurances of anonymity. This may have been compounded by our decision to interview participants in isiXhosa (except for the two Organisational employees whom I interviewed in English). Xhosa speaking colleagues at the CSSR pointed out that respect and praise for those in authority is an important aspect of the culture of the amaXhosa; by interviewing in isiXhosa, such cultural imperatives were likely to have been more pronounced, and hence trainees may not even have known how to critique the training. In this regard, our attempts to privilege the Xhosa language may have led to some reductions in the trustworthiness of trainees' feedback to us.

Given the rather painful conversational interactions that most of the mentoring recordings displayed between clients and mentors, one wonders whether clients really put up with such interactions week after week. The most generous hypothesis is that mentors erroneously thought that I was asking them to evaluate the Organisation through "interviewing" their clients, and given that some of them had been interviewed after their training, they may have been trying to emulate the interview setting. For example, they often asked evaluative questions of their clients, such as "has [Organisation] assisted you to reduce drinking?" They may also have been anxious due to being recorded, and it is possible that their actual mentoring sessions were more life giving. An alternative explanation could be that the mentors let their clients know that I would, in all likelihood, be giving clients tokens of appreciation for taking part in the research (which I did), and this then gave a perverse incentive to the clients to agree to be recorded and to take up obedient positions. Weekly interactions may in fact not happen often (even though mentors have to log whom they have seen and when.) Part of the mentoring programme includes regular workshops for the clients, where they are transported to a venue, receive a good meal, take part in some social activities, and listen to a talk on a chosen topic. Clients also receive about four counselling sessions from the social worker.

These workshops and counselling sessions may be the reason that some of them stay in the programme. All of these factors reduce the trustworthiness of the data from the mentoring sessions.

I now move onto the final sections of this chapter, where I discuss the two data analytical methods, Foucauldian Discourse Analysis (FDA) and Conversation Analysis (CA) that I used to analyse positioning within my data, before wrapping up the chapter with a conclusion.

9. Foucauldian Discourse Analysis (FDA)

Willig (2008) stated that FDA is concerned both with "language and its role in the constitution of social and psychological life" as well as with "the role of discourse in wider social processes of legitimation and power." (p.171). FDA, thus, looks at the way that discourses come to bear on the thoughts, feelings and practices of people, as well as on the material, contextual conditions within which such experiences are embedded (Willig, 2013). Arribas-Ayllon and Walkerdene (2017) delineated a Foucauldian framework of study as being along the axes of knowledge (the means of determining what is true), of power (ways in which power relations govern the conduct of others), and of ethics (manners in which a person constitutes themselves as a subject), and with an eye on the genealogy, or emergence over time, of such axes of truth/power/ethics.

FDA is distinguished from what is generally called "discursive psychology" in that the latter is concerned with interactional contexts and analyses what people do with the discursive resources at their disposal. FDA, on the other hand, is concerned with examining the discursive economy within which people are situated, and tracing the ways in which available discourses construct subjectivity (Willig, 2013).

9.1. Critiques of FDA

FDA has been criticised for its tendency to reify discourses, in other words, to apparently "discover" pre-existing but hard-to-find discourses (Parker, 1994). This tendency needs to be resisted. As Parker (1994) pointed out, "(t)he discourses are not really there hidden away awaiting discovery; they are indeed produced through analysis, but they do then give a coherence to the organization of language and tap institutional structures of power and ideology..." (p.104). Such an analysis, therefore, allows for an unmasking of power structures inherent in language use, which then paves the way for adjusting language use to bring about shifts in power balances. However, we also need to acknowledge that as we reconstruct and analyse discourses, so we are, to a large extent, constructing our own image of the world (Parker, 1994); there are multiple possible readings of texts, and different analysts will construct different analyses of the same text, depending on which

discourses they themselves are inhabiting at the time. Because of this, Schegloff (1997) accused discourse analysts of "theoretical imperialism" (p. 167), as their own preoccupations rather than those of the people who are producing the text shape their analysis (he was specifically referring to the analysis of talk-in-interaction). While those in the poststructural tradition acknowledge multiple "truths", Schegloff (1997) cautioned against viewing all "truths" as equally legitimate, and he argued that interpretations of data need to be anchored within the demonstrable orientations and interpretations of the participants. He claimed that the term "discourse" demarcates "a universe more for the concerns of those who will address it academically than for those whose efforts produced its objects." (p. 167). He did not necessarily dispute the value of a more critically inclined analysis of talk-in-interaction but believed that such an analysis needs to be preceded by one of "disciplined and molecular observation" (p.180) of the interactional text (as is offered by Conversation Analysis) in order to ensure that it is sufficiently grounded in participants' orientations and "truths".

Wetherell (1998) took up Schegloff's critiques, and she argued that it is important to also look beyond the minutiae of individual conversations to broader institutional meanings in order to understand in more depth why a particular utterance is made at a particular point in a conversation. As she pointed out, "participant orientations... [are] constructed by more than what is immediately relevant or set by the previous few turns in the conversation." (p.405). Factors such as participants' mutual histories, commonly understood meanings and vocabularies, societal and institutional roles and power structures, and institutions (or "'solidified' practices" (Törrönen, 2001, p. 317)) all impact on the "here-and-now" orientations of conversational participants (Törrönen, 2001). However, an analyst is often unable to verify all of these above factors and therefore relies on supposition. In the analytical steps outlined in the next section, stage 2 (locating discursive constructions within wider discourses), stage 3 (looking for the reasons for using a particular discursive construction), stage 5 (assessing the opportunities for action that a position provides) and stage 6 (implications for subjectivity) all required a measure of supposition on my part, as I drew off my own cultural and academic knowledge to provide insight. Hence, an analysis derived through FDA techniques needs to be offered with the understanding that it is only one of many possible ways of understanding a text. Marrying an FDA of interactional talk with a CA of the same talk, therefore, provides a greater measure of validity.

Some authors (for example, Frosh and Emerson, (2005)) critique FDA for not allowing an answer to the question as to why a subject will take up one available discursive position but not another, and they advocate for the use of psychoanalytic theorising to account for a person's emotional

investments in certain discourses over others. However, given the focus of this part of the thesis, which was to understand what discursive positions, or “ways-of-being” (Willig, 2013) are made available for pregnant women by the intervention, I considered an FDA to be an appropriate analytical tool.

9.2. FDA analytical steps

I followed a combination of Willig's (2013) and Arribas-Ayllon and Walkerdene's (2017; 2008) guidelines for conducting an FDA. The data that I analysed were: 1) The training manuals, power point slides, and videos used in the training provided by the Organisation; 2) Audio and video recordings of training sessions, translated into English where necessary and transcribed; 3) Audio recordings of interviews with training participants and Organisational staff, translated into English and transcribed; and 4) Audio recordings of mentoring sessions, transcribed directly into isiXhosa (the language of use) and translated into English. The stages of my analysis are summarised below. Although the steps are presented sequentially, the actual process was more iterative.

Stage 1: Discursive constructions and problematizations: My process of identifying the discursive constructions and problematizations in my data was, in theory, a bottom-up endeavour. However, as I was looking for discursive constructions through the lenses of my own academic and personal knowledges (or “games of truth”), these knowledges naturally guided my search. I looked for commonly used words and themes in the data, or objects, that related to drinking, pregnancy, foetuses and relationships, and also for notions that were problematized (Arribas-Ayllon & Walkerdene, 2017) or constructed as a problem, such as drinking during pregnancy and ignorance of alcohol’s teratogenic effects. The research texts were imported into an NVivo 11/12 qualitative data coding programme. I worked through all the texts in the programme, coding all implicit and explicit references to discursively constructed objects and associated problems into nodes that I created as I went through the data. A “node” is a term that NVivo uses for what can be thought of as an appropriately named folder. I was very inclusive, coding any data that referred in any way to objects in which I was interested, such as “pregnancy”, “woman/mother/girl”, “father/partner”, “baby/foetus/child”, “FAS/FASD”, “alcohol/drink”, and “party/socialising/friends”.

Stage 2: Discourses/technologies of power: I located the discursive constructions of the objects and problems within wider discourses. The same discursive object was often constructed using a number of diverse discourses. Foucault (1997a) used the term “technologies” to refer to modes by which humans are transformed into subjects through the exercise of power relations, and the wider discourses can be understood as technologies of power by which human subjects are constituted

“from a distance” by discursive practices (Arribas-Ayllon & Walkerdene, 2017). For example, constructing a pregnant woman as “mother” locates her within a mothering discourse, with associated notions of responsibility and sacrifice for the sake of her foetus/baby.

Stage 3: Action orientation/technologies of the self: This stage required that I examine “the discursive contexts within which the different constructions of the object are being deployed” (Willig, 2013, p. 386), in order to understand the functions and reasons for using that particular construction. For example, the function may be to deflect blame by constructing oneself as a woman who was ignorant of the harms caused by alcohol when pregnant. Or the function may be to feed into a pro-life agenda when a foetus is constructed as very precious. These functions or action orientations may be seen as technologies of the self, which are “truth games” in which individuals exert interactive power over others as well as problematize and manage themselves according to a certain moral order or goal (Arribas-Ayllon & Walkerdene, 2017).

Stage 4: Subject Positions: I analysed the subject positions that the discourses offered. These positions provided a discursive location for pregnant and newly parenting women, as well as for the Organisation, the interviewees, and the mentors; they situated all the participants, and objects constructed by the Organisational manuals and training, within structures of duties, rights, and morals, and provided an emotional landscape for habitation (Arribas-Ayllon & Walkerdene, 2017; Davies & Harré, 1990). Subject positions are always relational; for example, if a mentor, in a session with a woman, positioned herself as knowledgeable, then the automatic position for her client was one of ignorance, which the client could either resist or comply with.

Stage 5: Practice: This stage required that I explore the ways in which the discursive constructions and subject positions enabled or constrained opportunities for action. For example, constructing pregnant women as “mothers” within a pro-natalist discourse constrained the opportunity for those women to seek a termination of their pregnancy.

Stage 6: Subjectivity: In this stage I looked at the subjective consequences of taking up various subject positions. Subject positions not only enable actions, but also thoughts, feelings, experiences and beliefs (Willig, 2013). For example, by taking up a position as a previously ignorant pregnant woman, unaware of the consequences of alcohol on foetuses, a woman need not feel guilty for having deliberately caused harm to her foetus through drinking while pregnant. Instead, blame can be apportioned to societal factors that kept her ignorant. Willig (2013) noted that this stage is necessarily the most speculative, as the texts used do not give direct access to a person’s subjectivity, but merely give pointers to possibilities for subjectivities. Furthermore, my

understandings of the subjective possibilities of varying subject positions were inevitably shaped by my own demographic and personal locations, which were, in many ways, very different from those of the participants. This is a limitation of FDA; hence, supplementing an FDA with a CA provides a more data-centric method for theorising the possible subjectivities that arise from particular subject positions. This is because CA enables an analysis of some of the emotion encoded within non-verbal aspects of a conversation by shining a spotlight on tone of voice, volume, pitch, sighs and pauses.

The analytical chapters that follow do not present these sequential steps but utilised these steps to locate the subject positionings of pregnant and newly parenting women and to analyse the power apparatuses and the technologies of the self that were in play.

10. Conversation analysis (CA)

Social interaction between two or more people is the heart of who we are as human beings. It is the most immediate, frequent, and formative experience that creates us as subjects, and while such interactions often involve the use of words, which link to broader discourses, there is also so much more to an interaction. Non-verbal aspects such as gestures, tone of voice, rate of speech, pauses, eye contact, and proximity between speakers, as well as the structural aspects of conversations such as turn taking, relations between utterances, and coded practices tied up with giving and receiving particular types of information (Perãkylã, 2005) are all used by participants to manage the interactions happening between them. These conversational techniques are "predicated on a large base of shared cognitive presuppositions" (Goffman, 1983, p. 5), leading to conventions and conversational rules, and they are remarkably similar across diverse societies. However, there are also unique histories and cultural assumptions that participants carry, so caution needs to be exercised when presuming universality (Goffman, 1983).

Conversational techniques contribute to the bottom-up positioning of interactional partners. Schegloff (1997) argued strongly that it is this endogenous positioning that should be privileged in any analysis, rather than looking to factors outside of the interaction to guide the analysis (such as societal discourses). Given the multiplicity of possible interpretations of broad discourses, he believed that it is only through analysing the demonstrable orientations of the participants that a legitimate positional analysis can be provided. He stated that "(d)iscourse is too often made subservient to contexts not of its participants' making, but of its analysts' insistence." (p.183). CA, therefore, has a strong commitment to privileging the perspectives of the speakers, and desists from considering sociological variables (such as gender, class, and race) and broader institutional discourses unless the speaker can be shown to orient to that discourse within the analysed stretch of

talk (Kitzinger, 2000). This enables an analysis of the "moment-by-moment construction of reality" (Wilkinson & Kitzinger, 2003, p. 159) by speakers. It, therefore, highlights the agency of speakers. Wetherell (1998) stated that the analyst "must be able to show that participants had the orientation claimed for them and should be able to demonstrate how participants' subsequent behaviour in the turn-by-turn organisation of talk *displays* this understanding." (p. 391, emphasis in original).

With regards to societal discourses, CA attempts to show which sociological variables or identity categories or power relations are re-produced or resisted through the small details of talk, how these productions or subversions are achieved, and to what ends (Kitzinger, 2000; Wetherell, 1998). The productive/subversive effects arise through both the structure of the interaction, such as the overall organisation, turn-taking, and sequencing, as well as the choice of words and non-verbal aspects of the talk such as pauses, back-channel responses, hesitations, and false starts (Heritage, 2005; Kitzinger, 2000). CA takes the view that what people say (discursive formulations) and how they say it (conversational techniques) are inseparable (Wilkinson & Kitzinger, 2017). Kitzinger (2000) claimed that "CA offers the opportunity to render concepts such as 'resistance' and 'complicity' less opaque than they sometimes seem in some post-modern theorising, and instead to reveal them as concrete practices visible in talk." (p. 175). CA, thus, provides information about the fundamental organisations of social life, upon which discursive structures rest, which gives it the potential to provide very powerful techniques for promoting social justice and care, through the modification of these in-the-moment structures.

Stemming from an ethnomethodological standpoint, CA views people as active agents who engage with the macro- structures of the social order in order to collude with, transgress, resist or reproduce taken-for-granted aspects of the social world (Kitzinger, 2000). A distinctive feature of CA is that it uses naturalistic talk as its data source, rather than researcher-generated talk like interviews. Recordings are generally made without a researcher present but by participants themselves (Wilkinson & Kitzinger, 2017). Although knowledge of being recorded will affect the kinds of talk produced by participants, the fact that the talk is not researcher-generated contributes to the trustworthiness of analytical claims.

CA enables an analysis of what an utterance is designed to achieve, and how a recipient of an utterance understands and responds to it; it is interested in talk as action rather than talk as language (Kitzinger, 2000; Wetherell, 1998). CA has been widely used to investigate institutional interactions, which allows for an understanding of how the use of particular conversational practices influence the outcomes of the interaction, such as decision making, persuasion, or satisfaction

(Heritage, 2005). The talk that I studied in this project is considered to be institutional as it was produced within the context of the mentoring interventions that were geared towards a specific goal (assisting women to reduce drinking).

One of the aspects that makes CA so powerful, particularly when analysing institutional talk, is that the patterns and characteristics that it describes are based on a large body of data that can be quantitatively analysed. Wilkinson and Kitzinger (2007) stated that "CA is defined by a cumulative body of empirical research that describes the basic characteristics of talk-in-interaction. It develops technical specifications of the recurrent patterns, structures and practices that constitute key interactional phenomena." (p. 207). This quantitative aspect enables predictions to be made about the likelihood of certain outcomes based on aspects of the talk. For example, Heritage (2005) discussed studies that have shown that when doctors think parents expect antibiotic treatment for their children, the doctors' inappropriate prescriptions for antibiotics rise significantly. This expectation is assumed when parents suggest a diagnosis (like "ear infection" for their child's malaise), as opposed to merely reporting symptoms. However, on the parents' part, the manner in which they presented their child's problem was not linked statistically to their expectations of antibiotic treatment. Quantitative CA studies have also been used to show how journalistic interviews of American presidents have changed over time (Heritage, 2005). The use of questions has been shown conclusively to be a "powerful interactional resource…as well as enactment of power" (Bartesaghi, 2009, p. 154) which call for a response. In the field of counselling/psychotherapy, therapists are trained to use questions to further institutional goals by reframing the client's distress into a problem suitable for therapeutic discussion, guiding goal setting, and measuring and regulating psychological "disorders" (Bartesaghi, 2009).

However, Wilkinson and Kitzinger (2017), echoing Schegloff (1993), cautioned against a rush to quantification. CA is fundamentally about a highly detailed analysis of conversation, and many of its complex features cannot be subjected to quantification. Factors that can be appropriately quantified, with sufficiently large data sets, include turn designs, use of questions, response tokens, pauses, and the manner in which an object is constructed (such as "ear infection" as opposed to "sore ear").

10.1. Theoretical assumptions of CA

CA arose in the 1960s in reaction to the predominantly quantitative methods used to study social interaction. Sacks and colleagues such as Schegloff and Jefferson started to study the sequential ordering in interactions and the rules and patterns that structured such ordering (Perȁkylȁ, 2005).

CA developed as an empirical linguistic tool, rather than out of a specific theory, and hence the theory surrounding it has developed inductively from CA studies. Three basic theoretical assumptions can be articulated arising from CA; that: (1) talk is action; (2) this action is structurally organised; and (3) talk underpins inter-subjective reality (Peràkylà, 2005; Wilkinson & Kitzinger, 2017). In this regard, CA is aligned with discursive theories that likewise view talk as action and as constructing subjectivities. The idea that talk is action shows why CA was a useful method in this project: given the aim to study how participants provided, took up, or resisted particular subject positions, CA provided a close-up view of the in-the-moment actions through which subjects performed such moves.

The structural organisation of talk means that speakers need to orient to quite strict rules that organise interactions into sequences (see the next section for an elaboration on these rules.) Regarding the assumption that talk creates meaning and inter-subjective reality, Peràkylà (2005) claimed that "CA gives access to the construction of meaning in real time" (p.876) as it examines participants' understandings about one another's intentions. Participants co-construct meaning in conversations through the ways that they attend to and mutually agree upon certain concepts or understandings, and side-line or ignore others (Strong, 2005). The way a current speaker understands the preceding turn is the most basic level of inter-subjective understanding, and this understanding is displayed in the kind of utterance that the current speaker produces (Peràkylà, 2005). The participants' understandings of the contexts in which they are situated, and the purposes for which they are engaging, also structure their talk. For example, medical consultations, news interviews, and psychotherapy all have quite specific conversational actions associated with them in order to achieve their purposes (Peràkylà, 2005).

The second theoretical assumption mentioned above, that talk is structurally organised, departs somewhat from the concepts of Foucauldian discourse analysis, which can be termed "post-structural". Post-structuralism is interested in processes of subjectification to discursive regimes, leading to the construction of subjects that are variable and historically specific (Davies & Gannon, 2005), and it is premised on the understanding that there is no *a priori,* essential subject who pre-exists discursive subjectification. Structuralism, on the other hand, looks at universal and invariant structures of signification, which result in stable meanings (Lloyd, 2007). Nevertheless, within the broader ambit of Foucauldian theorising, CA can find a home. In his afterword to Dreyfus and Rabinow's (1982) book *Michel Foucault: Beyond structuralism and hermeneutics,* Foucault (1982) talked about "three modes of objectification which transform human beings into subjects." (p.208). One mode is that of "dividing practices" (p. 208), which apply binary distinctions that divide a

subject, either within herself or from others (for example, processes that classify people as mad or sane, sick or healthy, male or female, and so on). A second mode is the way in which a person turns herself into a subject through technologies of the self. These two modes were discussed in depth in the previous chapter. However, a third mode arises from what Foucault considered as scientific practices, such as biology, economics, or linguistics, which objectify the living subject, or the productive, economic subject, or the speaking subject. Foucault appeared to consider that this latter mode of objectification operates somewhat differently from the first two, which arise out of power relations. He stated

> (W)hile the human subject is placed in relations of production and of signification, he [sic] is equally placed in power relations which are very complex. Now, it seemed to me that economic history and theory provided a good instrument for relations of production and that linguistics and semiotics offered instruments for studying relations of signification: but for power relations we had no tools of study. (Foucault, 1982, p. 209).

He, thus, appeared to believe that relations of signification arise through different mechanisms from power relations enacted through bio-power and norms, and therefore need different instruments to study them. Likewise, in an earlier work, "What is an author?" Foucault (1977) distinguished between scientific programmes, including linguistics, and discursive practices such as psychoanalysis or Marxism. His pre-occupation was with discursive practices rather than scientific endeavours. Nevertheless, he was clearly not averse to the latter.

In a similar vein, Foucault (1982) distinguished between the power that inheres in relationships of communication, the power that stems from bodily aptitudes or objective capacities, and power relations that constitute subjectivities. Whilst these different types of power always overlap and support one another, they have different natures. Foucault's energies were spent on analysing power relations and their constitutive effects, rather than on communicative power, but he is not critical of linguistic modes of analysis that examine relationships of communication. Thus, the structural paradigm within which CA is situated is not antithetical to Foucault's theorising or FDA; rather, CA may be seen as a complementary lens through which to analyse manners in which compliance and resistance are managed in mentoring sessions.

10.2. Critiques of CA

Some authors have critiqued CA's myopic concentration on the "here-and-now" – turn-taking organisation, overlaps, sequence organisation, self-correction, repairs, and so on – to the exclusion

of the “there-and-then” – personal histories and narratives, cultural interpretative repertoires, institutional and structural power, societal discourses and so on (Kitzinger, 2000; Törrönen, 2001; Wetherell, 1998). Törrönen (2001) criticised those analyses that focus on the micro-processes of interaction as viewing subject positions as rapidly changing roles in interaction, and as “empty shells or armour which people can, each in turn, borrow for themselves or for others for presenting their action and their image in a positive light and in such a way that social order is maintained.” (p. 318). The temporal continuity of a person’s subjectivity, and the wider socio-cultural practices that affect the interaction, are ignored. Subject positions are analysed only from an interactional point of view, and the differing values that may be linked to a particular position depending on the wider discourses it is articulated in are overlooked (Törrönen, 2001).

Kitzinger (2000) responded to this critique of CA’s lack of focus on wider social discourses by pointing out that the CA analyst should not be blind to such discourses; if the analyst can show that participants are *not* orienting to particular issues such as racism or sexism or their own privilege in contexts where other participants might do so, this in itself may be a demonstration of mundane racism/sexism-in-action. The fact that participants are not aware of such power imbalances is a cogent demonstration of precisely how such imbalances are maintained. Furthermore, where participants *do* orient to inequalities, their conversational tactics can reveal resistance, compliance, complicity or subversion. Kitzinger (2000) gave an analysis of women coming out as lesbian in focus group discussions and showed how the women embedded the information on their sexual orientation in long speaking turns, which were designed to minimise the opportunity for others to respond to that information. This ensured that they were presenting the information as “not news-worthy”. From a political point of view, she suggested that this tactic resisted the dominant notion that people who identify with minority sexualities need to announce their orientation, or “come out” in order to ensure that they are not assumed to be heterosexual. At an interpersonal level, Kitzinger suggested that this tactic provides protection for both the speaker and hearers: there is no conversational pressure to respond to the information.

Wetherell (1998), likewise, made a case for paying attention to wider systems of meaning as such ideologies determine the values attached to varying positions; interactional partners draw their justifications, accusations, arguments and common-sense understandings of the world from broad discourses. One phrase or word keys the conversationalists into the relevant discourse, so that arguments and reasons do not have to be explained in detail. However, she also argued that we cannot fully understand a subject position by looking solely at its discursive location. Its significance and its connotations also arise out of the way in which a position is invoked on a specific occasion.

She presented an extract from a discussion by sixth form boys of one boy's sexual encounters the previous weekend. One boy referred to the protagonist as "on the moral low ground" (p. 397), which normally would index a highly negative discursive construction. However, the protagonist took up this position by stating "But I don't mind being on the moral low ground" (p. 397), thereby cleverly re-formulating his actions as creditable in the specific context of a male discussion about sexual activity. Utterances do interactional work as well as discursive work, and Wetherell (1998) stated that "[w]hat more clearly fuels positioning is accountability or participants' orientations to their setting and the emergent conversational activities." (p.401).

Another criticism of CA that Wetherell (1998) raised is that, due to its extremely detailed and fine-grained methods, it is not practical to use it to analyse more than tiny slices of conversations. In choosing a particular slice to analyse, the analyst is imposing their own decisions as to which are the most relevant pieces of the conversation, so the act of performing a CA still involves some "theoretical imperialism" (Schegloff, 1997, p.167), despite Schegloff's claims to the contrary.

With CA emphasising situationality, and FDA emphasising hegemonic or societal orders, some positioning theorists have developed hybrid formulations that incorporate both micro- and macro-processes (for example, Törrönen, 2001; Wetherell, 1998). This approach is antithetical to some CA practitioners (such as Wowk, 2007), who believe that any discursive or formal analysis is incompatible with CA because the two approaches are examining fundamentally different aspects of talk; discursive approaches look at societal meanings instantiated in talk (and some CA scholars like Schegloff (1997) and Wowk (2007) believe that the meanings "discovered" are more a reflection of the analysts' preoccupations than that of the speakers) while CA examines the talk actions and how such actions manage the here-and-now interaction. However, Wetherell (1998) was of the view that an analysis of interactional talk is not complete without paying attention both to the interactional and situated tactics of conversationalists, as well as the discursive backcloth that shapes the conversationalists' arguments and taken-for-granted understandings. Such hybrid methods are useful for some projects which are examining interactive data gleaned from interviews and focus groups. However, I chose to engage in two separate analyses because of the depth of analysis that each method provided, and because some of my data were not interactive. I discussed the methodological dilemma that I address in this thesis in the introductory chapter, but I will revisit it at the end of this chapter.

10.3. Conducting a CA

Schegloff (1997) discussed three tasks of a CA. The first is to specify the conversational practices that are underlying the text in question, such as interruptions, overlapping speech, pauses, the re-

starting of an interrupted turn, specific lexical choices, and so on. The second is to identify what those practices are apparently deployed to achieve. The third task is to show how the identified practices are understood by the conversational partner, as revealed in the ensuing talk. With the focus of this thesis being on the positioning of pregnant/newly parenting women, I conducted these tasks in order to identify how the women were positioned/positioned themselves.

These tasks are largely achieved through looking at the relations between different talk actions, or sequences. The fundamental hallmark of a conversation is that speakers take turns to speak. They construct their utterances to display to their conversational partner that they have attended to the partner's last speaking turn, and their current speaking turn then responds to the last speaking turn, as well as opening up a range of possible actions for the next speaking turn (Heritage, 2005; Schegloff, 1984, 1997). Conversational sequential resources have been shown to be relatively enduring across time and context (Goffman, 1983; Heritage, 2005), and relatively universal across different languages (Toerien, 2014), so while my raw data was primarily in isiXhosa, many of the same resources were at play as are described in the literature about English data.

Turn constructional units (TCUs) can be sentences, phrases, or just a word which are recognisable as constituting a complete turn, according to the context, with each speaker entitled, generally, to only one turn (Wilkinson & Kitzinger, 2017). The underlying turn taking organisation is one that is biased towards minimizing turn size, and so lengthy turns or ones with multiple TCUs are accomplishments that have superseded the inherent design of the system (Wilkinson & Kitzinger, 2017). Kitzinger (2000) documented the following techniques which are commonly used when people wish to speak for a long time: prefacing a phrase with "if", because the turn is not considered complete until the "then" phrase is used; taking a big in-breath; giving a "story bid" ("did you hear about…"); using a list launcher ("five things that…"); and by "using 'markedly first verbs' (such as 'I thought…' or 'I tried…' which are regularly used to mark things incorrectly thought, or unsuccessfully tried, and therefore project accounts of what is now known, or an account of failure)." (p.185). There are also methodical techniques to achieve multi-unit turns, such as rushing through transition points or not saying the final word or syllable of the TCU.

Conversational resources are biased towards bringing about affiliation and solidarity between speakers (Heritage, 2005), so for one conversationalist to resist the conversational actions of the other partner requires more labour on the part of the "resistor" than acquiescence would. When misunderstandings or resistance occur, then attempts at **repair** signal the participants' efforts to move back into a state of conversational affiliation. Such repair can be self-initiated, when a speaker recognises some trouble in what they have said or are about to say, and interrupts their own talk, or

it can be other-initiated (Wilkinson & Kitzinger, 2017). One example of this bias is the way conversationalists typically **decline invitations and requests**. In order to avoid seeming rude, the recipient of a request will generally hesitate, mitigate, or account for their declination rather than just saying “no” (Toerien, 2014). This bias towards social solidarity means that resistance to hegemonic discourses is difficult and occurs slowly. Other conversational resources are discussed below.

An **adjacency pair** provides particularly strong constraints on how a speaker orients to the previous utterance. Peràkylà (2005) defined an adjacency pair as “a sequence of two actions in which the first action (‘first pair part’), performed by one interactant, invites a particular type of second action (‘second pair part’) to be performed by another interactant.” (p.876). Adjacency pairs include questions, greetings, requests and invitations, and their associated responses. The relation between the first and second parts is quite rigid; social violation occurs if the second interactant does not provide a normative response. Various expansions may be inserted before, during, or after an adjacency pair (pre-expansions, insert expansions, and post-expansions), for example, requests for clarification, seeking of further information, or merely a wrapping up or closing off of an adjacency pair sequence (Peràkylà, 2005). Toerien and Jackson (2019) had the following to say about adjacency pairs, such as question-answer sequences:

> FPPs (First Pair Parts) (such as a question) set up the *conditional relevance* for what should come next. Thus, the absence of a relevant next turn becomes noticeable and morally accountable. Speakers of initiating turns will typically pursue a response if it is not forthcoming, thereby maintaining the interactional force of their FPP, and recipients of initiating turns will typically make some move other than simple non-response when attempting to evade the constraints imposed by the FPP. (p. 39-40).

Response tokens are small utterances, often merely an “mm” or nod, “through which the receivers of an utterance can ‘receipt’ what they have heard” (Peràkylà, 2005, p. 879). These tokens indicate that the receiver needs no further clarification, and that she is passing the turn of talk back to the initial speaker. **Postural orientations** indicate the relevancy of utterances for different participants, for example, a speaker tends to orient their posture towards the participant about whom they are speaking, or from whom they expect a response. However, as my data from the mentoring sessions was only audio recordings, not video recordings, this was not an aspect that I was able to analyse.

Interruptions and overlaps are generally assumed to signal conflict or power differentials between speakers. When wanting to complete their interrupted turn, the interrupted speaker will often start using the same starting words as the interrupted turn, signalling that the current saying is attempting to complete the previous partial saying (Schegloff, 1997).

In responding to an **assessment** of a situation (such as a speaker claiming that something was terrible), authors have shown that an effective agreement generally requires an upgraded assessment. If the receiver of the utterance merely gives a token response (such as "mm", or "yes"), this is a weak agreement, and is often understood as non-agreement. The first speaker may then upgrade her assessment through personalising it (such as providing her reactions to the situation) or intensifying the strength of the original assessment. A strong agreement by the receiver involves upgrading and/or expanding on what the first speaker has said (for example, by upgrading "terrible" to "absolutely disgusting", and/or providing one's own response to the situation) (Schegloff, 1997).

Misplacement markers, such as "by the way", show that the speaker is aware that a different response from what they are about to produce is in order, so it signals that they still understand the preceding utterance or sequence, but wish to give their forthcoming utterance regardless (Schegloff, 1984). The use of "anyway" signals a response, not to the immediately preceding turn, but to one prior to that (Schegloff, 1984).

An utterance may be defined as a **question** if it is the first pair part of an adjacency pair that constrains the next pair part to provide information (Schegloff, 1984). Questions may be constructed syntactically as an interrogative (using wh- words or "how"), but this is not always the case. They may take the form of a declarative statement, which is still intended to elicit further information (Bartesaghi, 2009). Similarly, a phrase that is syntactically constructed like a question may, in fact, perform a different function. Phrases such as "why don't you" and "would you like to" often function as invitations or suggestions rather than questions (Schegloff, 1984). A request for repetition or more information in response to a question (such as "pardon?") indicates that the participant is unclear about the motivation or basis of the previous turn (Heritage, 2005), or perhaps is seeking more time in formulating their response.

Repair work is instituted in a conversation where one or both participants feel misunderstood by the other, or where there is some form of conflict and parties attempt to move back into a position of alignment or rapport (Strong, 2005). **Pauses** can be highly consequential in a conversation. A small pause before responding to an invitation indicates that the respondent has some difficulty with the proposal, even if their words are affirmative (Toerien, 2014).

Where there is a choice of words to represent the same concept (for example, "alcohol" and "drink"), which word is used can indicate a participant's stance towards something. This is known as **lexical choice** (Heritage, 2005)**.** The word "alcohol" may be used in more formal or institutional settings, whilst "drink" has a more informal register. Another example is the use of the word "notice" (rather than "saw", "discovered", "realised" etc.). "Notice" conveys that the speaker's discovery was unmotivated and not sought out, and is used to bolster a claim to the veracity of what they are reporting (Heritage, 2005). Analysing the lexical choice of participants can show how the participant is orienting towards a particular circumstance, which indicates which position she is taking up in that moment. As I do not speak isiXhosa, and I had to rely on the translations to assist me in understanding my data, I was not able to look at this aspect in depth. However, I did notice how the use of the word *usana* (baby) was used routinely to refer to a foetus, rather than *umbungu* (worm or foetus). It was also interesting to note when speakers switched to speaking English, when the surrounding talk was in isiXhosa. I understood this as a means of taking up a more educated or powerful position at that point.

These and many other conversational conventions have been documented by conversation analysts, and indicate the speakers' understandings of what interactional goals are being accomplished in the conversation (Schegloff, 1984). This empirical grounding of CA means that analysts such as Schegloff (1997) believe that a more global discourse analysis of interactional data should only occur after an initial CA has "brought to the fore the import of the events for the participants." (Schegloff, 1997, p. 180). However, as researchers can never come to any data in a theoretically neutral manner, the choice of which segments of data to analyse is naturally driven by the research agenda. In my case, this was to look at what power apparatuses drove the positioning that was happening in the mentoring sessions, and whether care and/or justice was being provided or undermined. Therefore, I selected segments of text where women were either complying with, or resisting, or modifying the ways that the mentors positioned them. I also looked to see if there were discourses that participants were not orienting to, which showed what was being silenced.

10.4. Analysing institutional talk using CA

Institutional talk follows a more rigid and standardised turn-taking system than everyday conversations (Heritage, 2005), although ordinary conversational practices still underpin such talk (Wilkinson & Kitzinger, 2017). Institutional talk is characterised by orientation to specific institutional goals that constrain what is said, and that are linked to "institution-relevant identities" (Heritage, 2005, p. 106), such as doctor/patient or teacher/student. There is an unequal distribution of knowledge and resources, and consequently power, between conversationalists, and institutional

representatives can and do manipulate or adjust conversational structures in order to achieve specific goals (Heritage, 2005). For example, within medical institutions, professionals are trained to elicit institutionally relevant information from patients (such as quantity and severity of symptoms) whilst restricting the information that they provide to patients (Bartesaghi, 2009).

Questioning has been shown to be a key interactional activity and an enactment of power within much institutional talk. In many medical and educational settings, patient or student talk is restricted to answering questions (Heritage, 2005). In psychotherapeutic consultations, Bartesaghi (2009) discussed how much of the interactional effort of the therapist involves "re-formulating a problem fit for therapeutic discussion" (p.155), and questioning is a central activity in which the therapist engages. Likewise, Strong (2005) discussed how counsellors' questions are often a means "to elicit therapeutically relevant understandings." (p. 515). Questions may also be used by institutional representatives (such as therapists or teachers) as a vehicle to impart knowledge (such asking questions when they already know the answer), rather than to glean knowledge from the client/student. Yes/no questions, or closed-ended questions, frequently embed a preference as to which answer is preferred, and this feature is often used as an educational resource to impart knowledge (Koole, 2013). A common sequence in instructional settings is the IRF sequence: a teacher initiates (I) with a question or instruction; the student responds (R) with an action or answer; and the teacher then provides feedback (F) in the form of an evaluation of the student's response (such as "yes" or "not quite") (Koole, 2013). Questions are, thus, used by professionals to further institutional goals (Bartesaghi, 2009; Heritage, 2005). In my analysis, I show how mentors used questions in their sessions to assert their power, to construct problems to which they had the answers, and to position their clients as child-like and irresponsible.

Another difference that has been documented between institutional talk and ordinary conversation is the manner in which institutional representatives respond when one of their questions has been answered. In ordinary conversation, the questioner typically responds to the given answer with the response token "oh", which indicates receipt of new information. However, in institutional contexts, occurrences of "oh" are markedly reduced (Heritage, 2005). In instructional settings, teachers use questions to evaluate the knowledge of their students rather than to gain knowledge, so they evaluate answers in terms of whether they are correct or incorrect. This evaluation may be through a simple "yes/no", but it is often accomplished through repeating the student's answer, with prosodic elements indicating whether the answer was correct or not (Koole, 2013). In news interviews, interviewers do not respond to information in answers with "oh" (otherwise they would be accepting an answer as true), and nor do they evaluate answers, in order to remain neutral

(Heritage, 2005). In medical history taking, answers tend to be acknowledged with neutral markers like "okay" or "mm", rather than "oh", which might indicate to the patient that the answer is unexpected, which in turn suggests that the medical practitioner lacks knowledge (Heritage, 2005).

A current PhD study being conducted in our research unit is using CA to analyse pre-abortion counselling, and has found that the counselling sessions tended to follow a specific structural organisation in order to achieve the institutional goals of presenting options, providing procedural information, discussing contraception, and garnering consent for the procedure.

10.5. Analysing positioning using CA

When using CA to analyse positioning, the focus is on the turn-by-turn interaction, looking at the way conversational structures are used to achieve certain ends and not others (Korobov, 2001). Positioning in talk is generally performed to achieve some interactional goal (for example, to present oneself in a positive light), but it also contributes to taken-for-granted understandings of our social world (Wilkinson & Kitzinger, 2003). Therefore, two key analytical questions to ask are: what is a speaker actively trying to achieve through their positioning of themselves (reflexive positioning), their conversational partner (interactive positioning), or a third party (interactive positioning), and; how are their taken-for-granted, normative positionings (such as assuming that people have heterosexual partners, or that all women want to be married) contributing to on-going social construction. The interactive activity is often performed to position the speaker within a moral order (Korobov, 2001). As an example of this, Bamberg (2004) showed how a group of 15-year-old boys told a narrative fragment of a girl's allegedly promiscuous behaviour in disparaging terms to position themselves as morally respectable. Normative positionings are generally invisible and un-named, whilst non-normative categories are usually named to provide an account for a person's actions. By orienting to a non-normative position, that which is normative within a particular context is then made visible (Wilkinson & Kitzinger, 2003). Bamberg's (2004) account showed how "slut" behaviour by girls was considered non-normative in the teen culture of his participants, which indicated the strongly normative constraints on girls to be chaste or discreet in their sexual interactions.

Wilkinson and Kitzinger (2003) discussed how positioning in conversation is achieved through a number of different practices. The first practice is **indexing a category**, for example, "mothers" or "disabled people", and these may refer to first parties (the speaker), second parties (the conversational partner), or third parties. This practice subsumes a person into a category "such that the individual is positioned as a presumptive representative (or, sometimes, as an exceptional member) of that category." (Wilkinson & Kitzinger, 2003, p. 174). The second positioning practice is to **invoke categorical membership** through normative assumptions. A common example of this is

when heterosexuality is assumed and invoked in talk, but remains un-named. Wilkinson and Kitzinger (2003) gave an example of this when a woman in an all-women focus group said, “all men like boobs, don’t they?” (p.167). Through invoking categorical membership, speakers demonstrate to analysts the normative assumptions of their culture. The third practice that Wilkinson and Kitzinger (2003) discussed is **invoking attributes**. This is where a speaker attempts to display the sort of person that she is, such as reasonable or caring. She may name this attribute directly, but more often will construct the story line to position herself implicitly as demonstrating such an attribute.

Demonstrations of emotion can also be used to position oneself, which contributes to the social construction of emotion. Wilkinson and Kitzinger (2017) discussed their work on displays of surprise in conversations (such as “wow” or “ooh”). Whilst such displays may be spontaneous visceral eruptions (for example, a stunned silence or sharp in-breath to a particular piece of information delivered by the first speaker), they can also be used by the second speaker to position themselves in alignment with the first speaker, if the first speaker delivers the information as surprise-worthy through using techniques such as emphasis on particular words or word parts. The second speaker can also resist this invitation to surprise by not displaying surprise, thereby challenging what the first speaker understands as normatively surprising.

Bamberg's (2004) positioning analysis showed how a group of 15-year-old males used the telling of a narrative snippet of their classmate’s purported promiscuous actions to contribute to their identity constructions. While Bamberg aligned with Narrative Analysis approaches, he engaged in a very fine-grained analysis in this study, which is akin to CA. He also, like CA, bracketed off pre-existing identity categories or positions in order to focus on what was relevant for the participants in the interactive setting, and how positions emerged organically in the course of interaction. He advocated looking at two aspects to unearth a speaker’s positions. The first aspect is the “interactive space between the participants” of a conversation (Bamberg, 2004, p. 334), such as advice giver/receiver, gossiper, or normative adolescent male. The second is the order between characters in stories narrated by the speaker (either first person or third person accounts), such as how characters within the story are positioned with regards to one another, and how this orientates the speaker and audience to one another. Narratives told within conversations point to ways in which the speaker views the world and themselves (Bamberg, 2004).

Bamberg (2004) utilised three levels of positioning analysis in his study. The first level looked at the story theme and how characters were depicted. The second level focused on the interactive work happening between participants, and the interactive functions of the story narration. The third level looked at how the previous two positioning levels implicitly positioned the speakers vis-à-vis wider

cultural discourses and normative positions. It is clear that Bamberg was drawing from narrative analytic traditions in the first level, CA traditions in the second level, and critical discourse analytic, or FDA traditions in the third level.

10.6. CA analytical steps

In terms of the specific analytic steps that I followed in conducting the CA on my data, I roughly followed the four stages that Toerien (2014) identified. These are as follows:

1. **Collection building.** The goal of a CA is to identify practices or structures that manifest across a large number of cases, and so a collection of an interactional phenomenon needs to be made (Toerien, 2014). As I was examining positioning, I collected all the cases of this action that I could identify in my data, organising them into nodes in NVivo11/12, my data software management programme. Traditional CA involves collecting a very large sample of a conversational phenomenon, in order to delineate typical and atypical conversational tactics within that phenomenon. However, another kind of CA research involves analysing a single case, where the conversational tactics observed are interpreted based on findings from previous studies of large corpuses of data (Wilkinson & Kitzinger, 2017). My collection of examples of positioning in this project consisted of only 33 recordings, so was small. My CA may, therefore, be understood as a combination of both types of CA: I showed how compliance and resistance to being positioned as ignorant or sinful occurred across the collection, primarily through previously identified tactics of pauses, silences, strong or weak agreements, interruptions, and uptake of different positions.
2. **Individual case analysis**. This stage incorporates the three CA tasks that Schegloff (1997) identified, and which I mentioned at the beginning of section 9.3 (specifying the conversational practices underlying each of the cases; identifying what those practices are apparently deployed to achieve; and showing how the identified practices are understood by the speaking partner.) Toerien (2014) suggested that turn design and sequence organisation are likely to be relevant when analysing each individual case. In looking at the turn design, I needed to examine what exactly went into constructing the turn in order for me to understand it as positioning work, such as lexical choice, intonation, pace of speech, and so on. The sequential organisation between turns displayed how a speaker understood the action of a prior speaking turn and indicated the participants' orientations. It was important for me, as the analyst, to privilege the speakers' orientations; I could not claim that a speaker was positioning herself, her hearer, or a third party in a certain way if that was not verified by the orientation of the speakers. In this stage I looked at how women responded

to the ways in which they were being positioned by mentors – either through taking up the position by responding with strong agreement, or through resisting by responding with a weak agreement (pauses before responding; weak token responses like 'mm'; and so on), or through re-working the position to be more in line with how they wanted to be viewed.

3. **Pattern-identification**. This stage involved looking for patterns in the ways that positioning was done across cases through turn design and sequence organisation. It also involved looking for patterns in the responses by the conversational partner to such positioning. The dominant pattern used by mentors was to position themselves as knowledgeable teachers who dispensed information through long speaking turns, and who assessed their clients' knowledge through IRF sequences – an initiating question, which demanded a response from the client, and then feedback (such as "yes") to the response, indicating whether it was correct or not. The dominant pattern from clients was to respond obediently, thereby positioning themselves as obedient children.
4. **Accounting for or evaluating the patterns**. I needed to consider "where and how the … pattern in question arose" (Drew, 2003, cited in Toerien, 2014, p. 334), and then why that particular pattern or format was used at that particular time; in other words, what interactional outcome the use of that positioning pattern was achieving. For example, regarding the pattern that led to the knowledgeable teacher – obedient pupil positioning within mentoring sessions, I understood this as arising in response to the pastoral power that operated strongly in the training of the Organisation; mentors were perpetuating the positioning of pregnant women as ignorant children, just as the Organisation positioned them.

11. Conclusion

Given the centrality of the concepts of discursive practices and subject positions in this thesis, I began this chapter by revisiting and elaborating on these notions, which I had introduced in the previous chapter. Discursive practices are a means of linking power relations with knowledge; they construct objects, provide subject positions from which subjects can know about these objects, define norms, and establish truth games and moralities. The subjectivity of a person can be understood as an ensemble of subject positions within which a person is habitually situated. I then presented my research questions, which centre around looking at the subject positions that were evident in the data, the conversational practices that were used in this positioning work, and how these positions and conversational practices could be altered or expanded to promote an ethics of care and justice for pregnant and newly parenting women.

I moved on to provide a description of my data collection procedures. Four different types of data were gathered: the training materials (videos, power point presentations, and manuals) used by the Organisation; audio- and video-recordings of two three-day training sessions; audio-recordings of interviews with trainees and Organisational personnel; and audio-recordings of mentoring sessions. I then discussed my attempts to ensure that this research was ethical. I followed this by describing the formative feedback I gave to the Organisation, and I provided a personal reflection on my own quite conflicted positions and reactions during my engagement with the Organisation. Out of this reflection came a discussion of issues of credibility and trustworthiness in my analysis of my data. I proceeded to provide an in-depth discussion of my two data analytical procedures: Foucauldian Discourse Analysis (FDA) and Conversation Analysis (CA), and their associated theoretical roots, strengths, and weaknesses.

I chose these analytical procedures as this combination of analytical tools allowed an in-depth analysis of the broad power dynamics at play within the intervention, as well as a close-up look at the agentic positioning practices that mentors and women used in the mentoring sessions. As such, I was able to show, in my analysis of the data, how pregnant and newly parenting women were positioned in a top-down manner, and also how women complied with, resisted, or modified these positions in a bottom-up, agentic manner to position themselves.

I combine the insights from each analytical method in the following chapters to present my findings in an integrated manner. The first analytical chapter shows how the apparatus of coloniality was used to position the Organsiation/mentors as knowledgeable and the community/women as ignorant, while the apparatus of pastoral power positioned the Organisation/mentors as saviours and the community/women as sinners. The second analytical chapter details how patriarchy as an apparatus of power was used to position foetuses as precious babies, children with FASD as the defiled Other, and pregnant women as invisible mommies. The final analytical chapter highlights the few times when an ethics of care and justice was visible in the positioning work that was being carried out.

Chapter 6: Knowledge and ignorance; saviours and sinners

1. Introduction

The most common subject positions constructed by the Organisation in the data were that of knowing adults (the Organisation and its personnel) and ignorant children (pregnant and newly parenting women, and the community from which they come); and saviours (the Organisation and its personnel) and sinners (drinking pregnant women). Interlinked apparatuses of coloniality and pastoral power operated to construct these positions of knowledge/ignorance (coloniality) and saviours/sinners (pastoral power). Resistance by the women to being positioned as ignorant or sinful was sometimes evident in the mentoring sessions, and this resistance primarily manifested through silence.

I start this chapter by looking at how the positions of knowledge and ignorance in the training materials, training sessions, and interviews were innervated through what I understand to be the power apparatus of coloniality. Coloniality was evident through a taken-for-granted view that Western, individualising knowledge was superior to whatever knowledges communities contain, and an assumption that the communities and women it was targeting are ignorant. In the mentoring sessions, these same positions were constructed, but the underlying power apparatus shifted to that of pastoral power, as mentors positioned themselves as knowledgeable teachers, and women as ignorant children in need of guidance. Women generally complied with the ignorant position in mentoring sessions, but some resistance was evident. This was demonstrated frequently by silence, but also through positioning themselves as, likewise, knowledgeable.

The saviour – sinner positioning was constructed through pastoral power. The Organisation and its trainees and mentors positioned themselves as saviours, redeeming the pregnant women from their sinful, drinking positions. In mentoring sessions this position was, understandably, resisted by the women, through three primary mechanisms: silence; denial of any prenatal drinking; or taking up a position as previously ignorant of the ills of prenatal drinking. This last position was a helpful one; it absolved the woman of blame, and it reinforced their social alignment with their mentor and the Organisation by showing that the Organisation's mission to educate ignorant communities was necessary and important. One woman did not overtly resist the sinful position but complied with it

as someone who drank “just for fun” during her pregnancy. However, through openly acknowledging such a position, this woman was resisting the shame and silence associated with it.

In presenting my analysis, I divide it up according to the data source (training materials, training sessions, interviews, and mentoring sessions). This shows how the apparatuses of coloniality and pastoral power permeated each activity of the Organisation, and how the subject positions created by these apparatuses were pulled through from the initial training materials to the mentoring sessions.

2. Coloniality: (Western) knowledge and (African) ignorance

As Foucault cogently showed, knowledge is imbricated with power. Hence, an entity with knowledge is powerful. The Organisation’s primary means of intervention was to provide knowledge to the target communities, and through doing this it positioned itself as knowledgeable and the communities and pregnant women as lacking in knowledge, or ignorant. I regard the power apparatus underlying this positioning as coloniality. Whilst a knowledgeable-ignorant positioning duet is constructed by many different power apparatuses, particularly pastoral power in educational and familial settings, the specific raced context of South Africa, with its colonial history, meant that that the discourses and technologies used in this positioning came with a colonial and raced hue. The Organisation was started by a “White” Afrikaans pastor, and it targets poor “Coloured” and “Black” communities, so coloniality (and its close cousin, pastoral power, which will be discussed later in this chapter) would always already be present in the Organisation’s foundational roots. The *modus operandi* of the Organisation then continued this legacy through presenting supposedly scientific, “Western” facts and knowledge to inform communities, and positioning the target communities as ignorant and simple.

2.1. Training materials

Training materials consisted of a manual, powerpoint presentations, and video clips played at points throughout the powerpoint presentations. The powerpoint presentations were based on the manuals, using replicas of pictures and wordings from the manuals, but with less detail. I will, therefore, refer to the manuals and not the powerpoint presentations in my data analysis, unless the powerpoint contained something omitted from the manuals.

Right from the outset, the Organisation positioned itself as “knower” and educator. In its introduction in the manual, it stated the following:

p. 1. We give facts to communities about Foetal Alcohol Syndrome. Our programs are designed to inform communities that a woman should not drink any alcohol while she is pregnant, because alcohol during pregnancy causes **LIFE-LONG BRAIN DAMAGE** to the unborn baby.

The phrase "We give facts to communities" positioned the Organisation as experts and educators, and separated them from the generic "communities", who were in need of the facts that they were providing. The phrase "facts…about Foetal Alcohol Syndrome" draws off medical science discourses. Medical science is a discourse which originated in the global North and enjoys high acclaim, constructed as providing unequivocally true, unbiased, and correct information which changes the lives of people for the better. The training materials continued to use a medical science discourse sporadically throughout, as they explained each of the terms "foetal", "alcohol'" and "syndrome", provided diagrams and pictures of pregnancy, birth, and developing foetuses, and gave information about nutrition during pregnancy. However, as I shall show below, there were many times when the medical "facts" provided by the Organisation were inaccurate.

The Organisation's mission to "inform communities" implied that they did not entertain any uncertainty about whether communities needed informing, or whether the provision of information would be of assistance in reducing FASD incidence. In this regard, the Organisation was taking up dominant public health intervention methods, which revolve around providing information so that individuals can make "informed choices". The Organisation was also inciting communities to police pregnant women, as they informed communities about what a pregnant woman should and should not do. Such surveillance is a disciplinary technique which is commonly applied to reproducing women, who become "public figures", on display for others to critique (Lupton, 2012) in their reproductive journey.

The phrase "a woman should not drink any alcohol while she is pregnant" was one that the Organisation repeated frequently and was essentially their dictum. The training materials also constantly repeated the message that alcohol causes life-long brain damage in the foetus. The extracts below are just a few of the many statements carrying this message.

p. 1. ...alcohol during pregnancy causes **LIFE-LONG BRAIN DAMAGE** to the unborn baby;

p. 4. Very important**!!!** This chemical substance [alcohol] is **extremely toxic** and **harmful** to the unborn baby!

p. 4. **Any amount of alcohol damages the unborn baby.**

p. 4 ...when a drink contains alcohol, it is **extremely harmful** to the unborn baby. **It causes serious, life-long prenatal injury to the unborn child.**

p. 4. The only safe option is: **no alcohol during pregnancy!**

p. 5 A person with FAS has LIFE-LONG brain damage. **There is no way to recover from it. There is no cure!**

p. 10 **Alcohol during pregnancy, is the LEADING CAUSE of MENTAL RETARDATION in the world…!**

The stylistic manner of highlighting various phrases (capital letters, bold and enlarged font, different colours, and exclamation marks) and the hyperbolic language ("life-long", "extremely toxic/harmful", "any amount of alcohol", "only safe option", "no cure", "leading cause") positioned "the communities" and pregnant women as not only ignorant, but also lacking in intelligence and slow to learn, thereby requiring much repetition and emphasis to get the message through to them. Scare tactics are also evident in the quotes above, and throughout the training materials. Such tactics operate through attempting to manipulate audiences with the use of emotive language (for example, "There is no cure!") and inflated statistics (for example, "LEADING CAUSE of MENTAL RETARDATION in the world…!) and they can be understood as a tactic of the colonial apparatus; the Organisation was attempting to "scare" their audiences into behaving as the Organisation wanted them to behave, in order to produce productive and docile citizens.

Module 3 focussed on pregnancy and birth. Positioning pregnant women and target communities as ignorant continued in this module.

P. 55 **Very Important!** – Don't listen to all the aunts and uncles' so-called advice about pregnancy. You can put you and your baby's life in danger. **Get at all times professional help**

This statement constructed all the women's family members as entirely ignorant; their "so-called advice" was not only worthless but dangerous and even life threatening. The only people who were worth listening to were professionals, from whom the pregnant women should access help "at all times". Given the difficulty that poor women have in accessing professional help in this country, this advice displayed a lack of understanding of the context in which many women live. There was an unthinking assumption that Western models of "doing pregnancy" (where pregnancy is no longer seen as a natural state, but the domain of medical professionals (Lupton, 2012) can be transposed, unmodified, into African contexts.

2.2. Training sessions and interviews

Trainees were often eager to display their knowledge during training sessions. The facilitator took opportunities to commend trainees on their knowledge whenever she could, and position them as

"knowers". For example, a video of a rap song and visuals made by the Organisation was in Afrikaans, for which she apologised. When discussing the video, the following exchange ensued:

Trainee: Even this song states that high alcohol consumption while pregnant damages the brain of the child.

Facilitator: I'm impressed because she is even interpreting the song for us, I did not understand it (general laughter).

The trainees, who were drawn from the "ignorant communities" that were targeted by the Organisation, were transitioning from being ignorant to being knowers; they were being inducted into the Western discourses and positions of the Organisation. In this transitioning process, demonstrations of knowledge were used by trainees to indicate their worthiness of their new status. Unfortunately, some of these demonstrations were problematic as they perpetuated stigma and misinformation. For example, trainees stated the following in practice presentations:

- Even one glass is very dangerous to the child, they refer to it as lifelong brain damage to the child.
- I've seen some people who consumed alcohol while pregnant and what their children look like, they are mentally disabled and their body is not proportional. They usually have big heads, big eyes but their body is very small.
- Some of the damages that can occur to the child [from prenatal alcohol use] include blindness, disability, lack of focus and concentration at school.

There was a blanket and binary imposition here of the normal/abnormal poles; regardless of the type of disability, the assumption was that it is caused by "even one glass" of alcohol consumed by pregnant women. Hence, women are positioned as directly responsible for abnormalities of all types in their children through even minor deviations from prescribed behaviour, like "one glass". Such stigmatising produces shame, which is a barrier to seeking healthcare.

During interviews with trainees, the trainees expressed much appreciation for the knowledge that the training was providing to them. The training, therefore, had transformed them into "knowers" in the field of FASD, as shown in the extracts below. These extracts were responses to the question "How have you found the training?"

[24]Interviewee 1: *I'm also UNEDUCATED as well ...* Training was (.) hmm, *it was, was nice* because (.) it gave me more (2) uh (.) *to, to know* more about *things relating to the child*

Interviewee 4: *I'm not educated* (.)/mm/*... but I love educational things*

Interviewee 10: I'm helped (.) through this training (.) because there are many things (.) *that I learned* /ye::s/ many many things

[24] See Appendix O for transcription notations. Transcriptions of interviews use italics for translated material, and non-italics for speech in English.

Interviewee 11: [Organisation] *opened our mind*

The reflexive subject position of being uneducated/lacking knowledge but transitioning to a position of knowledge through the help of the Organisation, is dominant in the above extracts. At the same time, the Organisation was positioned as a redeemer of the trainees, redeeming them from their ignorant position. As Foucault (1978) pointed out, "knowledge constantly induces effects of power" (p.296), and the training had given the trainees power over pregnant women with their newfound knowledge. The majority of the trainees were unemployed, and, therefore, presumably had little in the way of social status and power. Hence, the knowledge/power that the Organisation provided to them would have been particularly welcome.

In considering the interactive positioning in the above extracts, the uneducated women were speaking to an educated interviewer. By declaring their lack of education up front, they were foreclosing judgement for anything they did not know (and as they were in an interview situation, they may have felt some pressure to "know" things). In terms of social desirability, they were taking up the Organisational script of being ignorant but becoming transformed by the input of the Organisation.

Interviewee 8, likewise, displayed similar positionings in the extract below. However, she explicitly linked the uneducated position to being "Black":

Interviewee 8: *It's actually very interesting because we didn't know about most things that can affect a pregnant person....but because we are Black people we are not well informed* /yes/*....because we have also been helped by* [Organisation]

Her statement that "Black" people are not well informed was, amongst other things, a legacy of the Apartheid system, with people of Colour generally receiving inferior education compared to "White" people. The racial signifier makes visible the colonial apparatus that was functioning here, where "Black"/African people are constructed as inherently ignorant, and reliant on "White"/Western people for help and knowledge. From an interactive point of view, Trainee 8 was providing an explanation for being uninformed: it is not because she was individually responsible for her ignorance, but it was because of her race. Her interviewer was also a "Black" person, but one who had fully transitioned to a knowledgeable, Western position: the interviewer was a Masters student at university, and had been to a private school, so she had a "White" accent.

With trainees taking up positions as "knowers", the counterpoint position for women was "ignorant ('Black') people". Trainees were being trained to give talks in community settings on the need for pregnant women to abstain from alcohol, and in the extracts below, the interviewees are speaking about this.

Interviewee 10: *So we explain to them that they should not drink and they should not smoke and don't use drugs /mm/ you see things like that (.) we explain* everything *to them* /okay/ *about what they should and should not do when they are pregnant.*

Interviewee 10 positioned herself as "knower", who has all the information - "everything" – about what women "should and should not do when they are pregnant." The third person positioning of the women to whom she would be speaking was that they know nothing.

The interviewee below brought in explicitly racialised tropes, and she discussed how information on FASD presented to pregnant women would be rejected because of their race:

Interviewee 2: *Because they'll say "No man! That's White people's sicknesses" AND REALLY we have that thing /yeah/ we do have that thing, it's said (.)that* once *you utter big English words /mm/ they say "you said* Fetal what? [giggles] okaaay…right (.) *No man, that's White people stuff, it'`s White people who have children with heads this big"*

The hypothetical pregnant woman that Interviewee 2 spoke of rejects the medical knowledge of FASD as being "White people stuff" that would not affect her. The trainee interactively aligned herself with "White/Western" knowledge, against the ignorant "Black" women who reject it. However, this participant also appeared to be cognisant of the precarious position that she was now in, expected to deliver "White" information to "Black" women, who may reject it because of the colonial binary between "Black" and "White". The Apartheid system created and perpetuated deep divides between the races, through multiple technologies – laws, spatial arrangements, geographies, discourses – and this legacy continues today. Hence, trainees were put into a double bind: they were expected to become transformed into knowers, in a very Western manner (and rewards would come with this, through the power that inheres in Western knowledge and organisations), but this would separate them from the communities to which they were required to speak.

Interviewee 4, below, refined the ignorant ("Black") position by linking it with youth:

Interviewee 4: [Interviewee 4 was a volunteer healthcare worker at a clinic] …*yes even when we were at the clinic we were told to speak to pregnant women* /mm/ *But now I have MORE knowledge, I'll speak about something I know of* /yes/. *If I pass by a girl child who's pregnant, I'll show her that you see this and this is what happens* /yes/ (.) *leave this thing* /ye::s/ *I've just been taught /* ye::s/ *I'm not just saying this, you see?*

This interviewee assumed that it would be a "girl child" who would be the most in need of the information that she was able to impart. This statement invokes the common assumption that all teenaged pregnancies are problematic. The interviewee bolstered her "knowing" position by reference to the fact that she had "been taught".

Further refining of the ignorant position for pregnant women was provided by the training facilitator in her interview. Pregnant women were ignorant, but also unwise with the knowledge that they did have:

Training facilitator[25]: I think more than anything number one it's a lack of information /mm/ cause people just don't know that if I drink (.) < They know that if I > It's not good to drink when you're pregnant … but they don't know wa what it does /mm/ I mean what are (.) effects… … it's like many things you grow up being told "you must not lie sleep with a MAN /mm/ when you're not married" or whatever… but you still do it anyway /mm/ so that's the (.) It's the same mentality /mm, mm/ not <u>of just not knowing the consequences</u> /mm/ and uh (.) how <u>bad</u> /mm/ the effects are

The training facilitator stated that it is common knowledge that pregnant women should not drink, but this knowledge is ignored, as "you still do it anyway" and people are unwise with this knowledge, because the consequences are unknown. Her use of the second person pronoun "you" positions her as slightly closer to the pregnant women in terms of alignment and understanding than the other interviewees, who all referred to the pregnant women with the third person pronoun ("they" or "her"). The training facilitator possibly felt secure enough to align herself with them (although she didn't position herself too closely – there was no first person pronoun "we") as she was a qualified social worker and had sufficient social distance from them so as to not be assumed to be "one of them". Other interviewees, on the other hand, came from the same "ignorant" class, so needed to insert as much discursive distance as possible between them and the ignorant pregnant women in order to secure their precarious position as newly educated "knowers".

With pregnant women being assumed to be ignorant of the consequences of drinking, and inclined to disregard health information, the Organisation could justify their emphasis on, and inflation of, the terrible effects of pre-natal drinking. Through the use of scare tactics, they attempted to drive home their message and break through any inherent resistance to it.

This section has shown how the colonial apparatus constructed positions in the training materials of the Organisation as (Western) knower, and pregnant women as ignorant (African) people. These positions were taken up in the training sessions and reproduced by trainees in interviews. A third position was constructed in the training sessions and interviews: that of the trainees transitioning from an ignorant position into a knowing position.

In the next section I examine data from the mentoring sessions. The same knowledgeable-ignorant pairings were dominant, but the dominant power apparatus shifted from coloniality to pastoral power.

[25] The training facilitator was interviewed in English by me, so there is no translated material in this extract.

3. Pastoral power: Knowledgeable teachers and ignorant children

In the mentoring sessions, the “knower-ignorant” positions were perpetuated vigorously by the mentors, primarily through pastoral means. The mentors frequently took up a teacher position, which can be understood as being innervated by pastoral power (Hook, 2007). They also positioned themselves as redeemers, as they attempted to redeem women from their ignorant position and transform them into knowers. Many mentors spent their entire mentoring sessions with their clients giving much unsolicited information, and repeating information that they had clearly provided in previous sessions. They also often provided erroneous information, for example, that eating too many bananas “can cause the baby’s eyes to look like they have syphilis…[and] ooze pus” (Mentor Zukiswa[26]), that caffeine can cause an abortion (Mentor Zukiswa) and that eating pineapples can give the baby a rash (Mentor Thobile).

There was some evidence of resistance to this “ignorant” position by clients during mentoring sessions, which I discuss in the next section. However, for the majority of the time during the recorded mentoring sessions, clients took up an ignorant child position, listening respectfully and obediently to their mentors, as is expected in educational or pastoral settings. The “knowing teacher/ignorant and obedient child” positions were by far the most common positions in the mentoring data.

In the extract below, there is a sequence that is clearly educational in nature. The mentor, who took up a position as teacher or instructor, quizzed the woman on what she had learnt from the Organisation. The mentor asked questions, and then evaluated the answers given. This initiation-response-feedback (IRF) sequence (teacher **I**nitiates with a question; student **R**esponds; teacher provides **F**eedback) is common in instructional settings (Koole, 2013). Not only did it position the woman as a pupil in need of instruction, but it also ensured that the conversational power and control remained in the hands of the mentor.

Mentor Thobile; Client 3

1. M*: Yintoni oyifundileyo ngo-[Organisation]* (What have you learned from [Organisation])
2. C: *into endiyifundileyo ngo-[Organisation], kuthwa masingabuseli utywala (*what I learned from [Organisation], is that we should not drink alcohol)
3. M: Mm
4. C: M*asingami emnyango* (We shouldn’t stand by the door/hesitate)
5. (.)

[26] Mentors have been given pseudonyms

6. C: N*xa ndiziva ndingekho right mandihambe ndiye eclinic okanye esibhedlele* (That I should go to the clinic or hospital if I don’t feel well)
7. M: Mm
8. (1.5 secs)
9. C: *Mandinantuke* (I must)
10. (.)
11. C: O*batywala buya ethunjini emntaneni* (The alcohol goes straight to the baby in the stomach)
12. M: Mm hmm?
13. C: *Athathe kade nasesikolweni (*and the baby will be slow even at school as a result)
14. M: Mm
15. C: N*amanxa ehleli nabanye abantwana uthatha kade* (even when playing with other children they will be slow)
16. M: Mm *akabikho right* (yes they won’t be ok)=
17. C: =*akabikho right* (they won’t be ok)
18. M: Mm
19. C: U*khula wrong* (they won’t develop properly)
20. M: *Mm hmm ngenxa yantoni?* (yes and that will be because of?)
21. C: *Ngenxa yotywala* (because of alcohol)
22. M: *Mm hmm* o*buselwa ngubani ?*(yes who drinks the alcohol?)=
23. C: =*Obuselwa ngumamakhe buya ethunjini pha kuye* (drank by the mother because it goes straight to the baby)
24. (.)
25. C: M*na ndiyasela buye pha [kuye* (I will drink and the alcohol will go to the baby)
26. M: [*mm*
27. C: *ethunjini* (through the uterus)
28. M: Okay

The opening question in line 1, “What have you learned from [the Organisation]”, was a leading question which presupposed that the client had indeed learnt from the Organisation. She complied by reciting as much as she could from the Organisation’s teachings. For most of this sequence, the mentor responded to the woman’s answers with “mm”, a token response that passed the turn back to the woman, which indicated that the mentor expected more answers from the woman. The 1.5 second pause in line 8 indicates some trouble in the conversational flow. It is clear that the mentor was waiting for more answers from the client, while the client presumably had no more to say at that point. The pause put pressure on the woman to talk more, so she started with the phrase “I must”, but then changed tack in line 11 and stated that “The alcohol goes straight to the baby...” The mentor gave another token response in line 12, but her rising intonation indicated renewed engagement with the woman’s answers, and that there was more to be said on this point. The woman complied and expanded on the effects of prenatal alcohol exposure on the child in lines 13 and 15. In line 16, the mentor summarised what the woman was saying with “they won’t be okay”. This is an example of a strong agreement, which encouraged the woman to repeat the mentor’s summary in line 17, and to re-word it in line 19 (“they won’t develop properly”).

Despite the client's clear understanding of the teachings of the Organisation, the mentor looped back from the talk on disabled children to question the woman again on what causes the disability (line 20) and who causes it (line 22). This repetition positioned the woman as being at risk of forgetting the information, and also of being potentially to blame, as she was a member of the class "mother" (pregnant woman) who causes FASD. Nevertheless, the woman responded obediently, and the mentor closed the sequence with "Okay" before moving on to a different line of questioning.

As teacher to an ignorant pupil, the mentor was taking on the task of transforming her client from a position of ignorance to one of knowledge. The mentor was thus redeeming the woman, in true pastoral style.

In the extract below, the mentor used a rapid speech rate which prevented the client from interjecting and enabled the mentor to continue on an excessively long speech turn. This characterised much of the talk in this mentoring session. As a "knower", this mentor's "expertise" now extended beyond FASD to other health concerns such as preventing mother-to-child HIV transmission.

Mentor Namhla; Client 1

[rapid speech rate from mentor throughout]

1. M: ok *ke sisi idate zakho awuziphosi* (ok dear and you don't miss your check-up dates)=
2. C: *andiziphosi* (no I don't)
3. M: *Ok ungakulinge ke uziphose because izawunxulumana nawe ke nomntwana while upregnant uyayibona lonto leyo* (ok you must not dare miss your date because it will affect the baby as well while you're pregnant do you see what I mean)=
4. C*:* *Ewe* (yes)=
5. M: *Xa ukhulelweyo ipilisi zakho kufuneka uzazi ke uba uyazitya ukwazi umntwana wakho angosuleleki yintsholongwane kagawulayo uyayibona lonto leyo* (when you are pregnant you have to know that you always take your medication so that you don't infect the baby with the virus do you get what I mean)=
6. C*: Ewe* (yes)=
7. M: because *kwa ukuba ipilisi zakho ungazisebenzisi* (because if you don't take your medication)
8. (.)
9. M: *umntana wakho kunga-easy ukuba osuleleke yintsholongwane kagawulayo* (it will make it easy for your baby to be infected with the virus)
10. (.)
11. M: *so ndicebisa ukuthi wena qho ngedate zakho ungaphosi idate zakho (*so I would suggest that you don't miss your dates)
12. (.)
13. *M: even kule clinical card yakho ndiyijongileyo apha ndiyabona ubanangaba idate yakho izawuba pha nge-04/10/2018* (Even your clinical card I'm holding says your next date is on the 24/10/2018)

14. *(.)*
15. *M: so ndiyakukhuthaza ke ukuthi uzumane ulijonga icard lakho ngalo lonke ixesha* (so I want to encourage you to keep checking your card at all times)
16. .....[Three more speaking turns by M before C gives a backchannel /mm/, followed by another three speaking turns by M on the same theme]

Over seven speaking turns, this mentor remained on the theme of compliance with clinic regulations, despite the client asserting her compliance in the first speaking turn (line 2). After line 2, barring three backchannel “yes”/”mm”s, the client was silent. The mentor’s rapid speech rate ensured that it was hard for the client to interject or join the conversation, and the mentor ignored the client’s assertion at the beginning of the extract that she doesn’t miss any clinic appointments. This enabled the mentor to construct a problem to which she had the answers. The rapid speech rate of the mentor may also have been because she was anxious being recorded, and she may have been eager to demonstrate to me, the researcher, that she was enthusiastically taking up the Organisation’s prescribed position of “knower”, and the prescribed task of redeeming and guiding the woman, in accordance with the dictates of pastoral power. However, the effect of these “knower” and “redeemer” positions on the client was to position her as ignorant, and to silence her.

A number of mentors took on a “stern schoolteacher/interrogator” position as they instructed their clients to talk. The mentors probably felt some pressure to get the women to talk because of being recorded, but the only position that they seemed to have in their repertoire of positions to achieve this was an educator/interrogator position.

Mentor Yandiswa; Client 2

1. M: *Ikhona oyifundileyo noyibonayo intobana inotshintsho kuwe kulento yakwa-* [Organisation] is there anything you have learned and that has brought about change in your life as a result of [Organisation])
2. (1)
3. C: *Ininzi kakhulu* (There’s a lot)
4. (1.5)
5. M: Support your statement [monotonous tone]
6. (2)
7. C: *Into eyenzekayo* (what has happened)
8. (3)
9. M: *Thetha nje nono ungoyiki* (speak dear don’t be shy)
10. (1)
11. M: *Ukhululeke* (Feel free)
12. C: *Senditshuba yonke into iright ndiziva ndikhululekile okokoko ndidibene nababantu bakwa-[Organisation]* (What I mean is that everything is going well and I feel so free since I met with the people from [Organisation])
13. M: *err usakuthanda usela utywala* (err do you still enjoy drinking alcohol)
14. N: *ha a andiseli okokoko ndathi ndadibana nani nandixelela ukuba utywala abukho right ngezondlela nanindicacisele ngazo* (no I don’t drink anymore ever since I met you and you explained to me the dangers of alcohol)

In line 1 the mentor appeared to have felt that it was her mandate to ask evaluative questions about the Organisation (imitating the position of myself and the assistant researchers) rather than conduct a regular mentoring session. Given that mentors had not had training in how to mentor, it is understandable that she would try and imitate other positions that she had observed, and were likely to be familiar to her from other contexts. The question that she asked in line 1 was a leading one, and the client would have felt constrained to provide answers that positioned the mentor (and, by extension, the Organisation) positively. Given that the question was not being posed by an independent researcher, and in order to maintain social solidarity (Toerien & Jackson, 2019) with her mentor, the client would have needed to affirm the input of the mentor and Organisation. However, resistance to positioning the mentor and Organisation as having brought about change in her life is shown in the client's pauses. This resistance, which can be understood as negative or corporeal resistance, will be unpacked further in the next section.

The 1.5 second pause in line 4 indicates that the mentor was expecting the client to elaborate on what she has learnt, and when she did not comply, the mentor proceeded to pressure her. In line 5 the mentor gave a very bald and quite academic instruction to "support your statement". This instruction was delivered in English (unlike the surrounding talk), which is the language of education and power, and this tactic positioned her as a stern and educated interrogator. However, the client was clearly unable to "support her statement", indicated by the long silences, so the mentor then softened her tone in lines 9 and 11, interactively moved closer to the client by reverting to isiXhosa, and instructed the client to "speak" and "feel free". This would have put the client into a double bind – she was being instructed to "feel free", despite the very anxiety-provoking and constraining instruction to "support her statement". Nevertheless, the interactional force of the initiating question compelled the client to eventually provide a response that was sufficiently affirming of the Organisation and the mentor (line 12). However, the client's long pauses suggest that there was much that she was not articulating. We can only guess at what it is that she was not articulating, but presumably it is counter to what the mentor would have liked to hear: possibly, that there was nothing that she has learnt from the Organisation that has brought about change in her life; she might even have still been drinking heavily. The client's response that she feels "so free" (echoing her mentor's instruction to "feel free") is ironic, given the very constraining nature of the interaction, and her clear difficulties in speaking; the nature of the conversation suggests that she did not feel free at all with her mentor.

The interaction from lines 1 – 12 was presumably difficult for both the mentor and the client, with much interactional trouble. The mentor would have been put in an awkward position by the clear

difficulties that the client had in articulating any changes in her life as a result of the Organisation's ministry, which suggested that she did not, in fact, manage to redeem her client, while the client may have felt shown up as a "failed" pupil. However, in line 13, the mentor asked directly about whether the client was still drinking, and her response that she had given up since meeting the mentor restored the social affiliation between the two parties. The mentor then proceeded to ask questions about the client's husband, whether the client was eating well and cutting out fatty foods, and whether she had made preparations for her forthcoming delivery and birth of her baby. In all these subsequent interactions, the client took up the mandated compliant position, and gave responses that were sanctioned by the Organisation.

Although the "knowledgeable teacher/ignorant child" positionings highlighted in the extracts above led to very stilted conversations, they served to uphold the institutional goals of the Organisation: namely, to exert a form of pastoral power over the reproductive lives of women through exhorting them to be "good mothers". The general obedience of the clients indicated compliance with the "ignorant child" position into which they were interpellated. However, there was also resistance to this position, as shown in the next section.

3.1. Resistance to the dominant positions

Many of the clients complied with the Organisation's positioning in the recordings by demonstrating that they were, indeed, ignorant, but were being transformed into knowers. This positioning may have been exacerbated due to being recorded. However, clients did display resistance at times. In the previous section, two of the three extracts displayed significant silences on the part of the clients. In the second extract in the previous section (Mentor Namhla; Client 1), the client's paucity of even backchannel responses indicates conscious resistance to the mentor's positioning her as ignorant of clinic regimens.

The third extract in the previous section (Mentor Yandiswa; Client 2) displayed many long pauses. These pauses were evident, not of resistance to the ignorant position, but of resistance to being transformed into an Organisational knower. In line 2, the client paused for a second before answering the mentor's question about what she had learnt from the Organisation that had brought about change in her life. A pause before responding to a question indicates difficulty. The client may have simply been thinking about which of the many things that she had learnt, but given the long pauses throughout this sequence, and the lack of specificity or elaboration in the client's answers, it is more likely that this initial pause before answering the question affirmatively shows that she was not responding entirely truthfully when she said that "there's a lot" that she had learnt from the Organisation. Kitzinger (2000, p. 179) stated that "one of the most potent indicators of refusal is a

short delay in responding.” This client appeared to be attempting to be obedient to the impetus to become a knower but failed initially. This may be understood as an instance of negative, or bodily, resistance (see chapter 4), where the client was unable to sufficiently take up the requisite “knower” position, despite attempting to. However, this led to a positioning vacuum, so she then took up a redeemed position, in line with the prevailing pastoral power, in lines 12 and 14, where she asserted that she felt “so free” and that she no longer drank after meeting the mentor.

Another form of resistance came in the form of clients’ displays of their own knowledge, as they resisted the ignorant position into which the mentors were interactively placing them. This was a form of positive resistance, as clients actively took up an alternative position

Mentor Buhle; Client 2

1. M: So *zonke izinto ngomntana uyayazi mos uba umntanakho u:: ok* (So do you know everything about your child that your child is:: ok) =
2. C: =*uyancanca usebenzisa inerviripine* (breastfeed the baby and use the nerviripine)
3. M: [*nevirapine*
4. C: [yes

In this extract, above, the client answered the mentor’s question quickly, to indicate her knowledge, and possibly to forestall the mentor’s inevitable provision of information that she already knew. The overlapping speech suggests a slight power struggle, as both client and mentor were eager to show their knowledge.

The extract below is again taken from the session between Namhla and her first client, and the mentor continued to forcefully take up a knower position by speaking very quickly and interrupting the client.

Mentor Namhla; Client 1

[Mentor speaking very quickly with no pauses]

1. M: ok *so ubusowuvile ubana ngaba xa uncancisa umntana kufuneka uthini* (so do you know what you need to do when breastfeeding)
2. C: *Ewe ndivile kuthwe ndingamtyisi kwanto [ngaphandle kwebele* (yes I know that I shouldn’t feed the baby anything else [except for breastmilk)
3. M: [Ok, *mna ndiyakukhuthaza ke umntana akufunekanga umix feed ke uyabona*….([Ok, I would personally encourage you not to mix feed your baby you see)
4. C: Mm
5. …[Mentor proceeds to instruct the client on the necessity of giving her baby Nevirapine because of her HIV positive status, over four speaking turns]…
6. M: …*ukwazi intobana umntana wakho isupreseke le ntsholongwana* because *ibele linayo* <u>*inintsi kangangoko intsholongwana*</u> *pha kulo (*so that the virus can be suppressed because <u>there is a lot of the virus from the breastmilk)</u> and *nawe* while you

ngobanje uncancisa kufuneka uzazi intobana uzigadile intobana ngaba ipilisi zakho uyazitya kangoko uyayibona lonto leyo (and since you are breastfeeding you also need to make sure that you also take your medication do you understand)

7. C: Mmh

8. M: *Kuba kaloku ewe siyayazi uba intsholongwane ayinyangeki zipilisi uyayibona* (even though we know that the medication does not cure the virus, do you understand)

9. (.)

10. M: *qha into eyenzekayo iya* (but what happens is that it) =

11. C: *Iyathomalalisa* (it gets weakened) =

12. M:*Yheke iyayisuppresa iyayicinezela ukuthi ingabi more uyayibona lonto leyo* (that's it it gets suppressed so that it doesn't become more you see what I mean)

In this extract, the mentor interrupted the client (line 3) while the client was answering her question, thereby disregarding the client's self-positioning as knowledgeable. The mentor proceeded to give the client a long speech on the necessity of not mixing breast feeding with bottle feeding, giving the baby Nevirapine, and ensuring that she took her own HIV medication. The rapid speech rate of the mentor made any form of engagement by the client very difficult, but eventually the client interjected (line 11) with her own knowledge of how medication affects the HIV virus ("it gets weakened"). The mentor did acknowledge this knowledge by responding "that's it", but then proceeded to use a different word ("suppressed" rather than "weakened"), thereby re-asserting her own superior knowledge.

The client below was a little more forthright in her resistance, stating clearly that she had already been told the information that the mentor was giving:

Mentor Thobile; Client 2

1. M: Ok, *njengoba umncancisa umntana uyazazi ukuba* before once a day *funeka umtyise inerviripine* <u>*before*</u> *umncancise umntanakho before* /mmh/ *ancance* (since you are breastfeeding your baby you do know that you have to give your baby nerviripine once a day <u>before</u> you feed him before /mmh/ you breastfeed)
2. C: *Ewe ndiyayazi ndandixelelwe* (yes I know I've been told)

The extract below came at the end of a long speaking turn by the rapidly speaking mentor, Namhla, with a different client:

Mentor Namhla; Client 3

1. *M: …but ke mnake into endikucebisa ngayo kukuba umntana qha uzungamix feedi uyayibona* (but personally I would advise not to mix feed you see)
2. (.)
3. *M: umntana uyazi uba njengoba nje uncancisa nje uzawumncancisa ibele lakhe* <u>*lodwa*</u> *ngoba ipha ebeleni* (know that you will just exclusively breastfeed the baby)

4. (.)
5. *M: amanzi pha ebeleni ibele linezakha mzimba ezininzi uyayibona* (the breast milk has water and all the nutrients the baby needs are in the breast milk)=
6. C: =[clears throat] *ewe bekutshiwo nasesibhedlele kwathiwa zendingamphi manzi* (yes they told me at the hospital as well that I shouldn't give the baby water)

In order to break into the flow of this mentor's speech, the client cleared her throat, which signalled that she would like to say something, and she stated that she already knows what the mentor is telling her. She also let the mentor know that she gained her knowledge from a creditable source different to the Organisation (the hospital).

By taking up positions as "knowers" and educators, the Organisation and its personnel provided very few positioning options for pregnant and newly parenting women. Although the women could legitimately resist the "ignorant" position through demonstrating their knowledge, this knowledgeable position was still sanctioned by the Organisation. Other valuable positions, such as fun-loving, agentic, or resourceful, or positions that are not valued but are important to be acknowledged, such as depressed, in need of care, or abused, could not surface within the generally overwhelming flow of advice that the mentors seemed to feel compelled to give. The only way women could resist the "ignorant child" or "transformed knower" positions was through subtle, or not-so-subtle, rejections of what mentors said. This came in the form of a loud sigh from one client, and an exasperated tone from another client. One client was blunter, and refused to engage in conversation:

Mentor Sbonga; Client 1

1. M: *Uthi ungubani ifani yakho?* (What did you say your surname was?)
2. (3)
3. C: *Awuboni pha kweza-signature zakho* (Can't you find it amongst those signatures)

This recording was only 10 seconds in length, and ended after the brief exchange, above. Other forms of resistance by the clients to the overall positionings of the Organisation were evidenced by clients dropping out of the programme, or avoiding the mentor when she came to visit[27], or disobeying the mentors' dictates. A small sample of five clients, surveyed by another researcher working on Project One indicated that their drinking had increased over the course of the mentoring. Rather than their drinking actually increasing, a more likely explanation for the results was that they had not been honest when they first took the survey test, administered by their mentor, but were more honest when they took the follow up test, administered by an independent researcher.

[27] Unfortunately, I do not have accurate statistics on these occurrences. The Organisation's social worker suggested that about half the clients dropped out before completing the 12-month programme. The mentors reported that clients were sometimes "asleep" or "out" when they paid visits.

Nevertheless, it was clear that these clients were still drinking at harmful levels six months after commencing mentoring.

Even more problematic than positioning pregnant women as ignorant children, was to position them as “sinners”. This came about through the Organisation’s self-positioning as “saviour”’, and through their blame of drinking pregnant women.

4. Pastoral power: saviours and sinners

The Organisation positioned itself as a noble “saviour” and occupied the moral high ground in the training materials, constructing drinking pregnant women as uncaring and blameworthy “sinners”. This positioning was mirrored in interviews with trainees, and the “sinner” position for pregnant women was a common one in training materials, training sessions and interviews. It was also evident in mentoring sessions, although not as strongly as the “knowing mentor/ignorant child” positions.

The only alternative to the “sinner’ position for drinking pregnant women that was available in the training materials was the “ignorant child” position: if a woman was ignorant of the harms that alcohol causes, she could not be blamed. However, as soon as the information was given (for example, through the teachings of the Organisation), then society was absolved of responsibility for FASD, and all blame now rested on the woman. In this sense, the Organisation was caught up in the dominant “responsibilisation” paradigm that underpins many public health initiatives that aim to change behaviour. This mode of intervention involves urging individuals to “make informed choices” and “be responsible” for their own health and that of their dependants, and there is scant regard for the societal and structural factors that lead to poor health outcomes in the first place (Trnka & Trundle, 2014).

There was occasional evidence of an alternative positioning in the training sessions, interviews, and mentoring sessions (but not in the training materials), namely, that a drinking pregnant women may be in need of care and support. This position is discussed in chapter 9. However, the overwhelmingly dominant position for drinking pregnant women, apart from being ignorant, was that of “sinner”.

4.1. Training materials

There was a great deal of implicit and explicit blame of drinking pregnant women in the training materials. The Organisation positioned itself as morally superior, resulting in an implicit third person position for drinking pregnant women as morally reprobate. Through constant exhortations to “simply not drink” and “choose a bright future” for their child, those women who did not follow the Organisational dictates were explicitly positioned as blameworthy. For example:

P. 1 We only want the best hope and future for each child that is born. We believe that every child has the right to develop his or her full potential. If a child is born with FAS,
he or she is deprived of that basic right.

Slide 2 of powerpoint Caption above picture of babies: "[Organisation]: We speak on their behalf"

P. 21 **The mother simply must drink NO ! ALCOHOL while she is pregnant !**

The first two sentences of the extract from p. 1, above, drew from pro-natalist and human rights discourses to position the Organisation as caring, sacrificial, and just, like a shepherd or pastor, while the third sentence positioned the entity who deprives the child of their "basic right", namely the pregnant woman, as sinful. A common slogan of the Organisation (shown in the second extract above) that they "speak on (babies') behalf" positioned it as god-like, having privileged knowledge of the needs of foetuses and babies, and also as noble and sacrificial in its quest to save babies from their drinking mothers. In the extract from p. 21, the use of the word "simply"' indicated that giving up alcohol is easy, so there must be something morally wrong with those women who do not. There was no acknowledgement of the myriad complex reasons why women drink during pregnancy, and all responsibility for drinking/abstaining was placed on the woman.

The extract below specifically linked those who drink during pregnancy with those with unplanned pregnancies and "teenage pregnancies".

P. 3 **The baby is very vulnerable and defenceless during pregnancy.** …If the baby is unplanned, this tiny little person is even more vulnerable. What happens when teenagers get pregnant? Do they welcome this child? Do they feel proud? Do they feel confident that they can look after a child? Or are they confused? If so, then the unborn baby senses the confusion. Is this a good way for the unborn child to start life? **If the mother drinks, the baby drinks too!**

Foetuses were considered "even more vulnerable" if the pregnancy was unplanned. The rhetorical questions emphasised the point that young women and those who have unplanned pregnancies cannot be proud of the pregnancy or welcoming of the child, and that this would automatically be harmful to the child. The questions also functioned to position anyone who thought otherwise as foolish. The positioning of young pregnant women as careless (for having an unplanned pregnancy), confused, and ashamed (as opposed to proud) was linked with the position of "drinker", suggesting that the one automatically leads to the other. The implication was that women who have unplanned pregnancies, or are teenagers, are even more culpable for harming the foetus, and are more likely to drink when pregnant.

The next extract described foetuses as “precious and vulnerable unborn babies”, and this was common throughout the manuals.

P. 4 All amounts and types of alcohol are harmful to the precious and vulnerable unborn babies

Module 1 (on FAS) used the word “vulnerable” to describe the foetus six times, and Module 3 (on pregnancy) used it three times. Additionally, except when presenting medicalised information on stages of pregnancy, the manuals and powerpoints always referred to the foetus as “baby”, and repeatedly as “precious” (nine times in both Module 1 and Module 3). This constant positioning of the foetus as “vulnerable”, “precious”, and as a person (“baby”)[28] positioned anyone who harms it as not only sinful, but criminal. The saviour – sinner positioning was hardening here into one of judge - criminal. The criminal positioning became more explicit in the next extracts:

P. 10 How many people in this country… sustained life-long brain damage because the pregnant women drank alcohol?

Answer : 7 - 9 million people !!

P. 5 **When the brain is damaged, important brain functions are missing. It is a life-long captivity sentence that no one deserves.**

The extract from p. 10 sensationalised (and probably inflated[29]) the number of people affected by FASD. The pregnant woman was explicitly blamed for causing life-long brain damage. The extract from p. 5 refers to FAS as a “life-long captivity sentence”. “Captivity” signifies being constrained by criminals against one’s will, while “sentence” suggests a punishment for a crime. This extract, therefore, indicated that the person with brain damage is being punished, but that the criminality lies not with the person, but with the ones who placed them in captivity. And that must surely be the one who caused the FAS - the mother of the person.

Towards the end of Module One (pp. 23-29), there were seven pages detailing the kinds of difficulties and negative behaviours that people with FASD display, from pre-school to adulthood. These included anger outbursts, lying, stealing, and getting involved with crime. The following is an excerpt from p. 27, printed in red lettering:

[28] ThE “precious, vulnerable baby” position is analysed in the next chapter.

[29] Prevalence estimates of FASD have only been made for certain communities in South Africa, and it is hard to estimate the countrywide prevalence. One expert suggested a prevalence of two to three million (Charles Parry, South African Medical Research Council, personal communication, February 2017).

P. 27 **People with FAS therefore do not only harm themselves with their inappropriate behaviour, but also their families, communities and THE WHOLE OF SOUTH AFRICA !!**

Alcohol consuming pregnant women, therefore, who were already blamed for harming their "precious babies" by causing FAS, were now also blamed for harming "THE WHOLE OF SOUTH AFRICA!!". The capital letters and exclamation marks drove home the extent of the women's culpability. The next extract explicitly criminalised such women:

P. 29 It is against the law to give liquor to 18-year olds and younger, BUT ~ **liquor is often given the first 9 months** by the pregnant woman to her unborn baby! What kind of hope and future is there for this damaged little human being? This is one of the most serious forms of human rights violation and child abuse.

The phrase "It is against the law" introduced a legal discourse, and there was a double reflexive positioning by the Organisation in this extract as both stern judge of drinking pregnant women – "against the law…serious forms of human rights violation…" – and also compassionate pastor to foetuses, concerned about the future wellbeing of "this damaged little human being." In both of these Organisational positions, the third person position for drinking pregnant woman was as a criminal.

The Organisation offered a way out of the sinful, criminal position; it presented a "choice", as shown below. However, the "choices" presented did not provide positive, agentic positions for women.

P. 9. Finally we must make a **CHOICE**: a choice of the suppressing of your emotional pain for a short while, or to have a 'lekker'[30] social life……..[31] or **a life sentence of suffering for your child**. What do you choose?[32]

P. 16 **What do you choose? A FAS child, or a child with a bright future?**

In the first line from p. 9, above, there is an interesting slippage of pronouns – "we must make a cholce… your emotional pain…". "We" positioned the Organisation as on the side of the women, facing the "choice" with them, but this was not sustained, as the Organisation slipped back over to the other side (the moral side) and distanced itself from the women again as it refered to "your emotional pain…[and] 'lekker' social life". This distance continued with the final pronoun in the extract: it was not a case of 'what do we as a society choose', but "What do you choose?" The women were called to account for their "choices" with this question (which was repeated three

[30] "Lekker" is a South African slang word meaning "great" or "wonderful"

[31] The ellipsis in this quote does not indicate omitted words, but is a stylistic device used in the manuals.

[32] Linguistically, this sentence does not work, as no choice is presented. "Suppressing emotional pain" and "having a 'lekker' social life", in the view of the Organisation, leads to a "life sentence of suffering for [the] child"; it is not a case of choosing between the two options.

times in both module 1 and module 3, along with two exhortations in both modules to "make the right choices.") The tone was strict and the answer was clear: pregnant women who try to suppress their emotional pain or enjoy socialising are giving their child a "life sentence" (another legal signifier) of suffering. The criminal positioning continued.

The common use of "choice" rhetoric positioned women as individually culpable for the harm that may befall their foetus. It also reduced the highly complex social context within which women in poverty live, procreate, and raise their children to a simple binary choice: that women have the power to choose between a child with FAS or a child with a "bright future" (extract from p. 16, above). Furthermore, it suggested that by abstaining from alcohol, women are thereby guaranteeing that their future child will have a "bright future". However, "bright futures" are not so easy to come by in contexts of poverty. The use of "choice" rhetoric could be defended as upholding the women's agency over their own behaviour; however, the "choice" that was given was simplistic and moralising. The women were presented with the "choice" of being an ignorant child who is now redeemed and obedient to the Organisation's dictates, or an ignorant child who is disobedient, and therefore sinful, and even criminal.

The use of such "choice" rhetoric is a common tactic by those attempting to exert forms of pastoral power over segments of the population, and it is part of the individualising and responsibilising project of pastoral and other forms of modern power. As discussed in Chapter 4, modern forms of power frequently make use of bio-power (defined as "the increasing ordering in all realms under the guise of improving the welfare of the individual and the population" (Dreyfus & Rabinow, 1982, p. xxii)) and technologies of the self (defined by (Foucault, 1997b) as "choices of existence" (p.89)) to control people. By presenting themselves as noble and sacrificial, and by urging women to "make choices" to improve their welfare and that of their unborn children, bio-power and technologies of the self were harnessed within the pastoral apparatus to exert control over the women.

4.2. Training sessions

The training sessions made use of powerpoints derived from the manuals, so the same messages of "choice" and blame came through. In taking up the "choice'" rhetoric of the Organisation, the facilitator stated the following on the first day of the first training session:

> Okay, this is very important, FAS guys is 100% preventable. It is up to the parent to decide whether she wants her child to have FAS or not you see? So if your child has FAS it is because you have decided that I want my child to have FAS and be mentally disturbed. You must always remember that it is 100% preventable, it is upon you and in your power to choose for your child not to have FAS.

The statement “if your child has FAS it is because you have decided that I want my child to have FAS and be mentally disturbed” is not only blatantly untrue – no parent decides that they want a “mentally disturbed” child – but it also places all blame for the ills of FASD on pregnant women.

Trainees seemed to automatically take up a blaming stance towards drinking pregnant women, even before they were exposed to much of the Organisation’s teaching. Research from Project Two (Macleod, Matebese, et al., 2020; Matebese et al., 2021) indicated that injunctions not to drink during pregnancy were seen to be part of Xhosa culture. One trainee stated, early on the first day of the first training session, that

> Most pregnant women like alcohol, when we try to talk to them and reprimand them, they do not care and first want to see it happening to me or someone else in order for them to stop. (This trainee may have been a volunteer at the local clinic, or a clinic nurse.)

There was the assumption in this extract that the majority of pregnant women engage in reprobate behaviour, and do not listen to the “shepherds” who are trying to guide them in the right paths. The women are unreasonable to the point of needing hard evidence of the ills of prenatal drinking. However, embedded in this extract, is an acknowledgement that the manner in which “saviours” are intervening with pregnant women, through reprimands, is not effective.

On the third day of the first training session, trainees were requested to do a practice presentation on FASD, as they were being trained to provide talks on FASD in various community settings. The following extract is from one of those presentations. It may have been given by one of the Clinic nurses who were in attendance.

> You will find that some people end up giving birth to underdeveloped or disabled children and then blame others for that. Just because they went to the clinic on time and did all the check-ups, they do not realise that drinking alcohol is what causes the damages that occur in the brain of the child and therefore they refuse to take responsibility… some people blame the clinics for such things, that the nurses are not doing their job. This is simply because they are not aware that the alcohol they consumed during pregnancy affected the child as well.

There was a strong blame/responsibility discourse in this extract. Women who gave birth to “underdeveloped or disabled children” were blamed for blaming others, particularly the clinic nurses, and for “refus(ing) to take responsibility” for their child’s disability. The speaker was taking up a position alongside nurses as aggrieved saviours; they were doing their job to keep people healthy, yet were blamed by women for the very disabilities which were caused by the women.

There were two somewhat contrasting positions constructed in this extract for women. The first one was that they are ignorant because they “do not realise” and “are not aware” of the teratogenic

effects of alcohol. As such, they were in a position to be redeemed by the Organisation, which emphasised spreading the message about the ills of prenatal alcohol consumption. As a conservative Christian entity, the Organisation was mimicking evangelical tactics of "preaching the Word of God" in order to redeem the souls of individuals. The second position for women was that they were reprobate sinners, in that they refused to take responsibility and blamed the clinics for their children's disabilities. This placed them beyond the reach of the Organisation's saving ministrations. "Taking responsibility" is a key tenet of bio-power, innervated by disciplinary techniques, which impel people to "take responsibility" for their individual health and welfare.

Another trainee stated the following in her practice presentation:

> Because a child's brain was damaged by the drugs or alcohol that you took during pregnancy, you find children who are now unable to behave properly at school.

This trainee spoke about pregnant women in the second person: she addressed them directly by using the second person pronoun in the phrase "the drugs or alcohol that you took". Her positioning of pregnant women as blameworthy was, thus, more direct and immediate. There was again a binary imposition of the normal/abnormal poles, with all causes of abnormality, including poor behaviour at school, being pinned on prenatal substance use.

The second training session was conducted with participants who had already been through training as community educators, and who were now recruited to be mentors. The training consisted of a revision of the earlier training, followed by (woefully inadequate) training in how to be a mentor. Because the same training materials were used as in the earlier training, the same blaming positioning was evident.

The extract below was spoken by the facilitator on the first day of the second training session:

> So we are speaking on their [foetuses'] behalf because they are in our tummies they cannot speak for themselves. They depend on their mothers, so if they cannot rely on their mothers, then they need us to speak for them.

As well as positioning mothers as potentially undependable, the Organisation positioned itself as a saviour of foetuses whose mothers cannot be relied upon. As a pastor protects the weak and vulnerable from the devil's clutches, so the Organisation would protect foetuses from their sinful mothers.

4.3. Interviews

Interviews with trainees indicated how blame and stigmatisation, and positioning pregnant women as "sinners", can arise when a person is transitioning to a "knower" position.

Interviewee 1: *I didn't even know that* (.) *the reason a child can be* hyper *doing bad things in the early stages,* /Hmm/ *is caused by the things they CONSUMED while still in the belly.*

Interviewee 7: *I got to do the training do you understand* /ok/ *so that I can be more informed about what is happening* /yes/ *because I didn't know before* /ye::s/ *I would just see a child being hyper /you didn't know/ and you realise that the disability* [rate] *is high you see* /ye::s/ *yes and I wouldn't know why* (.) so now *I've become* broad minded *do you understand* /ye::s/ mmh *so now I know what the cause is*

These interviewees positioned themselves as newly inducted into a knowledgeable position on childhood disability. Neither of them knew before the training, but now, through the training, they have "become broad minded" and "know what the cause is" of hyperactivity, "doing bad things in the early stages", and general disability. And the cause is "the things [pregnant women] consumed while [the foetus was] still in the belly." Women were therefore positioned as culpable for all difficulties their children may have.

Interviewee 4, below, likewise positioned herself as a newly inducted "knower", and mothers of disabled children as culpable:

Interviewee 4: *I've learnt a LOT because we didn't know that. I didn't know I would just see that a child there is in one crèche I usually go to, when they will when doing vaccination campaigns /yes/ while teaching is happening, he goes outside. He's shirtless, with a BIG head* /mm/ *I was thinking "juuust" but now I've got it here that it's the mother from when he was in the tummy, she didn't treat him well* /mm/ *I got that from here then the cause for that child to be like that /yes/even when it's raining... you'll find him standing outside it's not because he's neglected. Maybe he's topless /* Tjo/, *he's got a BIG HEAD*

This interviewee gave an energetic account of a child who she had seen who had a big head, avoided being in the classroom, removed his shirt, and even stayed outside when it was raining. She made it clear that his behaviour was not due to current neglect, and she stated that she had learnt from the training ("now I've got it here") that it was due to his mother "from when he was in the tummy". All blame for the child's actions and disabilities, therefore, fell on the woman for her behaviour when pregnant (even though FAS causes small heads, not big heads).

With the pregnant woman positioned as sinful, trainees mimicked the Organisation's "redeemer", or "saviour" positioning:

Interviewee 7: *...we need to teach those pregnant women because we are trying to protect the unborn child*

Interviewee 11: *...we even tell them that you can never reverse or cure a disability at all* /ye::s/ *you see what I mean (.) we are just trying to help the unborn baby so they need to stay away from alcohol*

Just as the Organisation redeemed the trainees from their position as "uneducated" to one of "knowers", so the trainees would redeem the pregnant women from their ignorant position in order to save the unborn child. The operation of pastoral power is clear in these extracts: the participants would attempt to save the pregnant woman from herself, and save the foetus from the pregnant woman, through inciting the woman to abstain from alcohol.

Like the training materials, interviewees also positioned teenagers who fall pregnant as particularly sinful. In interviews, trainees often assumed that it was "young girls" who were most likely to drink during their pregnancies and give birth to a child with FASD[33].

Interviewee 8: *...it's prevalent it's prevalent especially among these young children who do not care /yes/ it's prevalent among the younger children who actually do not care* (.) *while they are pregnant they are also busy consuming alcohol* (.) *they do not care* (.) *it's the children who fall pregnant at a young age=*
Interviewer: =yes *the youth*
Interviewee 8:=*yes it's mostly the youth and not older people /ja/ it's the youth*

Interviewee 8 referred to young women who fall pregnant as uncaring children. She used the phrase "do not care", and referred to them as "children", three times each in this extract. By repeatedly referring to them as uncaring children, she was emphasising their young age, and was constructing them as callous. There was a strong othering of such young women: it was they who were to blame, not "older people" such as herself. In this extract, she was expressing a common societal discomfort with young people procreating. Allen (2007) stated that "sex symbolically marks the boundary between childhood and adulthood" (p.578) and, therefore, anyone who is considered still a child is transgressing if they engage in sex. Perhaps it was this symbolic boundary that young people "do not care" about, more so even than the health of their foetus, in the view of this trainee. Young unmarried people who conceive are also flouting the dominant narrative of the "ideal" manner in which to bear children, which is when married.

The interviewer adjusted the word "children" to "youth", which is a less offensive word to call young adults, and this was taken up by the interviewee. However, she continued to stress that it is the youth who place their foetuses at risk through drinking, rather than older women. It was as if, because they are defying the dominant ideals of procreation, young people will automatically transgress in other areas as well, like drinking during pregnancy. The self-positioning as "saviour"

[33] Ironically, children with FASD tend to be born to older women who have had longer drinking histories.

had fallen away in this extract, and instead the interviewee was taking up a "judge" position. "Younger children" who fall pregnant and "do not care" about society's injunctions were beyond salvation.

In a similar vein, Interviewee 7, below, also blamed childhood disability on youthful pregnancies. She asserted that the reason that there are "children who are hyper" is because of "young girls" who "don't even care about their parents".

Interviewee 7: *…yes and children who are hyper you see /ja/ so now I'm discovering the reason why* /mm::h/ *yes* because *we have young girls in our communities* /mm/ *and sometimes you find that this young girl is pregnant, they drink, they are always out at night and they don't even care about their parents you see* /mm/ *and they give birth to a child like that you see* /mmh::/

…

Interviewer*: What do you think causes them to drink while they are pregnant* (1) *according to your observation?*

Interviewee 7: *hey I think it's because it's still fashionable for now* /ye::s/ because *you'll find that these young girls drink even though their boyfriends do take care of them* (.) *b::ack in the day people drank because they were stressed*

As a recently inducted "knower", interviewee 7 had discovered the reason for "hyper" children. Rather than being a saviour, she, too, was now a judge. As with Interviewee 8, above, she "othered" young women who fall pregnant, and expressed much blame towards them. She positioned them as neglectful ("always out at night") and disrespectful towards their elders ("they don't even care about their parents"). The interviewer asked her to reflect on the causes of the woman's drinking, possibly in order to try and shift her to a less blaming stance. However, she continued to position them as uncaring and blameworthy: they were only interested in doing what was "fashionable", which was to drink, and had no excuse, like "stress", for their drinking, as their boyfriends provided for them. They were, therefore, entirely to blame for their children's difficulties. A glaring silence in this extract, highlighted by the interviewer's question, was the lack of reference to any societal reasons for drinking; even usually blameworthy boyfriends[34] were not to blame, and were positioned by this trainee as caring. While the reference to doing what is "fashionable" spoke to societal influences, it was used pejoratively: uncaring "young girls" would mindlessly follow fashion, so they were still individually held accountable for their alcohol consumption.

In the following two extracts, the interviewees did acknowledge that pregnant women may drink in order to "de-stress": there was a nod in direction of societal influences on drinking

[34] Research from Project Two cited absent or violent partners as one of the reasons that women gave for their alcohol consumption during pregnancy (Macleod, Matebese, et al., 2020; Matebese et al., 2021).

behaviour. However, this was not sufficient to shift them from positioning pregnant women as sinners.

Interviewee 10: *Let's say they drank even before they fell pregnant so now they just decide to go drink alcohol in order to de-stress /mmh/ so she forgets how the future of the baby will be affected /ye::s/ how the future of the child will be /ye::s/ and when she discovers that the child has FAS she doesn't understand why you see /mmh/ and it is because she drank during her pregnancy and maybe even smoked*

Through deciding to "de-stress", the pregnant woman "forgets how the future of the child will be affected". She must have had knowledge initially in order to "forget" it and she was, therefore, culpable for not following the dictates of that knowledge, despite her stress.

Interviewee 2: *And you're bringing the presentation ... at the* clinic (.)/mmh/*when she's sitting there (.) maybe stressing about her issues, she's thinking this time she's (.) has a certain discomfort /Yes/ mostly she'll be concentrating on her discomfort and we come saying "Eeey! There's this thing like this and that" her response is "*Nah! *That is White people's sicknesses /Tjoh/ (1) that will never happen to me, they are jealous because I've already got plans for Friday"*/YES/ *that date* (.) to have a spree. *You understand*?

Interviewee 2, likewise, noted the stress that pregnant women are often under: "she's sitting there, maybe stressing about her issues". However, not only were such women positioned as unreceptive to attempts to redeem them from their ignorant position through the Organisation's presentations, but they were also preoccupied with their own socialising rather than the foetus that they are carrying. They would use nonsensical explanations ("White people's sicknesses") and exceptionalist thinking ("that will never happen to me…they are jealous [of me]") to reject the knowledge that they were being offered as not applicable to them. The interviewer's exclamations "Tjoh" and "YES" indicated agreement that such explanations are silly. Therefore, such pregnant women were beyond redemption; they were reprobate sinners. The racial references made it clear that such pregnant women were "Black" people. Because pregnant women were stuck in their ignorant, uncaring, "Black" position, they would reject the enlightened "White" knowledge being brought to them.

In mentoring sessions, the saviour-sinner positions were evident at times, but not as frequently as the previous positionings of knowing teachers-ignorant children. Resistance to the sinner position was clear, primarily through the use of silence.

4.4. Mentoring sessions: saviours, sinners, and silence

Following in the slipstream of their training, and drawing strongly from pastoral power, mentors took up a saviour position at times. The corresponding interactive position for women was "sinner". In this construction, the mentors sometimes blamed women explicitly, but at other times the blame

was more subtle, and seemed to arise because the mentors had not been trained in any other ways of positioning themselves or women. Understandably, the women resisted being positioned as sinners. This resistance manifested in three primary ways: through silence; through taking up an alternative, ignorant position; or through denying any sinful behaviour (pre-natal drinking). However, there was one woman who did take up a sinful position, but this overt up-take may be seen as an act of resistance in itself.

Mazzei, (2007) stated that "attentiveness to breath and silence … is an attentiveness to those who have no voice, or to those who … are unable or unwilling to give voice to their thoughts." (p.32). As often voiceless participants in mentoring sessions, the women's silences need to be foregrounded. Silence was the most common way for women to resist the ways that they were being interactively positioned as sinners by their mentors. The following extracts provide examples of explicit saviour-sinner positioning, with very noticeable silences on the part of the clients.

Mentor Amilisile; Client 1

1. M: *Ngoku ke sizama uku-cuttisha lonto kengoku uba abantwana basinde bangabinayo lento* because *lanto yenziwa nguwe wena mzali* and *ayinyangeki* (So now we are trying to cut that number of those children to save them so that they do not have it because it is caused by you as a parent and it is incurable)
2. (2)
3. M*: Kodwa wena uyakwazi ukuyicontrolla* (but you are able to control it)
4. (1)
5. M*: Uyicontrolla ngantoni?* (How do you control it?)
6. (.)
7. M: *Uba wena ku:: uzithi ecaleni etywaleni* (you:: you stop drinking alcohol)
8. C: Mmh

The mentor in the extract above took up a saviour position ("we are trying …to save [those children]"). She then proceeded to blame parents for FASD and used the second person pronoun in the phrase "it is caused by you as a parent", thereby explicitly positioning this client as sinful for being the cause of FASD. It is noteworthy that, despite the significant pauses (two seconds in line 2 and one second in line 4), the client did not comment or even provide a backchannel agreement, even after the question "How do you control it?", except to give a perfunctory "mmh" at the end. This silence by the client demonstrates powerful resistance to the sinful position.

In the next extract, the mentor was rebuking the client for not attending one of the Organisational workshops.

Mentor Luhle; Client 3

1. M: So *kengoku njeba ndize apha kuwe wena sewubelekile ke ungomnye wabantu bam abathathu qha zange uye kula-worskhop yezimithisane yiyona nto iyiproblem keleyo*

(So the reason why I am here also now that you have given birth is because you are one of my three clients but you didn't go to the workshop for pregnant women and that's where the problem lies)

2. (1)
3. M: *Uyaqonda? (*Do you understand?)
4. C: Mmh

Here again, the client was silent despite the one second pause, and responded with a token utterance only on direct questioning. Such silence points to a refusal to take up the disobedient, sinful position constructed by the mentor.

In the extract below, the client quickly answered the mentor's questions until there was the possibility that she would be positioned negatively.

Mentor Namhla; Client 1

1. M: *Zingaphi iinyanga zakho* (how far long are you)=
2. C: *Ziyi-4* (four months)
3. M: W*azenza zonke i-examinations zakho nhe* (You did all of your examinations right)=
4. C: *ewe* (yes)=
5. M: *Watesta everything* (and did you get tested for everything)=
6. C: *Yonkinto* (everything)=
7. M: So *istatus sakho sithini* (So what is your status)
8. (1)
9. C: Status?
10. M: mm
11. C: *err ndi-HIV* (err I am HIV [positive])

In this exchange, the client was answering the mentor's questions rapidly, without any pauses before answering. However, the mentor then asked a rather intrusive question about the woman's HIV status. Given the operation of pastoral power, this question is understandable: as a pastor and redeemer of the woman, the mentor was entitled to know private information about the woman. The confessional, where a client confesses intimate details of their life, is a key technology in the arsenal of pastoral power. However, this client paused significantly (line 8) before replying, indicating that she did not want to answer the question. In line 9, she delayed further by feigning confusion about the question, before confessing her HIV positive status in line 11. The client was, through these delaying tactics, resisting the intrusion of pastoral power into her life.

The extract below is taken from a recording where the client did more of the talking than the mentor, unlike the other mentoring recordings. The session lasted 23 minutes, and the mentor asked some open-ended questions, which led to the woman revealing some personal information. The mentor generally had a non-blaming stance towards the woman, and she was the one mentor

whose recordings suggested that she was providing something of value to her clients. Nevertheless, even she positioned her client as sinful in this extract. This seemed to come out of her obedience to the Organisaton's dictate to focus on the ills of FASD.

The extract is taken from a section where the woman had been describing her difficulties in procuring a birth certificate for one of her older children. She gave birth to him in Gauteng, then changed her name, and this had caused discrepancies which meant that she had been unable to get a birth certificate for him, despite many visits to various government departments.

Mentor Thobile; Client 1

C: *Abanye banazo yena akanaso okuba abheke esikolweni because into ebangela ukuba makangamameli kukuba akayi eskolweni makabheke eskolweni /mmh/ phayana akakho safe cause uyaphuma phaya /mmh/ ahambe ayodlala aye kwezindawo zakhe /ok/ and kengoku siyaphinda siyamsuspector nalapha ekutshayeni /mmh/ ngoba indlela le aneckiki ngayo nendlela le atya ngayo /mmh/ aphinde ke futhi into endiye ndayibona kukuba akanamntu amoyikayo phaya endlini because umamam uyasela (.) umamam uhleli nje ushushu /mmh/ nayo le boyfriend ndihlala nayo iyasela ngeeweekends (.) so akhomntu amoyikayo mna naye siyalingana xa endijongile ndingumntu alingana naye akandoyiki /mmh/ sendayeka nombetha ke futhi /mmh/ ndimjona nje* (Others do have [a birth certificate] he doesn't have one and all I wish is for him to be able to go to school because the reason why he misbehaves is because he doesn't attend school. He needs to go to school /mmh/ he is not safe where he is because he can go out anytime, /mmh/ he goes and plays and goes to other places as well /ok/, and now we even suspect that he smokes as well /mmh/ because of the way he eats and his cheekiness /mmh/. At the same time I've also noticed that he doesn't respect anyone at home because my mother drinks a lot (.) my mom is always drunk /mmh/ even my boyfriend whom I live with also drinks over weekends (.) so he is not afraid of anyone, and to him the two of us are just the same age, he doesn't respect me /mmh/ I don't even spank him anymore /mmh/ I don't do anything /ok/
(2)
M: Ok [in-breath], ok, *impawu zakhe uyazibona ukuba zezomntana ozelwe eneFAS yena kuqala* (do you notice any signs of a child who is born with FAS)
C: *mh-mh* because *ndandingaseli kuye* (no because I didn't drink when I was pregnant with him)

The mentor had been listening well, providing backchannel responses ("mmh") to indicate her attention, but without interrupting the woman as the woman talked about her tremendous difficulties with her son's behaviour as he was unable to attend school without a birth certificate. There were additional difficulties with her mother's and boyfriend's drinking. However, when it was clear that the woman had finished her speaking turn, indicated by the two second pause, the mentor seemed to be at a loss as to how to continue the conversation. She took an audible in-breath, possibly suggesting anxiety, and then she fell back on the Organisational mandate: she asked the woman if she noticed any signs of FAS in her son. On one level, this is an understandable question, given the alcoholic culture of the family and partner. However, the woman had been positioning

herself as a caring yet burdened mother, doing her best to obtain the necessary documentation for her son to attend school, but struggling greatly with the effects of governmental inefficiency, a wayward child, and a drunken mother and partner. Rather than reflecting this, the mentor's question suggested that the woman might be to blame for her son's behaviour. The woman resisted this blaming position by denying any sinful behaviour. However, had this mentor been trained in listening and reflecting skills, and the importance of taking a non-blaming stance, it is likely that she could have reinforced the woman's "caring mother" position, provided empathy for her struggles, and engaged with her in a more caring and life-giving way.

In the extract below, the client did, reluctantly, take up the sinful position of someone who drank during pregnancy "just for fun", but her long silences before her admissions, and her lack of intonation suggest not only resistance, but also shame.

Mentor Zukiswa; Client 1

1. M: *Ke kulo mntana wakho wokuqala mandikhe ndikubuze zange wasela* (if I may ask did you drink during your first pregnancy)
2. (2)
3. C: N*dandisela* (I drank)
4. M: Ok err *wawusela useliswa zizizathu ezithini mhlawumbi* (you drank what were your reasons for drinking perhaps)
5. (1)
6. C: *Nje ukonwaba* (just for fun) [very flat, emotionless tone to C's talk]

This client was 19 and had two children. In the talk preceding this extract, the mentor had asked pointed questions about her age, and why she already had two children. Already positioned negatively as a "teenage mother", this client was now shamed further as a drinker. Shefer and Munt (2019) asserted that "(s)hame and shaming are … bound up with social inequality, both reflecting and serving to reinforce, reinstate and legitimise social injustice." (p.146). The mentor's pointed questioning of this client perpetuated social injustice by highlighting the client's supposedly shameful positions and calling her to account for them ("what were your reasons"). By requiring an account, the mentor positioned the woman as individually responsible for having deliberately and consciously taken up such positions. Shaming is an individualising process and a means of policing others to ensure that normative positions are upheld (Shefer & Munt, 2019). However, as Matebese et al. (2021) showed, in their interviews with women who drank during their pregnancies from the same communities as these clients, shame resulted in women concealing their pregnancies and their drinking, and excluding themselves or being excluded from family, social and religious settings, which potentially could have been sources of support for them. Importantly, shame did not lead to health seeking behaviours or attempts to reduce drinking.

Returning to the above extract, there may be either resistance to the Organisation's responsibilising thrust, or confession in this client's self-positioning. Although seemingly reluctantly, she overtly took up the position of someone who drank during pregnancy "just for fun". She did not make use of other less shameful positions, such as denying pre-natal drinking, or of being ignorant of the harms of alcohol use, or of drinking because of stress. Her flat, emotionless tone suggests depression and hopelessness; it was as if she did not have the energy to position herself more positively, and she passively accepted the shameful position that the mentor constructed for her (Prof. A. Lyons, pers. comm, March 2023).

To avoid shame, clients sometimes took up an "ignorant child" position to explain their previous drinking:

Mentor Zukiswa; Client 3

1. M: *Ndicela ukubuza ke [*name of client*],kulomntana wokuqala wawusela kuy*e? (I would like to know [name of client], did you drink with the first child?)
2. C: *Kulomntana wokuqala ewe ndandisela kuye /*mmh*/ ngoyena mntana ndimselele kakhulu /*mm*/ kuba ndandingazinto mos /*mmh*/ kulantoba kwakusithwa hayi umntwana ufuna utywala obuthile so ndandisela [….] kuba ndingazi* (I did drink during my first pregnancy /mmh/ in fact I drank the most because I was unaware /mmh/ I used to hear people say certain kinds of alcoholic drinks are fine so that's why I drank [...] I lacked information)

The client above claimed she was unaware, influenced to drink by others, and lacked accurate information on the harms of pre-natal alcohol use. There is no silence in this extract; the client had ready access to discursive positions which deflected blame, such as ignorance (a position sanctioned by the Organisation) and being led astray by others, and she took up these positions with aplomb.

The client, below, also took up the ignorant child position, but went further to indicate that she had now been redeemed:

Mentor Amilisile; Client 1

1. M: *Ayinyangeki ingxaki* (the problem is that it's incurable)
2. (.)
3. M: *Umntana ukhula enalanto* (The baby will grow up with the disease)
4. C: Mmh
5. M: *Kufumaniseke intoba kengoku ubomi bakhe bonke uzawuba ngumntana owrongo (*and you will find that his whole life they will be like that) =
6. C: *=Ee uzawubangumntwana owrongo* (=yes they will be a problem child)
7. C: *so nam ndiye ndadecider ukuba ha a mandikhe ndiyeke etywalene ndiphumane notywala oko ndithe ndeva (*so I decided to stop drinking alcohol now that I am pregnant after hearing all that)
8. (.)

9. C: Otherwise *nam ndandingazi mos kuqala* (otherwise I didn't know about that before)

In line 6, the client broke in on the mentor's speech to assert her own newfound knowledge. This is an example of strong agreement: the client agreed, and also re-phrased and expanded on what the mentor had been saying. She was, thus, aligning herself with the mentor, and othering the "problem child" who has FASD. In line 7, the client positioned herself as a redeemed drinker who has now seen the light after hearing the Organisation's teachings. In line 9, the client positioned herself as previously ignorant, which absolved her of blame for any previous pre-natal drinking. Her emphatic use of the word "before" suggests an eagerness to prove her ignorance prior to the Organisation's input. This ignorant position counteracts the sinner position, and it is one that was sanctioned by the Organisation, as shown in the previous section.[35]

This section has shown how mentors positioned drinking pregnant women as sinful, and how the women resisted this positioning, primarily through silence, but also through either denying any sinful behaviour, or through taking up an ignorant position. There was one woman who did deliberately accept the sinful position of someone who drank during pregnancy "just for fun". However, this overt shameful positioning of herself can also be interpreted as an act of resistance. Shame thrives in unspoken and hidden, in silent but implicit, positions. In taking up rather than resisting the sinful positioning, the woman was, probably unwittingly, reducing the shame associated with it.

5. Conclusion: the pregnant/newly parenting woman as ignorant or sinful

In this chapter I have unpacked the ways in which the Organisation and their personnel positioned themselves as knowledgeable adults and saviours of drinking pregnant women and their foetuses. The counterpoint position for women was as ignorant children and sinners. At times, the saviour-sinner positions hardened into ones of judge-criminal, where women were criminalised for harming not only their foetuses, but also society and "the whole of South Africa" through their pre-natal drinking. Power apparatuses of coloniality and pastoral power were evident in these positionings.

[35] Interestingly, qualitative research done in Project Two, that looked at narratives of drinking and pregnancy in the same geographic location as this research, indicated that most women who drank during pregnancy were aware of the dangers of drinking during pregnancy (Macleod, Matebese et al., 2020; Matebese et al., 2021). Reasons provided for drinking during pregnancy in that research centred around lack of partner support, experiences of trauma (including intimate partner violence) financial and health stresses (including HIV diagnosis during pregnancy) and a social culture of drinking. Lack of knowledge of the harmful effects of prenatal drinking was not cited as a reason. Women who had previously consumed alcohol were willing to talk to the researchers at length about their situations, unlike clients in these mentoring sessions. The researchers had been trained in narrative and non-judgemental interviewing techniques, as well as deep listening.

Scare tactics and choice rhetoric were particular techniques that were used to exert colonial and pastoral power, respectively, over women. Scare tactics were used to emotionally manipulate women into behaving as the Organisation deemed that they should, while choice rhetoric, a particularly individualising technique, was used to position women as individually culpable for FASD, but also individually responsible for their own and their children's salvation from FASD. In these manners, the Organisation and its personnel incited pregnant women to become the type of productive citizen that the State requires – responsible, sober, caring mothers.

Clients in the mentoring sessions responded to such positionings in various ways. When positioned as ignorant, they either took up compliant child positions, as people who dutifully learnt from the Organisation, or else they resisted this position through silence or by asserting their own knowledge, and taking up a knowledgeable position. When positioned as sinful, all but one client resisted this position, understandably. Resistance primarily took the form of silence, or through returning to an ignorant position and claiming lack of knowledge of the harms of pre-natal drinking. In this way, clients were complicit with the Organisation in positioning themselves as ignorant. An ignorant position was a useful one for both the clients and the Organisation and its personnel: for clients, it absolved them from blame, and for the Organisation, it offered a very easy route to redemption – simply provide information. However, neither an ignorant nor a sinful position invite care, justice, or empowerment.

There were two other ways of resisting the sinful position that were manifest in these data: either through denying any sinful behaviour (pre-natal drinking), or, as one woman did, through consciously (although apparently reluctantly) taking up the sinful, shameful position of one who did, indeed, drink during pregnancy "just for fun". Whilst the mentors' positionings of the women as sinful reinscribed social injustice, the overt uptake of such a position by a woman reduced the shame associated with it by bringing it out into the open.

In the next chapter I analyse the positions of the foetus as a "precious baby", the person with FASD as the defiled Other, and the pregnant woman as "Mommy". These positions were innervated primarily by the apparatus of patriarchy. Thereafter, in the last analytical chapter, I draw out the few instances where women were positioned as victims of injustice, as agentive or as needing care, and I argue that these latter positions need to become far more prominent within the Organisational programmes, and in interventions aimed at reducing FASD.

Chapter 7: Precious “babies”, defiled Others, and Mommies

1. Introduction

In this chapter, I demonstrate how the Organisation constructed the foetus as a precious and vulnerable baby, and the pregnant and newly parenting woman as “Mommy”. The defiled Other, against whom the precious baby was positioned, was a child with FASD. Within the broad position of “Mommy”, I show how the woman was positioned as invisible (with the focus being almost entirely on the “precious baby”), highly gendered, and entirely and individually responsible for the health of her foetus and baby. Part of the project of responsibilising the pregnant woman involved constructing a sufficiently scary risk against which she needed to be ever wary - the risk of bearing a FASD child. Patriarchy innervated the gendered positioning and invisibilisation of women. Disciplinary techniques of surveillance, normative judgements, individualisation and risk consciousness were employed to responsibilise women, and were also used to create the dichotomy between the “precious baby” and the defiled FASD child. Pastoral power was used in the mentoring sessions in the service of the responsibilising project. I work through each data source in turn to illustrate these positions.

2. Precious “babies” and invisible women

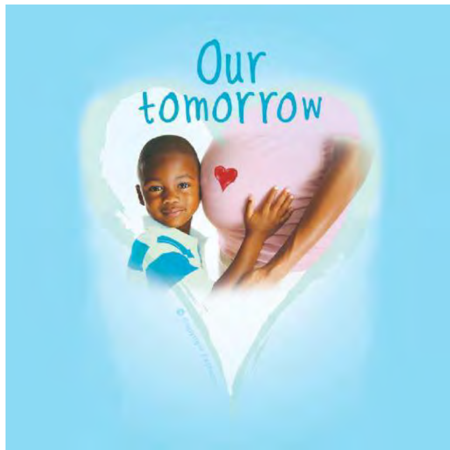
As pointed out in the previous chapter, the training materials always referred to the foetus as “baby”, except when providing medical information on the stages of pregnancy. The manuals used the descriptors “precious” and “vulnerable” repeatedly to describe the foetus (“precious” was used nine times each in modules 1 and 3, and “vulnerable” was used six times in module 1 and three times in module 3). Pictures were replete within the manuals, and foregrounded foetuses, babies, and pregnant bellies, with a generalised invisibilisation of the woman. Text did likewise. Five videos were shown during the first training session, three of which sent very strong “foetal preciousness” messages, with a concomitant invisibilisation of the pregnant woman. Training sessions and interviews perpetuated such messages, although not as frequently. The apparatus of patriarchy was the dominant power modality in the “precious baby/invisible woman” construction in the training materials, training sessions, and interviews. In the mentoring sessions, which employed pastoral

power, the foetus was positioned as a “precious baby” by only one mentor, and this was done in the context of strong anti-abortion rhetoric.

2.1. Constructions of “precious babies” in the training manuals

The image below was on the front cover of module 1 (on FAS), and at the start of the powerpoint presentation[36].

Image 1



In this picture, a young “Black” boy is shown smiling and pressing his ear and right hand to a pregnant belly. His face, shoulders, and right forearm and hand are visible. A small heart shape is placed on the belly, and the image is within a heart shaped frame. The caption at the top of the image reads “Our tomorrow”. Colours in the picture are pale blue, pale pink, and white - classic “baby” colours. Apart from part of her left arm and her distended abdomen, the woman is completely excluded from this picture. The message conveyed is that children and foetuses are “our tomorrow” or our future, and because of this, they hold pre-eminence in terms of importance. The value of the woman lies only in her capacity to incubate the foetus; the rest of her is invisible and, therefore, not of value. The heart shapes indicate that children and foetuses are entirely lovable. There is no space for not finding children and foetuses adorable and treating them as precious. The boy strikes a protective and loving stance towards the foetus. If young children can be so loving, surely adults must be doubly so?

The next picture, shown below, appeared on the front page of module 3 (on pregnancy), and also the powerpoint presentation.

Image 2

The picture depicts a mixed race or Asian baby inside a swaddling bag, with a large mauve flower attached to her head. The background and blanket on which the baby rests are also mauve.

[36] I was granted permission by the Organisation to reproduce their materials in this thesis

Only the baby's face and hands, clutching the swaddling, are visible. She faces the camera, and her expression is quizzical, or perhaps somewhat anxious, tightly bundled as she is. Her cryptic expression is in contrast to the peaceful tones of the dominantly mauve colouring. The unusual swaddling and the baby's slightly pained expression draw the viewer into the picture and arouse emotions: Why is she in the bag? Would she be more comfortable out of it? All of our focus, as viewers, is on the baby. No woman is in sight. The module that this picture introduces is about pregnancy, but the picture makes it clear that babies are the important issue. Pregnancy is only the means to produce such "precious" babies.

The manuals were replete with pictures of foetuses, with accompanying wording that asserted their vulnerability, as shown below:

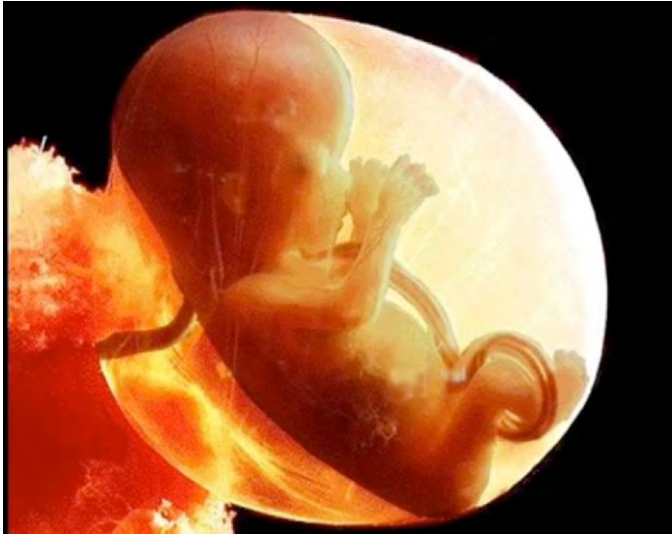
Image 3

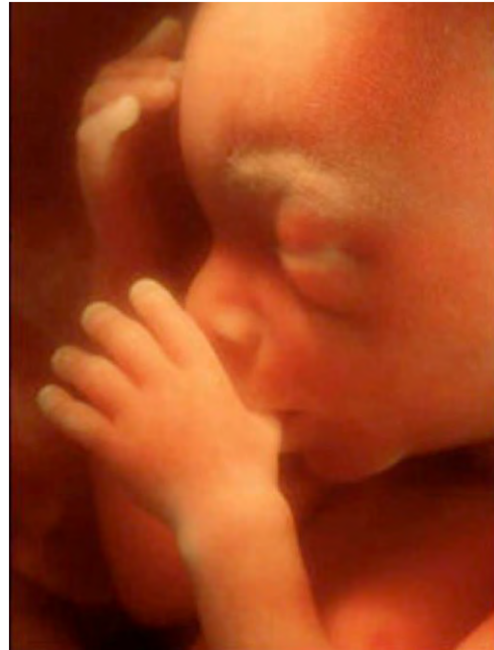
"The baby is very vulnerable and defenceless during pregnancy.

"The baby is totally dependent on the mother for food and protection. Without this nourishment and protection, the baby will die." (p. 3, module 1)

Although the picture is of a foetus, the accompanying wording refers to it as "baby". This personification of the foetus constructs it as a person in its own right, separate from the pregnant woman. This person is also "vulnerable", "defenceless" and "totally dependent". Being constructed as vulnerable and dependent invites care, while the term "defenceless" suggests that it is at risk of being attacked or harmed. The pregnant woman is referred to as "mother". Positioning the pregnant woman as such is discussed in section 4.

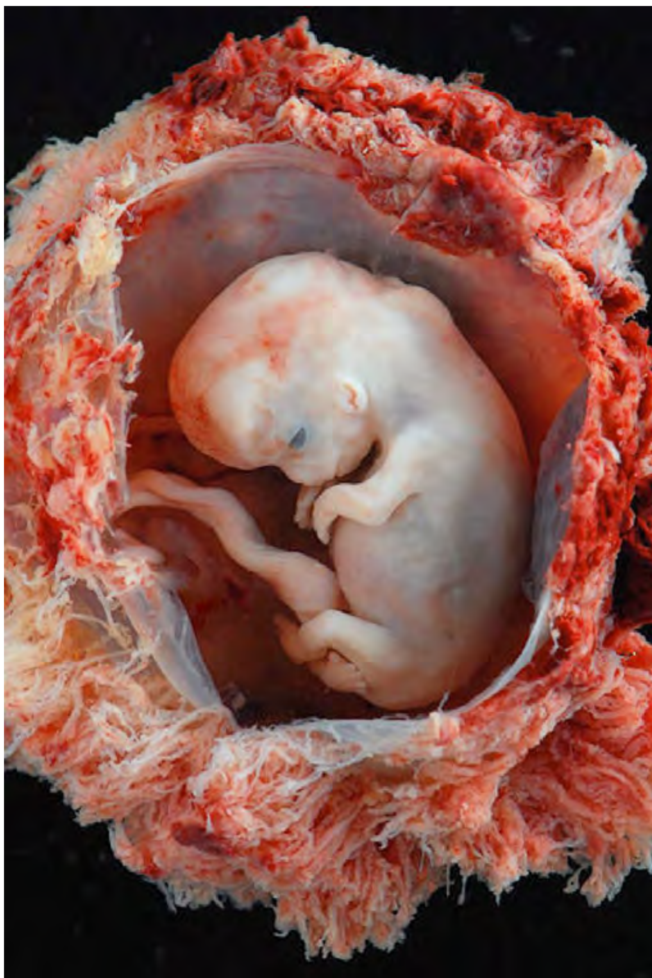
Images 4 and 5





During the first trimester the foetus is most vulnerable (p. 3, module one)

Image 6



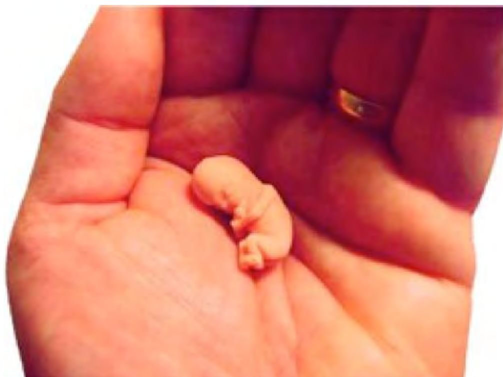
At 2 months, the fetus is still so small that it can fit into a teaspoon. . .

. . . and though this developing life is so tiny, he has the form of a human being, with the arms and legs clearly visible.

This little life is fragile and precious .. !

Boucher (2004) pointed out that most foetal photographs are of dead foetuses that have been back-lit, positioned (such as placing the thumb in the mouth), and photo-shopped in order to present an image that is alive and beautiful. The images above, as with most foetal images, give no indication of the foetus's embeddedness within the woman; the foetus is presented as completely separate from the woman and a person in its own right (Armstrong, 1998; Boucher, 2004; Lupton, 2012).
In image 6, the embryonic foetus is shown within a cross section of a uterus, which is depicted as free-standing and completely separate from any body. In the wording, the masculine personal pronoun 'he' is assigned to the foetus, constructing it as male. This male life is "fragile and precious". Patriarchy is operational here; the male is precious, while the female (woman and female foetus) are invisible and, therefore, inferior.

Image 7



P. 7, module 1

A life-size little model of the developing precious life at eight weeks shows that he has already a human shape with arms and legs ~ even though he is so tiny that a human hand can hold him.

Image 7 depicts the left hand of a "White" person holding a model of an 8-week-old embryo. The hand looks as if it belongs to a male, and a wedding band is clearly visible on the third finger of the hand. Patriarchy is again visible: the man is the protector of this tiny "precious life", which is also identified by the accompanying wording as male. Marriage, which can be understood as a traditional institution which often reinforces patriarchy, is foregrounded through the visible wedding band, and the implication is that it is married men who are the ones who will protect and care for their children. The strong, protective man and his precious, vulnerable, male "child" are seen; the invisible woman is not. From whom is the man protecting the foetus? Given the criminalisation of drinking pregnant women that was illustrated in the last chapter, it can only be the woman from whom the foetus needs protecting.

Lupton (2012) stated that "in recent years the foetus has become fetishised as a precious body to the exclusion of the pregnant woman's needs and rights." (p.329). The images and wordings used in the manuals did precisely this: highlighting and fetishising the "precious foetus" while making barely any reference to the pregnant woman's personhood, needs, or desires. In looking at foetal images used in anti-abortion/pro-life campaigns, Kelland and Macleod (2015) argued that most of the

images are an illegitimate use of visual images for moral persuasion. Citing philosophical literature on when visual images may be used legitimately for moral arguments, these authors argued that most foetal images do not present a true reflection of a foetus, embedded within the pregnant woman's body, but are of dead foetuses that have been positioned and photoshopped in an artistic manner to present an alive and appealing image. They also asserted that the images used "fail to present morally significant events that take place in both the past and the future that would potentially alter the way in which we think about a moral issue." (p.190). The images used entirely decontextualise the foetus from the event of pregnancy, the pregnant woman, the preceeding events of conception and following consequences of pregnancy, birth and child rearing.

Kelland and Macleod's (2015) arguments hold true for the images used in the Organisation's manuals and training materials. However, I am not suggesting that foetal images should not be used in campaigns to reduce pre-natal drinking. There is some evidence that seeing an ultrasound image of their foetus promotes a woman's bonding with it, and desire to invest in it and protect it (Rutman et al., 2000). Pajulo et al. (2012) found that relational training for substance using pregnant women, aimed at enhancing their relationship with their foetus, could reduce their substance use. To this end, it seems likely that, for pregnant women, seeing images of foetuses and learning about how they are developing and what they can sense at each stage of pregnancy may be helpful in promoting a positive woman-foetus relationship. However, it would be important that any images used make clear the embeddedness of the foetus within the woman, that the images are accurate portrayals of embryos and foetuses at the various gestational ages, and that the changes that the *woman* experiences through pregnancy, physically and emotionally, are foregrounded and addressed.

2.2. Constructions of "precious babies" in the training videos

Of five videos that were played during the training sessions, three strongly reiterated the "foetal preciousness" discourse. (Of the remaining two, one was made by the Organisation and gave the message that "as the mother drinks, so does the baby", while the other was made by another NGO depicting the effects of a man's drinking on his family). I analyse the three "foetal preciousness" videos in some depth, as the audio-visual medium used was a powerful inscriptor of foetal preciousness.

The **first of the three "foetal preciousness" videos** was called "Sleepsong", and can be found on the webpage of Ine Braat (Braat, 2010). It was six minutes long and depicted animated images of a being, supposedly a foetus, in the womb, and captioned words, narrated by a male speaker. The being looked like a baby of about six months of age, because it was chubby and attractive, and had

good motoric control over its limbs. The images portrayed a contented, sometimes smiling, peaceful foetus/baby, with mystical background music playing. The narration started with the words "Dear little one, our darling, we are eagerly waiting to welcome you to your new home, to your happy family. You are our future, and the future of mankind." During the "to your happy family" phrase, the images shifted from the foetus/baby to a silhouetted heterosexual couple walking arm in arm along the seashore. The frame then returned to the foetus/baby, before depicting shadows of men, cast upon a satellite image of the world during the phrase "and the future of mankind." No clothing or hair was apparent in the shadows, suggesting that the men were naked or scantily clad, with either shaven, and/or short African hair. One of the shadows carried a pot or bucket on his head, and another held a very long stick, pole or spear. The shadow depictions thereby gave the impression of colonialistic renditions of so-called "primitive" cultures. Foetal/baby animations then reappeared, and the being was instructed with the following: "So come to this world, happy, healthy, intelligent and brave. Be creative and loving, with qualities of leadership. Oh precious child, we await your arrival." This was followed by the lullaby "Sleep song", sung by Secret Garden, with images of animated foetuses/babies, interspersed with scenes from nature, flying storks, and mystical, cosmic imagery.

The animated foetal/baby images strongly constructed an actual foetus as an autonomous being, a fully developed baby of several months of age, but with a gentle, peaceful, contented personality, that was "floating independently in the cosmos." (Boucher, 2004, p. 70). There was also the construction, with the shadows of "primitive" men, the cosmic imagery, and the words "You are our future", that the foetus "represents life itself" (Boucher, 2004, p. 70) – the origin and also the continuation of humanity. This foetus/baby is "our darling", whom we await eagerly, and who is destined to be happy, healthy, intelligent, brave, creative, loving, and a leader (unless, of course, its mother gets in the way of its destiny). The narrator addressed the foetus/baby directly, reinforcing its construction as a human being, but also with mystical or spiritual qualities – it could be addressed as one addresses a deity. Therefore, the foetus is both fragile and vulnerable, but also in possession of mystical, god-like qualities.

This is an example of what (Boucher, 2004) referred to as a "public foetus", which is created by foetal imagery that is now in the public realm. This relies upon "a double suppression" (Boucher, 2004, p. 70): firstly, the pregnant woman is suppressed, and secondly, the complex technologies that create such images are masked. The suppression of the female and the pregnant woman were glaring in this video. The only female image was in the brief scene where a couple was walking along the seashore; the woman was only part of the whole, which was the couple. The narrator and the

shadows of "primitive" people were both male, and the foetus was described as "the future of mankind", not humankind. Patriarchy is strongly present in this video.

There was no acknowledgement of the realities of relationships, pregnancies, foetuses, babies, and children in this video – of the often messy, difficult, exhausting, and emotionally draining nature of each of these entities. Homes and relationships were constructed as normatively "happy", and expectant parents could only be delighted at the prospect of their forthcoming child. All was couched in mystical music, beautiful scenes, and emotive language and images. The images of the storks linked to the European myth of babies arising from some mystical location and being brought to families by storks – another colonialist imposition. A highly pro-life message was given; the suggestion was that it is unthinkable that anyone would choose to abort such a spiritual, beautiful creature who is destined to bring only joy. Anyone with a difficult home life, fraught or absent romantic relationship, or ambivalent or negative feelings towards the pregnancy must be abnormal.

The **second "foetal preciousness video** was short, less than a minute in length. It started with the words "When a mother drinks, the baby drinks too". It showed an animated image of a pregnant woman, with a visible foetus in her abdomen. Then the following wording was narrated in a woman's voice: "A pregnant woman shares everything she eats and drinks with her baby. When a woman drinks alcohol, it passes into her bloodstream and spreads throughout her body. As soon as the alcohol is in a pregnant woman's system, it enters her placenta and passes to the baby through the umbilical cord. Alcohol goes directly into the baby's blood-stream, where it can damage the brain, the face, and the organs that are developing at the time." This narration was accompanied by animated images that showed the spread of green shading, depicting alcohol, through a woman's and foetus's body, with strong green shading in the brain, face and abdominal organs of the foetus.

By referring to the foetus as "baby", foetal personhood was again invoked, with human rights and an independent existence. While the narration desisted from calling the woman "mother", (except for the inserted title "When a mother drinks, the baby drinks too") and instead referred to "pregnant woman", it persisted in using the term "baby" for the foetus. It did not specify what level of alcohol can cause foetal damage, but one was left with the sense that any alcohol consumption will cause damage.

The **third "foetal preciousness" video** had a clear Pro-Life and Christian agenda. It was three and a half minutes long and entitled "The miracle of life". Against an image of a pregnant woman holding her belly were sentences that came up in sequence against gentle background music. The sentences read: "What should I do? Is this a 'fetus' or a 'baby'? When does life really begin?" The images then

changed to a ball of cells, floating against a cosmic background, and DNA helixes. The following wording came up: "Do you know about the miracle of life? At the moment of conception, a unique human being's DNA is created. Human DNA that has never existed before…[37] and will never be repeated again." The image of a baby was then shown with the following sentences: "At the moment of conception, all the baby's physical traits… sex, hair color, eye color, have already been determined." This was followed by ultrasound images of pregnancies and animated images of foetuses, and a description of what features and abilities of the foetus develop at which stage of pregnancy. The foetus was designated as "her/she". Inflated claims of the foetus's abilities in the first trimester were made. The wording claimed that "By the 11th week: she can smile and frown… wiggle her fingers and toes … and even suck her thumb." This was followed by ultrasound images of an older foetus putting its thumb in its mouth. When the description reached the sixth month of pregnancy, pictures of babies, not foetuses were shown. The video ended with the words "The Bible teaches us that… God is the creator of life", followed by three Biblical verses and the words "Choose Life" set against pictures of babies.

The word "miracle", used in the title of the video, references an extraordinary and welcome event that is brought about by the specific intervention of God. Conception and birth are often designated as "miracles" by Pro-Life and pro-natalist networks, even though such events are certainly not usually extraordinary, and sometimes not welcome. The use of the word "miracle" and the references to uniqueness, God and the Bible all constructed pregnancy, foetuses and babies as especially miraculous, and as more important to God than other aspects of life.

The Bible verses used in the video are commonly used in pro-life discourses. They speak to

- God's knowledge of a person and their life, even prior to conception - "Before I formed you in the womb I knew you, before you were born I set you apart" (Jeremiah 1:5, New International Version) and "All the days ordained for me were written in your book before one of them came to be." (Psalm 139:16, New International Version). This verse was preceded in the video by the words "God has a plan for every life");
- That children are a gift from God - "Behold, children are a gift of the Lord; the fruit of the womb is a reward." (Psalm 127:3, New American Standard Bible).

However, these are the only verses in the Bible that claim these things. Other Bible verses, such as the Proverbs "Folly is bound up in the heart of a child, but the rod of discipline will drive it far from

[37] These ellipsis points are in the video wording; they do not represent words that I have omitted from the transcription.

him" and "The rod of correction imparts wisdom, but a child left to himself disgraces his mother"[38] (Proverbs 22:15; 29:15, New International Version), which speak to the more difficult, less "precious" aspects of children, are not mentioned in this video, or generally in Pro-Life material.

The questions at the beginning of the video "What should I do? Is this a 'fetus' or a 'baby'? When does life really begin?" were clearly answered through the rest of the video. The video asserted that life begins at conception; that a pregnant woman carries a "baby" not a "fetus" (by calling the foetus "baby" and using the human pronoun "she/her" rather than "it"); and that pregnant women should "choose life" rather than abortion. Such rhetorical questions suggested that the answers to the questions (as provided by the video) were obvious; any "normal" person would know such things, and someone who answers, or chooses, otherwise must be abnormal.

By inflating the abilities and development of the 11-week-old foetus (by claiming that it could suck its thumb and showing images of older foetuses), the video was giving the message that, even in the first trimester, the foetus is more human, more "baby-like" than it actually is. How could one think of aborting an 11-week-old foetus if it is so human? Likewise, by projecting pictures of babies when the words are discussing a six-month-old foetus, such foetuses are constructed as equal to babies.

These videos, particularly the first and the third, sent very strong 'foetal preciousness' messages. The constructed audiences were potential and expectant couples in the first one, and pregnant women who were possibly considering abortions in the third one. At no stage were the complex, multiple, and varying needs and desires of the audiences considered. While some expectant women and couples do, indeed, view their foetus as very precious, anyone who may not wish to parent or does not have the means to do so satisfactorily, is silenced and, therefore, shamed for not longing to parent such a "precious child".

2.3. Constructions of "precious babies" in the training sessions and interviews

Training sessions made use of the training powerpoints and videos, so naturally reiterated the "precious baby" constructions. However, compared to the training materials, there was less emphasis on this construction. Examples of the "precious baby" construction that were evident in the talk in the sessions are shown below:

[38] These proverbs are often used, problematically, to justify corporal punishment in conservative Christian circles.

Second training session day 1

Facilitator: So the mother and the father have to work together to ensure that the child doesn't have FAS because the child is special and=
Trainee: =precious
Facilitator: precious, what we want is to give the child a hopeful future. So it is important to make a correct choice so that your child can have a good future, for instance you want your child to become a doctor and all those things, so you must work towards it.

As well as a strongly gendered discourse ("the mother and father have to work together") and responsibilisation discourse ("it is important to make the correct choice"), both of which are discussed later in this chapter, positioning the foetus and child as special and precious is evident in this extract. One of the trainees eagerly added to the positioning as she contributed the word "precious" after the facilitator talked of the child being special. Having sat through the training videos and powerpoints, the trainee was now well versed in the fact that the foetus was "precious". The message that the facilitator gave is that, if both parents work together and the woman makes "a correct choice" by avoiding alcohol during pregnancy, then the child can become a doctor, or some other equally prestigious professional.

In the next extract, the "precious baby" construction has the effect of silencing women who may feel things other than wonder and joy in response to giving birth and playing with their children:

Second training session, day 3

Facilitator: …a new baby is like a new beginning of all things, wonder, hope and dreams of all possibilities. Perhaps when you're holding the child in your hands after giving birth to them you can feel all that. The things they are talking about there; wonder, hope, after you've given birth to them, you only have good wishes for them. And when you are playing with them, you say things like, "you will be a doctor right" so these are all the wonderful things they are talking about, the dreams and possibilities they are talking about.

Referring to the "things they are talking about" in the powerpoints and manuals, the facilitator claimed that a new baby is the beginning of all things positive. If, having just given birth, a woman does not feel such hope and wonder, then there must be something wrong with her. The facilitator also told the trainees that they needed to tell their children that they will be doctors and such like. There seemed to be no awareness of how much pressure such oft-stated expectations can cause growing children to feel. Such sentiments also buy into the liberal capitalist lie that individual hard work and dedication ensures worldly "success". The poor state of public schools, particularly in the poverty-stricken areas where the Organisation operates, and the very high levels of youth unemployment were completely glossed over.

However, by referencing "the things they are talking about" in this extract, it appeared as if the facilitator did not quite fully believe the overwhelmingly positive things that she mentioned; she seemed to have to bolster her own less-than-certain assertions about the "dreams and possibilities" of a new baby with reference to the fact that this was the Organisation's mantra.

An anti-abortion position flows out of, and also gives rise to "precious foetus" discourses. This is demonstrated clearly in the extract below, where the facilitator was discussing the picture shown in image 6:

First training session, day 1

Facilitator: Foetus though is an undeveloped two months old baby, that is why people do things to it that I will not call by names and they say "no it was not yet a baby" because even though the foetus can be a size of a teaspoon and not a spoon but still all his parts are there… you can see that this is a human.

The facilitator claimed that a two-month-old foetus is a "baby" who has all the body parts and "is a human", and she asserted that abortions arise because people do not see the foetus as a baby yet. By very obviously not naming "abortion/termination" directly, the facilitator was constructing terminations as so abominable that she could not even say the word.

The "precious baby" construction was reproduced by trainees in the interviews. The interviews with trainees were conducted in isiXhosa, and participants generally spoke about "child" or "baby" when referencing both foetuses and children. IsiXhosa words for "foetus" are *usana olungekazalwa* ("unborn baby", or "baby in the womb") or *umbungu* ("worm" or "foetus") but these terms are not in common usage, and speakers generally use the word *usana* ("baby"), sometimes with a hand placed on the belly, to designate a foetus (personal communication, Nozuko Konjwa, High School isiXhosa teacher, 20/07/2022). This speaks to the generalised cultural entrenchment of a discourse of foetal personhood. It is interesting that the word *umbungu* is not in common usage. Its use to designate either a worm or a foetus may speak to a historical view of the foetus as not being human, but rather 'worm-like' in nature. It would be interesting to know if *umbungu* was used more commonly in pre-colonial times, prior to Western influences and to foetal preciousness constructions.

In recordings of interviews, context helped determine whether speakers were referring to foetuses when they referenced child/baby. In the extract below, the trainee referred to the foetus not just as a child or baby, but as a person.

Interviewer: So *when we say* pregnancy and ALCOHOL *what have you learnt today*?
Interviewee 1: *I've learnt that* when *you're* pregnant (.) DON'T do drugs, /Hmm :/ (.) *don't drink.* Because that thing *doesn't mess up just your LIFE,* /Hmm:/ (.) alone. *It harms this person who (.) who is innocent*.

The interviewee constructed the foetus as an innocent person who does not deserve to be harmed by the pregnant woman's actions.

The interviewees were shown two pictures, taken from the manuals, at the end of their interviews, and asked what they meant to them. It is noteworthy that the majority of the "precious baby" constructions in the interviews occurred when interviewees discussed the pictures. This indicates the power of pictures to construct the foetus as a baby. The extract below was taken from the point at which the interviewee was shown the logo of the Organisation, which depicted a stylised image of a pregnant woman drinking from a bottle. The image of the woman was pink, but the bottle was blue, and blue liquid was depicted going into the visible foetus. The bottle was crossed out to indicate that the woman should not be drinking. In talking about the foetus, the interviewee stated the following:

Interviewee 1*...this child is still small, so is a future* leader (.) *to us.*

Because the image was of a foetus, the interviewee constructed it as, *ipso facto,* a future leader. There was a sense here that any foetus is destined to greatness, before its mother or the world can defile it.

The extracts below are taken from the point where the interviewees were shown Image 1 that is reproduced in section 2.1.1. This image depicts a boy hugging the belly of a pregnant woman.

Interviewee 2:…our future, kid in the tummy (1) has to be healthy, so that there can be a productive person

Interviewee 3: *... I see that mommy has another baby and THIS ONE* (.) *still needs to be loved but there's* /shame[39]/ *this ONE who has to be loved, also this child is still a child but* (.) *he has to, to LOVE this child in his mother's tummy* /Hmm/ as well

Interviewee 2 reproduced the oft-stated message of the training materials that foetuses are "our future", and she brought in capitalist tropes of the need for children to grow into productive citizens. As with interviewee 1 in the previous extract, interviewee 2 conflated the foetus and our future. Any threat to the health of the foetus meant a threat to society's future.

[39] The South African use of the signifier "shame" in this context refers to feelings of pity or empathy, or recognition of pain or hardship.

Interviewee 3 expressed empathy for the pregnant woman, even though the woman was not the focus of the picture, and she noted that the woman now has two children to love and care for. The interviewer's interjection "shame" (see footnote 38) helps us understand that the interviewee was recognising that this task is onerous. However, the interviewee also interpreted Image 1 as extending the requirement to love the foetus from the woman to the woman's other children, and she noted that this may be somewhat burdensome to another child, who is still a child himself, yet is required to "love this child in his mother's tummy." Although this interviewee was reinforcing the responsibilisation of pregnant women - *"this ONE …has to be loved…"* she was successfully resisting their invisibilisation by alluding to some of the realities of childcare that women face. She also touched on the costs that may be incurred by older children when a woman has another baby. Pregnant women who have had abortions often explain their decision by expressing how their other children will suffer if they need to raise another child, or how they will be unable to be a sufficiently "good mother" to a subsequent child (Chiweshe et al., 2017).

2.4. Constructions of "precious babies" in the mentoring sessions

Positioning the foetus as a "precious baby" was only done by one mentor, who used her mentoring sessions to preach against abortion. She did this in all three of her mentoring sessions that were recorded. Pastoral power was the apparatus that innervated this mentor's positioning work. In the mentoring session from which the following extract is taken, the mentor had earlier questioned the client as to whether she considered aborting her pregnancy, seeing as it was unplanned. The client denied considering an abortion, to which the mentor replied "Oh that's very good." However, the mentor then returned to the topic of abortion a bit later, as shown below:

Mentor Zukiswa; Client 2

M: *Ndicela ukubuza ke waye waziva njani ngokuba uzibone uba ukhulelwe ke njengoba kugqabukhe lecondom (*May I ask how did you feel when you found out you were pregnant after the condom broke)

C: (3) *ndandinestress yhu* (oh I was so stressed)

M: (1) m:mh ok (1) *hayke* (well) =

C: =Because *ndandingalindelanga mntana mna* (I wasn't expecting to have another baby)

M: (1) *Esi stress sakho zange tuu sikhe sikuthemele entweni yoba yhu ngaske ndim-aborte lo mntwana maan* (and didn't your stress lead you to a place where you considered terminating the the pregnancy)

C: *Ndandikhe ndayicinga lonto nje qha ndaqonda uba ha a* (2) *ndoyika ubulala umntana* (I did consider it but I then thought no (2) I was too scared to kill a baby)

M: Oh *waye waqonda uba waphinda wazijika kwangokwakho* (oh so you then decided to change your mind)=

C: =mmh (yes)

M: *Hayke kuhle ka xa uthi waye waphinda wazijika kwangokwakho* (.) *otherwise zange ucetyiswe mntu tut u ngalonto* (oh well it's good that you changed your own mind (.) otherwise no one ever tried to advise you otherwise at all)
C: *Mh-h* (no)

The mentor opened this sequence with a good open-ended question, asking about the client's feelings when she found out that she was unexpectedly pregnant. However, the client paused for three seconds before answering, which suggests some trouble. Earlier in the session the mentor had also asked about the client's reactions to her unplanned pregnancy, at which point she had readily stated that she was shocked. However, this had led to the mentor asking if she had considered an abortion, which she denied. Hence, in the extract above, the client may have been anticipating more questioning about abortion, which may have caused her hesitation. The mentor did, indeed, again ask if the client had considered a termination, and this time she confessed that she had considered it, but then decided against it as she was "too scared to kill a baby". Here, the client used common anti-abortion rhetoric that equated termination with killing a baby, and the mentor positively affirmed the client's change of mind. However, after a four second pause in the conversation, the following sequence of talk ensued:

M: (4) Oh *njobusithi kengoku ubusoyika ukubulala umntana ukhubone kukhona ezazinto zithi umntana lihlwili nhe* /mmh/ *uyakhumbula* /mmh/ *so wena zange ubenayo nalonto leyo ithi hayi suka lihlwili eli ndizawuvele ndenze u-*one *no-*two (Oh since you're saying that you were afraid of killing the baby have you ever heard of one of those things where they say it's just a clot /mmh/ do you remember /mmh/ so you never even had that in your mind that it was just a clot I will just do one and two)=
C: =*ha a kaloku ingxaki mna ndizazi ngoku iinyanga seziphambili* (no the thing is I found out I was pregnant when I was quite far along in my pregnancy)
M: M:mm (1) *mamela ke masithi kengoku inyanga zakho bezingekho phambili* (.) *uzazi une-2 weeks ubuzawukwenza njani* (1) *okanye unenyanga ezimbini* (so listen let's say for instance you were not too far long when you found out (.) perhaps you found out at 2 weeks what were you going to do (1) or at two months)
C: [laughs]
M: *Hayi* (no) to be honest
C: *Bendizawuyosikhupha tyhini* (.) *ngoba ndandinestress nyani* (I would have terminated the pregnancy (.) because I was quite stressed)

The mentor was taking up an interrogator position in this extract. She questioned whether the client ever considered that the embryo or foetus was "just a clot". If the embryo/foetus is constructed as a baby, then pregnancy termination can be equated with killing; but if it is "just a clot", then termination can be seen as merely a medical procedure to remove bodily tissue from the woman. Hence, the way that the embryo/foetus is constructed has major moral and ethical implications, with constructions by more powerful entities being considered more "moral" than by those with less power.

After the client let the mentor know that the "clot" issue was not relevant to her as she discovered her pregnancy quite late, the mentor continued to press for a confession from the client that she may have considered an abortion if she discovered her pregnancy earlier. The client stalled with a laugh, but the mentor continued to seek out a confession, which the client eventually supplied, along with an explanation for the reason why she would have considered such an act – "because I was quite stressed" (which was a theme that the mentor never explored with her). This confession gave the mentor the opening that she had been looking for, and she proceeded, in the extract below, to explicate how the foetus is a "full baby" at two months' gestation, using pictures from the manual to aid her, and to position the client as blameworthy for even considering an abortion.

M: *Mamela ke ndikubonise something* (.) *uba umntana* (listen let me show you something (.) your baby) *(2)* [sound of papers] *ngoku ucimba wena wawuzayo kumkhupha ukuba ungakanani xa ene-two months le foetus sithetha ngayo apha sube engakanani (*the size of your baby at the time you were considering termination or at two months the size of the foetus we are always talking about) (.) *ndifuna ukuthetha ngento oyibonayo ke sisi wam* (I want you to see what I am talking about my dear) (.) *ukwenzela nanini na ungaze (*so that next time you don't even consider a termination) (.) *ubangaka ke umntana one-two months uyambona uba ungakanani (* this is the size of the foetas as you can see at two months)

C: *Yhu* (wow)

M: *Ufitter apha kwi-teaspoon* (it fits into a teaspoon)

C: *Yho* (wow)

M: E<u>xactly</u> so *xa uzawubulala imveku seyiphelele inengalo* (so now you want to kill a full baby with arms and all) =

C: =*Oh hayi iphelele*= (oh no it's a full baby indeed)

The mentor's position moved from one of interrogator to one of judge: now that she had extracted a confession from the client, she proceeded to show the client "the size of your baby at the time you were considering termination" (even though the client did not actually consider a termination as she was not aware she was pregnant at two months' gestation). The mentor positioned the woman as culpable for wanting to "kill a full baby", but also ignorant of the fact that the foetus is not just a clot. As discussed in the previous chapter, ignorance exonerates culpability, and the client readily took up the ignorant positioning by expressing surprise ("wow") when she saw pictures of foetuses. Her utterance "Oh no it's a full baby indeed" also positioned her as ignorant of this fact until this point. An ignorant position acts as a defence against culpability.

The mentor then continued showing pictures from the manual and discussing the development of a foetus before moving into the following talk:

M: … so *ke u-two months se-full uyabo* /mmh/ so *omnye athi hayi lihlwili* <u>there is no such</u> *mntasekhaya sube ingumntana ephelele* (1) and *umntwana it's a precious gift ka Thixo …. ebesithi uyaqhomfa so ayikho mnandi because umntana uza emhlabeni eziswe nguThixo etransportwa ngawe qha uyaqonda* (so in two months it's already a

> full baby you see /mmh/ but someone will say it's just a clot there is no such [thing] my sister it's a full baby (1) and a baby is a precious gift from God….so termination is not great because you conceived and give birth to a baby according to God's plan he uses you as a vehicle to bring the child on earth do you understand)

In this extract, the mentor took up a morally superior preacher position as she expounded on God's workings, while she positioned pregnant women as "vehicles" to enable the "precious child" to come to earth. As vehicles being used by God, pregnant women should not question the fact or the timing of their conceptions and pregnancies; they should passively and gratefully accept their condition, regardless of their own needs and desires, and view their pregnancies and the ensuing babies as precious gifts. No agency or choice is afforded to the women in this construction.

This section has traced the construction of the foetus as a "precious baby" in the training materials, training sessions, interviews, and by one of the mentors. I have discussed how such a construction results in a complete elision of the pregnant woman as a person with her own needs and desires. Any woman who does not view her foetus as entirely desirable is shamed, particularly if she may have considered terminating a pregnancy. In the next section I discuss the counterpoint position to the "precious baby": this is the child with FAS.

3. The defiled Other: the child with FAS

In contrast to this "precious baby" is the defiled Other (Seidman, 2013) who is the child born with FAS. The life-long damage caused by alcohol to the developing foetus was mentioned frequently throughout the manuals, and seven full pages at the end of Module 1 were devoted to explicating the ills caused by FAS, from pre-school through to adulthood. Not only do people with FAS have disabilities, but, according to the manuals, they bring harm to the whole country; they are a threatening and dangerous entity. The excessively negative construction of the person with FAS stood in contrast to, and helped to construct, the "precious baby". I discuss below how these binary constructions of "precious baby"/"person with FAS" served to reinforce the apparatuses of patriarchy and coloniality.

3.1. The defiled Other in the training manuals

The extracts below give examples from the manuals of references to the "life-long brain damage" caused by FAS, as well as stigmatising messages about a child with FAS.

p. 5 Where is the FAS-person mainly disabled?

Answer : In his or her BRAIN. A person with FAS has LIFE-LONG brain damage.

There is no way to recover from it. There is no cure!

A child with FAS is disabled from normal participating in life.

P. 18 Can brain damage be healed?

No! No!! No!!!

The damage is **PERMANENT !**

It is **IRREVERSIBLE !**

Children **CANNOT OUTGROW** from it !

The brain cannot **RECOVER !**

The brain cannot be **REPAIRED !**

There is **NO MEDICINE** which you can drink,

to heal the brain !

While it is factually correct that a person with FAS has brain damage, and that this cannot be cured, the capital letters, red lettering, multiple repetitions and exclamation marks sensationalised this disability. The claim that there is no way to recover was hammered home repeatedly. This removes hope. In fact, a number of studies have shown that provision of early therapeutic interventions, a stable and caring home environment, caregiver support and training, pharmacotherapy, early choline supplementation, supportive schooling, and adaptive and executive functioning training can all reduce the disabilities associated with FASD (Hanlon-Dearman et al., 2015; Petrenko & Alto, 2017). While such interventions are often not available in impoverished communities, there is never nothing that can assist.

The following extracts moved to construct people with FAS as not only permanently disabled, but also as harmful to everyone in South Africa:

P. 16 This serious brain damage causes severe behavioural disturbances in these children and adults. This leads to **serious social problems** in our vulnerable at risk communities. **This has a negative impact on each South African citizen**.

The bold highlighting drove home the message of how dangerous people with FAS are. The text on p. 16 of the manual continued in the same vein:

P. 16 The public doesn't realize the source of so many preventable problems are people with FAS/FASD. Many people with FAS get involved in crime. If they have not being affected by FAS, they most probably would not get involved in these types of misbehaviours.
For example: teenage pregnancy, theft, assault, rape and murder.

In this extract, "the public" was constructed as naive and unaware of the "source" of the difficulties in their communities. People with FAS were positioned as criminals, with "teenage pregnancy" being called a crime, alongside rape and murder.

From p. 22 of Module 1, the manual went into detail about the kinds of disabilities that people with FAS experience. There was a page each on problems experienced at pre-school, school and adulthood. These included: lying, stealing, anger outbursts, special educational needs, mental health difficulties, sexual promiscuity, gangsterism, rape, substance abuse, and unemployment. The lists of problem behaviours were numbered, which emphasised how many there are (25 problem behaviours were listed for school-aged children). Nowhere was it acknowledged that the disabilities caused by FAS are heterogenous, so a person with FAS may exhibit only some of the listed behaviours. There was also no mention of the fact that home and community contexts and interventions mediate the kinds of disabilities displayed by people with FAS.

Pages 26 and 27 of Module 1 then discussed how the biggest problem of FAS is the lack of impulse control. This is caused by damage to the corpus callosum, which lies between the two hemispheric lobes of the brain, and to the frontal lobes of the brain. It compared the corpus callosum to a telephone line, and when it is damaged, it is not able to convey messages from the left hemisphere to the right hemisphere about appropriate behavioural responses. This kind of information can be helpful in assisting people who are raising or working with people with FAS/FASD to understand the reasons for their behaviour. However, the manual then went on to claim the following:

P. 27 A person with FAS is like a **permanent intoxicated person**

....

It is not a matter of conscious decision. It is a matter of permanent behaviour disorders. These misconducts can be very serious ~ particularly those which result in CRIME

People with FAS therefore do not only harm themselves with their inappropriate behaviour, but also their families, communities and THE WHOLE OF SOUTH AFRICA !!

Comparing a person with FAS to someone who is permanently intoxicated is stigmatising. The message was that a person with FAS is *ipso facto* a criminal who harms everyone.

Pages 28 and 29 continued the theme of the criminal activity of people with FAS. The wording, shown below, conflated the disabilities of FAS, the most severe form of the disability, with FASD, which encompasses a whole spectrum of disabilities, from mild to severe.

FAS and CRIME

7 ~ 9 million FASD people in South Africa . . .

(pictures of people in prison cells)

~ The bomb waiting to explode people ~

"For some people whose lives have a drunk beginning,
the only future is a prison cell"

...

1. A person with **FAS** is like **a bomb that could explode any moment.** We just do not know when, where and how.
2. People with **FAS** are **mentally** and **socially disabled.**

The use of statistics in the above extract - "7-9 million people with FASD in South Africa" is an illustration of disciplinary power at work. The population has been counted, measured, and evaluated as normal or not. The large number of abnormal were then held up as a threat. The threat was two- fold: for women of reproductive age, it indicated how easy it was for their child (and, therefore, for them too) to fall into the abnormal category; for the rest of society, it sent out a call to action against the threat of social dissolution by this "bomb waiting to explode", caused by irresponsible pregnant women.

Along with the first two numbered points, shown above, the text then continued to detail another 24 points of the ills of people with FAS, including that "they belong to gangs that commit serious crimes" (point 8) and "No amount of love can fix these people's brain damage" (point 11), which constructed them as dangerous and to be feared. Point 11 suggested that it is not worth caring for, loving, or trying to assist people with FAS, as they are not just people with disabilities, to be pitied and cared for, but they are dangerous and should be ejected from society into a prison cell.

At the end of the 26 points was the following text:

Examples of different types of crime

theft
home burglaries
assault like stabbings
vandalism - damage to property
gangsterism
drug smuggling
murder

The person with FAS was positioned as responsible for all crimes that beset this country. With the high and highly publicised rates of crime in South Africa, this positioning captures the attention of audiences; it suggests that the reason for crime in South Africa is simple - it is due to women who consumed alcohol during pregnancy and gave birth to people with FAS/FASD. No distinction was made between FAS and FASD; the terms were used interchangeably, despite the huge variations in disability levels of a person with full-blown FAS, and someone with much milder effects of prenatal alcohol exposure.

Apart from stigmatising all people with intellectual difficulties, not just those affected by FASD, these positions constructed the person affected by prenatal alcohol exposure as the "defiled Other". Seidman (2013) discussed two related but distinct concepts of the Other, as used in Euro-American social theory. In the first concept, which is situated within a politics of difference, the Other typically refers to those in subordinate, or non-normative positions, such as women in relation to men, or, in Western contexts, Arab Muslims in relation to European Christians. Although subordinated, such people of difference are still recognised as fully human citizens. In the second concept, the Other refers to those who are outsiders and are perceived as a social threat; they are "positioned outside of a normative civil order… [and] are symbolically associated with a condition of excess and ungovernability." (Seidman, 2013, p. 6). These Others occupy a position "between the human and non-human" (p. 6) and threaten the fundamental order of civil life. The Organisation's construction of the person with FAS/FASD unequivocally positioned such a person as the defiled Other - one that is ungovernable, dangerous, excessive and sub-human, unable to engage in '"normal" human activity, and from whom one should emotionally disengage, as "no amount of love" can assist them.

This Other, the person with FAS/D, stood in contrast to, and helped to construct, the "precious baby", the "normal" child, who has a "bright future" (Module 1, p. 16). The Other is the constitutive outside of normality; it starkly defines the boundaries of who is acceptable and who is not. By constructing the "precious baby" and the "defiled FAS/D Other" so vehemently, the Organisation was ensuring that the hierarchies of patriarchy and coloniality were maintained. The precious baby, reared by the invisible, responsible mother (discussed in the next section) and strong, visible, protective father, sustains the "natural" patriarchal order, and this baby grows into a civilised, employable citizen. In order to ensure such "positive" outcomes, communities need to be colonised with Western medical knowledge, and embrace notions of individuality, the nuclear family, and responsibility, thereby ensuring that the ills caused to society by colonising factors are hidden, while the ills caused by individual actions are magnified. The person with FAS/D, burdensome economically, unable to control their impulses, and dangerous in their unpredictability and

criminality, is the threatening presence that will undermine society. Therefore, society must redouble its efforts to uphold patriarchal and colonial norms as a protection against such defiled Others.

3.2. The defiled Other in the training sessions and interviews

The construction of people with FAS/D as the defiled Other continued in the training sessions, along with encouragement to try and identify such people.

First training session, day 1

Facilitator: So maybe you guys have seen from neighbour's children or some other children when you were at school. Maybe you noticed that a certain child whose mother used to drink a lot, ended up like this and that. So let's talk about that, when it comes to these children, what learning and behavioural problems does an affected child show, what are they like in terms of their behaviour and learning at school?

The trainees proceeded to explicate some of the disabilities that children with FAS/D may show, stating that they will be very slow to learn, disobedient, have anger problems, display moodiness, be sexually promiscuous, and will not "play the same way the other children are playing" which will result in them being sad and ostracized. Some trainees gave examples of children they knew who they felt had pre-natal alcohol exposure, and what they were like. The facilitator then added to the trainees' descriptions, expanding on, explaining, and giving examples of the kinds of disabilities that were described in detail in the manual. Some trainees added their own stories to hers. The facilitator's talk alone on the negative behaviours of people with FAS took up six pages of transcription as it moved from misbehaviour in pre-school to criminality in older people. In the second training session, the facilitator continued with the same constructions, although her talk then took up four pages of transcription. She was being true to the mandate given by the training materials, which was to construct the defiled Other in rich, thick detail.

As well as emphasising the disability of people with FAS/D, the incurability of the condition was also established.

Second training session, day 1

Facilitator: So FAS is 100% preventable and 100% incurable, what does that mean?

Trainee: FAS is 100% preventable; that means we are able to prevent it by encouraging and advising pregnant women not to drink while they are pregnant. When we say 100% incurable, we mean that if a woman gives birth to a child who already has FAS, it cannot be cured, the child is already disabled.

Facilitator: So that is true guys, it is preventable and that depends on the parent, whether the mother wants her child to have FAS or not. If she doesn't want, then she must stop

> drinking when she is pregnant. But if she drank while pregnant and the child has FAS, there is nothing that can be done; no doctor can cure it, no holy water can help her, nothing. If the child has FAS, they have FAS.

The emphasis on a lack of cure contributed to stigmatising those with disabilities, removes hope, and reinforces the positioning of the child with FAS as the defiled Other. The mother of the child is also held entirely culpable for the child's disability because the disability is "100% preventable".

First training session, day 3

> Trainee: After the child is born, they will still have that brain damage and it is not curable. After you've gone to the clinic to be tested and realised that you are pregnant, stop drinking alcohol perhaps your child won't get brain damage. But if you continue drinking while you are pregnant, your child will be brain damaged.

In the extract above, the trainee was giving a practice presentation at the end of the three-day training session, in which the incurability of brain damage was again highlighted. From this extract and the one above, we can see that the facilitator and trainees appeared to view FAS/D as an all-or-nothing condition, which a child either gets or does not, rather like HIV. Women were encouraged to stop drinking so that "perhaps your child won't get brain damage." Another trainee stated that a woman should stop drinking because she "might be lucky." The training materials repeatedly stated that "even one glass can cause serious, lifelong brain damage." Given that many women drink and give birth to seemingly normal children, then the logical conclusion would be that these women are "lucky". No information was provided in the training about the dose-response effect of alcohol on a foetus, or about other exacerbating or mitigating factors. Neither was the spectrum of disabilities caused by pre-natal alcohol exposure, from mild to severe, discussed.

In line with the training manuals, the criminality of people with FASD was explicated in thick, rich detail in the training sessions, and with the implication that all people with FASD become criminals. For example:

First training session, day 1

> Facilitator: Children and adults or everyone who is affected by FAS commit a lot of different crimes. Which ones can you think of?
>
> [*Trainees and facilitator proceeded to name multiple types of crime*]

This use of fear tactics serviced the responsibilising impetus of the Organisation: scare women into regulating their behaviour in order to protect society.

The interviews indicated how the construction of the child with FAS/D as the defiled Other leads to stigmatisation, both of people with FAS/D and their mothers.

Interviewee 1: [Drinking alcohol when pregnant] means (.) *by the time s/he is born, there is nothing that* (*?*) /Hmm/ *because you the parent have already messed them up* /Hmm/ (.) *you* understand? …. *They say the, the brain is* (.) *two-sided* /Hmm/ (.) *then one (.) you find that one side becomes COMPLETELY,* totally *damaged* /Hmm/, *so (.) the part that says* No or YES *is not there which makes the child not to grow the (.) proper way (.)* /ye:s/ (.) *and suffers in their development.* So (.) there's nothing (.) so, that means *you're giving your child a* life sentence

This interviewee expressed the finality of the disability, and that there was nothing that can be done about it. The use of the phrase "life sentence" brought in criminal tropes: although initially innocent, the child with FAS/D is punished by their mother with a life sentence, which is the kind of punishment that is meted out to murderers of the worst kind.

The extract below indicates how this strong construction of the defiled Other can lead to stigmatisation of any child with any difficulty, as well as their mother, as the cause of their "wrong" behaviour is assumed to be because of what they were exposed to in utero.

Interviewee 8: *Their actions* /mmh/ *their behaviour* (.) *they don't listen* (.) *they are* (.) *they hit other children* (.) *they are violent* (.) *they, can you see what I'm talking about* (.) *they are just consistently doing all the wrong things /yes/ and you realise that* (.) *oh something must have happened to this child* /ye::s/ *while they were still in their mother's womb* /ye::s/ *but because we are Black people we are not well informed* /yes/

This interviewee now assumed, after going through the training, that any difficult behaviour by a child was due to pre-natal drinking by their mother. However, although stigmatised, the mother of such a child was exonerated from blame due to her presumed ignorance of the teratogenic effects of prenatal alcohol exposure. Colonial constructions of "Black" people as ignorant and deficient were drawn on here. On one level, this colonial construction was used effectively to deflect blame, but on another level, it perpetuated the dehumanisation of "Black" people, positioning them as ignorant and inferior. Part of the colonising project is to turn the colonised against themselves (Lugones, 2010), and here is an example of such, where a "Black" person perpetuated the stigmatisation of "Black" people.

There was often an eagerness displayed by trainees, both in the training sessions and in interviews, to use their new-found knowledge to identify children with FASD in their communities. One interviewee asked for pictures and videos of people with FAS. The interviewee, below, now felt that she could recognise children who may have FAS.

Interviewee 12: *Yho* I've learned a lot because I wasn't aware about the FAS /mmh/ I wasn't aware really /mmh/ until n::ow… [now] I recognise some in my community around *that* "oh maybe there was a FAS" now that I know

Identifying a "defiled Other" can give a sense of power (which comes with knowledge) and also control: now one knows the cause of societal ills, and can guard against it.

In the mentoring sessions, the construction of the person with FAS/D as the defiled Other was not evident; the focus was, rather, on exerting disciplinary and pastoral power over the women to ensure that they were appropriately responsible, as shown in the next section.

In this section I have traced the construction of the person with FASD as the defiled Other in the manuals, training sessions and interviews. I have discussed how this defiled Other stood in contrast to, and helped to construct the "precious baby", and how this defiled Other was blamed for all manner of crimes and social disorder in South Africa. Such blame enables society's anxieties over crime and societal dissolution to be projected onto a unified object, the person with FASD, and it provides an easy answer to such anxieties: merely regulate the behaviour of pregnant women. The "precious baby"/defiled Other constructions also served to uphold patriarchy and coloniality: if the pregnant woman remained a docile, obedient and responsible wife and mother, ensuring that she only falls pregnant within the confines of marriage, and if her husband treats her as appropriately fragile and precious, and if she educates herself and follows the dictates of Western, individualising, 'healthy' behaviour, all will be well.

4. Mommies: visible only in their (ir)responsibility

Pregnant women were routinely positioned as mothers. In the manuals, they were only ever referred to as "Mom/Mommy" or "mother", and if the male partner was being addressed, she was referred to as "wife". This positioning continued throughout the training sessions, interviews, and mentoring sessions. This practice of indexing the category "mother" subsumed the women into that position, assuming that they were "presumptive representatives" (Wilkinson & Kitzinger, 2003, p. 174) of the category "mother". The Organisational focus was overwhelmingly centred around the health and wellbeing of the foetus, and pregnant women were only visible in an adjunctive position, as containers, protectors, and nurturers of the "precious baby", or in other words, as "Mommies" who were always, necessarily, married. There were strong responsibilisation and gendered discourses utilised in this positioning, which drew off power apparatuses of coloniality and patriarchy, and techniques of disciplinarity. As in previous positionings, pastoral power was strongly present in the mentoring sessions.

4.1. Training materials: Patriarchy, risk and responsibilisation

The following texts were taken from Module 3 on pregnancy:

p. 48. Congratulations…you are pregnant!

What now? What is busy happening inside of you?

Join us on a wonderful journey.

You begin with one of life's greatest adventures.

Mom & Dad:

A new baby is like the beginning of all things –

Wonder, hope, a dream of possibilities.

A "precious baby" discourse pervaded this extract, and the pregnant woman and the pregnancy partner were the stated audience (referring to them as "Mom & Dad" will be unpacked in the next sub-section.) There was a complete omission of any reference to anything difficult or negative about pregnancy, babies, and child rearing. There was no space for anyone who may be feeling overwhelmed or scared by their pregnancy, or unable or unwilling to parent. Lafrance and McKenzie-Mohr (2013) stated that "(t)his idealised construction of motherhood, so strongly embedded and cherished in Western society, serves to obscure the possibility that life as a mother may be 'depressing'"(p. 129). They also claimed that "being situated as a 'bad mother' … (may be) one of the most vilified identities possible." (p. 129).

The extracts below constructed the foetus as a precious baby to whom one should relate, communicate with, care for, and even touch through rubbing one's belly (even though the foetus is unable to feel such external touching).

p. 65. Mommy, remember to always talk to your baby, to sing to him or her and to rub your pregnant belly to let your baby feel safe...

P. 58 Remember.. you already are a Mother who must care for her baby during Pregnancy!

A "mother" signifier positioned the pregnant woman as already a parent, and the extract above, from p. 58, stated this explicitly: the pregnant woman must now take on the mother subject position. By always referring to the pregnant woman as "Mom/Mommy", pregnant women were not allowed *not* to parent, through terminating the pregnancy. Furthermore, the implication was that she is *only* that – a mother who needs to foreground her foetus's wellbeing. "Good mother" discourses, stemming from gendered apparatuses that construct a good mother as self-sacrificial,

ever-giving, and unwaveringly dedicated to the welfare of their children (Kruger & Lourens, 2016; Salmon, 2004) were evident in these extracts. The pregnant woman was expected to be constantly pre-occupied with her foetus and demonstrate her love and care for it through demonstrable acts like talking and singing to it and rubbing her belly. A pregnant woman whose preoccupations lay elsewhere (such as with other children, partners, difficult home situations, employment, poverty survival and so on) was, by implication, a bad mother. The woman, outside of her potential mothering role, was invisible.

The "absent but implicit" within these extracts (and many others in the manuals) which exhorted the pregnant woman to adore her foetus, was the woman who does not want her foetus, and does not consider it "precious" or the beginning of all things wonderful. This is the bad mother, the woman who terminates her pregnancy, or neglects her foetus and baby, or engages in behaviours such as drinking that could harm it. The drinking pregnant woman was the defiled Other against whom the good mother was positioned.

4.1.1. Patriarchy in the manuals

Manuals regularly linked "Mom with "Dad", as shown in the extract below, and the one in the previous sub-section from p. 48.

p. 50. Mom and Dad, your unborn baby is very precious!

The Organisation was making an effort to include men in the care and responsibility for pregnancies and children. However, the assumption it was making was that the pregnancy partner was always present and supportive of the pregnancy, in other words, prepared to be a "Dad". This perpetuated the normative ideal of the two-parent heterosexual family and excluded pregnant women who did not have a supportive partner, which leads to shaming of them. In fact, surveys have shown that two out of every three "Black" South African children do not live with their biological father (Van den Berg et al., 2018). Despite this, and despite single motherhood being a common form of parenting in many parts of the world, it is still considered a deficit position, and is "often infused with a sense of shame" (Morris & Munt, 2019, p. 235), with single mothers being constructed as immoral, irresponsible and "bad mothers" (Morris & Munt, 2019). The training manuals suggested that "Mom" is only legitimate if there is also "Dad". Patriarchy underpins such notions: a woman cannot be complete, or be a "proper" mother, without a male partner. Another example of patriarchy is shown below:

P. 12 **The father must ensure with love and care that his wife must not drink when she is pregnant. The father must not drink himself, so that his wife will not be**

tempted to drink alcohol. He must make sure that she is not exposed to people who drink.
He must help her nicely … with compassion and respect.
"Dad . . . your wife and unborn child is very precious."

In this extract, the assumption was that the parents of the foetus are married: the pregnant woman is referred to as "wife". Literature does show a strong influence of the partner's drinking on a pregnant woman's drinking, so the Organisation was correct in suggesting that pregnancy partners should not drink. But its methods were problematic and simplistic in suggesting that the only reason for this was so that the woman was not "tempted". Traditional patriarchal tropes were drawn on, as the man was positioned as the guide and protector of his wife, and as needing to monitor her behaviour. The man was, therefore, the stronger, the wiser, and the more responsible of the two. The woman was positioned as a child: she needed to be protected from adverse outside influences such as other people who drink; she required assistance ("he must help her nicely"); she was prone to engaging in reckless behaviour like drinking; and she was "precious", along with the foetus. More examples of positioning the pregnant woman as a partner to a man are shown below:

P. 51 It is essential that both parents are involved in the preparation for the precious little life and work together.

P. 52 Mom & Dad, what future do you choose for your child?
With hope… [picture of a chain turning into doves]… or without hope?

Because the extract from p. 51 said that it is "essential" that both parents are involved in the preparation for the birth of the child, it suggested that, should this not happen, dire consequences will result. The extract from p. 52, again linking the woman with a male partner, and shaming those who are single parents, claimed that, together, parents have the power to choose the destiny of their child. The picture below (Image 8), of a happy pregnant woman with a male partner, joined coupledom with pregnancy, indicating that this is the normal state of affairs and the way things "should be". Both partners are dressed in white, which suggests purity. Although the couple are African, they both have long hair attachments, the woman with weaves and the man with braids, which upholds Western hairstyles and hides natural African hair.

Image 8

p. 56

Image 9

P. 57 Daddy, put your ear to Mom's pregnant tummy and hear your baby's heart beating. It is very special. Daddy has to do this regularly to make sure if your baby's heart is still beating strong. If there are any deviations, get medical attention immediately.

In the picture above (Image 9) and the accompanying text, the only part of the woman that is visible is her pregnant abdomen and her forearm and hand, holding a picture of a pregnancy scan. The man's smiling face and shoulders are visible. The man is agentic, protective, and visible, tasked with the important job of listening to the foetus' heartbeat to check if it is beating normally. The woman is the passive container of the "precious baby" and reliant on her male partner to ascertain the health of the foetus. Such constructions control and responsibilise the male partner just as much as the woman.

There were strong risk and responsibilising messages in these and other extracts throughout the manuals, and these are discussed next.

4.1.2. Risk and responsibilisation in the manuals

I discussed the frequent use of "choice" rhetoric in the manuals, used as a means of "responsibilising" individual women through the apparatus of pastoral power, in section 4.1 of the previous chapter. In this section I look at other ways that the manuals exerted an individualising, "responsibilising" force on pregnant women.

Taking on the "knower" position as described in the previous chapter, the manuals instructed pregnant women in how to incubate their foetuses in the "best" way possible. The extract in section

4.1, from p. 65 of the manual, told women what they must "always" do in order for their foetus to feel safe (Mommy, remember to always talk to your baby, to sing to him or her and to rub your pregnant belly to let your baby feel safe...). Women were also instructed in multiple health related behaviours; apart from exhortations to "simply not drink", they were also told to: avoid drugs and tobacco; eat healthily; always attend their clinic appointments; and follow the advice of health professionals, not community members. As such, they were being responsibilised into being the prototypical "good mother". Further examples are shown below:

p. 51 **Plan your Baby!**

Before you can become pregnant, it is extremely important that you make the right health choices. Start at least **3 months before you can get pregnant**, to do the right things. It is essential that both parents are involved in the preparation for the precious little life and work together.

….

It is ***very important to PLAN your pregnancy.***

Most families in South Africa do not plan their pregnancies, which is a tragedy. In poorer communities unplanned pregnancies imply great expenses. The mother cannot work anymore and the cost to raise a child rises rapidly. This situation contributes to even more poverty.

Because women generally do not plan their pregnancies, they **often are unaware that they are pregnant. If they are drinking alcohol, they therefore continue doing it.**

This contributes to the high rate of children born with Fetal Alcohol Syndrome in South Africa. A totally preventable tragedy.

….

Did you save enough money for your new baby? It costs a lot of money to raise a child and you, as parents, especially Mom and baby should eat enough healthy food. **REMEMBER!** The "all-pay"[40] is not even enough to buy diapers or other basic necessities. **Be a happy family…..** Use safe contraception until you have enough money to properly care for yourself and your precious baby.

This page was replete with responsibilising and judgemental messages. If the woman does not follow these dictates, tragedy can ensue. The statement that "the mother cannot work anymore" is erroneous: it buys into the middle-class ideal of the stay-at-home mother and ignores the fact that paid maternity leave is mandatory in South Africa. The final sentence quoted above constructs happy families as those where the parents planned their pregnancies and saved money. In a country where people living in poverty find it almost impossible to save money, the injunction that women save money to raise their child is not only judgemental of those who don't save, but also unrealistic and out of touch with the communities that the training was attempting to reach.

[40] This presumably refers to the child support grant that is provided to children's caregivers if they earn below a certain amount.

The injunctions contained in the above are an example of economic governmentality, which stem from a neoliberal impetus to economically govern the population. This governmentality attempts to ensure that individuals “correct their deviations from rational, self-interested, utility-maximizing cognition and behaviour, such that they effectively and efficiently conform to market logics and processes.” (McMahon, 2015, p. 137). The statements assume that planning and saving is feasible, desirable, and the ultimate way in which reproductive life should be lived to ensure happiness.

Studies have shown that young people’s sexual and reproductive behaviour is influenced far more by peer norms than by the messages of responsibilisation contained in official programmes to govern sexual and reproductive behaviour (Macleod & Jearey-Graham, 2015). If the norms of a person’s peers do not involve planning of pregnancies, consistent contraceptive use and saving money for future children, then communication such as is contained in these manuals will be disconnected from the audiences’ realities, and therefore irrelevant. Jearey-Graham and Macleod (2015) discussed how such “responsible” sexual and reproductive subject positions, imposed by authorities, are not considered to be performable by young people if they are not undergirded by a strong relational base with the person who is exhorting young people to “be responsible”. In this FASD programme, relational attempts were made through the mentoring programme. However, the majority of mentors merely reiterated the messages of risk and responsibility, without forming strong relational bonds with their clients through listening and empathy.

The above extracts, and many others throughout the manuals, exaggerated the risks of drinking, smoking, poor nutrition, and taking medicines during pregnancy, as well as the supposedly dire consequences of having an unplanned or “teen pregnancy”. The binary between an “unplanned” versus “planned” pregnancy is itself problematic. Pregnancy intentions are complex and multifaceted, and are influenced by layers of psychological, socio-cultural, economic, familial and gendered factors. They cannot be neatly divided into planned/unplanned or intended/unintended (Dr. Zoe Duby, personal comm, March 2023).

Macleod (2011), in looking at the persistence of “danger and disease” messages in sexuality education manuals, asserted that there is a fear of societal degeneration which motivates such communications. There is a colonialist anxiety that the wayward sexual behaviours of some individuals will cause entire societies to revert to more disordered or “primitive” states. In order to protect society, individuals (not societies) are tasked with “responsible” sexual and reproductive behaviours. The exhortations to responsibility contained in these Organisational manuals can be understood as technologies of the self, undergirded by strong colonialist assumptions, where individuals are urged to manage themselves for the good of society.

Another example of the Organisation's attempts to discipline women into being "responsible mothers" can be seen in the nutritional advice that they gave. On p. 13 of Module 1, a whole page was devoted to telling pregnant women what they should and should not consume, as shown below. The information was repeated in Module 3, on p. 71.

P. 13 Caffeine

> Keep in mind that caffeine can make you and your baby restless and even give you heart palpitations. It also affects your ability to absorb calcium. And if you really go overboard, it can cause your baby to be born with a smaller head! …[Information on sources of caffeine listed] Remove the caffeine products from your shopping list entirely…
>
> Junk food
>
> You don't do you and your baby any favour if you live from fast food meals. It is full of unsaturated fats and harmful trans fats and offers very little nutritional value. Rather choose fruits, vegetables, raw nuts or yogurt for a quick meal instead of chips, sweets, cookies, pies, cake and ice cream.
>
> Salt
>
> Too much salt during pregnancy, can lead to water retention, swelling and high blood pressure. **It can also lead to pre-eclampsia and kidney failure**. …try to stick to 3 grams salt per day, no more…
>
> What to avoid
>
> Food poisoning is very harmful during pregnancy. [Further information given on the effects on a pregnancy, types of food from which poisoning can be contracted, and ways to avoid food poisoning.]

Caffeine was presented as a dangerous product to consume during pregnancy, which the pregnant woman should eliminate from her diet. She was also instructed to eat healthy foods such as raw nuts, to analyse the amount of salt she consumes, sticking to no more than 3g a day, and to ensure she does not get food poisoning. There was a complete disconnect here between the realities of communities living in poverty, and the information presented. "Healthy" snacks such as fruit, raw nuts and yoghurt can often only be afforded by middle class people, and the advice to eat raw nuts, as opposed to any other kinds of nuts, implied that many snacks are in fact dangerous. Furthermore, it is likely that only a trained dietician can work out the exact number of grams of salt in a diet.

By inflating risks and inducing anxiety, the impetus of these texts was to ensure that an audience becomes more compliant with the bio-power embedded in the texts; they are exhorted to engage in self-surveillance of their consumption to avoid risk, and ultimately produce a more productive society. The socioeconomic disadvantages that can severely limit women's choices are hidden

(Lupton, 2012). However, Lupton (2011) pointed out that such risk aversion is a middle-class phenomenon, perhaps because the middle class have more resources that enable them to avoid risk. In the context of this FASD prevention programme, such middle-class concerns may further disconnect the audience from the content of the programme.

Lupton (2011) discussed how there is a “network of expert advice” (p. 637) surrounding motherhood in modern Western societies, with an “ideal of intensive mothering” (p. 637) being upheld. The so-called expert advice given in the manuals to potentially pregnant or pregnant women demanded that they pay careful attention to their diets, consumptive behaviours, finances, and contraceptive choices. A pre-occupation with the foetus and its health was required, and any misfortune that may affect a child is then, by implication, the fault of its mother for her lack of care. Lupton (2011) has shown how the discourses of maternal responsibility, needed to protect the “vulnerable foetus”, can lead to guilt and shame in women who transgress the dictates of healthy consumption while pregnant, even if the “transgression” is innocuous, such as eating ice cream. This is an example of how disciplining techniques, exerted “from above” through so-called expert advice, become internalised, and how women spontaneously apply them to themselves in a bottom-up manner. Technologies of the self are, thus, inserted into the populace.

A risk focus also constructs pregnancy as needing medical expertise, and removes it from the natural realm (Lupton, 2012). A woman and her family and community, therefore, are no longer competent to manage their pregnancy, but need to passively rely on expert advice, while simultaneously actively following the dictates of the experts. The “precious baby” discourse adds to the responsibilisation project: the foetus/baby is so precious and vulnerable that women need to be excessively cautious to ensure optimal development.

Lupton (2012) pointed out that the focus on protecting the foetus means that “the maternal body and the foetal body are represented in opposition to each another” (p. 331), rather than in a conjoined state. If the pregnant woman engages with her own embodied desires in terms of consumption and behaviour, this is seen as acting in opposition to the foetus. With the foetus being constructed as so important and as holding society’s future in its tiny hands, any “irresponsible behaviour on behalf of the pregnant woman, who has now become a public figure (Lupton, 2012), leads to harsh sanctions.

The responsible, risk-averse pregnant “good mother” was constructed in the manuals in opposition to the degenerate, substance using, irresponsible “bad mother” who ignores the expert advice freely given to her and continues to ingest harmful substances. There is always the risk that women may

degenerate into “bad mothers”, which may explain the defensive vehemence with which the “responsible mother” is constructed. There is also the anomaly of the pregnant body, with blurred boundaries between the woman and foetus, and Lupton (2012) claimed that “(l)iminality of body boundaries creates cultural imperatives to control and contain such ambiguity. It is here perhaps that anxieties about controlling the pregnant/maternal body and protecting the foetal body are generated.” (p. 333).

This sub-section has shown how the pregnant woman was visible in the manuals only as a responsible, sacrificial, married, foetus-focussed “Mommy”. Apparatuses of patriarchy and coloniality, and the disciplinarity of bio-power cohered to construct this subject position in the manuals. The following sections illustrate how this position was carried through in the training sessions, interviews, and mentoring sessions.

4.2. Training sessions and interviews: Regulation, responsibilisation, and patriarchy

The responsibilisation and regulation of pregnant women is inherent in the “precious baby” construction. Some of the explicit responsibilisation and patriarchal messages that occurred in the training sessions are shown below. The trainees were taking up a mandate to regulate the lives of pregnant women. The extracts presented below are from trainees who were giving practice presentations at the end of the first training session.

Trainee 1: So I’m here to attest to what they are saying about pregnant mothers or women, things that we are not supposed to do when pregnant. …. Here in hospital, we have a section that is meant for malnourished and underdeveloped children. So when I think about it, I think this is the cause [prenatal alcohol exposure]. ….

Trainee 2: I just want to thank you and the organisation you’re from for coming to explain to us about how a pregnant person should conduct themselves… I will also speak about how a pregnant woman should conduct themselves. According to what has been mentioned here, a pregnant woman should do away from alcohol. ….

Trainee 3: …Personally, I was not aware that there are some children who struggle to concentrate in class [because of prenatal alcohol exposure]….

Trainee 4: ….You will find that some people end up giving birth to underdeveloped or disabled children and then blame others for that. Just because they went to the clinic on time and did all the check-ups, they do not realise that drinking alcohol is what causes the damages that occur in the brain of the child and therefore they refuse to take responsibility….

Trainees 1 and 2 gave strong regulatory messages regarding pregnant women. The blaming stance that the Organisation took up came through in the trainees’ presentations: Trainee 1

now assumed, after her training, that the cause of all malnourishment and underdevelopment seen in children in her hospital was due to prenatal alcohol exposure; Trainee 3 now believed that all children who struggle to concentrate in class have been prenatally exposed to alcohol; and Trainee 4 claimed that alcohol consumption is the reason why some women give birth to "underdeveloped or disabled children" and "they refuse to take responsibility" for this. There was regulation in the talk of the trainees: pregnant women were expected to behave in a certain pre-determined way. But there was also responsibilisation: pregnant women were tasked with the responsibility of ensuring that they conduct themselves accordingly, and with taking the blame for any adverse outcomes in their children. The Organisation policed pregnant women, but pregnant women were also expected to police themselves.

As discussed in section 4.3 of the previous chapter, interviewees frequently positioned a drinking pregnant woman (as well as any woman with a disabled child) as sinful, within a pastoral/Christian discourse. The discourses of regulation/responsibilisation were less common in the interviews, but still evident.

Interviewee 1: [This picture] *shows she shouldn't be doing that thing of drinking while pregnant*

The logo of the Organisation, which interviewee 1 was discussing, was interpreted as regulating the behaviour of pregnant women. Interviewee 2, below, made explicit use of the "choice" signifier to position pregnant women as responsible for their behaviour.

Interviewee 2: [Women must] *UNDERSTAND that* okay it's a choice (.) I have to /yes/ make for myself and for my child, *you* understand? Because as much as we can say *that* "*No your* boyfriend *as well should (.) do this and that*" (.) the choice always depends on=
Interviewer: =the woman
…
Interviewer: Okay. So, do you think *quitting dinking* during pregnancy is a sacrifice on the woman's part?
Interviewee 2: No it's not a sacrifice it's a choice /Mm (.) Okay/ Because at the end of the day, now that you have this kind of information, (.) *for you it now becomes a* choice
….
Interviewee 2: *Yes,* you make a choice if *you want your child to be* (.) *like THIS* or *you want your child to be* normal.

The interviewer in this extract joined the interviewee in constructing pregnant women as entirely responsible for choosing not to drink by finishing the interviewee's sentence in the second utterance. Once women are given information on the teratogenic effects of alcohol consumption on the foetus, this interviewee made it clear that women are consciously choosing to give birth to an abnormal child if they continue to drink. This extract shows how an ignorant position absolves

blame, but as soon as knowledge is provided, women are held culpable for adverse outcomes in their children.

Patriarchy was visible in a number of the statements that occurred in the training sessions, although not in the interviews, possibly because the interview schedule did not probe for patriarchal discourses.

Trainee 3: Also, when the woman is pregnant, it is important for the man to show love and care to their partners and be gentle with her because if the woman gets stressed then child also gets stressed.

Whilst a woman certainly needs support when pregnant and raising young children, Trainee 3 identified "the man" as the one to provide love and care, thereby excluding females from providing this network of care, and marginalising single women who don't have the support of a male partner. She also tasked the man with needing to be "gentle" with his pregnant partner, which positioned the pregnant woman as fragile and easily stressed.

However, the trainee below inverted the patriarchal tone of the training to one of matriarchy, and instead positioned the woman as the strong, responsible one, needing to take care of her wayward husband:

First training session; first day

Facilitator: So now we are saying, if a woman is pregnant then the husband is supposed to help and support her in every possible way but not to help or encourage her to drink. Are you saying something sister?

Trainee: Yes. The role of the father is very important; however, we do not have to compare ourselves with them because that can mislead you as a woman. If you notice, what makes women to be misled, is that we tell ourselves that whatever the male figure is doing, I must also do it. A male was created to have mistakes; if a male was created to be perfect then God would not have looked for a wife for him. (*laughter*). So a male is my sheep and as a woman I am his shepherd. Every time I do not see him when I have to dish up for him food, I have to go out in the streets and look for him … So a male is wrong by being drunk but he is not wrong because the woman is already worse than him. A woman is a builder (*laughter*); it does not mean you have to build only houses when you are married, but you will also build the mind of this male because he will be all over the place like a pig and you have to try and tie him. We grew up being given a husband, and while you are newlyweds, wearing *umbhaco*[Xhosa traditional attire], you will be told that your husband is a drunkard and you will have to tie him yourself… We are even told to go to church so that the male may also be inspired and go.

This trainee claimed that the reason for women being "misled" is through emulating male behaviour. She painted a caricature of a male as genetically pre-determined to waywardness

(“created to [make] mistakes”), drunken, “all over the place like a pig”, and needing a woman to shepherd him, build up his mind, “tie him”, and inspire him to go to church.

This could be understood as resistance to the patriarchal presentation of women as fragile, passive, and needing care from a male. However, not only does such an extreme characterisation of the male not promote equality and justice, it also extends the responsibilisation of the woman from not only her foetus and children, but also to her male partner as well. She is responsible for rehabilitating him from his drunken ways and ensuring that he leads a Godly life. The woman is also held to higher standards than the man: “the woman is already worse” than the man if she emulates his drunkenness.

In the mentoring sessions, regulation of pregnant and parenting women was amplified, as shown in the next section. Patriarchy was evident in the transcripts of one mentor, who forcefully upheld marriage as an ideal to which women should aspire.

4.3. Mentoring sessions: regulation and conjugal idealism

In the transcripts, mentors energetically attempted to regulate their clients’ behaviours as they positioned them as “Mommies”, and one of them upheld marriage as the ideal state towards which clients should be aiming. Kruger and Lourens (2016) stated that “good mother” discourses “legitimise a kind of surveillance that involves … the monitoring of how mothers care for their foetuses, infants and children” (p.138). The Organisation tasked the mentors with engaging in surveillance of their clients by doing surprise visits over the weekend to check if they were drinking. The mentors also took it upon themselves to survey other aspects of the clients’ childcare and self-care behaviours when they visited them in their homes, using the pastoral power that they had been granted by the Organisation. In the transcripts, clients’ resistance to this regulation was infrequent, and was not usually overt, but was evident in some silences, laughter, sighs, and an occasional exasperated tone. However, one client proved how she was appropriately responsible in preparing for the birth of her baby, and not in ways that the Organisation had coached her, indicating resistance to the Organisation’s attempts to regulate her. Another client wrested power from the mentor by asking if the mentor had any other questions.

Pastoral power is evident in the extract below, as the mentor took up a knowledgeable teacher position and ensured that her client had complied with state regulations (registering her baby’s birth and clinic vaccinations) and the Organisational regulations (stopping drinking). She also instructed her client in how to take care of her baby, ensuring that she was a sufficiently responsible mother. This extract is typical of most of the mentoring recordings.

Mentor Amilisile; Client 3

1. M: *Lo mntanakho kengoku sewumregisterishile* (So have you registered your baby)
2. C: *Ewe sendiregisterishile eclinic* (yes I have registered her at the clinic)
3. M: *kwa-Home Affairs sewuyile* (have you gone to Home Affairs)
4. C: *Xa uphuma esibhedlele uphuma sewunaso icertificate ngoku* (You get the birth certificate before you leave the hospital)
5. M: *Oh ndiyashika ok ke sisi* (.) *so eclinic sewumsile se:: se:: senazo i*(inaudible)[vaccines] *esezenziwe* (oh I'm behind alright then (.) so you said you've taken the baby to:: to:: the clinic she already has (inaudible) [vaccines] that have been done)
6. C: (2) *Ewe senaso esi sokuqala* ((2) Yes she does have the first one)
7. M: Oka::y (2) *Uyamthanda lo mntanakho* (Oka::y (2) Do you love your baby)
8. C: *Yhu ndimthanda ukufa umntanam* (Oh yes I love my baby to death)
9. M: Ok:: *kusebusika kengoku ndifuna ukuxelela into enye umntanakho ungam-expose engqeleni uyaqonda* (Oka::y it's winter now and I want to remind you not to expose your baby to the cold do you understand) …
10. … [Mentor continued to tell the client to keep her baby warm but not too warm]
11. M*: Wayeka mos ukusela?* (Did you stop drinking?)
12. C: *Ewe ndayeka* (Yes I stopped)
13. M: *Yintoni ebangela uba uyeke usela?* (Why did you stop drinking?)
14. C: *Wandinceda ngemfundiso zakho* [laughs] (Your teachings helped me a lot [laughs])
15. M: *Suhleka kaloku* (don't laugh) (3) *Ndakunceda ngemfundiso zam nhe* (So I helped you)
16. C: *Ewe sisi yhu wandinceda kakhulu* (Yes, oh you helped me a lot)

The client took up the mandated obedient child position, and indicated her compliance with state regulations, as well as the fact that she was a good, responsible mother in loving her baby and ceasing drinking. In turn 6, the client paused significantly before answering the mentor's question, suggesting some trouble. It is unclear whether the client was not being entirely truthful in asserting that her baby had had her first vaccines, or if the client was merely calculating in her head which of the vaccines her baby had had. Either way, she was not able to unequivocally say that her child's vaccines had already been done.

In turn 11, the mentor asked the client if she had stopped drinking, even though she said, a little after this extract, that the client had already told her that she had stopped drinking. Hence, this question appeared to be designed to display to the audience who would listen to the recording that the mentor had done a good job. The client duly provided the correct answer – that she had stopped drinking. However, in line 14, the client gave a laugh when claiming that she stopped drinking because of the mentor's teachings, and the mentor responded in line 15 by telling her not to laugh.

There is a sense here that the client was aware of the game that was being played in this recording: she obediently stuck to her script as the once-sinful-now-redeemed ex-drinking mother, newly responsibilised by the mentor's ministrations, but her laugh indicates a slippage in her performance. The mentor's rebuke of the laugh showed that the laugh was indeed a slippage. The three second pause after the mentor's instruction not to laugh confirmed that the instruction was indeed a rebuke, rather than a playful response.

In the second part of line 15, the mentor then worked to repair the damage done by the laugh – "So I helped you" – and the client was this time able to respond appropriately with a strong agreement, increasing the force of the statement to "Oh you helped me a lot". At no stage throughout this recording, or most of the others, was there any focus on the woman's needs or desires. The emphasis was entirely on ensuring that the woman was being an appropriately responsible mother.

In the extract below, as well as the pastoral and disciplinary force of responsibilisation, there was also a patriarchal tone, as marriage was upheld as the ideal state to which women should aspire. The client in this extract was 19 and had two children.

Mentor Zukiswa; Client 1

1. M: *Ndicela ukubuza ke sisi inumber yabantwana onabo* (I would like to know how many children do you have)
2. C: *bayi-two* (I have two)
3. M: Okay (3) [possibly fiddling with recorder] *Ingaba uziva njani ube unabantwana ababini* at your age (How do you feel about having two children at your age)
4. C: (2) *Andiziva right* (I don't feel fine)
5. M: Okay *ngoba kutheni sisi wam* (why is that my sister)
6. C: *Ndimncinci for uba nabantwana abayi-two* (I am too young to have two children)
7. M: *Okay ke kumnandi xa uyibonayo imistake yakho* (1) *ok ke sisi yimake zange ukhe ucinge uba mhlambi apha ebomini ungaze utshate* (.) *utshate ke futhi ungazange wabanabo abantwana* (okay at least you can see your mistake (1) ok then dear so have you ever imagined that you would get married first before you have children)
8. C: *Ndakhe ndacinga* (I once imagined it)
9. M: *Waze wastotshwa yintoni ke sisi wam* (and so what stopped you)
10. C: (2) [heavy sigh] *Ngobanabantwana but ke ndisamcinga umtshato nangoku* (because I had children but I still do consider marriage even now)
   …..

The mentor then continued on the theme of marriage, and raised it a little later in the session, as shown below:

11. M: *Ingaba usafuna uphinda ubenabanye abantwana?* (Do you still wish to have more children?)
12. C: (2) *oyi-one emtshatweni* (just one more when I'm married)

13. M: *oh hayke kuhle ke sisi wam* (.) *ndicela ukubuza ke nhe* (.) *unalo ithemba loba ungatshata?* (ok that's good my dear (.) I would like to know right (.) do you still have hopes to get married?)
14. C: *ewe* (yes)
15. M: (1) *kutheni uyicinga lonto yoba unganethemba loba ungatshata* (why do you think or hope to still get married)
16. C: (2) *neyiphi na intombazana inethemba loba ingatshata* (any girl has hope to get married one day)
17. M: Okay
    …..

The mentor then raised the topic of marriage a third time, as shown below:

18. M: …*and ebomini uzifundise uba uyawufuna umtshato because intombazana iyintombi ngokuba itshate uyaqonda* /mmh/ *and abantwana bakho* (.) *ubeneresponsibility ngabo kwa-cent oyicholayo uyazi uba it's for my children ungaphileli obakho ubomi kuphela uyayiqonda? /ewe/* (and it's also important to desire marriage because a girl is a girl if they actually get married do you understand /mmh/ and your children (.) be responsible for them whatever cent you get it must be for your children because you can no longer live for just yourself alone, do you understand /yes/)

In turn 3, the mentor asked how the client felt about having two children "at her age." Blame was evident: reference to the client's age invoked the common discourse of the irresponsibility of early procreation. The client paused for two seconds before answering (turn 4), indicating resistance to answering this question, and possibly shame. However, the interactional force of being asked a question required that the client give an answer; apparently unable to resist further, she duly positioned herself as ashamed (turn 4). After she answered, the mentor then insisted that she explicate why she is "not fine" with her current state of affairs. The mentor was ensuring that she confessed her sin in full, which she did in turn 6 ("I am too young to have two children"). This led to the mentor granting forgiveness – "Okay at least you can see your mistake". Pastoral power was at play here, using the classic confessional format, to regulate the client's behaviour.

The mentor then introduced the conjugal ideal of marriage before having children at the end of turn 7: "have you ever imagined that you would get married first…". The client's answer in turn 8, "I once imagined it", was poignant, suggesting lost dreams and hopes. Again, the mentor required an account: "and so what stopped you". The client paused before answering, and gave a heavy sigh (turn 10), indicating difficulty or frustration with the question. By having to, again, give an account, the client was being required to repeatedly perform her guilty status as an unwed teenaged mother. To mitigate this guilt slightly, the client asserted that she does still consider marriage "even now". Remaining positioned within the patriarchal discourse of the ideal of conjugiality, the client indicated that she was still hoping for redemption through marriage.

In turn 16, in response to the mentor's further questioning on why she still hopes to get married, the client responded that "any girl has hope to get married one day." This is an example of what Wilkinson and Kitzinger (2003) refered to as invoking categorical membership, which demonstrates the normative assumptions operating in these speakers' context. Here, located within an apparatus of patriarchy, the client assumed that all girls have a desire for marriage, and the mentor's response, "okay", indicates that she shared this assumption.

The mentor, throughout this recording, was taking up a position as a defender and promoter of patriarchy, as she repeatedly asserted the desirability of marriage. At no time did she indicate that marriage is desirable in order to spread the load of childcare, to share the financial burden, or for mutual support and nurturance. Rather, she claimed that "a girl is a girl if they actually get married" (turn 18), in other words, a woman is not a "real" woman if she is not married. Her worth is measured by the status of marriage, and singleness is a "deficit identity" (Reynolds et al., 2007).

Although this mentor was the only one who promoted marriage in this way, she did so forcefully in all three of her recordings. The irony is that she revealed in one of her other recordings that she, too, has two children and is not married. All her clients took up the normative position of desiring marriage. This position did not need to be accounted for: it was taken for granted that young women want to get married.

In the last part of the last extract, above, the mentor reiterated the normative discourse of maternal responsibility and self-sacrifice: "and your children (.) <u>be responsible for them</u> whatever cent you get it must be for your children…" Again, there was no acknowledgement or space in this interaction for the client to be anything other than a mother.

4.3.1. Resistance to the Organisation's responsibilising thrust

The resistance of the clients to their mentors' efforts to responsibilise them in the extracts above have already been identified, namely, a performance slippage in the first extract as the client gave a laugh, and pauses and a sigh in the second one, as the client resisted (unsuccessfully) the pastoral impetus to confess her irresponsibility. These examples of resistance can be seen as negative, or bodily resistance (Dreyfus & Rabinow, 1982; Guilfoyle, 2014), where the clients attempted but failed to adequately perform the subject positions into which they had been interpellated in those moments. The resistance below was more overt - an example of positive resistance - as the client indicated that she was, indeed, being responsible, but not in a way that had been taught to her by the Organisation or mentor. She was demonstrating agency in using different discursive resources from what she had been taught by the mentor. However, her agency was not affirmed by the mentor.

Mentor Yandiswa; Client 3

1. M: E:h, *umntana wakho* (.) *ingaba akhona amalungiselelo awenzileyo umama wakhe okanye utata wakhe njengokuba ezawuzalwa umntana* (E:h, your baby (.) are there any arrangements or preparations you've made as the mother or the father for the birth of the baby)
2. C: (1) [clears throat] *Ewe ikhona* (yes there are)
3. M: *Zintoni izinto osewumlungiselele ngazo umntana* (.) *mhlambi u-[Organisation] ebekhe wakuxelela ngazo* (.) *uYonela lo undim* (What kind of things have you prepared for the baby (.) things that you heard about maybe from [Organisation] (.) from myself Yanela)
4. C: (2) *Ndibeke imali ebank* (.) *ndenzela intobana xa ndithe ndalunywa ndingabe ndisokolisa eziclinic* (.) *because eclinic akubelekiswa ndihambe ndifune imoto ndiye esibhedlele* ((2)I have some money in the bank (.) so that I don't bother anyone when I go into labour (.) because they don't help with the delivery at the clinic so instead I will hire a car to take me to the hospital)
5. M: *Ingaba unalo ulwazi lwentobana eclinic akubelekiswa and then kengoku njemba eclinic uhlukuhla* (.) *ngaba amanesi akuphatha kakuhle* (since you already know that they don't do deliveries at the clinic and because you go there for your check up (.) do the nurses treat you well)

The Organisational manual stated the following: "**IMPORTANT!** Make sure your suitcase with everything you will need in the hospital is ready when you are going to give birth to your precious baby" (Module 3, p. 65) and the training of the mentors reiterated this teaching. It is likely that this mentor had already passed on this advice to her client. However, when the mentor asked what kinds of preparation that the client had made for her delivery, the client did not reference this advice.

In asking whether the client had made any arrangements for the birth of the baby, the mentor indexed the categories "mother" and "father", thereby explicitly positioning the woman as a parent (turn 1), and, therefore, needing to be responsible. The client paused and cleared her throat before answering that she had made arrangements (turn 2), indicating some trouble with responding to this question. She possibly had not, in fact, made any arrangements. The mentor then asked for details of her preparation, and explicitly asked that she indicate what she had learnt from the Organisation and the mentor (turn 3). The mentor appeared to be wanting to demonstrate to me that she had fulfilled her obligations as a mentor. Given that the mentor was trying to explicitly demonstrate this, it makes clear how the Organisation was positioning its mentors - as knowledgeable teachers who were tasked with ensuring that the clients were sufficiently responsibilised.

The client's response is interesting, as it appeared to be a deliberate resistance to what the mentor was asking (turn 4). After a two second pause, she indicated that she was being responsible, by ensuring that she had sufficient money to get her to the hospital when she went into labour. This may have been something that the mentor had suggested to her in previous sessions, or it may have been discussed at one of the monthly meetings that the Organisation's social worker arranged with

the clients. However, it does not appear to be the answer that the mentor was looking for, as instead of responding to the client's answer by giving feedback in some way, for example with a "yes" or "that's good", which is what conversational convention dictates when a question has been answered (Koole, 2013), the mentor immediately moved on to ask another question. The fact that she did not give feedback on the client's answer suggests that she was displeased with it. The client appeared to be demonstrating that she was responsible, but not due to the mentor's ministrations.

At a later stage in the session, the client indicated her resistance with an obvious sigh, and by clearing her throat, below. These non-verbal interjections sounded quite intentional in the recording.

Mentor Yandiswa; Client 3

1. *M: Xa engahluthi mama yiza kusixelela emtholampilo uba umntanam akahluthi [libele* (if the baby doesn't get full you must alert the nurses that the child is not full)
2. C: [*akahluthi* (not full)
3. M: *Usuke umthengele [ubisi* (don't feed them formula milk)
4. C: [heavy in-breath]
5. M: *Msusuke umthengele iroobos [umgalele etitini* (or rooibos, having decided that yourself)
6. C: [heavy out-breath] mmh
7. *M: senza kengoku imix feed [apho* (because that is regarded as mix feeding)
8. C: [mm (.) mm
9. M: …*Ndicinga ukuba mama sizawuphathana kakuhle siqhubane kakuhle sobabini ude uyobeleka*= (I think that you and I are still going to continue working well together as we continue until you give birth=)
10. C: *=ndiyobeleka=* (I give birth=)
11. M: *uyobeleka funeka uyazi intobana xa sele [ubelekile andikuyeki* (when you're going to give birth you must understand that I am still going to continue working with you)
12. C: [clears throat

The client in this extract was showing her participation in and understanding of the mentor's teachings by repeating words (turns 2 and 11) and by giving backchannel responses (turns 6 and 8). However, the client's non-verbal interjections before the mentor had finished a speaking turn (turns 4, 6 and 13) sounded like deliberate expressions of frustration or boredom.

The client below asserted her agency by deliberately finishing off the engagement by asking "Is there anything else?" (turn 9). Asking questions is an enactment of power in educational settings (Heritage, 2005), and the mentoring sessions generally took the form of an educational encounter, with mentors questioning clients on what they had learnt. Such questions were aimed at furthering the Organisation's goals. However, this client claimed the power that the mentor was wielding by asking her own question to terminate the session in turn 9. Her question was not designed to

request knowledge (for example, asking why she shouldn't bottle feed her baby) but was used to indicate that it was she who was providing the mentor with information, rather than the other way round. It was also a way of indicating that she had answered enough questions and was ready to end the session unless the mentor had any more burning questions. The client also took a long speaking turn (turn 11) to let the mentor know that the flow of information that she provided was redundant.

Mentor Amilisile; Client 2

1. M: *Nawe mos awusenatshomi oye uhambe nayo niyokonwaba ushiye lomntanakho* (And you also don't have friends you go out with leaving your child behind) =
2. C: =*Hayi ha a ha a andisenazo itshomi okokoko andisenazo itshomi* (no no I no longer have friends since then I don't have friends anymore)
3. M: *Umntanakho uyamnancisa ibele* (Do you breastfeed your child)
4. C: *Ewe uyancanca sisi* (yes I'm breastfeeding) =
5. M: *Xa encanca ibele kufuneka amabele akho abe-clean yonkinto (.) phofu ndifike ndabona apha endlini yonkinto yakho iright* (if you are breastfeeding you have to make sure that your breasts are clean and everything else (.) in fact I noticed when I got here that everything is in order)
6. C: mmh=
7. M:=mmh
8. (3)
9. *C: Ayikho enyinto?* (Is there anything else?) =
10. M: *Akhonto ufuna ukundibuza yona*= (Is there anything you would like to ask me)
11. C: *Hayi akhonto ezinto uzithethayo zezi sizititshwayo pha kwa(*Organisation) *esinzayo phaya (.)* so *akhonto siyilanto ndifuna ukuyibuza ngoba lento uyithethayo zezinto sizifundiswayo sizixelelwayo okoko besikhulelwe*= (no there is nothing I want to ask because everything you are telling me is the same as what they teach us at (Organisation) (.) so I have no questions because they have been telling us the same things since pregnancy)
12. M:=yes=
13. C: =*Ewe* (yes)
14. M: *Ndiyambona umntanawakho umphethe kakuhle* (I can see you are taking good care of your baby)
15. C: [laughs]

In turn 2, the client provided a strong negative response ("no no") to assert that she did not leave her baby with friends. However, she also said that "since then" (presumably since giving up drinking) she no longer has any friends. Here is an indication of one of the primary drivers of alcohol consumption - it is a means of socialising and connecting with friends, and it seems that, in this client's context, there was no other way of connecting with friends. This coheres with findings from Project Two (Macleod, Matebese, et al., 2020). The pathos of positioning herself as lacking friends was not acknowledged at all by the mentor, who continued with her responsibilising thrust.

The mentor then did provide the client with some positive feedback, noticing the tidiness of the client's abode (end of turn 5), which the client received with a backchannel "mmh". After that, there

was a three second pause (turn 8), before the client took matters into her own hands and questioned the mentor on whether she had any more questions. It is possible that the preceding affirmation from the mentor provided the client with some agency in this interaction, and the three second silence gave the client the space to wrest some power from the mentor.

The mentor quickly took back her authority to ask questions (turn 10), but the client then proceeded to let her know that her teachings were repetitious and unnecessary, as everything she told the client had been repeatedly taught to her by the Organisational workshops since the start of her pregnancy (turn 11). General conversational norms dictate that one does not tell someone things that they already know (Heritage, 2013), and the mentor was flouting these norms. The mentor received this negative feedback ("yes") but used English rather than Xhosa here. This may have signalled her awkwardness at being rebuked in this way. The mentor then scrambled to repair the loss of social cohesion caused by this rebuttal by affirming the client for the good care that she was providing to her baby (turn 14), which the client received with a laugh. As well as repairing the situation, the affirmation was also a way of re-asserting her own power to evaluate the client.

In this section, I have outlined how the Organisation positioned pregnant women routinely as "Mommies", who were either appropriately responsible or sinfully irresponsible. In the training materials, training sessions, and interviews, this positioning was accomplished using the apparatus of patriarchy and the disciplinary tools of risk, responsibilisation, and regulation. Risk and responsibilisation, as well as "good mother" discourses, can also be understood as being innervated by coloniality, as Western ideals of intensive and responsible mothering were being imposed on the "less sophisticated" target communities. In the mentoring sessions, the same positioning was evident, but the dominant power apparatus was pastoral power. However, patriarchy was also evident in the promotion of conjugal idealism. There was a glaring absence of any other positions for pregnant women. Clients' resistances were both negative, as corporeal slippages occurred, and also occasionally positive: one client worked to prove that she was independently responsible, outside of the mentors' teachings, and another wrested power from her mentor by moving to terminate the session, and to indicate that the mentor's teachings were redundant. The few times that clients positioned themselves as in need (for example, as lacking friends, or being sad at being a young mother without a partner) were not acknowledged, reflected, or empathised with by the mentors.

6. Conclusion

In this chapter I discussed how foetuses were positioned either as precious babies or placed in the position of the defiled Other if they were born with FASD (or any other disability). This defiled Other,

who threatens to disrupt and damage society, functioned as a convenient receptacle for society's concerns and anxieties around crime and poverty, and provided an easy solution to these societal ills – merely regulate pregnant women. The concomitant positioning for pregnant and newly parenting women was as "Mommies" – either good mothers who were responsible, pre-occupied with their foetuses, married, and abstemious, or, in the absent but implicit position, bad mothers who were irresponsible, considered terminating their pregnancies, did not want their pregnancies, were teenaged, were single, who drank, or who did not follow the dictates of "healthy eating".

Patriarchy worked strongly in these positionings to place women in a subordinate position to men, and as fragile and needing men's assistance, while at the same time being required to subsume all their needs in the service of being mothers. Men were constructed as the protectors of "precious babies", and as needing to ensure that their mothers did not harm them through drinking, while women were the passive incubators of these beings. The apparatus of coloniality was evident as middle class, Western pre-occupations with risk, "healthy eating" and "good mothering" were imposed on the target communities to ensure the propagation of an economically useful population. Disciplinary techniques of bio-power were used in the service of responsibilising and regulating pregnant women.

These positionings were not only innervated by patriarchy and coloniality, but inversely, they also served to uphold these apparatuses: if the pregnant woman remains a docile, obedient and responsible wife and mother, ensuring that she only falls pregnant within the confines of marriage, and if her husband treats her as appropriately fragile and precious, and if she follows the dictates of Western, individualising, "healthy" behaviour, all will be well.

In the mentoring sessions, pastoral power was the dominant apparatus that was used by mentors to impart to their clients lots of information that they already knew, and to extract confessions of "bad mothering" from them. Resistance in the mentoring sessions was limited in the transcriptions, although was no doubt expressed repeatedly through avoiding the sessions. In the few examples of resistance in the recordings, it took the form of both negative and positive resistance: negative when clients slipped in their performances as obedient children who were being responsibilised, or as confessing sinners who now understood the error of their ways; and positive when they took up alternative discourses and powerful positions as providers of information to the mentors.

In the next and final analytical chapter, I analyse the few instances when women were positioned as suffering from social injustice, as agentive, or as needing care. In the concluding chapter, I then use all the positioning analyses that I have engaged in to suggest ways that women may be positioned that promote an ethics of care and justice for pregnant and newly parenting women.

Chapter 8: Towards an ethics of care and justice

1. Introduction

As discussed in Chapter 1, section 8, an ethics of care and justice incorporates the notion of reproductive justice, but also extends it with a specific focus on care. Care is a concept that coheres more easily around pregnancy, childbirth and parenting than justice. Reproductive justice, situated within a social justice framework, is a notion that is being increasingly taken up by critical feminist scholars (Bailey, 2011; Chiweshe et al., 2017; Cook & Dickens, 2009; Macleod et al., 2017; Morison & Macleod, 2013). This notion includes concepts of human rights, but it moves away from the individualising focus of rights and incorporates a focus on the social factors that can lead to negative outcomes in the areas of sexuality and reproduction. The notion of justice is a universalising one; it emphasises the equal treatment of all, and redress when there has been injustice. However, women who are pregnant and newly parenting seldom draw from such notions when they discuss their pregnancies and children, and instead use emotional, relational, and familial discourses (Chiweshe et al., 2017; Macleod, Matebese, et al. 2020; Watt et al., 2014), with the notion of care (or lack thereof) being central. Hence, I argue that, in the arena of FASD interventions, an ethics of care needs to be introduced, as well as an ethics of reproductive justice.

In this final analytical chapter I draw out instances that were present in the data from the training sessions and interviews where drinking pregnant women were positioned as being negatively affected by social injustices or lack of care. Social injustices that were identified by participants included the cultural hegemony of drinking, unemployment, poverty, lack of recreational outlets, patriarchy, and ignorance. Women were also positioned as affected by a lack of care from their partners or family. These positionings enable empathy for women who drink during pregnancy, which is important when providing care. In the last sections of the chapter I analyse the few times in the mentoring sessions where women were positioned within a relationship of care or agency through the conversational tactics of the mentor. Care was evident when mentors were attentive to them, interested in their stories, and responsive to their expressions of pain, while agency was foregrounded in one interaction as a mentor and client co-constructed a narrative of her as agentic in overcoming pressures to drink.

2. Positioning drinking pregnant women as affected by social injustices

There were some instances in the data where it was acknowledged that drinking is potentiated by social factors such as cultural norms, gender-based inequities, and poverty, rather than an individual woman's personal or moral failure or ignorance. In the manuals, Module 2 on alcohol and drugs presented some social reasons for alcohol abuse, and when trainees were asked to reflect on causes of drinking in training sessions when covering this module, and also in the interviews, they came up with many cogent social reasons why women might drink.

In the manuals, Module 2 was adapted from material made available to the Organisation from a centre for alcohol and drug dependence in the Western Cape. It referred to the availability and normality of using alcohol, as well as factors such as poor policing, poverty, high stress levels, childhood trauma, family histories of addiction, boredom, anxiety and depression as reasons for substance dependency (the material from this centre addressed substance use by the general population, rather than focussing just on pregnant women.) In this manner, this module located the drivers of substance use primarily in social factors, which does not position individuals as blameworthy. Even the individual factors that were mentioned (anxiety and depression) pointed to mental health difficulties rather than moral failure as factors that potentiated substance use.

On the second day of both training sessions, this module was covered with the trainees. The facilitator asked them to discuss the causes of alcohol dependency in groups of three, and then feed back to the whole group. In interviews with trainees, the interviewer asked them to reflect on alcohol use in their contexts, and possible causes for high alcohol consumption. Two major discourses which point to social injustices were used by trainees in the explanations of drinking: the cultural hegemony of drinking; and structural injustices like unemployment, poverty, and boredom. One interviewee identified a third discourse, patriarchy. A fourth discourse, lack of knowledge, was also used by three participants.

2.1. The cultural hegemony of drinking

In both the training sessions and the interviews, trainees spoke at length about the prevalence of alcohol consumption in their communities, and how any form of socialisation invariably involves drinking. The cultural hegemony of drinking was the most prominent of the discourses utilised to position drinking pregnant women as negatively affected by social factors.

2.1.1. Training sessions: "We can no longer do anything without alcohol"

In the training sessions, when Module 2 was discussed, many trainees, as well as the training facilitator, utilised the discourse of the cultural hegemony of drinking to explain alcohol use. Their narratives spoke to the fact that alcohol use is not just normative but is completely dominant as a social behaviour in their contexts; they provided rich insights into the particularities of how the cultural hegemony of drinking plays out in their communities.

First training session day 2

Trainee 1:…when it comes to kids' birthday parties, people are unable to be happy or enjoy without alcohol, so they always bring alcohol with them and they get used to it. … We also socialise using alcohol, you will find that whenever there are group gatherings, there is always alcohol. Another thing is peer pressure...

…

Trainee 2: … then there is influence from peers, it is such a big issue. For instance, I recently heard that there are some kids who bought alcohol, went to the beach and got drunk and then ended up getting raped. Some of them have never touched alcohol in their life, it was their first time but because they wanted to fit in, they ended up drinking. And also just like the other group said, parties also play a major role. Someone tastes the alcohol or sees it in parties but they don't know what it tastes like and then they decide to go and get it from themselves and they end up getting deeper.

…

Trainee 3:...We can no longer do anything without alcohol; we are consumed with it, alcohol and drugs.

Second training session day 2

Trainee 15: ….you meet up with your friends and most of the time there are men who are always keen to buy you alcohol even if you don't have money. Then again the friends will tell you that next Friday there is some other guy who is getting paid let's go. Then on Saturday you just have a bit just to cure the hangover. And then you end up being dependent on alcohol.

Trainee 16: I think peer pressure as well, if your friends drink then you also want to fit in with the group.

Trainee 1 indicated that, even at children's celebrations such as birthday parties, alcohol is prevalent. Hence, children learn early that alcohol and parties are inseparable, and that social events are characterised by drinking. Many of the trainees and the facilitator spoke about the influence of friends, and Trainees 1, 2 and 16 referenced peer pressure directly. Peer pressure can be understood as a normalisation of a certain way of acting or thinking amongst a peer group, such that those desiring to fit into the group feel a need to engage in the said activity (Lashbrook, 2000). Trainee 15 spoke of how it is easy for someone to find people who will buy them drinks, even if they have no money. This may point to the acceptability of transactional sex in South Africa, where alcohol is used as the currency of exchange (Dr Zoe Duby, personal comm, March 2023). Trainee 15's description of

how friendship groups will identify people who will be getting paid on a certain day indicates how much of a person’s income in such contexts is spent on alcohol.

Trainee 3 summed up the trainees’ sentiments by saying “we can no longer do anything without alcohol.” In this manner, people who drink were positioned as part of the “we”, or part of a society for which drinking is not only normative but is a behaviour that completely dominates most forms of social life. In using the first-person plural pronoun “we”, Trainee 3 was positioning herself as a member of that society; she was including herself as someone whose social life was captured by the hegemony of drinking. She was also not othering women who drink by speaking of them in the third person, but was positioning herself with rather than against them, which is important when intervening.

Relatedly, the training facilitator, in the second training session, as shown below, spoke about how initiates at initiation school are inducted into alcohol consumption, even if they are still in their early teens, and how school farewells likewise involve alcohol consumption. Initiation schools and school farewells can be understood as rites of passage, as childhood is left behind and a young person enters adulthood. With drinking being a prevalent part of these practices, the message is given that adulthood involves alcohol consumption.

Second training session day 2

Training facilitator : A person has their first drink when they have their [school] farewell or when they go to initiation school. … where I’m from, the kids can go even if they are 14 years. When they went to initiation school, they would have never had alcohol or smoked. But when they come back, they now drink and smoke because they started experimenting there so when they come back, they just continue. Most people, it’s because of friends...

As well as the social and relational aspects of the cultural hegemony of drinking that the extracts above identify, another important factor is the excessive availability of alcohol.

First training session, day 2

Training facilitator: ... let’s say for instance in [this area], there are ten places where you can buy alcohol and so as you are walking by bored on a Saturday, you find yourself surrounded by these places and you end up going into one of them.

The training facilitator pointed out the ubiquity of alcohol outlets in the trainees’ residential areas. Given that alcohol consumption is so prevalent, and enforcement of liquor laws is so lax in many parts of South Africa, the illegal selling of alcohol is an easy way to generate income in a country where unemployment is high. This feeds into and bolsters harmful drinking patterns.

All of these narratives ground the discourse of the cultural hegemony of drinking within the trainees' contexts and illustrate how this discourse controls the social and relational lives of many. In interviews, likewise, this discourse was prominent, as shown below.

2.1.2. Interviews: "It's the only way we socialise nowadays"

Interviews with trainees and the Organisation's personnel confirmed this cultural hegemony of drinking. Interviewees either deplored the amount of drinking that occurs in their communities, or admitted that they, too, consumed alcohol, and many confirmed that drinking is the dominant way of socialising in their communities. Even those who did not drink did not know of ways of socialising without alcohol.

Interviewee 7: *...they don't sleep they drink the whole night over there* /oh/ *they do not sleep in my area (.) they get drunk until the next morning*

Interviewer: *The alcohol issue in the area where you live (.) what's it like?*
Interviewee 10: *Yho listen* (.) they drink Monday to Monday /sho/ Monday up to Monday =
Interviewer: *Who are they?*
Interviewee 10: *It's mostly =*
Interviewer: *What kind of people?*
Interviewee 10: *The youth* /mmh/ (1) everyday they drink =

The two interviewees, above, expressed in strong terms how much drinking occurs in their areas. Interviewee 7 claimed that people "*drink the whole night*", indicating hazardous alcohol usage by the people involved. Interviewee 10 said "*yho listen* (.) they drink Monday to Monday." The underlining in the transcripts show emphasis on words or phrases, and these two interviewees were talking emphatically about how much drinking occurs in their neighbourhoods. Interviewee 10's introductory wording ("yho listen") to her answer about alcohol usage in her area served to emphasise her point about how much drinking occurs, and that people drink on a daily basis. Most of the time, Interviewee 10 spoke in Xhosa, but she used English, along with strong emphasis, when she stated "They drink Monday to Monday." Her specification of "Monday to Monday", her repetition of this phrase, strong emphasis, and use of English, were all conversational techniques to emphasise the fact that such drinking is excessive, prolonged, repetitive, and problematic. The fact that she was aware of such drinking patterns also indicates that the consumption is excessive and visible.

The following interviewees spoke about drinking being a peer endorsed behaviour that was "fashionable" and "cool":

Interviewee 7:*...drinking is also fashionable* /ye::s/ *they do not sleep* (.) /ye::s/ *in the area I*

live in (.) I think *we are in between taverns* (.) *one on both sides* /ye::s/ and *they don't sleep because you'll hear* blaring *music the whole night you see* /ye::s/ yes

Later

Interviewer: ja *because perhaps that's how culture is /mmh/ everyone is doing the same thing* =

Interviewee 7: *And what's happening is that (.) they laugh at each other and they call a person a fool who doesn't understand how things work* [unfashionable] /ye::s/ *so the person has to join in on what people who are in his age group are doing*

Interviewee 9:…. *there are a lot of places where they go to drink here in* [this township] /mmh/ there are so many taverns at [this township] /mmh/ *so:: I don't know whether* ... [Organisational talks] *would even help* /mmh/ because *they are no longer interested in listening* /ja/ but *there are a lot of places where they go to drink*

Interviewer: … can you tell me about alcohol use and pregnancy in your community?
Interviewee 12: Yho /laughs/ it's a big deal /laughs/ … because they drink (.) they do drink a lot
….
Interviewer:….what do you think leads them to drinking...?
Interviewee 12: Yho .... just to be cool /ok just to be cool/ just to hang there friendly if you are staying altogether the only thing they do (.) is drinking

The statements that drinking is "fashionable" (Interviewee 7) and "cool" (Interviewee 12) indicates that drinking is used as a means of fitting in and being part of a group. Interviewee 12 said that "the only thing they do is drinking", which points to the hegemonic nature of drinking as a pastime. Interviewee 7 recognised how coercive this drinking culture is, so that a young person "has to join in on what people who are in his age group are doing". Both Interviewees 7 and 9 talked about the great number of alcohol outlets in their communities. The fact that such outlets operate all through the night shows that they are not complying with liquor laws that limit trading hours, which points to poor policing and enforcement of laws. It also disrupts the sleep of people living in surrounding areas ("you'll hear blaring music the whole night"); excessive alcohol use has ramifications well beyond the individuals who drink.

All the interviewees, above, spoke about the generic "they" who drink. This was a means of separating themselves from those who drink: if "they" drink, the implication is that "we" do not. None of them were specific as to who is drinking, except for Interviewee 10, who claimed that it is "the youth" who drink. She only specified the youth in response to a direct question by the interviewer. By claiming that it is the youth who drink excessively, she was separating herself from this group of people. Given that the interviewees were going through training that was speaking about the ills of drinking, this conversational tactic can be seen as a means of aligning themselves

with the anti-drinking stance of the Organisation.

In the extract below, the interviewee spoke about her worry that children, including hers, are exposed to such excessive alcohol consumption.

Inteview 1_Buhle

1. B: *There's nothing you won't find* /Hm!/ *in this place (1) drugs, what. And you find that it's small children that get affected* (.) /Hm:/ You understand? /Hm::/*There's no type of DRUG you won't find in that place. There's no KIND OF (.) OF ALCOHOL (1) that is not consumed in this place of mine* ….BECAUSE OF (.) *you meet a child this small* (.) *all over the streets with her mother /*Tjo:/ *you understand? With (.) with the parents,* /Hm:/ *they meet at home all drunk* /Hm:/ *you understand? With (.) with the parents,* /Hm:/ *they meet at home all drunk*
2. ….
3. B: *you see. No, you can go to my place on a* weekend /Hm:/ … *you'd leave thinking that really,* ... this is bad.
4. I: Especially over the weekend?
5. B: Especially over the weekend!/Tjo!/ *You see now!* Its Festive season /yeah/ (.) yhooo: everyday!
6. I: *It's* December (.) yeah!
7. B: YHO! *And then you'll* (.) *meet them fighting on the streets.*/Hm:/ <*and then they're with small children* because (.) *you see now the child is learning that thing* /Hm:/, *a child sees this as a good* thing /Hm:/ because *they say that a child (1) the thing that you do* regularly (.) *that s/he keeps watching (.)* /Hm:/ *the thing you do as a parent* =
8. I: *even they will do!*=
9. B: *is good* /Tjo!/ *you see?* And *you become worried [as a parent]... When [your children are] in the streets, they see all of that* (.) /Hm:/ *being done there*

This interviewee spoke emphatically about how available all types of drugs and alcohol are in her neighbourhood (utterance 1), and how, during weekends and the Festive season, usage is excessive (utterances 3 and 5). Her deep feelings about the situation were evident in the loudness and emphasis on certain words and phrases. She expressed her concern that young children are observing their parents' drinking behaviours and resultant fights (utterances 1 and 7), and she pointed out that children learn from the example of their parents and elders (utterances 7 and 9). She was also concerned about the fact that her own children witness drunken behaviour (utterance 9), which may lead them into patterns of substance abuse as they grow up. The interviewee's concerns highlight the way that hegemonic cultural practices get passed down through generations. Her evident emotion points to the pain of living within such a hegemonic alcohol culture.

Unlike other interviewees, Interviewee 2, below, counted herself as amongst those who use alcohol, and drank during their pregnancies.

Interview 2_Phakama

1. P: So we make DATES to have drinking sessions. So…
2. I: So you do it (for) having fun?
3. P: …So that is why. *I don't want to exclude myself* because at the end of the day, *even I* do make dates to have a drinking session (//Yeeees!) even throughout the weekend for that matter

Later:

4. P*:…because there are also stokvels now so they're* distributing *and what not*
5. I: *Ye:s*
6. P: *So "I'm gonna lose that money, busy consuming soft drinks* /Hm:/ *when other people are having fun"* /Hm:/ or *they go to* [place] *for [Christmas] lights* /Hm:/ *I had plans, or to* [place]… we had plans /Hm:/, *so I'm gonna lose my money that I contributed because of that…*

….

7. P: So now, rather than taking the risk with the knowledge that you have /hm:/, you understand? /Yeah:/ rather than taking the risk, just make the choice that "okay, *I'll just throw myself a party when I give birth* /Hm:/ *and just know that I'm reclaiming even that* 9 months" *you ever see?* If it's possible but I doubt that [giggling] and then alcohol-use… we can say that okay, it damages and everything and everything. Everyone knows of this, but we keep on doing it
8. I: Yeah…
9. P: Because at the end of the day, it's the only way we socialize nowadays

The interviewee indicated that drinking sessions with friends are planned in advance ("we make DATES" - utterance 1); they are not only responses to particular stressors, or as a result of spontaneous peer pressure when out socialising. She claimed that, by not joining in the plans for drinking, she would be "excluding" herself (utterance 3).

The interviewee went on to discuss how *stokvels*[41] are formed to save up for alcohol expenditure during December (utterance 4). *Stokvels* are informal saving "clubs", where members contribute a fixed amount each month and the money is invested in a short-term savings account. After a predetermined amount of time, the money is paid out to the members for certain occurrences, such as funerals, or certain seasons of the year, like Christmas (Matuku & Kaseke, 2014). *Stokvels* are crucial savings platforms for poor people, where more interest can be earned for larger sums of money. From utterance 4, it appears that the interviewee was discussing *stokvels* to which people contributed throughout the year, and at the end of the year the money would be used to pay for a year-end celebration, including the bulk buying of alcohol[42]. She indicated that, if a pregnant woman who is part of such a *stokvel* does not drink alcohol, then she would be getting less benefit for the

---

[41] The name *stokvel* appears to have originated in the Eastern Cape in the early 19th century, when 'White' farmers held stock fairs to buy and sell stock. 'Black' farmers and labourers socialised at these stock fairs and used whatever resources they had to purchase their own stock (Matuku & Kaseke, 2014).

[42] This type of *stokvel* would contribute to the culture of drinking rapidly, to consume as much as possible in a short space of time, so that a member would get as much alcohol as possible for their contributions before it ran out.

money she contributed.

In utterance 7, the interviewee opined about how pregnant women should think about alcohol. She suggested that, rather than take the risk of drinking when pregnant, they should abstain throughout pregnancy, and then "throw [themselves] a party… [to] reclaim… that nine months." Her suggestion that women can drink after birth to "reclaim" the time when they abstained points to the premium placed on alcohol consumption by this interviewee; she indicated that abstinence is a big sacrifice, and women would then want to make up for their abstinence by drinking a lot after giving birth. Her next utterance (utterance 9) indicates part of why drinking is so important - "because it is the only way we socialise nowadays."

All of these extracts, above, show how captured the participants' society is by drinking. The next discourse that was evident as participants positioned drinking pregnant women as affected by social injustice was one of unemployment and poverty, and the resultant stress and sense of futility.

2.2. Structural injustices: unemployment, poverty and boredom

In the extracts below the speakers talked about unemployment, and how poverty and not having anything useful to do were drivers of drinking behaviour.

First training session day 2

Training Facilitator: … Unemployment is also another cause, when you don't have anything to do, you end up going to a drinking place.

….

Trainee 1: And then you'll find a young man, who completed school a longer time ago but they are struggling to find a job. Year in and year out they keep hoping that they will get a job but nothing happens until they lose hope and end up drinking alcohol

Second training session day 2

Trainee 15: I would say that it's being at home all the time, maybe you don't have a job. So you always have time on your hands, so you meet up with your friends and most of the time there are men who are always keen to buy you alcohol even if you don't have money….Then you end up going [to drink] everyday because you are always available since you don't have a job.

Interviewee 10: *The youth* /mmh/ (1) everyday they drink ...because there is no work / ja::/ *there is no employment there is no… if you are bored there's nothing to do so a person decides to go and drink just to de-stress you see* /mmh/ *things like that* /mmh/ *there isn't anything decent they can do*

These speakers pointed to the sense of futility and stress that unemployment and lack of gainful occupation leads to. Trainee 1 narrated how a young man's hope can be eroded and eventually destroyed through never being successful at finding employment, which then leads to drinking. Trainee 15 spoke about unemployment leading to being "home all the time", "always hav[ing] time on your hands" and being "always available" to drink. Interviewee 10 discussed boredom, having nothing "decent" to do, and the need to relieve stress when there is no work available. Having nothing "decent" to do highlights the sense of "indecency" and shame that commonly besets an unemployed person, and which inevitably leads to "stress". From such feelings of inadequacy, it is a short step to "de-stress" through the hegemonic activity of getting drunk. These speakers' analyses of the drivers of drinking positioned them as empathic commentators on the pain of unemployment. Interviewee 10 was herself an unemployed single mother, so she had an insider's knowledge of unemployment.

The interviewee below understood this need for having something "decent" to do and suggested possible solutions. She was unemployed but she was married to a pastor and she earned some money through selling food in her community. She had two teenage and one primary school aged children.

Interviewee 9: Like (.) *I wish there could be a place right /mmh/ like if a young person is unemployed* /mmh/ it's either *they receive training perhaps they could do sewing /mmh/ baking* (.) all those things *that will keep them* <u>*busy*</u> */mmh/ so that they won't just loiter around* /ye::s/ *and end up finding a place where they can drink*

In her phrase "I wish ...", the interviewee displayed a longing for solutions to the problem of young people not having fulfilling occupations. Although sewing and baking, as she suggested, may not generate much income, she was aware of the need for young people to "keep busy" so that they would not "just loiter around", even if their labour did not result in much profit. In her longing, and her attempts to suggest some solutions, she positioned herself as caring, agentic, and concerned for the welfare of future generations including, probably, her own children. Her identification of the need for "a place" is important; a physical gathering place where activities and training occur allows people to get out of the house and gather with others, which is crucial for motivation and social support while engaging in activities. This would also facilitate socialisation without alcohol.

Unemployment almost inevitably leads to poverty, and participants discussed the resultant stress of this, which then leads to drinking. In the extract below, the Training Facilitator had asked trainees to discuss reasons for alcohol use.

Second training session, day 2

Trainee: poverty [all participants laugh]
Training Facilitator: That is so true, because you are unemployed so you have no food, you basically have nothing and you just wish you could forget everything or all your problems so you end up going to drink.
…..
Trainee: Another thing we sometimes don't notice is when, say for instance you earn R1000 and then you get into a lot of debt. Then the month ends and all the money is finished and that stresses you out so you decide to go get drunk to forget about your problems [participants speaking at the same time – inaudible] the person is in debt, they don't have food and they don't have money and they are stressed out, so they take what they think is the easy way to deal with the problem

The laughter from the participants when the first trainee stated "poverty" as a reason for drinking is notable, as poverty is no laughing matter. Perhaps it was due to the irony that drinking requires money, and yet some in poverty drink excessively; perhaps it was because the participants themselves may have experienced poverty, and their laughter indicated an anxious identification with being poor. The Training Facilitator and the second trainee, above, both referenced the desire to forget about the difficulties arising from poverty, such as having no food and being in debt, as reasons for drinking. When the second trainee talked about someone getting drunk to forget about the stresses of their debt, this generated much spontaneous talk from the other trainees. Such talkative energy suggests that this issue was highly salient in trainees' lives. Many low-income households are unable to access credit from formal financial institutions, which has led to the proliferation of micro-lenders in poor communities. Micro-lenders often charge extremely high interest rates (Mashigo, 2012), and can use abusive practices to extract payments from the borrowers, such as confiscating ATM bank cards (Mashigo, 2012) or Social Security cards which enable access to child and pension grants (Liso Tsotsi, personal communication, August 2014). Many micro-lenders are also *shebeen* owners (Mashigo, 2012; Liso Tsotsi, community member, personal communication, August 2014), which enables people to drink on credit, further exacerbating their debt. These factors may have been why the issue of drunkenness and debt generated so much talk amongst the trainees.

As well as the boredom arising from unemployment, participants also cited the lack of other social outlets as a contributor to boredom, which then contributes to high alcohol consumption.

First training session day 2

Trainee 3: ...that whole thing of attending entertainment events that used to help us avoid alcohol no longer exist anymore, things like beauty pageants. We can no longer do anything without alcohol….
…
Training facilitator: …as you are walking by bored on a Saturday, you find yourself surrounded by … [alcohol outlets] and you end up going into one of them

Interviews

Interviewee 9: ...there are no activities here at …[this location] /ye::s/ *which is why people are drinking*

Interviewee 2: ...*here at* [this township] (2) uhm (.)alcohol is like King (.) because they used to have activities like uu:h likes of rugby /I1: Hm!/ like *kids would COME home from school and go to the* gym and then most of them *would come here then, the smaller ones* /I1: *yes/* So (.) u:h, at some point due to (.) use of that alcohol still, /I1: Hm:/ *they stopped those things (1) those* games *were stopped* because they had them (.) every Sunday /I1: Hmm!/ at least someone (.) *a person* looked, looked forward to going (.) *to those* matches, even I, I used to go as well, just to go and watch because I understand rugby.

Interview 12 - Community Worker

I: So you've mentioned socialising (.) are there other ways of socialising without alcohol in the community?
CW: No no I don't see any /ok/ (.) you drink
I: So that's the only way to socialise?
CW: That's the most way /mmh/ maybe there [are] but that is the most way=
I: Mh okay, so there is nothing like sports club or, u::hm, choir you know church choir =
CW: =there's nothing that keeps them busy /ok ok/ I don't see anything there (.) maybe a gym or sport no=
I: Nothing

The Training Facilitator gave an example of someone being bored on a Saturday and going into a tavern as the only thing to do. Trainee 3 and Interviewees 9, 2, and the Community Worker pointed out that there are no activities or entertainment events for young people that do not involve alcohol anymore. Interviewee 2 even attributed the falling away of rugby matches to the use of alcohol. The hegemony of alcohol consumption had captured all social and recreational events, meaning that boredom ensued if a person does not drink.

Interviewee 9 causally linked high alcohol consumption with lack of other activities - "there are no activities here...which is why people are drinking" - and in this manner she positioned drinkers as passive victims of their circumstances. Interviewee 2 assigned agency to "King alcohol", which she positioned as instrumental in doing away with sporting activities. There is a great sense of loss in her narrative, as she claimed that children and others, including her, are deprived of sporting activities due to the hegemony of alcohol.

These positionings constructed heavy drinkers as victims of structural injustices, like poverty, unemployment, and lack of recreational outlets that do not involve alcohol consumption. In this manner the speakers were not blaming individual drinkers for their consumption but were fingering social issues as reasons for problematic drinking.

2.3. Patriarchy

A discourse of patriarchy was drawn on by one interviewee. She was reflexively aware of how this power apparatus was operating in her community, and the inequities that it generated in the arena of alcohol consumption and child-care. She pointed out that intervention efforts to reduce prenatal drinking are focussed only on females, to the exclusion of males, and how some prenatal drinking is potentiated by abandonment during pregnancy. She then went on to describe the pain of being abandoned at home when a partner goes drinking.

Interview 1 - Buhle

1 B*: ...sometimes you find that these things* [training courses] *are done* (.) *in* clinics, *you* understand? /Hmm/
2 B: (.) But <u>they don't</u> (2)
3 B*: they don't <u>emphasize</u> that even the <u>father</u> when it comes to a pregnant person at home (.)*/Hmm/ *has a role to play* /yess/
4 B: (1) *They always focus on females* /Hmm/
5 B*: (.) Even though sometimes the woman does some things because the father never cared for them* /Hmm/
6 B*: (.) You* understand? /yes/
7 B: So I think *there should also be a <u>focus</u> on men, and <u>emphasis</u> on them as well.*
8 I: <u>Yes</u>
9 B: Because *I think maybe if there was (.5) partnership some of the things wouldn't happen that much.*
10 *B: Because some things a person does out of <u>stress</u> that* /Hmm/ (.)
11 *B: "my boyfriend impregnated me and left" you* understand? */yes/*
12 *B: Other people believe then that "If I (.) could drink, my stress cou (.)* /Hmm/. (.) *could get* relieved" /yes/
13 B: [unclear] I know that *I've that "Mx! Let me go drink man*" *you* understand? /Hmm/
14 *B: Then you find that, I drank and drank and drank but as I'm sitting quietly <u>that thing that was stressing me,</u> is still there (.)*
15 I: <u>Sure</u>
16 *B: and even tomorrow that thing (.5) I used to think that you will drink such that come tomorrow, you won't be thinking about <u>that thing</u>*
17 I: Sure
18 *B: (.) You* understand?
19 I: <u>Yeah</u>
20 B: So I think we (.) *should emphasize on (.) even if there are (.) for men only,* /Hmm/ (.) *to make them understand that this and that way (.)*
21 *B: because men* [or *fathers*] *are the ones who aren't clear <u>about their</u>* <u>role</u> *<u>at home</u>.*
22 I: *<u>Yes</u>*
23 *B: It's a painf (.5)*
24 <u>B: More especially</u> when you're pregnant, like (.)
25 <u>B: My husband,</u> *right*? Sometimes I feel like (gasp) very small because sometimes he said "I'm going out but I'm not going (.) with you"
26 I: <u>Tjo</u>
27 B: (.)"because you're pregnant!"

28 I: Yeah (.5)
29 B: "So you should stay at home" /Hmm/ (.)
30 B: and then (.) *in my mind I'd be thinking "No! this person is lying, he is cheating*" /Hmm/ (.) *you* understand? /Hmm/ (.)
31 B: Even though at times he is not CHEATING but (.) is just like "just relax at home" (.)
32 I: *Yeeees (.)*
33 B: "and I'll go on my own" *you* understand? Things like that.

In utterances 1 - 4, the interviewee pointed out that clinic training courses, which educate people on issues such as HIV, nutrition, and health practices during pregnancy, focus on women, to the exclusion of men. This positions women as the sole custodians of such things, and as the ones who are responsible for the health of their families and communities. In utterance 5, the interviewee cogently stated that women sometimes engage in unhealthy practices, which would include drinking when pregnant, because the pregnancy partner does not care sufficiently for them. She, thus, positioned drinking pregnant women as lacking the care that they need, and health institutions, such as clinics, as unfairly burdening women with sole responsibility for their offspring. She proceeded to elaborate on how a pregnant woman may drink to try and forget the stress of events such as a partner abandoning her during her pregnancy (utterances 10 - 12). She wished that there could be a partnership between parents (utterance 9), feeling that, if this was the case, some of the negative behaviours that a pregnant woman may engage in would not happen. Her desire for partnerships between parents speaks to equal responsibility and mutual care.

The interviewee then proceeded to talk very personally about her own struggles. In utterance 13, her speech was initially unclear, and she then confessed to having tried to "drink away her stress" at one point in her life. Her unclear speech may indicate that she was feeling trepidation at confessing that she once did the very thing that the Organisation spoke so strongly against. It is noteworthy that, throughout this extended extract, the interviewer (who was training as a counselling psychologist at the time) was listening actively - indicated through her frequent backchannel responses ("Hm") and strong agreements ("Yes", "Sure") - but did not provide her own opinions, or interrupt with questions. In this manner, the interviewer honoured the interviewee's views and story, which positioned the interviewee as a worthy individual whose wisdom and pain deserved to be heard. This very activity of deep listening was an act of care, and it provided the interviewee with a non-judgemental and receptive space in which to express and process her past mistakes and current struggles.

In utterance 21, the interviewee stated that "*men* [or *fathers*] *are the ones who aren't clear about their* role *at home."* Here, she elaborated on her assertion earlier that men need input, and,

perhaps, convincing, that they need to assist with pregnancy and child rearing journeys. There is a sense of longing underlying her emphatic statement: she was pregnant with her fourth child at the time of the interview, and may have felt a lack of assistance from her husband. Her subsequent utterances indicated that unequal gendered norms were at play in her home, as her husband went out drinking, and left her alone with the children.

The interviewee went on to reveal a great sense of abandonment by her husband when he went out drinking without her (utterances 23 - 33). She appeared to be trying to convince herself that her husband was not cheating, but was merely concerned for her health as a pregnant woman when he would not take her out with him (utterances31 - 33). However, her sense of abandonment is evident in the unfinished word "painf(.)" in utterance 23, and her gasp in utterance 25 when she admitted to feeling "very small". This feeling of abandonment could easily lead a pregnant woman to join her partner at the tavern in order to ensure that he does not meet up with another woman.

This interviewee positioned herself outside the discourse of patriarchy in order to critique this power apparatus, thereby positioning herself within feminist apparatuses. However, the interviewee below positioned herself squarely within patriarchy:

Interviewee 9: Yes (.) they do not know *that when you are pregnant you are not supposed to drink /ye::s/* even if you are not pregnant (.) it's not nice [for] a woman to drink liquor

Interviewee 9 was explaining to her interviewer why she thought pregnant women drank. As well as claiming that they are ignorant of the teratogenic effects of alcohol, she stated that "it's not nice" for women to drink, thereby implying that it is fine for men to drink. Here, this interviewee was reiterating patriarchal assumptions about the need for women to monitor their behaviour far more strictly than men.

Interviewee 1's partner used her pregnancy as an excuse that she should not accompany him when he socialised, indicating that it is common knowledge that pregnant women should not drink. This indicates that the Organisation's mission to tell communities that pregnant women should not drink is insufficient. Indeed, when discussing reasons for alcohol use, lack of knowledge was cited, but only very limitedly, as shown below.

2.4. Ignorance

Positioning drinking pregnant women as ignorant of the teratogenic effects of alcohol occurred only three times in the data, by three interviewees. Two of the interviewees were the community worker and the social worker (who was also the training facilitator) of the Organisation; hence, these two

interviewees would have been imbued with the ethos of the Organisation, and their mission would have been to educate women about how to prevent FASD.

The interviewee below positioned mothers of children with FASD as ignorant and steeped in primitive beliefs about witchcraft.

Interviewee 9*: ...then they* [mothers of children with FASD] *say things like 'oh the reason I gave birth to a child like this is because they have been bewitched by the neighbours'* because some of them they say so=

Interviewer: ye::s *they bewitched them* =

Interviewee 9: yes (.) they do not know *that when you are pregnant you are not supposed to drink*

By positioning drinking pregnant women as ignorant and misguided, interviewee 9 was positioning herself as educated and enlightened. The training facilitator and the community worker, in their interviews below, provided more nuance, and acknowledged that people do know that you shouldn't drink during pregnancy, but that people were unaware of the consequences.

Training Facilitator: It's like many things you grow up being told "you must not (.) sleep with a MAN /Mm:/ when you're not married or whatever" you know? So "you will get pregnant" /Mm/ but you still do it anyway /Mm/ so that's the (.) It's the same mentality /Mm: (.) Mm/ not of just not knowing the consequences /Mm/and uh (.) how bad /Mm/ the effects are

The training facilitator identified a common difficulty with risk-based messages given to young people: that they often do not work. She used the example of injunctions given to girls not to have sex until they are married, but which are ignored, and she felt that pre-natal drinking was a similar phenomenon. She identified the reason for young people not following such advice as being that they are not aware of the consequences of their behaviour. The community worker suggested a similar reason:

Community Worker:It's a general work [knowledge] if you are pregnant you (.) you don't have to drink /mm/ a person knows that /mm/ but they don't know <u>deep</u> about it /*ja*/ mm:

The community worker also acknowledged that it is common knowledge that women should not drink when pregnant, but she expressed that people lacked "deep" knowledge; in other words, they did not know the consequences of pre-natal drinking. For example, she said that she herself did not know that pre-natal drinking leads to brain damage before she joined the Organisation. She claimed that topics such as TB and HIV are commonly taught in clinics, but that there is no teaching on FASD, and she believed that further knowledge on the topic would assist in reducing the incidence of FASD.

Both the community worker and training facilitator believed that awareness raising and education about the consequences of pre-natal drinking - what is termed "universal interventions" - were needed to reduce the incidence of FASD. However, literature suggests that, while such interventions increase knowledge of the consequences of pre-natal drinking, reduction in drinking behaviours of women most at risk is questionable (Crawford-Williams, Fielder, et al., 2015).

2.5. Conclusion: Positioning drinking pregnant women as affected by social injustices

In this subsection, I have unpacked instances in the data where pregnant women who drink were positioned as affected by social injustices, rather than as individually culpable. A dominant discourse that was utilised in this positioning was the cultural hegemony of drinking. Participants spoke at length about how alcohol consumption is ubiquitous at social gatherings, about how accessible alcohol is, and about how drinking is considered to be the only way to socialise. Related to this was the issue of boredom: it was evident that, in the participants' contexts, there were no recreational outlets that did not involve alcohol. Alcohol consuming pregnant women were also positioned as affected by unemployment and poverty, which were seen as contributing to alcohol consumption through the stress and sense of futility that such conditions engender. One woman identified the apparatus of patriarchy, which leads to unequal gendered norms, as something that needs to be addressed in order to reduce pre-natal drinking. Three participants mentioned lack of knowledge of the teratogenic effects of alcohol as causative factors in pre-natal drinking, and two of those participants were employees of the Organisation. All these positionings are important, as they indicate where interventions should be targeted.

3. Positioning drinking pregnant women as affected by lack of care

Another non-blaming position that came through in training sessions and interviews was placing drinking pregnant women within a discourse of lack of care, which could contribute to their alcohol consumption. In the extract below, trainees were asked to discuss what may contribute to high alcohol consumption.

Second training session day 2

Trainee 1: Sometimes it's the stress from life's problems in general, like being unemployed, if you are married, your partner is giving you problems.
Trainee 2: Stress from home, when they don't treat you well at home you end up being [involved] in alcohol
…..

Trainee 3: Another thing that can be frustrating is when at home they don't notice or take your job seriously or perhaps you judge yourself or you disagree about things and they don't have the same perspective as you. So you decide to go and deal with the stress and frustration by drinking and when you come back from drinking, no one says anything about the fact that you went drinking. And so you decide perhaps that's where or what they prefer you to do

….

Trainee 1 acknowledged that "life's problems in general" can cause stress, which leads to drinking, and she then went on to specify unemployment, which has been discussed above, and intimate partner difficulties, which is shown in the literature to be correlated with risky drinking during pregnancy (Choi et al., 2014; Russell et al., 2013).

Trainees 2 and 3 spoke about the difficulties that can arise in the home with other family members, such as "when they don't treat you well", do not provide acknowledgement for a person, or "disagree about things". Trainee 3 described someone who is not feeling recognised in her home environment, and who is not even rebuked for drinking. This, along with the inevitable self-criticism ("you judge yourself") that stems from lack of recognition, can make a person feel that being at the tavern is the best place for them. Such observations are again backed up by research, as both qualitative and quantitative studies link negative affect with increased prenatal alcohol consumption (Tomlinson et al., 2014; Watt et al., 2014).

The trainees and the interviewee, below, spoke about another correlation that has been identified in the literature – that of increased prenatal drinking when partners drink (May et al., 2008; McBride & Johnson, 2016; van der Wulp et al., 2015).

First training session day 2

Trainee: Let me start with a home environment where there is a man and a woman who are married to each other. The man abuses alcohol and as a result they're always cursing, shouting and beating up the children. Even though they go to work, they don't bring home a cent and that leads to constant fights at home. The man beats the woman to a point where the woman also decides to start drinking to cope with the situation even though they never used to drink. But because they are being beaten up and abused by the husband and no longer happy at home, they end up abusing alcohol thinking that it's better to do that but it makes the situation worse.

Second training session day 2

Trainee: …another thing, for instance there are women who live with their partners who drink. So, each and every time after month end, sometimes the woman is unemployed. So, when her partner has been paid, they don't come back home, instead they spend the night at the tavern. So, the woman knows that when her partner comes back, they will be a nuisance and so she decides that, since he goes and gets drunk, she'll also go and join him wherever he is. Her reasoning is that, "If he won't come back home with

> the money when he gets paid, I'll go help him spend it wherever he goes to get drunk" and that's how some other people end up drinking and they even continue to drink in the middle of the month as well.

The trainee from the first training session painted a picture of a home marred by the alcohol abuse of the man, and due to this, the woman would turn to alcohol as a coping mechanism. Whilst the alcohol consuming pregnant women was not blamed, this trainee placed all blame for the woman's drinking on the male partner. The trainee from the second training session provided a poignant example of how a woman may join her partner in drinking on his payday as there would be no other way that she could benefit from his earnings. Rather than enduring the "nuisance" of a drunk partner returning home, she would join him at the tavern to "help him spend [his money]" seeing as he wouldn't return home with any. Culpability for drinking during pregnancy is, here, laid at the door of relational factors rather than individual failings.

> Interviewee 10: *…let's say for example I am pregnant* /mm/ *and I have a boyfriend who drinks* /mm/ *so I am with this boyfriend and he is abusing me in a certain way* /mm/ *it's better to be in the same mood he is in through* <u>*drinking*</u> *you see* /mm/ *so that perhaps we will be on the same level of thinking*

This interviewee talked about a boyfriend abusing his partner, and it is well known that intimate partner violence increases with alcohol consumption. However, the interviewee may also be referencing emotional abuse when she talked about abusing "in a certain way." She stated that it is "better to be in the same mood" and "on the same level of thinking" as a drunk partner, and this may refer to the emotional inhibition and dulled cognitive processing that occurs with intoxication: she suggested that it is easier to endure a partner in this state when one is intoxicated oneself.

In highlighting the contributions of life stressors, domestic violence, and affective difficulties to prenatal drinking, these participants were positioning women who drink in pregnancy as suffering from a lack of care.

In the next two sections I look at data from the mentoring sessions and draw out instances where women were positioned in ways that align with principles of care and justice. In the first section I analyse positionings that legitimise a woman's need for care, and in the second section I look at the only time when a woman was positioned as agentic, and as having the internal resources to overcome the hegemony of the drinking culture of which she was a part.

4. Women positioned within a relationship of care

Frank (2013) stated that "People whose reality is denied can remain recipients of treatments and services, but they cannot be participants in empathic relations of care." (p. 109). In line with Frank's

thinking, I believe that it is imperative that women's realities are heard and acknowledged in order for them to receive care. I understand conversational care as a process by which someone enables a person to tell self-narratives, particularly about painful episodes, and then positioning themselves as a respectful, interested, and empathic receiver of those narratives. This is a hallmark of counselling. Counselling and related psychological disciplines can be critiqued as modern iterations of colonial and pastoral power aimed at creating psychologically healthy citizens. I address this further in the concluding chapter, but this is one of the reasons why an ethics of care needs to be complemented with an ethics of justice.

Whilst positionings in the mentoring sessions were often ones that placed the women in unequal power relations within apparatuses of patriarchy, colonialism, or pastoral power, there were a few times when women were positioned within a relationship of conversational care. Mentors did this by discursively positioning themselves alongside the women and provided recognition of their needs and difficulties. This was done through asking about, and listening to, women's narratives of their struggles. The use of open-ended questions is a well-known counselling technique that was used by two mentors to enable women to talk about their difficulties, and the mentors were then able to provide empathy. Empathy occurs when a conversational partner positions themselves with, rather than opposite the speaker, thereby reducing power differentials.

The mentor below was skilled at using the open-ended feeling question - "how do you feel…" and may have had some basic counselling skills training previously. This excavation of affect is a mainstay in the apparatus of counselling.

Mentor Thobile; Client 1

1. *M: so ingaba uziva njani ngoku khulelwa kwakho ngoku (*so how do you feel about being pregnant)
2. (3)
3. C: *Ha::yi ndiziva right* (.) *ndothuka ekuqaleni kodwa ngoku sendamkela ukuba ndikhulelwe* /mmh/ mmh (No I'm fine (.) I was shocked at first but I have accepted that I am now pregnant/mmh/ mmh)
4. M: Okay *but kengoku yakuphatha njani lonto xa sewuyazi kengoku ok ke wothukile then ikuphethe njani lonto ngoku* (.) *uyayamkela ngoku intoba ukhulelwe* (okay but how did that make you feel now that you know after you got the shock how are things now (.) have you accepted that you are pregnant)
5. C: *Ewe kuqala ndandingayamkeli kuba ndandifuna mhlambi ndandifuna ne-form uba ndifilishe iform uba ndenze i-abortion* (.) *but ekugqibeleni wathi umama intobana ha a xa sele ekhona ukhona umntana /mm/ sawusesibone ukuba masithini na* (Yes at first I didn't want to accept it because I was even trying to get forms to apply for an abortion (.) but in the end my mom said that I shouldn't do it it's already done we will see what we can do)
6. M: mm *kungenziwa abortion* (mm and not do an abortion)

7. C: Mm
8. (1.5)
9. M: okay

In this extract, the mentor started by asking an open-ended question about the client's feelings about being pregnant. This question did not prescribe how the client "should" feel, which allowed the client to express her shock when she initially discovered that she was pregnant. There was a significant silence of three seconds (line 2) before the client answered. Conversationally, this would have put pressure on the mentor to fill the space, and yet she was able to hold the silence, allowing the client space to think, until she was ready to talk. This would have positioned the client as having something worthy to say and indicated the mentor's desire to hear about the client's feelings.

In utterance 4, the mentor gave a rather convoluted response to the client's answer about being shocked at first but now accepting her pregnancy. Possibly, the mentor felt an anxious need to continue questioning the client, and so asked if the client had accepted the pregnancy, despite the client's answer in utterance 3. This made it clear what the "preferred" response was: that of accepting the pregnancy. Despite this, the client was still able to expand on her experience of discovering that she was pregnant and talk about her initial desire to abort the pregnancy (utterance 5). The mentor received this information without judgement ("mm"), and merely reflected back the client's final decision to not abort (utterance 6), There was then another silence of 1.5 seconds, which would have allowed the client to say more if she wished to. She did not, and mentor then wrapped up this exchange with "okay" before moving onto another line of conversation.

The mentor's open-ended question about the client's feelings about being pregnant, her non-judgemental acceptance of the client's initial desire to abort the pregnancy, and her attentive silences all constructed the client's feelings about the pregnancy as legitimate, and as worthy of being heard. Indeed, most of this mentoring session was characterised by the mentor asking open-ended questions and listening actively (with backchannel "mm"s but minimal interruptions) to the client's responses. Due to this, her client talked about many difficulties she had, including not being able to send her older child to school as she was struggling to get him a birth certificate, and how the father of her younger child was not supporting the child in any way. Another example of this mentor's questioning style is shown below:

M: Okay, *u::hm masibule emvakancinci nhe* (.) *ingaba kengoku uqala kwakho ukuziva ukuba unalentsholongwane wayithatha njani lonto wena* (u::hm let's back track a bit (.) the first time you discovered that you were HIV positive how did you deal with it)

The client answered by telling the story of her initial diagnosis with HIV with her first pregnancy, and how her mother supported her but her partner at the time initially denied paternity. Privileging a

client's narrative is another technology within the apparatus of counselling. By enabling and receiving this woman's difficult narratives, this mentor was not only legitimising the woman's struggles, but also assisting her to process and metabolise her difficulties. In this manner, the mentor was providing significant care to the woman.

The extract below is from the same mentor with a different client. The client had just been talking about her financial difficulties as neither she nor her partner were working.

Mentor Thobile; Client 2

M: So *kengoku ifamily yakho xana kukho ezingxaki zinje iziva njani ingaba iyancedisa yona* (So since you are experiencing these challenges how does your family feel do they support you)=

C: = *yho yho yho iyafana noba awuthethi xa uthetha nge-family yam* [chuckle] (yoh yoh yoh you might as well not mention my family)

After acknowledging the client's challenges, the mentor probed about whether the client had support from her family. Although the mentor added a closed-ended question onto her initial open-ended question, which indicated what the "preferred" answer was, the client was able to resist the preferred response, and talk about her struggles. The quick answer from the client indicated that she was eager to talk about the fact that her family was unsupportive. Her repetition of the interjection "yoh" added exclamatory weight to her answer, and she went on to detail how, since she disclosed that she was HIV positive, her family were no longer supportive of her. She told a long narrative about how her sister and sister's children were supported by her mother, but she and her children were not, and the only person she could lean on was her partner. The mentor listened actively without interrupting. The extract below continues from the end of the client's narrative:

1. C: ...*so bona ngabona basupportwayo nguye* (so they [sister and children] are the ones who are being supported by her)=
2. *M: =umamakho* (your Mom)
3. *C: =umamam uhoye bona kunam (.) abe yena engazi nanto endlini because yena akhonto eza nayo kuqala but ngoyena endibonayo ukuba uthando likuye mna andinalo [uthando* (by my mom she is more interested in them than me (.) even though my sister doesn't bring anything to the table because she really doesn't contribute anything but she is the one who gets all the [love)
4. M: [*awusajongelwanga [ntweni* (you are insignificant)
5. C: [*andisajongelwanga [ntweni ngoba akhonto ndi* (I am insignificant there is nothing I) =
6. M: [ever since *wachaza istatus sakho*=(ever since you disclosed your status=)
7. C:=mmh
8. M:= mmh

9. C: *Akhonto nento endinoyenza mna ayibalulekanga* (nothing I do is significant to them
10. (3)
11. *M:* Mmh
12. *C: Injalo (.) so andinayo ifamily andinaye umntu wasekhaya endinothi endinokhalela kuye /mmh/ ukuba akukho ukutya apha endlini akukho (.) if andiyanga kwamheza umheza wathi akanayo into ndizaw- uba utata akayifumenanga ijob ndizawuhlala* (That's how it is (.)so I don't have a family I don't have someone from my family I can cry to /mm/ if there is no food here then that's that (.) if I don't get anything from the neighbours or the father of the baby doesn't get any job then we go without)
13. M: Mm [rising tone] *ube unomntana omncinci uncancisa* (especially because you are breastfeeding)
14. C: Mm:
15. (3)
16. M:Mm:
17. (2)
18. M: That's bad news (.) *so xana kengoku utata womntana ezazi ezindaba zoba ifamily yakho ayihoyanga nto ngawe uye azive njani yena because naye lento iyamaffacector utata womntana* (that's bad news (.) so when the father of the child hears about the issue with your family and how they don't care about you how does he feel about it because it affects him as well)

[Client proceeded to speak about how her partner reacts and how they support one another]

In utterance 2, the mentor clarified that the "her" that the client was referencing was the client's mother. In this way, she was ensuring that she got the facts of the story straight, and the client would have known that she was listening closely. In utterance 4, the mentor interjected with an interpretive statement "You are insignificant". She had been listening closely prior to this extract, without interrupting, so now had a good grasp of the narrative. She introduced a new word to the story ("insignificant") to expand on how the client felt, and this clearly resonated with the client, who immediately repeated the phrase "I am insignificant" in utterance 5 and expanded on it in utterance 9 ("nothing I do is significant"). The mentor then held a silence of three seconds (line 10), allowing the pain of what had been said to sink in, and the client then talked some more, summing up her narrative with "that's how it is". This implied that there was nothing that could be done about the situation. In her response, the mentor had a rising tone (utterance 13), indicating her own strong emotions as she listened to the client. Her tone was possibly an expression of anger at the client's family, and at the injustice of a breastfeeding woman going hungry. Her expression of affect indicated that she was positioning herself within the client's narrative, which would have given the client a sense of affective support. More silences followed before the mentor asked about the client's partner's reaction. This led to some redemption in the client's story, as she proceeded to talk about how she and her partner support one another in their difficulties.

Through active listening, and an honouring of the client's story, the mentor, above, positioned herself with her client by entering the pain of her client's situation, offering empathy and understanding. Other mentors occasionally managed to provide some elements of empathic care, but their lack of training, and their need to position themselves as knowers and regulators of the women, in other words, as opposite their clients and with greater power, kept getting in the way of positioning themselves in alignment with the women. The mentor, below, was able to grasp some of the relational struggles that her client was experiencing before lapsing into a standard regulator position.

Mentor Namhla; Client 1

1. M: Ok, so *i-i-imvisiswano phakathi kwakho notate wakho ikhona* (Okay, so how is your relationship with the father of the child do you get along)
2. C: *Kancinci nje kodwa likhona ixesha loba sixabane nje* (Just a little bit but there are times when we fight)
3. M: Mm *xa nixabana mhlambi sube kutheni inoba kuzube iyintoni mhlambi enixabanisayo* (Mm so what do you usually fight about when you fight)
4. C: *Mhlambi kucingela yena* (.) *zikhona izinto ahamba eziva mhlambi apha endaweni* /mmh/ *ubana mna kukhona into endizenzayo like ukujola* /mmh/ but *ke ufuna ukuqinisekisa ngalonto ndithi xa ndimcacisela ngalonto enyuke* (maybe it's being suspicious (.) there are things that he hears from around the area /mm/ and then he usually just wants to find out more about it and then when I try to explain it then he would get angry)
5. M: O::h so *ungumntu ongakuthem[banga* (so he doesn't trust you)
6. C: [*ewe akandithembanga* (yes he doesn't trust me)=
7. M: Okay *ke sisi hayi ndiyakuva ke nontombi* (.) *so ithi ke lento nihlelisene* (.) *nihlala nobabini mos nhe* (okay dear I hear you (.) so that means you're trying to make it work (.) you live together right)
8. C: *ewe* (yes)
9. M: *Okay ke nana* (.) *ubusowu-bookishile mos* (okay dear (.) so you have already booked right)=
10. C: *ewe*

    [Mentor then proceeded with the standard "regulatory" questions and speeches as to how the client should manage her pregnancy]

In the exchange above, the mentor asked an open-ended question about her client's relationship with her partner (utterance 1). Although she then followed up this opening question with a leading question ("do you get along"), which gave the message that she wanted the client to agree that she got along with her partner, the client was able to comply with this pressure to an extent ("just a little bit") yet still respond to the opening question by mentioning her struggles: "but there are times when we fight" (utterance 2). The mentor then enquired further (utterance 3), which led the client to expand on one of their difficulties (utterance 4). In utterance 5, the mentor gave an interpretive summary of the client's narrative by saying "so he doesn't trust you". Through an initial open-ended

question, followed by probing and listening, the mentor came to understand one of the issues that the client was struggling with and reflect this understanding back to the client. This was clearly an accurate reflection of what the client was feeling, as she answered quickly with a strong agreement (utterance 6), before the mentor had finished her turn. The understanding manifested by the mentor's interpretation was an act of care for the client in her relational difficulties. Unfortunately, the mentor then left no space before taking up her next turn (utterance 7), and she then reverted to positioning the client as an ignorant child in need of regulation.

The mentor, below, was able to provide some care to her client through the simple act of positioning herself as having faced a similar struggle with her infants as the client was having.

Mentor Nomvuyo; Client 2

[baby cries]

1. M: *Nanku esiza mthathe umfake ebeleni* (laughs) *sothetha ngoku alapha wena akhongxaki* (.) *yiboy kaloku lena iboy xa kukho umoya abanjena (*There he is coming take him and breastfeed him (laughs) we will talk while he is here it's not a problem (.) he is a boy and they are like this when it is windy)
2. C: [to the baby] *Tshini bawo ngoku ndikushiye ulele* (oh my goodness I left you sleeping)
3. M: *Xa kukho umoya abanjena amaboy awonwabi* (.) *kuthwa yintoni ngumhlengetho* /mmh/ *kuthwa mninzi emakhwenkweni* (When it is windy all boys are not happy (.) they call it *umhlengetho* /mm/ and they say that boy babies have a lot of it)
4. (1)
5. M: *Mfake ebeleni* (Put him on the breast)
6. C: *Uyaloyika* (he is scared of it [the wind])
7. M: *Ewe kutshiwo kuthwa bangamagwala bona bangamakhwenkwe* = (Yes they say that boys are cowards=)
8. C: =*Ewe*= (Yes)
9. M: =*nam ndakhe nam kwababam nam bendisandulo banamawele mos ana-two years ngoku* (I also had it with mine I just had twins they are now two years old=)
10. C: *Ewe*= (Yes)
11. M: *Benjalo bebekhathaza* (they were like that they used to be bothersome)
12. C: Yho
13. M: *Kuthwa bayawoyika kakhulu umoya ababantwana bangamakhwenkwe*... (they say that boys are scared of the wind…) [Mentor then proceeded to give a long speech on how the woman should continue abstaining, and how she should look after the baby. No enquiries about how the woman was doing]

Although this mentor was able to momentarily position herself in alignment with the client, through talking about how she also had bothersome infants (utterances 9 and 11), this positioning was also used to bolster her own "knower" position: she knew why the client's baby was unsettled, because she, too, had had such babies. The care that she could have provided would have been so much deeper if she had been trained in a "not knowing" stance, as narrative counselling traditions

emphasise, and if she could have wondered with the client as to why the baby was unsettled, how often he was like this, and how this affected the woman.

This section has shown how the use of some basic counselling skills provided significant emotional care to a few of the clients. The next section will look at one time in the mentoring sessions when a women was positioned as agentic. This is a necessary position for women to inhabit in order to overcome some of their difficulties.

5. Women as agentic

There was only one instance that I could find in all of the data where the woman was positioned as agentic, and this was in a portion of a mentoring session. Agency is an important aspect that women need to overcome disadvantaging conditions, and foregrounding narratives where women are positioned as agentic will assist them to inhabit such a subjectivity. In narrative therapeutic terms, it is important to "thicken" narratives where people have acted against their problem (White, 2007). In the extract below, the mentor identified and highlighted her client's ability to resist drinking, despite living with people who drink.

Mentor Zukiswa; Client 3

1. M: *Enyi-challenge endiqonda uba wena unayo although ukwazile ukumelana nayo yile yohlala nabantu abaselayo ube wena ungaseli* (.) *but ukwazile* (.) *ndifuna ukwazi iku-affecta njani lonto leyo wena* /ok/ *iku-affecta kanjani* (A challenge that I think you might also have although you managed to withstand it is living with people who drink alcohol even though you do not drink (.) but you withstood (.) I would like to know how that affected you /ok/ how did it affect you)
2. C: Like (1*) Kuba kuqala nhe* /mmh/ *bendihlala nabo like /mm/ xa besela nam ndisela uyabo* /mmh/ so *xa besela sometimes /mm/ ndiye ndibawele ukhubone* /mmh/ *ndibawele ndiqonde hayi ngoku ndiyazincama but ndiphinde* (Like (1) because at first right /mm/ I would hang out with them when we were drinking you see /mm/ so when they drink sometimes I feel tempted /mm/ I feel like having some as well like just giving in to the temptation) =
3. M: *kubekho lento ikunqandayo* (but something stops you) =
4. C: =*mandikhe ndiyeke uyabo* /mmh/ *and* (1) *like ukuhlala nabantu abenza into oyiqhelileyo kunzima* /mmh/ but *kwelinye icala xa wena uzazi uba /mm/ ufuna ntoni like uzixelele ngoku ebomini bakho uba ngoku ndifuna uphumana nento ethile ndifuna ujongana* like according to *ubomi bam ngoku* /mmh/ *abuphelanga* /mmh/ *kum ingathi* it's a new beginning */mm/ uyabo,* so *ndiyayazi uba ndifuna ntoni* /mmh/ *ndiyazazi uba ngomso ngaske kuthi* /mmh/ *so:: ewe bayandi-affecta but andi::* (I decided it's better not to /mm/ and (1) like being around people who are doing something that you also used to do can be difficult /mm/ but on the other hand when you know what you want and have told yourself that at this point in your life this is what you want to quit and that is what you want to focus on as per my life /mm/ it's not the end of the world

/mm/ in fact to me it feels like a new beginning so I know what I want /mm/ I know what I want for my future /mm/ so:: yes it does affect me but I don't::) =

5. M: *Awu-affecteki* (it doesn't really affect you) =
6. C: =*andinalo ixesha labo andibahoyi* (.) *ewe bakhona abanye abebede bandibuza uba haybo kutheni wena ungayi endaweni ethile* /mmh/ *abanye abantu sebeyile nje kwezondawo banabantwana bayafana nawe* /mmh/ *mna ndingu [*name] *bona bangabo /mm/ ayibaleki lanto yinto ezawuhlala ikhona /ja ja/* so *uba ndizawuthi mna ndileqa kuyo kanti ndileqa ngexesha eli wrongo /mm, mm/ndizawushiya abantwana bam ngasemva* /exactly/ *then kengoku mna* I've decided *ukuba ndifuna ukuphilela abantwana bam nam [*upward intonation*]* (I don't have time for that I don't pay attention to them (.) yes there are some who actually even ask me why I don't go to certain places /mm/ they even compare me to others who gave birth around the same time as me and are back in those places /mm/ but I am [name] and they are themselves those places and those things are not going anywhere they will always be there /yes yes/ so if I'll decide to rush to those things at the wrong time then I will leave my children behind /exactly/ so I have decided that I want to live for my children and myself) [upwards intonation]
7. (2) M: *Uyaz[iphilela* (you're living for yourself)
8. C: *[Ndifuni into endizawube ndisithi ndenza into eyenziwa ngobani* /mmh/ *ja* (I don't want to do something just because other people are doing it /mm/ yes)

Although this mentor was generally very committed to inhabiting a "knower" position and spent much time in her sessions giving (sometimes erroneous) information on topics such as breastfeeding, HIV medication, and so on, in this instance she was able to identify the client's agency in moving out of drinking behaviour. She opened the line of enquiry by identifying and asking about the client's ability to withstand the pressure to drink ("but you withstood" - utterance 1), which positioned the client as strong and independent. This invited the client to build on this positioning, and she did so by telling a classic "conqueror" narrative, where she positioned herself as a vanquisher of the pressure to drink.

Using a chronological structure, the client first talked about how things used to be - "at first I would hang out with them...sometimes I would feel tempted…" (utterance 2). Aided by the mentor, who moved the story along by saying "but something stopped you", the client then spoke about her decision not to drink - "I decided it's better not to" (utterance 4). This positioned her as rational and determined. She talked about the hardships she faced in taking this decision - "being around people who are doing something that you also used to do can be difficult" - which reinforced her positioning as a conqueror, and she then drew off liberal and individualistic discourses, which emphasise "knowing yourself", to elaborate on how she achieved success: she knew what she wanted, and what she wanted for her future (utterance 4). In utterance 4 she used the phrase "I/you know what I/you want" five times, building up to an emphasis the fifth time round - "I know what I want for my

future...” The client’s narrative moved from her past status (“at first”) through the struggles which she had managed to conquer, to a present reality (“it feels like a new beginning”), and with an eye to the future.

The client continued to flesh out her positioning in utterance 6 as someone strong enough and independent enough to resist ongoing peer pressure to drink. Whilst the pressure does affect her, she “doesn’t have time for that”, indicating that she has more important things to attend to. Her statement “I am [name] and they are themselves” reinforced her identity positioning as separate from the drinkers. She ended utterance 6 with an upwards intonation as she stated that “I want to live for my children and myself.” This intonation suggested that she had more to say on the topic. The mentor, helpfully, waited for two seconds before replying, which would have allowed the client to say more. When she did not, the mentor partially repeated the client’s last utterance, and the client then intervened to conclude her self-positioning (utterance 8) by re-stating her desire to act independently of others (“I don’t want to do something just because other people are doing it”).

In this exchange, the mentor and client co-constructed a narrative of the client being strong, agentic, independent, and living for herself and her children. Positioning within such a narrative is helpful to assist people to move away from positions within discourses that lead to problematic behaviours. Given that we cannot exist outside of community, it would also have been helpful if the mentor had enquired as to whom the client could align herself with. In distancing herself from drinking peers and family members, she would have needed to move towards others who embodied more helpful behaviours, in order to resist falling back into drinking.

6. Conclusion

In this chapter, I started by reviewing the concept of an ethics of care and justice, which I suggest needs to undergird FASD interventions. I went on to detail ways in which drinking pregnant women were positioned as affected by social injustices and a lack of care during training sessions and in interviews. In terms of social injustices, women were positioned within two main discourses: the cultural hegemony of drinking, and structural injustices like unemployment, poverty and boredom, of which the cultural hegemony of drinking was the most prominent. One interviewee drew off a patriarchal discourse to explain prenatal drinking, and three interviewees positioned women as ignorant of the teratogenic effects of alcohol. These social injustices that participants identified indicate areas that interventions to reduce FASD should target.

Drinking pregnant women were also positioned as suffering from a lack of care, with trainees and interviewees referencing relational difficulties, intimate partner violence, and affective difficulties as

contributing to their drinking. It is in these areas that the mentorship programme of the Organisation has the potential to offer conversational care. However, times when women were positioned within a relationship of conversational care in the mentoring sessions were not frequent. When it did occur, it was achieved through enquiring about, and listening to, women's stories of their struggles, thereby recognising and understanding the women's realities. The mentors who managed to do this utilised the basic counselling techniques of active listening, open-ended questions, reflection, and a non-judgemental stance. In order for this caring position to occur, the mentors' preferred stances of "knower" and "regulator" needed to be set aside so that they could position themselves in alignment with the women, as respectful and empathic listeners, rather than opposite the women as teachers or judges. There was one instance in the mentoring sessions when a woman was positioned as agentic, as her mentor identified her agency in resisting drinking, and she and her mentor then co-constructed a narrative which positioned her as a conqueror of the pressure to drink. This co-construction of a hopeful, agentic narrative with people in difficult circumstances resonates with Narrative Therapy principles (White, 2007). If mentors were trained to listen out for even small acts of resistance against injustices in women's narratives, this would have assisted women to recognise and enhance their own agency.

In this chapter I have highlighted some ways in which drinking pregnant women may be positioned within an ethics of both justice and care. In the next and final chapter of this thesis, I give a synopsis of the main aspects of this work. I draw out the likely consequences of all the positionings of drinking pregnant women by the Organisation, which have been detailed over the last three chapters. I then provide recommendations for how interventions could position themselves, their personnel, communities and women in manners which promote women's agency, counter injustices, provide care, and recognise the interdependence and relationality of all people.

Chapter 9: Conclusion and recommendations: an ethics of care and justice, and decolonial feminist psychology

1. Introduction

I start this chapter by highlighting the inadequacies of FASD interventions in South Africa, and I suggest that FASD cannot be meaningfully addressed in this country without looking at broad societal factors that promote risky alcohol consumption by all members of the population, not just pregnant women. I go on to provide a synopsis of the literature on FASD interventions, before reviewing the rationale for this research, the methodological approach, and the theoretical paradigm within which it is situated. I then draw together the findings of this research as to how the Organisation positioned pregnant and newly parenting women who are affected by alcohol use, and I suggest that a number of negative consequences may arise from their dominant positionings. The bulk of this chapter is then devoted to providing recommendations for interventions at macro-, meso-, and micro-levels. I divide these recommendations into country-wide policy and intervention recommendations, and specific FASD intervention recommendations. I close this chapter, and thesis, with a discussion of the contributions that this research has made at various levels, and its limitations, and suggestions for future research.

2. The inadequacy of FASD interventions in South Africa

With some communities in South Africa carrying the highest recorded incidences of FASD in the world, estimated to be in the region of 20 – 28% (May et al., 2017), interventions that reduce alcohol consumption during pregnancy are a critical public health necessity. However, such consumption cannot be separated from the contextual factors within which pregnant women are located. Major factors include the cultural hegemony of drinking in some communities, particularly binge drinking, as well as endemic poverty, lack of service provision, and lack of healthy spaces for social interaction. It has been estimated that, amongst drinkers, South Africa has one of the highest incidences of alcohol consumption in the world (World Health Organisation, 2018), and without

addressing this, interventions focussing on reducing pre-natal alcohol consumption will not only be relatively futile but will continue to place unjust burdens of responsibility on pregnant women.

The World Health Organisation (2018) reported that increasing taxes on alcoholic beverages, restricting advertising, and comprehensive, countrywide restrictions on sales of alcohol reduces alcohol related harms, but such measures have not been leveraged maximally in South Africa (Adebiyi et al., 2021). Existing laws, such as requiring liquor outlets to be licenced and to operate only during sanctioned hours, are poorly enforced. Furthermore, the population wide interventions that do exist in South Africa to reduce alcohol related harms rely on awareness campaigns that provide knowledge and urge people to "drink responsibly", in other words, to take individual responsibility for their health (with blame accruing if they fail), despite the well documented failure of such campaigns to reduce alcohol consumption by heavy drinkers (Young et al., 2018). Given the anxieties and surveillance that already exist around pregnancy, such awareness campaigns can perpetuate a moral panic (Bell et al., 2009; Salmon, 2004) around pregnant women who drink alcohol, far more so than other drinkers who may experience or inflict alcohol related harms, such as domestic violence or motor vehicle accidents.

The alcohol reduction and FASD interventions that exist in South Africa are primarily run by NGOs, which rely on fundraising from private donors and governmental departments. Hence, their reach is limited, and there is no broad oversight of their approaches and programmes to ensure that they are following best international practices. There is no coherent governmental policy on FASD (Adebiyi et al., 2021), and service provision for disadvantaged women is inadequate and uncoordinated. For example, women need to access: a Health Department clinic for contraception and maternal and child healthcare; the Department of Social Development to obtain childcare grants; an NGO or social worker in the Department of Social Development for assistance with domestic violence, mental health and substance use difficulties; the Department of Justice for orders pertaining to child maintenance from a pregnancy partner, and for restriction orders; and the South African Police Service to enforce such orders if a pregnancy partner is not compliant. This takes a considerable amount of time, travel, and persistence, especially for women living in rural areas. Some recent initiatives in Canada are providing "wrap-around" services to "vulnerable"[43] women and their young children, where they can access multiple health and social services either at one site, or at a centre that coordinates these services (Rutman & Hubberstey, 2019). Not only does this model allow better

[43] I put this word in inverted commas as vulnerability is usually conceptualised as an internal attribute of a person. In line with Treharne et al. (2018) I understand vulnerability to arise due to multiple injustices to which a person has been subjected, so the inverted commas function to problematise the notion of "vulnerability".

access to critical services, but it can also provide a sense of community and social support amongst women, which is crucial to assist women in overcoming difficulties they are facing.

Factors that have been identified in the literature as contributing to alcohol use during pregnancy, as discussed in Chapter 1, section 4, include: social norms around drinking; alcohol consumption by male partners and family; maternal stress levels and exposure to trauma; a lack of emotional attachment to the pregnancy; and alcohol use disorders. These factors are all inter-related, and poverty is often a common denominator. Pregnancy outcomes for comparable consumption of alcohol are significantly worse in low socio-economic settings compared to middle or high socio-economic settings, and while the mechanisms for this are not well understood, poor maternal nutrition has been conclusively identified as a contributory factor to the development of FASD. If interventions urge pregnant women to stop drinking but there is scant regard for these potentiating factors, the interventions are unlikely to have a positive impact.

While the event of pregnancy often results in a woman reducing her alcohol consumption, pregnancy recognition frequently only occurs in the second trimester in impoverished settings in South Africa (de Vries et al., 2016). In small communities, confidentiality may be compromised when visiting a clinic for contraception or a pregnancy test, and young women may face scolding by clinic nurses if they request these services (Feltham-King, 2015; Wood & Jewkes, 2006). Clinics are only open during office hours, and patients frequently face long queues before being attended to. Certain services (such as reproductive care) are often only available on particular days of the week. As well as possible psychological resistance to finding out her pregnancy status, impoverished women face many structural barriers to accessing pregnancy tests and contraception (Feltham-King, 2015; Wood & Jewkes, 2006).

All of these factors need to be addressed in a coherent manner if the incidence of FASD is to be reduced in South Africa. I provide some suggestions for interventions towards the end of this chapter.

3. Synopsis of the literature on FASD interventions

Interventions that aim to reduce FASD can be classified into two broad types: universal interventions (also known as population level or public health interventions), which target a whole population or community and aim to increase knowledge of the teratogenic effects of alcohol and shift drinking norms; and clinical interventions which target individuals who are considered to be at risk of having an alcohol exposed pregnancy. Both quantitative and qualitative studies on FASD interverventions, which were discussed in Chapters 2 and 3, are sparce, and many lack methodological rigour.

However, the limited evidence available suggests that well designed, well implemented universal and brief clinical interventions (one to four sessions) can increase knowledge and may lead to a reduction in drinking by episodic and non-dependent pregnant drinkers. Messages should include both risk-based messages (known in the literature as threat-based messages[44]), which accurately communicate the risks of pre-natal alcohol consumption, and also self-efficacy enhancing messages, which aim to increase the target audience's confidence that they can engage in the recommended adaptive behaviour. Self-efficacy enhancing messages have been shown to decrease psychological resistance to the risk-based message. More intense clinical interventions are required for heavy or dependent drinkers. Some clinical interventions that target non-pregnant women who are judged to be at risk of an AEP due to ineffective contraceptive use and heavy alcohol consumption have shown improvements in contraceptive use. Clinical interventions that have shown some evidence of success have used well-trained service providers who follow motivational interviewing (MI) techniques in their clinical encounters with women. MI is an evidence-based counselling technique for working with people with substance use disorders. It focuses on being entirely non-judgemental, helping the person set their own goals regarding substance use, and supporting them in their journey towards these goals.

Critiques of interventions in the international literature, which I discussed in Chapter 3, highlight how they can inadvertently reinscribe unjust power relations. Authors point to how such interventions often take an individualistic, risk-management approach which locates responsibility for the harms caused by FASD in individual women, and which places undue responsibility on them for overcoming the disadvantages that accrue to them from social injustices. According to Foucauldian thought, modern power relations function largely in secret to construct "neutral" knowledge, to illuminate individuals, and to judge such individuals according to socially constructed norms as either "normal" or "abnormal". Many FASD interventions unwittingly construct women who drink during pregnancy as morally degenerate, and as existing outside normality.

Within this risk management approach of many FASD interventions, the foetus is, for the most part, conceptually separated from the pregnant woman. With the aid of photo-shopped foetal photography, it is constructed as an independent human in its own right. This can lead to the pregnant woman being positioned in opposition to her foetus, with her needs and desires being subsumed in pursuit of maximising the health of the foetus. Male pregnancy partners are usually relatively invisible, and there is no mention in universal interventions of the negative effects of alcohol on sperm health. Although harm reduction approaches have been shown to be more

[44] I prefer the term "risk based messages" rather than "threat based messages" as the latter term assumes a power hierarchy between messenger and recipient.

effective than abstinence-based approaches in reducing the harms associated with alcohol use, many interventions still focus on messages of abstinence. There are a large number of studies examining the effects of low to moderate alcohol use during pregnancy, with no conclusive results as to whether such consumption causes foetal harm. These studies in themselves perpetuate social injustices: resources are spent trying to increase knowledge of minutiae to enable exact classification, while there is a dearth of research on attempts to address the well-established effects of poverty and trauma on pregnant women. There is also a relative lack of engagement with the social motivators and pleasures of drinking, and an ongoing marginalisation of disadvantaged women.

4. Rationale for this research and methodological approach

Whilst quantitative studies are required to understand the overall effectiveness of an intervention on its target outcomes, they necessarily look at aggregated data, and are less sensitive as to which aspects of an intervention are helpful and which are not. Qualitative studies are better able to provide this specificity. Formative evaluations assist with intervention development to try and ensure that resources are not unnecessarily spent on aspects of an intervention that are counter-productive or ineffective, to maximise helpful aspects, and to identify any barriers that may impede intervention rollout. With the introduction of a pilot FASD intervention in the Eastern Cape, a qualitative formative evaluation of this intervention was indicated.

As well as the formative evaluation that I provided to the Organisation (the recommendations of which are given in section 6 of Chapter 5), I engaged in a critical discursive analysis of the data to highlight the manners in which pregnant women were being discursively constructed and regulated by the Organisation, and how pregnant women responded to these constructions and regulations. This enabled me to make recommendations on how the intervention could be adjusted to provide more helpful positions for drinking pregnant women. I collected four different types of data from the Organisation's intervention: their training materials; recordings of training sessions for community members; recordings of interviews with people being trained and Organisational personnel; and recordings of mentoring sessions. I used Foucauldian Discourse Analytic methods (FDA) to reveal the dominant power apparatuses that were being brought to bear to position pregnant women, and the specific technologies that were at play. FDA enables an in-depth analysis of these power relations. However, an FDA does not illuminate how such power relations are used agentively during interactions by subjects to position themselves. Therefore, I used Conversation Analytic techniques on sections of data from mentoring sessions to reveal the micro-processes that mentors and women used to position themselves, each other, and foetuses and babies.

I chose to use FDA and CA methods separately, rather than combining them into a synthetic or hybrid method, for two reasons: the nature of my data, and the depth of insight that each method provides in their pure form. Regarding the nature of my data, some of my data were not interactional, so did not lend themselves to hybrid methods which look at interactional processes as well as wider discourses. In terms of the insights afforded by each analytical method, FDA enables a deep understanding of the power apparatuses that organisations and institutions use, sometimes unwittingly, to achieve their goals, and my use of this method brought into sharp relief the apparatuses of power that the Organisation used in their training. These apparatuses were then used by mentors in their mentoring sessions to position women, using varying technologies of the self. I analysed what I believed to be power relations that were unjust and uncaring, but in order to lessen my “theoretical imperialism” (Schegloff, 1997), I needed to see how women actually responded to these power relations and positionings, and whether my assumptions regarding the ethics of the power relations were verified in the in-the-moment interactions within mentoring sessions. CA gave me a lens with which to view their responses.

Regarding CA, this method rests on a large body of empirical evidence regarding what particular conversational moves achieve interactively. It has been widely used to analyse talk in institutional settings and to provide recommendations on how institutional representatives (such as medical personnel and call centre responders) can more efficiently and effectively achieve their goals through modifying some of their talk. I used CA on portions of mentoring sessions to show how the discourses which encoded the technologies of power were deployed by mentors to position themselves and the women. The women’s responses to the subject positions provided by the mentors were uniquely captured by CA techniques, which made visible their (usually quite subtle) resistances, as well as their uptake or modification of positions in-the-moment. Using insights from each analytical method, I was able to show how the apparatuses of coloniality, patriarchy and pastoral power inflicted injustices and resulted in “violent relationships” (Bevir, 1999) within the mentoring sessions.

The overarching research question that guided my analysis was: What power apparatuses and technologies were used to discursely position pregnant women during the intervention, and how may these positionings be altered or expanded to promote an ethics of care and justice? Specific questions were as follows:

1. What discursive subject positions were evident during a FASD prevention intervention?
2. What power apparatuses and technologies innervated the construction of these positions?

3. What power relations were evident in the conversational practices used in the mentoring sessions of the intervention, and what positions did this lead to?
4. How may these positions and conversational practices be altered or expanded to promote an ethics of care and justice for pregnant and newly parenting women?

5. Theoretical paradigm

My approach to this study was from a social constructionist and critical feminist standpoint. Social constructionism understands social and psychological realities and knowledges to be constructed through social processes, and within this broad school of thought, critical feminism aims to uncover taken-for-granted power vectors that can inadvertently cause or contribute to social injustices, particularly against women. Literature has identified that it is women who are disadvantaged, often in multiple intersecting manners, who are most at risk of bearing a child affected by FASD; hence, it is critical for any FASD intervention to ensure that it is not perpetuating micro-injustices against the very women they are purporting to assist, and that they are, rather, working to bring about social and reproductive justice for their target population.

Within an understanding of the socially constructed nature of social and psychological realities, including human subjectivities, I used Foucauldian and some post Foucauldian theories to understand how the person may be conceptualised as both a constituted subject and an ethical subject. The constituted subject is one who is constituted by being positioned within prevailing power relations, operationalised through discourses. This can be seen as top-down positioning. The ethical subject is one who is able to reflect on their positions, and, within the constraints of the dominant discourses in their environment, has some limited agency, or freedom, to position themselves in varying ways by complying with, resisting, or modifying the constituted positions. This can be conceptualised as bottom-up positioning. However, along with the discursive constraints of available positions, human embodiment always and necessarily sets limits as to which positions a person can take up. Guilfoyle (2014) understood these embodied limits as negative resistance to certain positions. Nevertheless, with a pre-discursive drive to be constituted discursively, the person cannot remain “un-positioned”, so they either move into a different position, or modify the existing position in an act of positive resistance. Ethics, in a Foucauldian economy, is “the conscious practice of freedom” (Foucault, 1997c, p. 284). I believe that the ethical task of social and psychological interventions is to enhance the freedom of others through enlarging the ensemble of subject positions available to them, primarily by reducing social injustices, and to promote their agency to position themselves within available subject positions.

Regarding the constituted subject, I used Foucauldian theories of power relations to illuminate how the Organisation positioned pregnant and newly parenting women. Foucault understood apparatuses of security, or what I call power apparatuses, to be broad networks of loosely aligned and disparate discourses, organisations, architectures, laws, policies, moral propositions, and so on, that enhance the power of the state to produce productive and docile citizens. Apparatuses are the macro-structures of power relations, and I analysed which apparatuses were dominant in the Organisation's construction of pregnant women. Techniques, or technologies, are the capilliary functions or micro-physics of power relations (Gough, 2008) that are brought to bear on individuals and societies to operationalise the reach of apparatuses. Disciplinary power includes the technologies of individualisation, ranking, surveillance, and normalising judgements and they function, largely invisibly, to constitute and illuminate subjects in a manner consistent with the aims of the prevailing power apparatuses. Technologies of the self are the ways in which power relations exhort subjects to act upon themselves, or position themselves, in ways that enhance the power of prevailing apparatuses. The brilliance of these techniques is that they insert the aims and goals of apparatuses within individuals, thus ensuring that individuals manage themselves in ways that maximise their productivity and docility, and thereby reducing the need for external control. The linkage of power apparatuses and technologies of the self is termed governmentality, whereby subjects are produced to govern themselves. In my analysis of the data collected from the Organisation, I explicated how the Organisation used various techniques to position women within the apparatuses of coloniality, patriarchy, and pastoral power. I also showed the few instances where women were positioned within discourses of social justice and care, and I suggest that these are more helpful apparatuses within which to position women to assist them to reduce alcohol consumption.

In order to understand how the ethical subject revealed itself during the Organisation's mentoring sessions, I used post-Foucauldian theories of resistance and agency to guide my analysis of how the women complied with or resisted the positionings into which they were pressed by the mentors, and also the few times when mentors encouraged women to position themselves in ethical manners. Women's freedom was severely constrained within the recorded mentoring sessions by the limited positions that were available to them, but their resistances and agency were visible through the various conversational tactics that they used to position themselves.

6. Positionings of pregnant and newly parenting women in the data

The dominant power apparatuses that were used to construct pregnant women by the Organisation were apparatuses of coloniality, patriarchy, and pastoral power. Coloniality and pastoral power were used to position the women as ignorant children in need of education and as sinners in need of redemption, while patriarchy positioned women as invisible mothers who need to be responsibilised into their duty of care. In this process, the Organisation positioned itself as a saviour and protector of foetuses, which they constructed as precious and vulnerable babies in need of protection from ignorant and/or sinful drinking women. As part of this positioning project, the Organisation constructed the person with FASD and the woman who continues to drink during pregnancy as the defiled Others – the entities responsible for societal degeneration against which society needs to guard itself.

6.1. Ignorant children and reprobate sinners

The Organisation and their personnel positioned themselves as knowledgeable adults and saviours of drinking pregnant women and their foetuses, with the counterpoint position for women being ignorant children and sinners. These were the most common positionings that occurred in the data. In the training materials, training sessions and interviews, the dominant power apparatus that constructed the knowledgeable and ignorant positions was coloniality, while in the mentoring sessions it was pastoral power that was the dominant apparatus. Pastoral power was used throughout the data to construct the saviour-sinner positionings, which at times hardened into ones of judge-criminal, where a legal apparatus criminalised drinking pregnant women for the harms caused by FASD.

The Organisation's primary means of intervention was to provide knowledge to the target communities, and through doing this it positioned itself as knowledgeable and the communities and pregnant women as lacking in knowledge, or ignorant. I regard the power apparatus underlying this positioning as coloniality. Whilst a knowledgeable-ignorant positioning dyad is also constructed by pastoral power, particularly in educational and familial settings, the specific raced context of South Africa, with its colonial history, meant that many of the discourses and technologies used in this positioning came with a colonial and raced hue. In the data, coloniality was evident through: a taken-for-granted view that Western, individualising, risk-averse and supposedly medical knowledge was superior to whatever knowledges communities contain; an assumption that the communities and women it was targeting were ignorant and simple; and the imposition of middle class methods for "doing pregnancy" on women living in poverty.

The first page of the training manual stated that the Organisation's mission is to "inform communities" with "facts" about FAS. The assumption was that "the communities" were in need of the so-called facts that they were presenting, despite research with women who drank during pregnancy showing that it is common knowledge that a pregnant woman should not drink. The Organisation was inciting communities to police pregnant women through the disciplinary technique of surveillance. The "facts" they presented were simplistic and sometimes inflated, and were repeated frequently throughout the manuals, with fonts, colours, and hyperbolic vocabulary used maximally to inflate the risks of even small amounts of alcohol consumption. Scare tactics were used to incite anxiety and emotionally manipulate pregnant women into abstaining from alcohol. Training materials assumed that the poor women it was targeting had the resources to manage their pregnancies in a middle class, individualistic, risk-averse manner, with easy access to health professionals and they promoted Western "health diets" with no attempt to contextualise their advice according to local and affordable food sources. Training sessions and interviews continued this knowledgeable – ignorant positioning. Interesting movements of positions were seen in the interviews, as interviewees claimed that they had been ignorant, as "Black" people, but now, through the training of the Organisation, they were newly inducted into a Western, knowledgeable, and powerful position.

In the mentoring sessions, the power apparatus shifted to one of pastoral power, as mentors positioned themselves as knowledgeable teachers who had the right to assess whether their clients had learnt the requisite information from them and were now obediently following the dictates of the Organisation and their mentor. These dictates were not just around drinking, but around many other aspects of pregnancy and childcare as well. Women generally complied with this ignorant position and took up a position as an obedient child who was, indeed, following the mentors' teachings. However, resistance was seen in silences, lack of engagement with what the mentor was telling them, and with taking up an already-knowledgeable position.

Pastoral power was evident throughout the data in the positioning of the Organisation and its personnel as noble saviours who are championing the rights of the helpless foetuses of drinking women. There were frequent references to the harms caused by women who drink during pregnancy, which positioned them as sinful, and as solely responsible for the harms caused by FASD.

At times, the saviour-sinner positions hardened into ones of judge-criminal, where women were criminalised for harming not only their foetuses, but also society and "the whole of South Africa" through their pre-natal drinking. A legal apparatus was evident in phrases used in the judge-criminal positoning, Women were offered a supposedly easy route away from the sinful or criminal position:

they simply had to choose to abstain from alcohol, and thereby give their child a "bright future". Choice rhetoric locates responsibility for societal ills within individuals and enables blame for those who do not "choose" the sanctioned behaviour. The population is incited to engage in technologies of the self, monitoring their own behaviour in order to produce healthy and productive citizens.

Within training sessions and interviews, blame of women who drank during pregnancy, or even gave birth to a child with any disability, was frequent. Because the once-ignorant-now-knowledgeable trainees had new-found knowledge, they now had the power to survey pregnant women and children and identify children whose mothers drank during pregnancy. Hence, they felt that they were now able to judge those who were Other amongst them. They were positioning themselves, with the Organisation, as saviours of foetuses and judges of sinful drinking pregnant women. In mentoring sessions, clients usually resisted being positioned as sinners in three primary ways: through silence; through denying any pre-natal alcohol consumption; or through positioning themselves as previously ignorant of the harms caused by pre-natal alcohol consumption. The ignorant position was a useful one for both clients and the Organisation: for clients, it absolved them from blame and aligned them with the Organisation; and for the Organisation, it reinforced their mandate to "educate" such women and save them from their ignorance.

6.2. Precious "babies", defiled Others, and invisible Mommies

Throughout the training materials the foetus was repeatedly constructed as a precious and vulnerable baby who holds "the future" in its hands. Foetal pictures and animated videos portrayed it as independent of the pregnant woman, and often as being more developed and "babylike" than it actually is at a particular developmental stage. Its needs, its vulnerability, and its importance were inflated, and the pregnant woman was only ever visible as a "mommy", in an adjunctive and subordinate position, whose entire focus and functioning needed to be on her foetus. The woman's own needs, desires, and difficulties, and all other aspects that may be part of her life were entirely eclipsed, thereby deeming them unimportant. Patriarchal and colonial apparatuses, and the disciplinarity of bio-power, animated this positioning: the ideal pregnancy happened within marriage, where the male partner was a strong, protective, agentive "daddy" who needed to guide and protect his passive, vulnerable, and childlike wife in the project of producing a "precious baby"; pregnant couples could only be delighted at the "miracle" of their pregnancy, and a strongly anti-abortion stance was promoted; although passive and invisible, the pregnant woman needed to actively take responsibility for ensuring the health of her foetus through abstaining and adhering to Westernised "healthy" habits by carefully monitoring her diet; and she needed to be entirely foetus-focussed by demonstrably loving her foetus through talking to it and rubbing her belly.

Positioned as the constitutive outside of the precious baby and the invisible mommy were the child with FASD and the woman who continued to drink during pregnancy, despite knowing better. These were the defiled Others, who were dangerous entities responsible for societal degeneration. The person with FASD, their disabilities, and the harms that they could cause to society were explicated in great detail, with no acknowledgement of the wide variation in disabilities caused by pre-natal alcohol consumption. This dangerous Other arose from the often unnamed, but always present "bad mother", who was degenerate, substance using, irresponsible, and pre-occupied with her own needs and desires at the expense of her foetus.

In the training sessions, the facilitator did her best to remain true to these constructions, although some slippages were evident when she was unable to construct the foetus as quite as precious and desirable as the training materials did. Nevertheless, she was able to be faithful to the construction of the person with FASD as the defiled Other, and the "good mother" who made the correct choice by abstaining from alcohol. The facilitator, trainees and interviewees made frequent use of the disciplinary technology of individualisation as they presented abstinence as a choice to be made by individual "mommies" who were solely responsible for the health of their foetus. The patriarchal construction of the "good mother" remained unquestioned.

This construction of the "good mother" legitimated the surveillance that mentors attempted in their mentoring sessions as they energetically tried to regulate their clients' caregiving behaviours. Using the pastoral power that the Organisation had vested in them, they usually positioned themselves as knowledgeable and strict teachers and guides, with unquestioned authority to assess their clients. Resistance by clients was not usually overt, and was shown in silences, laughter, sighs, and an occasional exasperated tone. However, one client did agentically take up an independently knowledgeable, responsible position, thereby resisting the mentor's attempts to regulate her, and another client wrested power from the mentor by asking her if she had any other questions.

These positionings of precious babies, defiled Others, and invisible mothers were not only innervated by patriarchy and coloniality, and upheld through pastoral power, but they also served to uphold these apparatuses. If the pregnant woman remains a docile, obedient, and responsible wife and mother, ensuring that she only conceives within the confines of marriage, and if her husband treats her as appropriately fragile and precious, and if she follows the dictates of Western, individualising, "healthy" behaviour, then the precious baby will grow into a productive citizen, and all will be well.

6.3. Positions within an ethics of justice and care

I argue that drinking pregnant women need to be positioned within an ethics of care and justice. I conceptualise such an ethics as incorporating reproductive justice, but I also extend this notion by foregrounding the particularities of care that women need in their reproductive journeys. An ethics of justice and care recognises the sociality and interdependent nature of all people, shaped as we are through our discursive, contextual, and relational locations. Reproductive justice highlights the social injustices that often lead to adverse reproductive outcomes, such as discrimination, poverty, gendered inequalities, violence, and restricted access to quality healthcare, and it addresses common resources that women need on their reproductive journeys. Care foregrounds relationships and the need that we all have to give and receive care in differing and particular ways throughout our lives. Care for women is particularly important during their pregnancies and early parenting due to the demands placed on them in these periods of their lives. Care is situated and specific to the individuals giving and receiving it, while justice is universalising, attempting to afford equal benefits and rights to all, and to redress injustices.

Within the data there were a few times when drinking pregnant women were positioned as being affected by social and reproductive injustices. This only occurred sparsely in the training materials but was common in discussions during training sessions and in interviews. Drinking pregnant women were positioned within three major discourses that point to social injustices, namely: the cultural hegemony of drinking, where all social and recreational life has been captured by alcohol; unemployment and poverty, which leads to stress and boredom; and patriarchy, where a woman who is abused or abandoned by her partner turns to drink as solace. Data gathered directly from the same communities (in Project Two of the larger research project) highlighted similar discourses (Macleod, Matebese, et al., 2020). The cultural hegemony of drinking was the dominant discourse in my data, and participants in training sessions and interviews spoke at length about how accessible alcohol is, how ubiquitous its consumption is, and how a person will feel excluded if they do not drink. With drinking pregnant women positioned within these discourses, they were not blamed for their drinking, but were understood to be victims of adverse social circumstances.

In the training materials, there was no reference to women needing care except when a rigid patriarchal discourse was invoked to instruct men to look after their wives when they are pregnant. Rather, women were constantly exhorted to provide care to their foetuses. However, in training sessions, when trainees were asked to discuss what may contribute to high alcohol consumption, and in interviews, some participants referenced stress from relational difficulties, and affective difficulties. This positioned women as lacking psychological and relational care.

In mentoring sessions, there was very little evidence of relational care being provided, and the mentors had had no training in basic listening and lay counselling skills. However, there was one mentor who was skilled at asking open-ended questions, listening, and reflecting back women's own positions as they shared narratives of their difficulties. This provided significant emotional care and recognition for her clients. She was comfortable with their expressions of affect and had a generally non-blaming stance. She also did not appear to feel the need to position herself as a knower and regulator, but rather took up a position as a supportive ally to her clients. Another mentor was able to position one of her clients as agentic in resisting the social pressure to drink, and the mentor and her client co-constructed her as a conqueror of the evils of alcohol for the sake of her life and that of her children. I argue that these positions of care, agency and justice need to be foregrounded in order to assist women to move away from heavy drinking.

7. Unintended negative consequences of the dominant positionings

None of the dominant positionings that were evident in the data promote care, justice, or agency. Colonial apparatuses have inflicted great harm on colonised people, including contributing to alcohol use disorders among indigenous populations. It is impossible, therefore, to bring healing or change using the same apparatus. The same holds true for apparatuses of patriarchy and pastoral power; new discourses are necessary that emphasise decoloniality, feminism, reproductive justice and care.

Positioning the pregnant woman as an ignorant child does not foster agency or creativity, which is what women need to parent effectively, especially in the kinds of difficult social circumstances within which target audiences live. An ignorant child position invites passivity, and this could be seen in the mentoring sessions, where most women passively accepted their mentor's teachings; there was no sense that mentoring sessions were assisting them to agentively care for their foetuses, babies, and other children, or to find solutions to their difficulties. There was barely any acknowledgement within the mentoring sessions of the knowledge that women already had, and had received from sources more knowledgeable than the mentors, like clinic nurses. This was ultimately disrespectful towards the women.

A position as sinful creates shame, which induces negative affect and concealment. Research with women who drank during pregnancy highlights the shame they felt, and how this did not help them to stop drinking but led to avoidance of health services, church, family, and other potential sources of care (Matebese et al., 2021). Being constructed as a sinner by this Organisation may lead to drinking women avoiding all future interventions that could assist them. The denial and concealment that shame leads to does not assist people with substance use difficulties to overcome their

difficulties; these difficulties rather require an accepting and entirely non-blaming stance that enhances a person's strengths and agency to tackle their problems.

A position as only a "Mommy" invisibilises all other aspects of a woman's life. Women were asked to take up this idealised position, as foetus-focussed, self-sacrificial, risk-averse, responsible and caring mothers, with no cognisance of the resources they lacked that made it impossible for them to do this. Women who were single, teen-aged, or who wished to socialise through the dominant practice of drinking, were shamed for being outside of the idealised normative position of the "good mother", and such shaming is the antithesis of care and justice. Shaming of women for not being "good mothers" can lead to aggressive acting out towards their children or foetuses, or passive withdrawal from them (Kruger & Lourens, 2016).

There were also negative consequences that were evident from trainees now being newly positioned as knowers and regulators of pregnant women, and saviours of foetuses. Some of them wielded their newfound knowledge in a destructive manner to judge all women who had children with difficulties as blameworthy for pre-natal drinking. Such positions also seemed to negate any inherent empathy they may have had for their clients, as the mentors felt duty-bound to "educate" and regulate women and maintain their precarious position of power over them through no acknowledgement of women's own knowledge, struggles, or strengths. Mentors also sometimes provided erroneous information. A "knower" position resulted in mentors imposing "knowledge", irrespective of whether their clients needed or wanted that "knowledge". By taking up saviour and judge positions, trainees and mentors easily slipped into blame which positioned them in opposition to the women they were purporting to assist. The pastoral power that was granted to mentors, and their efforts to insert technologies of the self into their clients, led to blame and othering if women resisted their input.

The precious baby/defiled Other constructions served to uphold patriarchy and coloniality, as the message was given that if pregnant women subsumed all of their needs and desires in the service of producing and raising a healthy child in individualistic, risk-averse, Western manners, then productive citizenry would ensue, and the social ills of crime and poverty would fall away. These constructions promoted blame and shaming of drinking women, which then easily spilled over to stigmatising all people with disabilities and their mothers. Positioning the foetus as a precious baby also resulted in blame and stigmatisation of women who terminated their pregnancies, or even considered doing so.

The Organisation's self-positioning within the training materials as knowledgeable saviour, but with simplistic, un-nuanced, and sometimes erroneous "facts" was likely to be counterproductive. As well as an uncritical assumption that simply providing information would automatically lead to behaviour change, this stance suggested that the target audiences were not able to observe instances where pregnant women drink and give birth to a healthy baby. This could lead to communities disregarding the Organisation's messages. Taking up a "knower" position without being fully cognisant of facts about FASD (such as the finding that research has consistently failed to demonstrate a link between low alcohol intake by pregnant women and adverse effects on the foetus) is dishonest. In one of our quarterly meetings with the management of the Organisation and the funders, the Organisation justified its abstinence stance by, firstly, stating their belief that two glasses can cause damage, and also by saying that women "take chances", and that they will push the boundaries of what is allowable in terms of alcohol consumption; therefore, it is necessary to set the bar exceptionally high. However, this is a colonial position, and it does not honour women's own abilities to interpret factually accurate information.

All of these positions created a huge gulf between the Organisation and its trainers and mentors on the one hand, and the communities and women they were trying to assist on the other hand, with all responsibility and blame for FASD placed squarely on individual women. With such diametrically opposite positions, help could not in actuality happen. True care and justice can only occur when power differentials are minimised, as far as possible, blame is absent, and all players are positioned in alignment with one another as they attempt to overcome an identified difficulty.

8. Recommendations for interventions

The recommendations that I present are informed by the studies and critiques of FASD interventions that I reviewed in Chapters 2 and 3, as well as from my findings in this research. My overarching recommendation is that all levels of interventions need to be informed by an ethics of care and justice. An ethics of care and justice, when applied to interventions to reduce alcohol exposed pregnancies, would, therefore, attend to the following issues: at the particular level, attention would be paid to a woman's emotional, physical, social and practical support requirements, as well as to ways in which she could be empowered in order to assist her to care for herself, her children, and others; at the social level, the multiple inequalities which contribute to injustices and AEPs would be given weight. These include poverty, gender-based violence, patriarchy, lack of access to quality educational, health and housing resources, and normative binge drinking cultures. Within this guiding principle, I provide recommendations for the Government, arguing for coherent country-

wide policies and plans to tackle alcohol related harms and FASD in an integrated manner, and then I provide specific recommendations for FASD interventions.

8.1. Recommendations for country-wide policies and interventions

International perspectives on FASD are recognising that, firstly, FASD is a major public health concern, and, secondly, that better outcomes are achieved when there is a country-wide integrated approach to research, prevention, and management of FASD (Petrenko & Alto, 2017). In South Africa, there is no specific governmental policy on FASD, although elements that speak to its prevention and management do exist in other policies (Adebiyi et al., 2021). I propose that it is necessary for the South African government to tackle alcohol use and FASD together to reduce the emphasis on pregnant women and to contextualise the problem of FASD. These issues need to be addressed in a broad and integrated manner, with coordinated policies informed by best international practices, and interventions at multiple macro-, meso-, and micro-levels to enhance social justice and provide care for reproducing women. Such policies and interventions need to be carefully developed so that colonising and patriarchal discourses are not reinscribed. It is important that FASD is not implicitly constructed by these policies and interventions as perpetuated by women of Colour, through neoliberal discourses of people having free choice over their health; policies and interventions need to recognise that women living in poverty often do not have the economic, social, or psychological resources that enable "healthy" choices. Rather, alcohol related harms, including FASD, need to be seen as a result of intersecting harms in the psychological, social, economic, and structural arenas that have been, and continue to be, inflicted on colonised populations (Hunting & Browne, 2012; Jonsson et al., 2014).

In line with the ethics of care and justice that I recommend, I argue that frameworks of social justice, critical feminism and decolonial psychology would reduce power differentials and invoke more helpful power relations to tackle alcohol use and FASD in our current age and context. While there are many knowledges and techniques within public health apparatuses that are useful and should be incorporated into policies and interventions, these would need to be interrogated through the decolonial, feminist lenses of reproductive justice and care to ensure unintentional harms are not being perpetuated. Positionings need to be in alignment with women and communities struggling with alcohol related harms, rather than in opposition to them as occurred in this Organisation, so that interventions, communities, families and individuals can together tackle the problem of excessive alcohol use. All of this is hard to achieve. Frank (2013) stated that "society prefers medical diagnoses that admit treatment, not social diagnoses that require massive change in the premises of

what that social body includes as part of itself" (p. 113). However, I believe that such "social diagnosis" and intervention is the only way to move forward effectively.

While it is lamentable that South Africa does not have a coherent policy to tackle alcohol related harms, including FASD, this also provides an opportunity for critical health psychologists and feminists to lobby for such policies to be developed in line with our principles. At the macro-level, in order to enhance social justice, and along with addressing the ongoing problems of unemployment and social inequality, governmental policies need to be developed and implemented to reduce alcohol consumption and improve health and reproductive services, particularly in impoverished areas. Given the huge costs of alcohol related harms in South Africa, investing resources into such efforts makes economic sense. The development and implementation of policies would require collaboration between multiple governmental departments, including Health, Social Development, Trade and Industry, Police, and Education (recognising that poor educational outcomes contribute to increases in alcohol related harms). In line with a decolonising approach, it would be important that the individuals and communities most affected by alcohol related harms have input into the development of such policies. A recent policy brief for preventing and managing FASD has been developed and published by Adebiyi et al (2021), but while these authors paid lip-service to decolonising approaches, their methods for developing the policy brief involved interviews and focus groups with policymakers and service providers, a scoping review of literature on FASD interventions, and consultations with "local and international experts" (p. 2). However, there was no consultation with or input from service users or people directly affected by FASD. Hence, they were perpetuating colonial impositions on marginalised people.

The World Health Organisation (2018) has recommended that laws that reduce the availability of alcohol through further limiting times when alcohol can be sold, a ban on alcohol advertising, a reduction in the alcoholic strength of beverages, a ban on selling alcohol to intoxicated customers, and an increase of the pricing of alcohol through taxation should be implemented and enforced. Price increases have been shown to be particularly effective in reducing alcohol consumption. Furthermore, better policing of liquor outlets, illegal *shebeens*, and drink driving is important.

As the worst damage to a foetus occurs in the earliest stages of pregnancy, which is often before a woman knows that she is pregnant, providing better access to reliable contraception, pregnancy tests, and abortion services to reduce the incidence of unsupportable pregnancies is important. This needs to be done in consultations with local communities to ensure that the provision of this access is contextually appropriate. Clinic nurses need to be better supported and monitored as they are often the first contact that a pregnant woman has with health services. They need to be trained in

how to effectively counsel pre-pregnant and pregnant women and their partners, with a particular emphasis on being non-judgemental (Duby et al., 2019), as it is well documented that they often take up a stern and judgemental attitude towards young women seeking reproductive services (Feltham-King, 2015; Wood & Jewkes, 2006). Additionally, they should screen all women of reproductive age for alcohol use disorders (Jonsson et al., 2014) and mental health disorders, and provide referrals where necessary.

Depression, distress, and trauma are correlated with both increased drinking and less effective contraception use amongst both women and men (Choi et al., 2014; Levola & Aalto, 2015; Penberthy et al., 2013). Studies with both non-pregnant and pregnant women have indicated that those with depressive symptoms respond well to short term face-to-face counselling interventions, and such interventions improve their contraceptive use and/or decreasing binge drinking (de Vries et al., 2016; Penberthy et al., 2013). The provision of free and accessible psychological services for both women and men in communities that are affected by high alcohol consumption and FASD should therefore be a priority, for example, by providing a psychological counsellor in every clinic. Women tend to use clinic services more than men, so innovative ways of encouraging men to use psychological services need to be developed. There is a paucity of services to assist people with alcohol use disorders, and these services should be increased. If relevant health, social, and psychological services for women and young children could be provided at the same site (Adebiyi et al., 2021; Rutman & Hubberstey, 2019), this would go a long way in assisting women to access these services easily, as well as providing emotional support to women in their reproductive and parenting journeys.

With low socio-economic status and malnutrition being key correlates with FASD prevalence, economic upliftment programmes need to be implemented in areas of high FASD prevalence. Clinics could assess the nutritional status of pregnant women and provide supplements for those who are malnourished. Campaigns to highlight the effects of intimate partner violence need to be strengthened, along with support centres to assist victims of violence and trauma.

Interventions in both South Africa and elsewhere are predominantly carried out by not-for-profit entities such as Non- Governmental Organisations (NGOs) and charitable organisations. This poses a problem of sustainability, as financial support of such organisations is often precarious or short-term, and the organisations need to commit substantial amounts of their resources to fund-raising. It also means that there is no broad oversight over the types of the programmes that are implemented, so programmes that inadvertently re-inscribe social injustices may continue to be imposed on communities. Furthermore, implementation by NGOs tends to be confined to

circumscribed geographical locations, leading to fragmented and uncoordinated services. For these reasons, Government ownership, implementation, and evaluation of interventions is recommended, to enable broad roll-out and sustenance of programmes, and on-going oversight.

8.2. Recommendations for specific FASD interventions: a feminist decolonial psychology approach

I propose that a feminist decolonial psychology approach may be usefully drawn on to guide interventions with pregnant and newly parenting women in contexts of poverty. Decolonial psychology has arisen in response to the assumption that psychological theories and interventions, developed in Euro-American scientific contexts, are universal, and can be applied, untransformed, onto people of diverse cultures (Boonzaier & van Niekerk, 2019). Decolonial psychology looks at the effects of colonisation and subjugation on people of Colour and attempts to reintroduce contextual understandings of psychological pain and healing, and connection with the Spirit world. In contrast to Western psychology, which treats people as unified individuals who need to learn to manage themselves (Bhatia, 2017), and judges people of Colour and those in the Global South against the standards set by "white", Euro-American norms (Boonzaier & van Niekerk, 2019), a decolonial psychology recognises that all psychology is contextual and local, and calls for a privileging of collective wellbeing over individual wellbeing (Ali-Faisal, 2020).

A feminist decolonial psychology works to undermine the gendered colonialities of knowledge, power and being that are inflicted on previously colonised people groups, and to counteract oppressive gendered and colonialist discourses that have been internalised (Ali-Faisal, 2020). An example of this internalisation was shown in my interview data, where participants indicated that the fact that they were "Black" automatically meant that they were uneducated. A feminist decolonial psychology recognises the concept of intersectionality, where intersecting power vectors of race, gender, class, and geographies have compounding influences on subjectivities; proponents seek to reduce the power inequalities and enhance the agency and freedom of marginalised people and communities (Macleod, Bhatia, et al., 2020). Counteracting internalised colonialist and patriarchal discourses requires a dialogical pedagogical approach (discussed below) that conscientizes people to the socially constructed, colonial and patriarchal injustices that result in negative positionings, such as the fact that many "Black" people have received inferior education, rather than "Black" people, by default, being uneducated.

The links between risky alcohol use and adverse social circumstances (such as poverty, trauma and marginalisation) suggest that the former often arises in response to experiences of powerlessness and societal injustice. If this is so, then it is crucial that interventions do not re-inscribe such

injustices by imposing on communities programmes that have been conceived and designed by those in power, with no input from communities and individuals who are most affected by FASD. In line with a decolonising emphasis, women who use substances and their families and community members should be central in all aspects of identifying particular problems, defining approaches to well-being, and designing interventions (Hunting & Browne, 2012; Rutman et al., 2000).

Ways of foregrounding the voices of those who are most affected by alcohol use include the use of Freirian dialogical methods (Freire, 1993, 2003) and participatory action research methods (Kemmis & McTaggart, 2005) in the conception and design of interventions. Freirian dialogical methods, based on the seminal ideas of Paulo Freire, arose from the belief that in order to overcome oppression, the oppressed need to develop critical consciousness over the socially constructed roots of their disadvantage, and then engage in some form of collective action to resist or transcend such disadvantaging situations (Campbell & MacPhail, 2002). Freire posited that critical consciousness can only develop through dialogue, and he developed a highly influential method of dialogical pedagogy (Freire, 1993, 2003). Dialogical pedagogy involves dialoguing with people affected by a particular problem or oppression, with a strong emphasis on surfacing participants' understandings of a difficulty, and their own possible solutions to the difficulty. Egalitarian and horizontal relationships are promoted to engender trust, empathy, and critical engagement (Freire, 2003). Rather than prescribing solutions to problems, a problem-posing approach is advocated, whereby outside facilitators and community participants are all "critical co-investigators" of a problem (Freire, 1993, p. 61), leading to locally generated solutions. This leads to a decoloniality of knowledge production. A dialogical investigation is an iterative one, where reflection leads to action to address the difficulty, and this then promotes further reflection (Freire, 1993).

Participatory action research (PAR) likewise has emancipatory intentions and it has many synergies with Freirian theory. It emphasises "shared ownership of research projects, community-based analysis of social problems, and an orientation towards community action." (Kemmis & McTaggart, 2005, p. 560). It also engages in an iterative process of planning a change intervention, initiating it, reflecting, then re-planning further actions (Kemmis & McTaggart, 2005). Using Freirian and participatory methods with a community mean that a particular intervention focus cannot be pre-defined but will arise out of dialogue with the community; outside agencies are facilitators and supporters of community action, but do not import or impose their own solutions and agendas.

Within this feminist decolonial approach, specific aspects that should be foregrounded in the planning and implementing of interventions include: a focus on societal factors that lead to alcohol

consumption; the use of harm reduction rather than abstinence approaches; a focus on enhancing the agency and relational ability of women; and the provision of psychological and practical care.

8.2.1. Focus on broad, social factors more than individual behaviours of women

A shift from viewing poor child outcomes as the failure of the mother or family to being an indicator of social injustices and inequality would reduce individual blame and would place an obligation on governmental and societal agencies to provide support to individuals and families who are pregnant and parenting (Rutman et al., 2000). Recognition and acknowledgement of the effects of marginalising and unjust processes on the health and behaviours of people who drink would enable a more integrated and woman-centred approach to interventions (Hunting & Browne, 2012). Multiple social influences that potentiate alcohol use in pre-pregnant and pregnant women have been identified: low SES; ongoing oppression; past and ongoing trauma; intimate partner violence; heavy alcohol use by male partners and family members; and being part of a community where drunkenness is normative (Choi et al., 2014; Cloete, 2012; Macleod, Matebese, et al., 2020; May et al., 2008; Watt et al., 2014). Additionally, heavy drinking women are more likely to bear a child with FASD if they are malnourished (Coles et al., 2015; May et al., 2008). All of these factors should be the starting points, rather than the post-scripts of campaigns and interventions.

Given the fundamentally social motivators of drinking for people who are not dependant drinkers, and the way in which the pursuit of intoxication is often a primary route to pleasure (Hutton et al., 2013) and group belonging, it is important that interventions give these factors due weight. Participants in this research identified peer pressure and lack of entertainment possibilities that do not involve alcohol as drivers of heavy alcohol consumption. Asking people to say “no” to an activity, when there is no socially viable alternative to which they can say “yes” is unlikely to work. Promoting critical consciousness, through dialogical methods, around social and pleasurable motivations to drink may assist individuals, social groups, and communities to critically engage with reasons why they pursue drunkenness. From such reflection, action can ensue to provide alternative sociable and pleasurable pursuits in a community. From a positioning perspective, it is important that people have a range of socially valued personal positions available to them (such as soccer player or choir member or community activist) in order for them to move out of an unhelpful position, such as a drinking position. Interventions, communities, and people affected by alcohol related harms need to be positioned in alignment with one another, united in tackling the problem of alcohol use, rather than opposite one another; blame should be apportioned to “King Alcohol” rather than individuals who drink.

FASD prevention campaigns need to target men as actively as they target women and aim for a community-wide shift in drinking norms, rather than focussing primarily on pregnant women. I agree with Jonsson et al. (2014), in their report on the international charter on prevention of FASD, who claim that "(t)he perception that fetal alcohol spectrum disorder is affected only by a woman's choices is a major barrier to prevention efforts." (p. e136). The effects of normative heavy drinking cultures on foetal health should be emphasised over and above the effects of individual pregnant women's drinking. Universal, population-wide interventions such as awareness campaigns need to be developed carefully, and in an iterative manner, using both factually based risk messages and self-efficacy-based messages, and in ways that uphold decolonial, feminist principles. As FASD, at the most proximal level, arises from heavy pre-natal alcohol consumption, the temptation is always to exhort women not to drink when pregnant. However, I argue that the focus of messages needs to shift and broaden to more distal targets, such as exhorting liquor outlets to obey operating hours and to check the ages of their patrons, and addressing cultures of binge drinking on weekends and holidays through promoting other social activities. Isolating FASD from other alcohol related harms, such as road accidents and inter-personal violence, reinforces patriarchal constructions of pregnant women needing to sacrifice all for the sake of their foetus, and invisibilises the harms caused by other people who drink heavily.

Partnerships with liquor outlets to provide posters and pregnancy tests may prove to be helpful, and to get them on board with a fight against binge drinking. Engagements with school children to discuss alcohol related harms, as well as motivators to drink, is important. Such engagement should use consciousness raising exercises around why people drink, and why drunkenness is glamorised, as drinking often starts during adolescence.

8.2.2. Utilise harm reduction approaches with well-trained providers in clinical interventions

Whilst traditional approaches to intervening in high-risk activities have been to advocate complete abstinence from the activity, more recent approaches have tended to focus on harm reduction, with a strong emphasis on non-judgementalism and empathy for the user. The World Health Organisation (2018) promotes a harm reduction policy rather than an abstinence policy as the preferred approach to intervening in general alcohol misuse, and this approach was described in section 3.1. of Chapter 2. Rutman et al. (2000) described harm reduction strategies as follows:

> Conceptually, harm reduction adopts a value-neutral approach toward [alcohol] use and [alcohol] users. They are not seen as sick or deviant, but as normal people engaging in

> human behaviour. The focus in harm reduction is on the problems caused by use, and the user is seen as integral to developing effective solutions. (p.12-13).

The destructiveness of “preachy” or non-empathic intervention methods or personnel was made clear by Canadian Aboriginal participants in research conducted by Rutman et al. (2000). These participants spoke about how negative or judgemental attitudes towards pregnant substance users are a barrier to women seeking help. Likewise, Duby et al. (2019) reported that so-called “key populations” (sex workers, men who have sex with men, and people who use drugs) in South Africa who are at greater risk than the general population of contracting HIV, face much stigmatisation, discrimination, neglect and refusal of care when trying to access healthcare services. This negatively affects their engagement with prevention and treatment services. Duby et al. (2019) evaluated the effects of a one-day sensitisation training intervention for healthcare providers towards these key populations. They found that such training led to significantly increased empathy, a reduction in moral judgements, and increased self-perceived ability by the recipients to provide healthcare services to these population groups.

Well trained providers, who receive sensitivity training as well as basic counselling training are needed to implement such harm reduction programmes in clinical interventions for alcohol consuming pregnant women. The “responsibilisation paradigm” is well entrenched in health care and educational settings, and it requires in-depth and deliberate counselling training for many practitioners to move away from this paradigm. Hubberstey et al. (2021), in discussing multi-service sites for substance using women, highlighted the need for ongoing dialogue with the involved partners in order to increase their use of harm reduction processes, and Gaume et al. (2014) found that the counselling competency of providers was important for ensuring positive outcomes in substance use programmes.

The knower and judge positions that many participants in this research seemed to take up automatically was, no doubt, a familiar one to them, as schoolteachers, clinic nurses, and priests to whom they are likely to have been exposed often use such positions, and the participants may have had little or no exposure to positions of empathy, non-judgement, and empowerment from people in positions of authority in their daily lives. It is, therefore, understandable that mentors had such a paucity of positions to take up in their mentoring sessions. This indicates how important it is to intentionally train people who provide interventions in positions as empathic listeners and allies of people struggling with substance use, and to demonstrate how counterproductive a blaming stance is.

8.2.3. Focus on enlarging women's ensemble of habitual subject positions

Cloete (2012) considered identity as one of the factors to consider when designing interventions, and she suggested that the effectiveness of interventions is dependent on their ability to assist with the reconceptualization of individual and social identities. In her Western Cape study with women who consumed alcohol during pregnancy, she found that drunkenness was the norm in the women's context, and their identities were strongly imbricated with drinking. My understanding of identity is that it is a person's ensemble of habitual subject positions. The ethical mandate is, therefore, to enable a variety of subject positions for women that they can consciously choose to inhabit. By expanding the availability of alternative subject positions for women to embrace, through practical provisions of different occupations and ways to socialise, through dialogical pedagogical discussions, and through narrative methods of counselling, people's habitual positions can shift.

Providers of clinical interventions need to be trained in basic counselling techniques. Assisting women who use substances to focus on and talk through difficult feelings in a therapeutic relationship can help them to find new ways of dealing with emotional pain, rather than turning to substances (Pajulo et al., 2006). Counselling that draws off narrative therapeutic traditions, which is grounded in Foucauldian theory, aims to deconstruct problem-saturated stories and enhance marginalised yet emancipatory stories within clients' narratives, and this assists clients to take up more empowering positions in their lives (Lafrance & McKenzie-Mohr, 2013). A belief in one's ability to successfully take up an adaptive positon (such as investing in things other than alcohol), with the support of others, is crucial for motivating behaviour change (Cismaru et al., 2010). This can be understood as a sense of personal agency. Whilst agency may focus narrowly on a woman's ability to reduce drinking, a broader focus on economic, gendered, sexual and social agency and empowerment may have longer lasting effects. Training in even basic counselling takes much more time and resources than this Organisation was able to invest in training its mentors. Hence, there is a need for more financing of interventions.

Given that a woman's relationship with her foetus, other children, and other important people in her life are crucial factors in motivating sobriety, interventions that enhance relational functioning are indicated (Pajulo et al., 2006). Rather than aiming solely for substance use reduction or abstinence, a two-pronged approach that incorporates relational training and a strengthening of maternal-foetal attachment may be more effective (Pajulo et al., 2006, 2012). Pajulo et al. (2006) described an approach that was implemented in residential treatment facilities for addicted pregnant and newly parenting women in Finland. The approach had a strong focus on enhancing the parent-child

relationship through improving maternal reflective functioning[45], and the authors hypothesised that this assisted women to invest in their child or future child, rather than in substances. Preliminary studies indicated significant improvement in reflective functioning during the intervention (Pajulo et al., 2012). The data also indicated that women with lower postnatal reflective functioning abilities relapsed into substance use more frequently after completing the programme. For women who are affected by alcohol dependence or addiction, peer support from other women who have overcome addictions can provide important role models and practical advice (Rutman et al., 2000).

As discussed in Chapter 7, section 4.1.2., peer norms influence young people's sexual and reproductive behaviour far more than official programmes aimed at reducing risk. With this being so, group processes (such as dialogical pegagogy around peer norms) are indicated to conscientize people about what norms are influencing their behaviours, and to discuss whether they'd like to shift those norms.

8.2.4. Intentionally focus on provision of care

This Organisation's motivation for intervening with drinking pregnant women and communities was to care for the foetus, and to care for societies through attempts to reduce the incidence of FASD. However, it lacked a focus on care for reproducing women, which, I argue, undermined its objectives, and had unintentional negative effects. Additionally, its mode of caring was innervated, unreflexively, by pastoral, colonial, and patriarchal power. If its caring was informed by ethics of care and reproductive justice, with a reflexive use of a range of power-knowledge constructions, it could provide care at a particular and focussed level to the drinking pregnant woman through its mentoring programme, and promote reproductive justice at a societal level through its community educators by addressing and motivating communities to tackle issues such as gender inequalities and violence, lack of access to quality educational, health, and housing resources, and the cultural hegemony of drinking.

At the level of care, pregnant and newly parenting women and men need to receive sufficient care in order to appropriately care for their foetuses and children. Care is not just practical, but is fundamentally relational, and can only occur in relational contexts where women feel seen and heard. Using Tronto's (1995) four interrelated aspects of care - "caring about, attentiveness; taking care of, responsibility; care-giving, competence; and care-receiving, responsiveness" (p. 142) - to

[45] The concept of reflective functioning is based on the notion of mentalizing, and may be understood as "the psychological processes underlying one's capacity to understand oneself and others in terms of mental states (i.e. feelings, beliefs, intentions, and desires) and to reason about one's own and others' behaviours in relation to mental states. (Reflective functioning) enables an individual to understand another person's behaviour as meaningful and predictable." (Pajulo et al., 2012, p. 71).

guide interventions that aim to reduce alcohol consumption during pregnancy, interventions could look something like this:

Table 4: Practical suggestions for care

Aspects of care	**The care required by pregnant and newly parenting women from an intervention**	**Ways an intervention can help women to care for themselves, their pregnancies, and their children**
Caring about, attentiveness	Deep and compassionate listening to women's narratives of their pregnancies, births, parenting, relationships, and struggles	Assisting women with maternal bonding processes and reflective functioning with regards to their offspring
Taking care of, responsibility	Providing practical support to women to assist them, e.g., assistance with obtaining grants, appropriate health care, etc.	Providing guidance on appropriate pregnancy care, baby care, and child rearing
Care-giving, competence	Competence of personnel in deep listening, narrative techniques, and mentoring; respect for women's own knowledge and competencies; surfacing women's needs and problems and jointly problem-solving	Promoting women's agency to assist them with managing parenting, partner relationships, reducing/ceasing drinking, and earning money

Care-receiving, responsiveness	Helping women to understand when they need to seek psychological, physical, or practical care from external resources, and where to access such care; providing communal forms of relational bonding such as group story telling, singing, dancing, or drumming.	Providing guidance to women on signs to look out for in their pregnancies or in their infants and children, that signal the need for medical, psychological or behavioural input or changes

If there is no positive relationship between people, then any assistance provided may be seen as "treatment" or "service provision", but not care (Frank, 2013). Providers of care also need to be recipients of care, through debriefing, supervision, and peer support, which organisations need to make available to their personnel.

8.2.5. Take a feminist decolonising approach to FASD interventions

Drawing these strands together, I argue for a feminist decolonial psychology approach in interventions to address alcohol related harms and FASD, in order to undermine the gendered coloniality of power, of knowledge, and of being that have been instrumental in creating alcohol related harms in South Africa. Such an approach could look like this:

Table 5: A feminist decolonising approach to FASD interventions

Decoloniality of power	**Decoloniality of knowledge**	**Decoloniality of being**
• Actively work to reduce the power of the global alcohol corporations through banning alcohol advertising, stricter alcohol legislation, and greater enforcement of such legislation. • Lobby government for increases in funding for alcohol reduction initiatives, yet with community input on interventions. • Work dialogically with	• Honest dissemination of knowledge • Acknowledging women and communities as experts in their own lives • Collaborative knowledge building on how to reduce social injustices • Engage in dialogical pedagogy with communities struggling with alcohol related harms, and other difficulties they may	• Shift causal weight for adverse foetal outcomes away from individual women and onto societal and contextual factors • Adopt a harm reduction approach • Use a person-centred, narrative approach to mentoring that promotes deep listening, witnessing of women's stories, and the surfacing of alternative, preferred

communities most affected by FASD to initiate, plan, design, implement, and follow up on interventions • Intervention personnel need to reflexively consider their self-positioning and interactive positioning, to reduce power differentials • Acknowledge structural constraints on women's health, and harmful social norms • Acknowledge and work to reduce gendered power relations that foster harmful drinking during pregnancy	face.	subject positions • Telling life stories in groups • Thickening of narratives of agency within women's lives

However, Salmon (2011) sounded a warning regarding decolonial efforts. They could be used by neoliberal interests to position communities as responsible for their own interventions, thereby absolving the Government of responsibility to fund such initiatives. This needs to be resisted. A decolonial approach requires partnering with the Government for funding and resources at the same time as foregrounding the voices of communities most affected by alcohol related harms. Salmon (2011) stated that

> FASD is a condition unparalleled in its compliexity as both a public health issue and an expression of gendered and racialised conditions of disenfranchisement and abandonment. Its prevention requires comprehensive responses to support change that can rarely be measured over the short term in brief windows of policy attention. (p. 174).

The neoliberal constraints on the funding of most interventions relies on evidence of "success" over short periods of time, which is unrealistic when working to reduce the incidence of a condition that is driven by so many complex social factors. This needs to be highlighted when discussing funding for interventions.

9. Contributions and limitations of this research

As a social constructionist, I cannot assume that my "truths" of feminism and social justice are superior or "more true" than the "truths" that guide this Organisation. However, I argue that, as advocated by Lafrance and McKenzie-Mohr (2013), I can suggest which discursive formulations may be more useful in assisting women to reduce drinking. I have shown how the apparatuses of coloniality, patriarchy and pastoral power constructed positions for women as ignorant children, as sinners, and as invisible mothers. In the data from the mentoring sessions, I have highlighted how women responded to these positionings in overwhelmingly passive and unengaged ways. The few times when they were positioned in a caring or agentive way, through active listening, non-judgementalism, respect for their own knowledges and achievements, and empathy, the conversations that ensued indicated engagement, connection, and positive relating between the two women. The conversational strategies used by the mentor who positioned her clients in a relationship of care indicated an honouring of the client's stories through empathic listening and acknowledged the realities of the women's pain and struggles without positioning them as individually dysfunctional. This would have reduced shame, increased positive affect, and helped them to see where they have succeeded, all of which are necessary if women are to overcome the hegemonic injustices of the alcoholic, colonial and patriarchal cultures within which they are embedded.

The fact that there are questions around the voluntary participation of the mentors, and the clients even more so, is an ethical limitation of this study. The very stilted conversations in the recorded mentoring sessions, evidencing many examples of "violent relationships"[46], means that some of the clients may have suffered some harm through the process, which is not something that I had anticipated prior to gathering the mentoring recordings. A better strategy for negotiating participation in the mentoring recordings would have been for someone outside of the Organisation to do this task. However, at a broader level, I hope that the formative feedback given to the Organisation, and our re-writing of the training manuals with a particular focus on non-judgementalism and basic counselling training, means that less of these harms were inflicted on future clients.

The range of data that I gleaned increased the trustworthiness of my findings. Data obtained from the mentoring sessions may not have been very representative of the types of interactions that actually occurred, due to the mentors possibly misunderstanding their mandate from me, and possible anxiety at being evaluated. Video-recordings would also have improved the quality and

[46] As discussed in section 7.2 of Chapter 4, Bevir (1999) described violent relationships as those in which one party denies the agency of the other by pre-defining the actions in which the other must engage.

trustworthiness of the mentoring data. However, as I gleaned 33 recordings and most of them were very similar in nature it is likely that the kinds of positionings that I identified in them were true of the mentoring sessions in general. Furthermore, the positions I identified in the other data were mirrored in the mentoring sessions, suggesting that these positions were representative of what occurred in mentoring sessions.

Methodologically, I used both Foucauldian discursive analytical techniques and simplified conversation analytical techniques. Due to the fact that the data that I subjected to CA was only audio- and not video-recorded and was also in a language that was foreign to me, the depth of my CA was necessarily limited. Nevertheless, I believe that, by listening closely to the sections of the recordings that I was analysing, and with the translated transcriptions in front of me, I was able to identify many affective, non-verbal aspects of the conversation, such as sighs, pauses, overlaps, changes in rates of speech, and tone of voice. All of this gave me insights into the emotions that were elicited, and the conversational tactics that the participants were using to position themselves and each other as they drew off the discourses that were available to them. FDA enabled me to provide an in-depth analysis of the discourses that the Organisation perpetuated and highlight the power apparatuses that were operating in the Organisation, while my use of CA illuminated participants' agentive engagement with these discourses.

I believe that the depth of focus that each of these analytical techniques afforded me provided better insights than if I had used a hybrid approach on the interactive data. In particular, FDA showed the top-down constitution of subjects by the prevailing power apparatuses of coloniality, patriarchy, and pastoral power, while the CA shone a light on participants' bottom-up positionings, within the discursive resources that were available to them. I showed how mentors used conversational tactics of long speaking turns, closed-ended questions, and initiation-response-feedback (IRF) sequences to position themselves as knowledgeable teachers or saviours and their clients as ignorant children or sinners. Clients, in turn, generally resisted being positioned as ignorant or sinful through lack of response tokens, weak agreements, silences, sighs and pauses. However, there were occasions where clients took up previously knowledgeable positions, or wrested power from the mentors through asking their own questions. One notable manner of resisting a sinful position was to eagerly comply with an ignorant position, as this was a way of foreclosing judgement of drinking during pregnancy. Pauses were used for different purposes in the mentoring sessions. Mentors generally used pauses to place interactional pressure on clients to answer their questions, thereby positioning them as ignorant children, while clients used pauses to resist such pressure. However, one mentor used pauses to honour her clients' narrative, and allow space for the client to think, or add more to her story.

I showed how drinking pregnant women could be more usefully positioned within discourses of social justice, agency and care. Conversationally, this was achieved through co-constructing a narrative of a woman agentively resisting pressures to drink, and by one mentor expressing relational care through conversational tactics of open-ended questions, enquiring about affect, and encouraging women to take long conversational turns through minimal response tokens, reflecting affect, and allowing pauses.

At a theoretical level, I have extended the notion of reproductive justice by incorporating the notion of care, which I believe allows an analysis of women's needs at both global and particular levels. The focus on care that I have incorporated provides a more relationally centred analysis than if I only looked at reproductive justice, and this focus has fleshed out the kinds of recommendations that I make. I have also shown how a framework of feminist decolonial psychology may be applied to provide socially just and caring ways of intervening to reduce FASD incidence.

While critical researchers have been accused of critiquing, or "tearing apart" their object of study, without providing helpful and realistic suggestions for improvements, my analysis has been able to show which aspects of the Organisation's interventions were helpful and should be maximised, and which aspects should change. I used these findings to provide practical suggestions in my formative reports to the Organisation on how to improve their intervention. However, one of the challenges of this research was that the Organisation was situated within apparatuses that were antithetical to those of our research team, so it took much energy to try and find common ground, and it limited the extent to which we could try and assist with improving the intervention. Nevertheless, I do hope that we have assisted them to move away from the more extreme colonial and patriarchal positionings that they perpetuated. I have also used my findings in this report, and hopefully in future papers, to point to ways that the government and other interventions could more usefully intervene to reduce the incidence of FASD.

As a formative evaluation, I had hoped that the input that I provided in the way of a formative report on the training manuals would be used to adjust the intervention before other data were collected, so that I could then assess how helpful my suggestions were proving to be and re-adjust them accordingly. Unfortunately, that did not happen, so my data and subsequent analysis were of the original intervention. This is a limitation of this research. There was also a sense that the Organisation, who believed that their intervention worked well, was not heavily invested in changing their programmes and was merely agreeing to the evaluation to satisfy funders' requirements. This hampered our efforts. We may have needed to spend more time at the start of the research, when we were drawing up the terms of agreement, to negotiate specifically with the Organisation as to

what we each were expecting of the other, and to come to agreements on this. However, a strength of the larger research project was the three different projects that we conducted on alcohol consumption during pregnancy in the identified location, so we could triangulate our findings, which added to their trustworthiness. Another strength was our quarterly meetings over four and a half years with all stakeholders, at which we gave feedback. Hence, we tried to disseminate our findings both verbally and in writing, and also to hear from Organisational representatives their ideas on our suggestions.

I faced a big tension in this evaluation between necessarily critiquing what I felt to be unjust or uncaring in the Organisation's methods, but doing it in an encouraging manner and in a way that would affirm them for their efforts and not make them resist all my suggestions. So, for example, I did not critique their anti-abortion stance or conservative Christian ethos, but merely tried to highlight the necessity of being non-judgemental. I needed to be mindful of engaging with them in ways that I was recommending that they engaged with drinking pregnant women – in a respectful, caring manner which highlighted their contributions yet did not shy away from any harms I felt may be perpetuated.

Probably the most beneficial aspect of my engagement with the Organisation was the re-writing of their training manuals that I and one of the assistant researchers did. We tried to keep the "flavour" of the Organisation by using their logo and some of the same pictures and colours, but significantly changed the language and included many brainstorming activities to enhance the surfacing of participants' own knowledges, to highlight the social injustices that lead to heavy drinking, and for participants to think about how such social injustices may be addressed. We also provided a whole new section on training mentors in basic listening skills. This was a way of practically intervening, rather than remaining in the realm of critique.

10. Suggestions for future research

With the paucity of evaluations of interventions for FASD, a great deal more research, both qualitative and quantitative, is indicated in this arena. Critical feminist researchers need to heed the call to conduct more engaged research, to operationalise their theories in practical ways. With so few interventions operating in South Africa, the field is ripe for action research and formative evaluations of interventions at all levels of the ecological system of alcohol use – macro, meso, and micro – and, as I stated earlier, I believe more energy needs to be focussed on the macro and meso levels of intervention, such as policy development and provision of resources to reduce alcohol

related harms. Research that uses lenses of both care and justice would be able to provide input into women's and communities' needs at both structural and relational levels.

With research with women who drank during pregnancy highlighting their lack of structural and personal support which potentiated their drinking, research on interventions at these meso- and micro-levels, such as wrap-around services, is indicated. More formative evaluations of interventions that aim to assist communities struggling with alcohol use and FASD are required. Ideally, formative evaluations should be built into programme designs before they are even rolled out, and it is at this stage that agreements should be made about what each party expects of the other. It is much more difficult to bring about change in established programmes like the one I evaluated, even though it was being piloted in a new area. Partnering with organisations who are closer to the researchers' positions, and who understand the rationale for formative evaluations, would lead to an easier research process, with presumably quicker implementations of suggestions for change.

This research has shown the fruitfulness of examining discursive positionings within interventions. Further discursive analyses of positions constructed and taken up in interventions are indicated. Conversation analyses of clinical interventions with people who drink using both video- and audio-recordings, and with researchers who are fluent in the language used, would be helpful to refine which conversational techniques are helpful or counterproductive in such encounters. The insights from this kind of research need to be applied in the development of programmes to train people who provide counselling/mentoring services.

At a theoretical level, further refinement of an ethics of care and justice within a framework of feminist decolonial psychology is indicated. An analysis of the kinds of power relations that these concepts draw on would enable this ethics to be fleshed out and deepened. An examination of its founding power-knowledge relationships could highlight unintended negative consequences that may arise from its use.

The proximal causes of FASD are clear, and I believe that further research trying to pinpoint the exact quantities of alcohol needed for harm, and exact maternal vulnerabilities, are ultimately an unjust use of research resources. The urgency now is to find ways to support women, families and communities in efforts to reduce harmful alcohol use.

References

Adebiyi, B. O., Mukumbang, F. C., & Beytell, A. M. (2021). Policy Requirements for the Prevention and Management of Fetal Alcohol Spectrum Disorder in South Africa: A Policy Brief. *Frontiers in Public Health*, *9*(April), 1–5. https://doi.org/10.3389/fpubh.2021.592726

Ali-Faisal, S. F. (2020). Islamic anti-patriarchal liberation psychology: A framework to decolonize psychology for Muslims. *Feminism and Psychology*, *30*(3), 343–362. https://doi.org/10.1177/0959353520941350

Allen, L. (2007). Doing "it" differently: relinquishing the disease and pregnancy prevention focus in sexuality education. *British Journal of Sociology of Education*, *28*(5), 575–588. https://doi.org/10.1080/01425690701505367

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing. ISBN978-0-89042-555-8

Anderson, A. E., Hure, A. J., Kay-Lambkin, F. J., & Loxton, D. J. (2014). Women's perceptions of information about alcohol use during pregnancy: A qualitative study. *BMC Public Health*, *14*(1). https://doi.org/10.1186/1471-2458-14-1048

Apple, M. W., Au, W., & Gandin, L. A. (2009). Mapping critical education. In M. W. Apple, W. Au, & L. A. Gandin (Eds.), *The Routledge international handbook of critical education* (pp. 3–19). Routledge.

Armstrong, E. M. (1998). Diagnosing moral disorder: The discovery and evolution of fetal alcohol syndrome. *Social Science and Medicine*, *47*(12), 2025–2042. https://doi.org/10.1016/S0277-9536(98)00308-6

Arribas-Ayllon, M., & Walkerdene, V. (2017). Foucauldian discourse analysis. In C Willig & W. Stainton Rogers (Eds.), *The Sage handbook of qualitative research in psychology* (pp. 110–123). Sage.

Arribas-Ayllon, M., & Walkerdine, V. (2008). Foucauldian discourse analysis. In Carla Willig & W. Stainton-Rogers (Eds.), *The Sage handbook of qualitative research in psychology* (pp. 91–108). Sage.

Babbie, E., & Mouton, J. (2001). *The practice of social research (South African edition)*. Oxford University Press Southern Africa.

Bailey, A. (2011). Reconceiving surrogacy: Toward a reproductive justice account of Indian surrogacy. *Hypatia*, *26*(4), 715–741. https://doi.org/10.1111/j.1527-2001.2011.01168.x

Balachova, T., Bonner, B. L., Chaffin, M., Isurina, G., Shapkaitz, V., Tsvetkova, L., Volkova, E., Grandilevskaya, I., Skitnevskaya, L., & Knowlton, N. (2013). Brief FASD prevention intervention: Physicians' skills demonstrated in a clinical trial in Russia. *Addiction Science & Clinical Practice*, *8*(1), 1-10. https://doi.org/10.1186/1940-0640-8-1

Bamberg, M. (2004). Form and Functions of 'Slut Bashing' in Male Identity Constructions in15-Year-Olds. *Human Development*, *47*(6), 331–353. https://doi.org/10.1159/000081036

Bartesaghi, M. (2009). Conversation and psychotherapy: how questioning reveals institutional answers. *Discourse Studies*, *11*(2), 153–177. https://doi.org/10.1177/1461445608100942

Bell, K., McNaughton, D., & Salmon, A. (2009). Medicine, morality and mothering: Public health discourses on foetal alcohol exposure, smoking around children and childhood overnutrition. *Critical Public Health*, *19*(2), 155–170. https://doi.org/10.1080/09581590802385664

Belt, R., Flykt, M., Punamaki, R.-L., Pajulo, M., Posa, T., & Tamminen, T. (2012). Psychotherapy groups and individual support to enhance mental health and early dyadic interaction among drug-abusing mothers. *Infant Mental Health Journal*, *33*(5), 520–534. https://doi.org/10.1002/imhj.21348

Benoit, C., Stengel, C., Marcellus, L., Hallgrimsdottir, H., Anderson, J., MacKinnon, K., Phillips, R., Zazueta, P., & Charbonneau, S. (2014). Providers' constructions of pregnant and early parenting women who use substances. *Sociology of Health & Illness*, *36*(2), 252–263. https://doi.org/10.1111/1467-9566.12106

Berger, R. (2015). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219–234. https://doi.org/10.1177/1468794112468475

Bevir, M. (1999). Foucault and critique : Deploying agency against autonomy. *Political Theory*, *27*(1), 65–84. https://www.jstor.org/stable/192161

Bhatia, S. (2017). *Decolonizing psychology: Globalization, social justice, and Indian youth identities*. Oxford University Press.

Bijloos, A. D. (2017). *Ethics and risk: toward a responsible approach to acceptable risk impositions* [Doctoral dissertation, University of Stellenbosch, South Africa]. https://scholar.sun.ac.za

Boonzaier, F. (2017). The Life and death of Anene Booysen: Colonial discourse, gender-based violence and media representations. *South African Journal of Psychology*, *47*(4), 470–481. https://doi.org/10.1177/0081246317737916

Boonzaier, F., & van Niekerk, T. (2019). Introducing decolonial feminist community psychology. In F. Boonzaier & T. van Niekerk (Eds.), *Decolonial feminist community psychology* (pp. 1–10). Springer.

Boucher, J. (2004). The politics of abortion and the commodification of the fetus. *Studies in Political Economy*, *Spring/Sum*, 69–88. http://0-www.tandfonline.com.wam.seals.ac.za/doi/pdf/10.1080/19187033.2004.11675152

Braat, I. (2010). *Sleep song*. http://www.ine-pps.nl/?page=search&item=sleep song

Braun, V., Clarke, V., & Terry, G. (2015). Thematic analysis. In P. Rohleder & A. Lyons (Eds.), *Qualitative research in clinical and health psychology* (pp. 95–113). Palgrave Macmillan.

Brown, R., & Gregg, M. (2012). The pedagogy of regret: Facebook, binge drinking and young women. *Continuum: Journal of Media and Cultural Studies*, *26*(3), 357–369. https://doi.org/10.1080/10304312.2012.665834

Calhoun, F., & Warren, K. (2007). Fetal alcohol syndrome: Historical perspectives. *Neuroscience and Biobehavioral Reviews*, *31*(2), 168–171. https://doi.org/10.1016/j.neubiorev.2006.06.023

Campbell, C., & MacPhail, C. (2002). Peer education, gender and the development of critical consciousness: Participatory HIV prevention by South African youth. *Soc Sci Med*, *55*(2), 331–345. https://psycnet.apa.org/doi/10.1016/S0277-9536(01)00289-1

Chersich, M. F., Urban, M., Olivier, L., Davies, L. A., Chetty, C., & Viljoen, D. (2012). Universal prevention is associated with lower prevalence of Fetal Alcohol Spectrum Disorders in Northern Cape, South Africa: a multicentre before-after study. *Alcohol and Alcoholism*, *47*(1), 67–74. https://doi.org/10.1093/alcalc/agr145

Chiweshe, M., Mavuso, J., & Macleod, C. I. (2017). Reproductive justice in context: South African and Zimbabwean women's narratives of their abortion decision. *Feminism & Psychology*, *27*(2), 203–224. https://doi.org/10.1177/0959353517699234

Choi, K. W., Abler, L. a, Watt, M. H., Eaton, L. a, Kalichman, S. C., Skinner, D., Pieterse, D., & Sikkema, K. J. (2014). Drinking before and after pregnancy recognition among South African women: The moderating role of traumatic experiences. *BMC Pregnancy and Childbirth*, *14*(1), 97.

https://doi.org/10.1186/1471-2393-14-97

Cismaru, M., Deshpande, S., Thurmeier, R., Lavack, A. M., & Agrey, N. (2010). Preventing fetal alcohol spectrum disorders: The role of protection motivation theory. *Health Marketing Quarterly*, *27*(1), 66–85. https://doi.org/10.1080/07359680903519776

Cloete, L. (2012). *Developing appropriate Fetal Alcohol Spectrum Disorder (FASD) prevention initiatives within a rural community in South Africa*. [Doctoral dissertation, University of Cape Town]. http://hdl.handle.net/11427/10278

Coles, C. D., Kable, J. A., Keen, C. L., Jones, K. L., Wertelecki, W., Granovska, I. V., Pashtepa, A. O., & Chambers, C. D. (2015). Dose and timing of prenatal alcohol exposure and maternal nutritional supplements: Developmental effects on 6-month-old infants. *Maternal and Child Health Journal*, *19*(12), 2605–2614. https://doi.org/10.1007/s10995-015-1779-x

Cook, R. J., & Dickens, B. M. (2009). From reproductive choice to reproductive justice. *International Journal of Gynecology & Obstetrics*, *106*(2), 106–109. https://doi.org/10.1016/j.ijgo.2009.03.018

Crawford-Williams, F., Fielder, A., Mikocka-Walus, A., & Esterman, A. (2015). A critical review of public health interventions aimed at reducing alcohol consumption and/or increasing knowledge among pregnant women. *Drug and Alcohol Review*, *34*(2), 154–161. https://doi.org/10.1111/dar.12152

Crawford-Williams, F., Steen, M., Esterman, A., Fielder, A., & Mikocka-Walus, A. (2015). “If you can have one glass of wine now and then, why are you denying that to a woman with no evidence”: Knowledge and practices of health professionals concerning alcohol consumption during pregnancy. *Women and Birth*, *28*, 329–335. https://doi.org/10.1016/j.wombi.2015.04.003

Cromby, J., & Nightingale, D. J. (1999). What’s wrong with social constructionism? In D. J. Nightingale & J. Cromby (Eds.), *Social constructionist psychology: A critical analysis of theory and practice* (pp. 1–19). Open University Press.

Davies, B., & Gannon, S. (2005). Feminism/poststructuralism. In B. Somekh & C. Lewin (Eds.), *Research methods in the social sciences* (pp. 318–325). Sage.

Davies, B., & Harré, R. (1990). Positioning: the discursive production of selves. *Journal for the Theory of Social Behaviour*, *20*(1), 87–106. https://doi.org/10.1111/j.1468-5914.1990.tb00174.x

Day, K., Gough, B., & Mcfadden, M. (2004). “Warning! Alcohol can seriously damage your feminine

health": A discourse analysis of recent British newspaper coverage of women and drinking. *Feminist Media Studies*, *4*(2), 15–183. https://doi.org/10.1080/1468077042000251238

de Vries, M., Joubert, B., Cloete, M., Roux, S., Baca, B., Hasken, J., Barnard, R., Buckley, D., Kalberg, W., Snell, C., Marais, A.-S., Seedat, S., Parry, C. D., & May, P. A. (2016). Indicated prevention of Fetal Alcohol Spectrum Disorders in South Africa: Effectiveness of case management. *International Journal of Environmental Research and Public Health*, *13*(1), 76. https://doi.org/10.3390/ijerph13010076

Department of Health Medical Research Council. (2007). *South African Demographic and Health Survey 2003*. http://www.mrc.ac.za/bod/sadhs.htm

Doi, L., Jepson, R., & Cheyne, H. (2015). A realist evaluation of an antenatal programme to change drinking behaviour of pregnant women. *Midwifery*, *31*(10). https://doi.org/10.1016/j.midw.2015.06.007

Drake, P., Driscoll, A. K., & Mathews, T. J. (2018). Cigarette Smoking During Pregnancy: United States, 2016. *National Centre for Health Statistics (NCHS) Data Brief*, *305*, 1–8. https://www.cdc.gov/nchs/data/databriefs/db305_table.pdf#1

Dreyfus, H., & Rabinow, P. (1982). *Michel Foucault: Beyond structuralism and hermeneutics*. The Harvester Press.

Driscoll, D. L., Barnes, V. R., Johnston, J. M., Windsor, R., & Ray, R. (2018). A formative evaluation of two FASD prevention communication strategies. *Alcohol and Alcoholism*, *53*(4), 461–469. https://doi.org/10.1093/alcalc/agx122

Du Plessis, U., Young, C., & Macleod, C. I. (2017). *Harm reduction strategies in alcohol use and abuse : A critical review of interventions*. Critical Studies in Sexualities and Reproduction, Rhodes University, South Africa. https://www.ru.ac.za/criticalstudies/booksandpublications/reports/

Duby, Z., Fong-Jaen, F., Nkosi, B., Brown, B., & Scheibe, A. (2019). "We must treat them like all the other people": Evaluating the integrated key populations sensitivity training programme for healthcare workers in South Africa. *Southern African Journal of HIV Medicine*, *20*(1). https://doi.org/10.4102/sajhivmed.v20i1.909

Duignan, P. (2009). Evaluation types: Formative/developmental, process and impact/outcome. *Outcomes Theory Knowledge Base*, 256, 1–6. http://knol.google.com/k/paul-duignanphd/-/2m7zd68aaz774/119.

Eagly, A. H., & Riger, S. (2014). Feminism and psychology: Critiques of methods and epistemology. *American Psychologist*, *69*(7), 685–702. https://doi.org/10.1037/a0037372

Eaton, L. A., Pitpitan, E. V., Kalichman, S. C., Sikkema, K. J., Skinner, D., Watt, M. H., Pieterse, D., & Cain, D. N. (2014). Food Insecurity and Alcohol Use Among Pregnant Women at Alcohol-Serving Establishments in South Africa. *Prevention Science*, *15*(3). https://doi.org/10.1007/s11121-013-0386-6

Evans, W. D., Wallace, J. L., & Snider, J. (2012). Pilot evaluation of the text4baby mobile health program. *BMC Public Health*, *12*(1031), 1-10. https://doi.org/10.1186/1471-2458-12-1031

FARR. (2016). *Foundation For Alcohol Related Research*. https://farrsa.org.za/about-us/

Feltham-King, T. (2015). *Risk and responsibility: The management of the teenaged pregnant woman within the antenatal healthcare nexus*. [Doctoral dissertation, Rhodes University, South Africa]. https://commons.ru.ac.za/vital/access/services/Download/vital:20029/SOURCE1?view=true

Flak, A. L., Su, S., Bertrand, J., Denny, C. H., Kesmodel, U. S., & Cogswell, M. E. (2014). The association of mild, moderate, and binge prenatal alcohol exposure and child neuropsychological outcomes: A meta-analysis. *Alcoholism: Clinical and Experimental Research*, *38*(1), 214–226. https://doi.org/10.1111/acer.12214

Floyd, R. L., Jack, B. W., Cefalo, R., Atrash, H., Mahoney, J., Herron, A., Husten, C., & Sokol, R. J. (2008). The clinical content of preconception care: alcohol, tobacco, and illicit drug exposures. *American Journal of Obstetrics and Gynecology*, *199*(6, Supplement B), S333–S339. https://doi.org/10.1016/j.ajog.2008.09.018

Floyd, R. L., Sobell, M., Velasquez, M. M., Ingersoll, K., Nettleman, M., Sobell, L., Mullen, P. D., Ceperich, S., von Sternberg, K., Bolton, B., Skarpness, B., & Nagaraja, J. (2007). Preventing Alcohol-Exposed Pregnancies. A Randomized Controlled Trial. *American Journal of Preventive Medicine*, *32*(1), 1–10. https://doi.org/10.1016/j.amepre.2006.08.028

Foucault, M. (1977). What is an author? In D. F. Bouchard (Ed.), *Language, counter-memory, practice: selected essays and interviews by Michel Foucault* (pp. 113–138). Cornell University Press.

Foucault, M. (1978). *The history of sexuality: volume I, an introduction (R. Hurley, trans.)*. Penguin Books.

Foucault, M. (1982). The subject and power. In H. Dreyfus & P. Rabinow (Eds.), *Michel Foucault:*

Beyond structuralism and hermeneutics (pp. 208–226). University of Chicago Press.

Foucault, M. (1984). *The Foucault reader: an introduction to Foucault's thought* (P. Rabinow (ed.)). Penguin Books.

Foucault, M. (1985). *The use of pleasure: volume 2 of the history of sexuality (R. Hurley, trans.)*. Pantheon Books.

Foucault, M. (1986). *The care of the self: The history of sexuality volume 3 (R. Hurley, trans.)*. Random House.

Foucault, M. (1977/1995). *Discipline and punish: the birth of the prison (A. Sheridan, trans.)* (2nd ed.). Vintage Books.

Foucault, M. (1997a). Subjectivity and truth. In P. Rabinow (Ed.), *Michel Foucault: Ethics, subjectivity and truth* (pp. 87–92). The New Press.

Foucault, M. (1997b). Technologies of the self. In P. Rabinow (Ed.), *Michel Foucault: Ethics, subjectivity and truth* (pp. 223–251). The New Press.

Foucault, M. (1997c). The ethics of concern of the self as a practice of freedom. In P. Rabinow (Ed.), *Michel Foucault: Ethics, subjectivity and truth* (pp. 281–301). The New Press.

Foucault, M. (1997d). The will to knowledge. In P. Rabinow (Ed.), *Michel Foucault: Ethics, subjectivity and truth* (pp. 11–16). The New Press.

France, K. E., Donovan, R. J., Bower, C., Elliott, E. J., Payne, J. M., D'Antoine, H., & Bartu, A. E. (2014). Messages that increase women's intentions to abstain from alcohol during pregnancy: results from quantitative testing of advertising concepts. *BMC Public Health*, *14*(1). https://doi.org/10.1186/1471-2458-14-30

Frank, A. W. (2013). *The wounded storyteller: Body, illness & ethics* (2nd ed.). University of Chicago Press. https://doi.org/10.7208/chicago/9780226067360.001.001

Freire, P. (1993). *Pedagogy of the oppressed (M. Bergman Ramos, trans.)*. Penguin Books.

Freire, P. (2003). *Education for critical onsciousness*. Continuum.

Frosh, S., & Emerson, P. D. (2005). Interpretation and over-interpretation: Disputing the meaning of texts. *Qualitative Research*, *5*(3), 307–324. https://doi.org/10.1177/1468794105054457

Gaume, J., McCambridge, J., Bertholet, N., & Daeppen, J.-B. (2014). Mechanisms of action of brief

alcohol interventions remain largely unknown: A narrative review. *Frontiers in Psychiatry*, *5*, 108. https://doi.org/10.3389/fpsyt.2014.00108

Gilinsky, A., Swanson, V., & Power, K. (2011). Interventions delivered during antenatal care to reduce alcohol consumption during pregnancy: A systematic review. *Addiction Research & Theory*, *19*(3), 235–250. https://doi.org/10.3109/16066359.2010.507894

Gilliam, M. L., Neustadt, A., & Gordon, R. (2009). A call to incorporate a reproductive justice agenda into reproductive health clinical practice and policy. *Contraception*, *79*(4), 243–246. https://doi.org/10.1016/j.contraception.2008.12.004

Goffman, E. (1983). The interaction order: American Sociological Association, 1982 presidential address. *American Sociological Review*, *48*(1), 1–17. https://www.jstor.org/stable/2095141

Gossage, J., Snell, C., Parry, C. D., Marais, A.-S., Barnard, R., de Vries, M., Blankenship, J., Seedat, S., Hasken, J., & May, P. A. (2014). Alcohol Use, working conditions, job benefits, and the legacy of the “dop” system among farm workers in the Western Cape Province, South Africa: Hope despite high levels of risky drinking. *International Journal of Environmental Research and Public Health*, *11*(7), 7406–7424. https://doi.org/10.3390/ijerph110707406

Gough, B. (2008). Foucault, psychology and the analytics of power – By D. Hook. *The British Journal of Sociology 59*(2), 375-376. https://doi.org/10.1111/j.1468-4446.2008.00198_2.x

Guilfoyle, M. (2014). *The person in narrative therapy: A post-structural, Foucauldian account*. Palgrave Macmillan.

Gupta, K. K., Gupta, V. K., & Shirasaka, T. (2016). An update on fetal alcohol syndrome—pathogenesis, risks, and treatment. *Alcoholism: Clinical and Experimental Research 40(*8), 1594-1602. https://doi.org/10.1111/acer.13135

Hanlon-Dearman, A., Green, C. R., Andrew, G., LeBlanc, N., & Cook, J. L. (2015). Anticipatory guidance for children and adolescents with fetal alcohol spectrum disorder (FASD): Practice points for primary health care providers. *Journal of Population Therapeutics and Clinical Pharmacology, 22*(1), e27-e56. https://www.researchgate.net/publication/271140236

Hanson, J., Ingersoll, K., & Pourier, S. (2015). Development and implementation of CHOICES group to reduce drinking, improve contraception, and prevent alcohol-exposed pregnancies in American Indian women. *Journal of Substance Abuse Treatment*, *59*, 45–51. https://doi.org/10.1016/j.jsat.2015.07.006

Hanson, J., & Jensen, J. (2015). Importance of social support in preventing alcohol-exposed pregnancies with American Indian communities. *Journal of Community Health*, *40*, 138–146. https://doi.org/10.1007/s10900-014-9911-1

Hanson, J., Miller, A., Winberg, A., & Elliott, A. (2013). Prevention of alcohol-exposed pregnancies among nonpregnant American Indian women. *American Journal of Health Promotion*, *27*(3 Supplement), S66–S73. https://doi.org/10.4278/ajhp.120113-QUAN-25

Hanson, J., Nelson, M., Jensen, J., Willman, A., Jacobs-Knight, J., & Ingersoll, K. (2017). Impact of the CHOICES Intervention in Preventing Alcohol-Exposed Pregnancies in American Indian Women. *Alcoholism: Clinical and Experimental Research*, *41*(4), 828-835. https://doi.org/10.1111/acer.13348

Hanson, J., Winberg, A., & Elliott, A. (2012). Development of a media campaign on Fetal Alcohol Spectrum Disorders for Northern Plains American Indian communities. *Health Promotion Practice*, *13*(6), 842–847. https://doi.org/10.1177/1524839911404232

Heritage, J. (2005). Conversational analysis and institutional talk. In K. L. Fitch & R. E. Sanders (Eds.), *Handbook of language and social interaction* (pp. 103–147). Lawrence Erlbaum Associates.

Heritage, J. (2013). Asymmetries of knowledge in patient-provider encounters: Three studies adopting conversation analysis. *Patient Education and Counseling*, *92*(1), 1–2. https://doi.org/10.1016/j.pec.2013.05.003

Holland, K., McCallum, K., & Walton, A. (2016). “I’m not clear on what the risk is”: Women’s reflexive negotiations of uncertainty about alcohol during pregnancy. *Health, Risk & Society*, *18*(1–2), 38-58. https://doi.org/10.1080/13698575.2016.1166186

Holmqvist, M., & Nilsen, P. (2010). Approaches to assessment of alcohol intake during pregnancy in Swedish maternity care - a national-based investigation into midwives’ alcohol-related education, knowledge and practice. *Midwifery*, *26*(4), 430–434. https://doi.org/10.1016/j.midw.2008.10.009

Hook, D. (2007). *Foucault, psychology and the analytics of power*. Palgrave Macmillan.

Hoyme, H. E., Kalberg, W. O., Elliott, A. J., Blankenship, J., Buckley, D., Marais, A.-S., Manning, M. A., Robinson, L. K., Adam, M. P., Abdul-Rahman, O., Jewett, T., Coles, C. D., Chambers, C., Jones, K. L., Adnams, C. M., Shah, P. E., Riley, E. P., Charness, M. E., Warren, K. R., & May, P. A. (2016). Updated clinical guidelines for diagnosing fetal alcohol spectrum disorders. *Pediatrics*, *138*(2),

e20154256, 1-20. www.aappublications.org/news

Hubberstey, C., Rutman, D., Van Bibber, M., & Poole, N. (2021). Wraparound programmes for pregnant and parenting women with substance use concerns in Canada: Partnerships are essential. *Health & Social Care in the Community*. https://doi.org/10.1111/hsc.13664

Hunting, G., & Browne, A. J. (2012). Decolonizing policy discourse: Reframing the "problem" of fetal alcohol spectrum disorder. *Women's Health and Urban Life*, *11*(1), 35–53. https://tspace.library.utoronto.ca/bitstream/1807/32417/1/11.1_Hunting_Browne.pdf

Hutton, F., Wright, S., & Saunders, E. (2013). Cultures of intoxication: Young women, alcohol, and harm reduction. *Contemporary Drug Problems*, *40*, 451–480. https://doi.org/10.1177/009145091304000402

Ingersoll, K. S., Ceperich, S. D., Hettema, J. E., Farrell-Carnahan, L., & Penberthy, J. K. (2013). Preconceptional motivational interviewing interventions to reduce alcohol-exposed pregnancy risk. *Journal of Substance Abuse Treatment*, *44*(4), 407–416. https://doi.org/10.1016/j.jsat.2012.10.001

Ingersoll, K. S., Frederick, C., MacDonnell, K., Ritterband, L., Lord, H., Jones, B., & Truwit, L. (2018). A pilot RCT of an internet intervention to reduce the risk of alcohol-exposed pregnancy. *Alcohol Clin Exp Res*, *42*(6), 1132–1144. https://doi.org/10.1111/acer.13635

Jacobsen, B., Lindemann, C., Petzina, R., & Verthein, U. (2022). The universal and primary prevention of foetal alcohol spectrum disorders (FASD): a systematic review. *Journal of Prevention*, 1–20. https://doi.org/10.1007/s10935-021-00658-9

Jacobson, S. W., Carter, R. C., Molteno, C. D., Stanton, M. E., Herbert, J. S., Lindinger, N. M., Lewis, C. E., Dodge, N. C., Hoyme, H. E., Zeisel, S. H., Meintjes, E. M., Duggan, C. P., & Jacobson, J. L. (2018). Efficacy of maternal choline supplementation during pregnancy in mitigating adverse effects of prenatal alcohol exposure on growth and cognitive function: a randomized, double-blind, placebo-controlled clinical trial. *Alcohol Clin Exp Res*, *42*(7), 1327–1341. https://doi.org/10.1111/acer.13769

Jearey-Graham, N., & Macleod, C. I. (2015). A discourse of disconnect : Young people from the Eastern Cape talk about the failure of adult communications to provide habitable sexual subject positions. *Perspectives in Education*, *33*(2), 11–29. https://0-hdl.handle.net.wam.seals.ac.za/10520/EJC171669

Jewkes, R. K., Dunkle, K., Nduna, M., & Shai, N. (2010). Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: A cohort study. *The Lancet*, *376*(9734), 41–48. https://doi.org/10.1016/S0140-6736(10)60548-X

Jones, S. C., Telenta, J., Shorten, A., & Johnson, K. (2011). Midwives and pregnant women talk about alcohol: What advice do we give and what do they receive? *Midwifery*, *27*(4), 489–496. https://doi.org/10.1016/j.midw.2010.03.009

Jonsson, E., Salmon, A., & Warren, K. R. (2014). The international charter on prevention of fetal alcohol spectrum disorder. *The Lancet Global Health 2*(3), e135–e137. https://doi.org/10.1016/S2214-109X(13)70173-6

Kaner, E. F., Dickinson, H. O., Beyer, F. R., Campbell, F., Schlesinger, C., Heather, N., Saunders, J. ., Burnand, B., & Pienaar, E. D. (2007). Effectiveness of brief alcohol interventions in primary care populations (Review). *Cochrane Database of Systematic Reviews*, *2*, 1–90. https://doi.org/DOI: 10.1002/14651858.CD004148.pub3.

Kaskutas, L. A. (2000). Understanding drinking during pregnancy among urban American Indians and African Americans: Health messages, risk beliefs, and how we measure consumption. *Alcoholism: Clinical and Experimental Research*, *24*(8), 1241–1250. https://doi.org/10.1111/j.1530-0277.2000.tb02090.x

Keane, H. (2003). Critiques of harm reduction, morality and the promise of human rights. *International Journal of Drug Policy, 14,* 227-232. *https://www.sciencedirect.com/science/article/abs/pii/S0955395902001512*

Kelland, L., & Macleod, C. (2015). When is it legitimate to use images in moral arguments? The use of foetal imagery in anti-abortion campaigns as an exemplar of an illegitimate instance of a legitimate practice. *Philosophy and Social Criticism*, *41*(2), 179–195. https://doi.org/10.1177/0191453714556691

Kelly, J. F., & Ward, C. L. (2018). Women who drank while pregnant: The importance of social context in the lives of South African pregnant women. *Drugs: Education, Prevention and Policy*, *25*(5), 438–445. https://doi.org/10.1080/09687637.2017.1316703

Kemmis, S., & McTaggart, R. (2005). Participatory action research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 559–603). Sage.

Kessi, S., & Boonzaier, F. (2018). Centre/ing decolonial feminist psychology in Africa. *South African*

Journal of Psychology, *48*(3), 299–309. https://doi.org/10.1177/0081246318784507

Kincheloe, J., & McLaren, P. (2008). Rethinking critical theory and qualitative research. In N. K. Denzin & Y. Lincoln (Eds.), *The landscape of qualitative research* (3rd ed., pp. 285–326). Sage. https://doi.org/10.1007/978-94-6091-397-6

Kitzinger, C. (2000). Doing feminist Conversation Analysis. *Feminism & Psychology*, *10*(2), 163–193. https://doi.org/10.1177/0959353500010002001

Koole, T. (2013). Conversation analysis and education. In C. Chapelle (Ed.), *The encyclopaedia of applied linguistics: English books 3* (pp. 1–6). Blackwell Publishing Ltd. https://doi.org/10.1002/9781405198431.wbeal0199

Korobov, N. (2001). Reconciling theory with method: from conversation analysis and critical discourse analysis to positioning analysis. *Forum: Qualitative Social Research*, *2*(3), NP. http://www.qualitative-research.net/index.php/fqs/article/view/906

Kruger, L., & Lourens, M. (2016). Motherhood and the “Madness of Hunger”: “...want almal vra vir my vir 'n stukkie brood” (..."because everyone asks me for a little piece of bread"). *Culture, Medicine & Psychiatry*, *40*, 124–143. https://doi.org/10.1007/s11013-015-9480-5

Kukla, R. (2010). The ethics and cultural politics of reproductive risk warnings: A case study of California’s Proposition 65. *Health, Risk & Society*, *12*(4), 323–334. https://doi.org/10.1080/13698571003789708

Kvale, S., & Brinkman, S. (2009). *InterViews: Learning the craft of qualitative research interviewing* (2nd ed.). Sage.

Lafrance, M. N., & McKenzie-Mohr, S. (2013). The DSM and its lure of legitimacy. *Feminism and Psychology*, *23*(1), 119–140. https://doi.org/10.1177/0959353512467974

Lashbrook, J. T. (2000). Fitting in: exploring the emotional dimension of peer pressure. *Adolescence*, *35*(140), 747–757. https://www.proquest.com/openview/bf0267e0821e0a803053c8c94a60b928/1?pq-origsite=gscholar&cbl=41539

Leppo, A., Hecksher, D., & Tryggvesson, K. (2014). “Why take chances?” Advice on alcohol intake to pregnant and non-pregnant women in four Nordic countries. *Health, Risk & Society*, *16*(6), 512–529. https://doi.org/10.1080/13698575.2014.957659

Levola, J., & Aalto, M. (2015). Screening for at-risk drinking in a population reporting symptoms of depression: A validation of the AUDIT, AUDIT-C, and AUDIT-3. *Alcoholism: Clinical and Experimental Research*, *39*(7), 1186–1192. https://doi.org/10.1111/acer.12763

Lloyd, M. (2007). *Judith Butler: From norms to politics*. Polity.

Logan, D., & Marlatt, G. A. (2010). Harm reduction therapy: A practice-friendly review of research. *Journal of Clinical Psychology: In Session*, *66*(2), 201–214. https://doi.org/10.1002/jclp.20669

London, L. (1999). The "dop" system, alcohol abuse and social control amongst farm workers in South Africa: a public health challenge. *Social Science & Medicine*, *48*(10), 1407–1414. https://doi.org/10.1016/S0277-9536(98)00445-6

London, L. (2000). Alcohol consumption amongst South African farm workers: A challenge for post-apartheid health sector transformation. *Drug and Alcohol Dependence*, *59*(2), 199–206. https://doi.org/10.1016/S0376-8716(99)00120-9

Loxton, D., Chojenta, C., Anderson, A. E., Powers, J. R., Shakeshaft, A., & Burns, L. (2013). Acquisition and utilization of information about alcohol use in pregnancy among Australian pregnant women and service providers. *Journal of Midwifery and Women's Health*, *58*(5), 523-530. https://doi.org/10.1111/jmwh.12014

Lugones, M. (2010). Toward a Decolonial Feminism. *Hypatia*, *25*(4), 742–759. https://doi.org/10.1111/j.1527-2001.2010.01137.x

Lupton, D. (2011). "The best thing for the baby": Mothers' concepts and experiences related to promoting their infants' health and development. *Health, Risk and Society*, *13*(7–8), 637–651. https://doi.org/10.1080/13698575.2011.624179

Lupton, D. (2012). "Precious cargo": Foetal subjects, risk and reproductive citizenship. *Critical Public Health*, *22*(3), 329–340. https://doi.org/10.1080/09581596.2012.657612

Macleod, C. I. (2011). *"Adolescence", pregnancy and abortion: Constructing a threat of degeneration*. Routledge.

Macleod, C. I., Beynon-Jones, S., & Toerien, M. (2017). Articulating reproductive justice through reparative justice: Case studies of abortion in Great Britain and South Africa. *Culture, Health and Sexuality*, *19*(5), 601–615. https://doi.org/10.1080/13691058.2016.1257738

Macleod, C. I., Bhatia, S., & Liu, W. (2020). Feminisms and decolonising psychology: Possibilities and

challenges. *Feminism and Psychology*, *30*(3), 287–305. https://doi.org/10.1177/0959353520932810

Macleod, C. I., & Jearey-Graham, N. (2015). “Peer pressure” and “peer normalization”: Discursive resources that justify gendered youth sexualities. *Sexuality Research and Social Policy*, *13,* 230-240. https://doi.org/10.1007/s13178-015-0207-8

Macleod, C. I., Matebese, S., & Tsetse, N. (2020). “I drank because I wanted to deal with the frustration”: Explaining alcohol consumption in a low-resource setting - women’s, partners, and family member’s narratives. *Social Work/Maatskaplike Werk*, *56*(1), 88–96. https://doi.org/10.15270/52-2-792

Macleod, C. I., Young, C., & Molokoe, K. (2021). Alcohol use during pregnancy: Prevalence and patterns in selected Buffalo City Areas, South Africa. *African Journal of Reproductive Health*, *25*(1), 114–121. https://doi.org/10.29063/ajrh2021/v25i1.13

Mager, A. (2004). "White liquor hits black livers": Meanings of excessive liquor consumption in South Africa in the second half of the twentieth century. *Social Science & Medicine*, *59*(4), 735–751. https://doi.org/10.1016/j.socscimed.2003.12.005

Mamluk, L., Edwards, H. B., Savović, J., Leach, V., Jones, T., Moore, T. H. M., Ijaz, S., Lewis, S. J., Donovan, J. L., Lawlor, D., Smith, G. D., Fraser, A., & Zuccolo, L. (2017). Low alcohol consumption and pregnancy and childhood outcomes: Time to change guidelines indicating apparently “safe” levels of alcohol during pregnancy? A systematic review and meta-analyses. *BMJ Open, 7*(7), e015410, 1-13. https://doi.org/10.1136/bmjopen-2016-015410

Marais, S., Jordaan, E., Viljoen, D., Olivier, L., de Waal, J., & Poole, C. (2011). The effect of brief interventions on the drinking behaviour of pregnant women in a high-risk rural South African community: A cluster randomised trial. *Early Child Development and Care*, *181*(4), 463–474. https://doi.org/10.1080/03004430903450392

Marlatt, G. A., & Witkiewitz, K. (2010). Update on harm-reduction policy and intervention research. *Annual Review of Clinical Psychology*, *6*, 591–606. https://doi.org/10.1146/annurev.clinpsy.121208.131438

Mashigo, P. (2012). The lending practices of micro-lenders and their impact on low-income households in South Africa: a case study for Mamelodi township. *New Contree: A Journal of Historical and Human Sciences for Southern Africa.*, *65*, 23–46. http://hdl.handle.net/10394/8260

Matebese, S., Macleod, C. I., & Tsetse, N. (2021). The Shame of Drinking Alcohol While Pregnant: The Production of Avoidance and Ill-Health. *Affilia - Journal of Women and Social Work*, *36*(4), 629–646. https://doi.org/10.1177/0886109920985139

Matuku, S., & Kaseke, E. (2014). The role of stokvels in improving people's lives: The case in Orange Farm, Johannesburg, South Africa. *Social Work (South Africa)*, *50*(4), 504–515. https://doi.org/10.15270/50-4-388

May, P. A., Blankenship, J., Marais, A., Gossage, J. P., Kalberg, W. O., Joubert, B., Cloete, M., Barnard, R., De Vries, M., Hasken, J., Robinson, L. K., Adnams, C. M., Buckley, D., Manning, M. A., Parry, C. D., Hoyme, H. E., Tabachnick, B., & Seedat, S. (2013). Maternal alcohol consumption producing fetal alcohol spectrum disorders (FASD): Quantity, frequency, and timing of drinking. *Drug and Alcohol Dependence*, *133*(2), 502-512. https://doi.org/10.1016/j.drugalcdep.2013.07.013

May, P. A., Brooke, L., Gossage, J. P., Croxford, J., Adnams, C., Jones, K. L., Robinson, L., & Viljoen, D. (2000). Epidemiology of fetal alcohol syndrome in a South African community in the Western Cape Province. *American Journal of Public Health*, *90*(12), 1905–1912. https://doi.org/10.2105/ajph.90.12.1905

May, P. A., De Vries, M., Marais, A., Kalberg, W., Buckley, D., Adnams, C., Hasken, J., Tabachnick, B., Robinson, L., Manning, M. A., Bezuidenhout, H., Adam, M., Jones, K., Seedat, S., Parry, C. D., & Hoyme, H. (2017). Replication of high fetal alcohol spectrum disorders prevalence rates, child characteristics, and maternal risk factors in a second sample of rural communities in South Africa. *International Journal of Environmental Research and Public Health*, *14*(522), 1-22. https://doi.org/10.3390/ijerph14050522

May, P. A., Gossage, J. P., Marais, A. S., Hendricks, L. S., Snell, C. L., Tabachnick, B. G., Stellavato, C., Buckley, D. G., Brooke, L. E., & Viljoen, D. L. (2008). Maternal risk factors for fetal alcohol syndrome and partial fetal alcohol syndrome in South Africa: A third study. *Alcohol Clin Exp Res*, *32*(5), 738–753. https://doi.org/ACER634 [pii]\r10.1111/j.1530-0277.2008.00634.x

May, P. A., Hamrick, K., Corbin, K. D., Hasken, J. M., Marais, A., Blankenship, J., Hoyme, H. E., & Gossage, J. P. (2016). Maternal nutritional status as a contributing factor for the risk of fetal alcohol spectrum disorders. *Reproductive Toxicology*, *59,* 101-108. https://doi.org/10.1016/j.reprotox.2015.11.006

May, P. A., Hamrick, K. J., Corbin, K. D., Hasken, J. M., Marais, A., Brooke, L. E., Blankenship, J.,

Hoyme, H. E., & Gossage, J. P. (2014). Dietary intake, nutrition, and fetal alcohol spectrum disorders in the Western Cape Province of South Africa. *Reproductive Toxicology, 46,* 31-39. https://doi.org/10.1016/j.reprotox.2014.02.002

May, P. A., Hasken, J. M., Blankenship, J., Marais, A., Joubert, B., Cloete, M., de Vries, M. M., Barnard, R., Botha, I., Roux, S., Doms, C., Gossage, J. P., Kalberg, W. O., Buckley, D., Robinson, L. K., Adnams, C. M., Manning, M. A., Parry, C. D., Hoyme, H. E., … Seedat, S. (2016). Breastfeeding and maternal alcohol use: Prevalence and effects on child outcomes and fetal alcohol spectrum disorders. *Reproductive Toxicology*, *63,* 13-21. https://doi.org/10.1016/j.reprotox.2016.05.002

May, P. A., Marais, A. S., De Vries, M., Hasken, J. M., Stegall, J. M., Hedrick, D. M., Snell, C. L., Seedat, S., & Parry, C. D. H. (2019). The dop system of alcohol distribution is dead, but it's legacy lives on. *International Journal of Environmental Research and Public Health*, *16*(19), 3701, 1-17. https://doi.org/10.3390/ijerph16193701

May, P. A., Marais, A. S., Gossage, J. P., Barnard, R., Joubert, B., Cloete, M., ..., & Blankenship, J. (2013). Case management reduces drinking during pregnancy among high risk women. *International Journal of Alcohol and Drug Research, 2*(3), 61-70. https://0-www.ncbi.nlm.nih.gov.wam.seals.ac.za/pmc/articles/PMC3981106/

Mazzei, L. A. (2007). *Inhabited silence in qualitative research: putting poststructural theory to work*. Peter Lang.

McBride, N., & Johnson, S. (2016). Fathers' role in alcohol-exposed pregnancies: Systematic review of human studies. *American Journal of Preventive Medicine*, *51*(2), 240-248. https://doi.org/10.1016/j.amepre.2016.02.009

Mckenzie, J. A., & Macleod, C. I. (2012). Rights discourses in relation to education of people with intellectual disability: Towards an ethics of care that enables participation. *Disability & Society*, *27*(1), 15–29. https://doi.org/10.1080/09687599.2012.631795

McMahon, J. (2015). Behavioural economics as neoliberalism: Producing and governing homo economicus. *Contemporary Political Theory*, *14*, 137–158. https://doi.org/doi.org/10.1057/cpt.2014.14

Meurk, C. S., Broom, A., Adams, J., Hall, W., & Lucke, J. (2014). Factors influencing women's decisions to drink alcohol during pregnancy: findings of a qualitative study with implications for health communication. *BMC Pregnancy and Childbirth*, *14*(246), 1-9. https://doi.org/10.1186/1471-

2393-14-246

Morison, T., & Lynch, I. (2016). “We can’t help you here”: The discursive erasure of sexual minorities in South African public sexual and reproductive health services. *Psychology of Sexualities Review*, *7*(2), 7–25. http://hdl.handle.net/20.500.11910/10280

Morison, T., & Macleod, C. I. (2013). A Performative-Performance Analytical Approach: Infusing Butlerian Theory Into the Narrative-Discursive Method. *Qualitative Inquiry*, *19*(8), 566–577. http://qix.sagepub.com/cgi/content/abstract/19/8/566

Morris, C., & Munt, S. R. (2019). Classed formations of shame in white, British single mothers. *Feminism and Psychology*, *29*(2), 231–249. https://doi.org/10.1177/0959353518787847

Mouffe, C. (1992). Feminism, citizenship and radical democratic politics. In J. Butler & J. W. Scott (Eds.), *Feminists theorise the political* (pp. 369–385). Routledge. https://doi.org/10.5565/rev/athenead/v1n9.260

Mungwini, P. (2012). "Surveillance and cultural panopticism": Situating Foucault in African modernities. *South African Journal of Philosophy*, *31*(2), 340–353. https://doi.org/10.1080/02580136.2012.10751780

National Department of Health; Statistics South Africa; South African Medical Research Council; ICF. (2019). *South Africa Demographic and Health Survey 2016*. Pretoria, South Africa and Rockville, Maryland, USA. https://dhsprogram.com/pubs/pdf/FR337/FR337.pdf

Ndlovu-Gatsheni, S. (2018). *Epistemic freedom in Africa: deprovincialisation and decolonisation*. Routledge.

Neighbors, C., Lewis, M. A., LaBrie, J., DiBello, A. M., Young, C. M., Rinker, D. V, Litt, D., Rodriguez, L. M., Knee, C. R., Hamor, E., Jerabeck, J. M., & Larimer, M. E. (2016). A multisite randomized trial of normative feedback for heavy drinking: Social comparison versus social comparison plus correction of normative misperceptions. *Journal of Consulting and Clinical Psychology*, *84*(3), 238–247. https://doi.org/10.1037/ccp0000067

O’Connor, M. J., & Whaley, S. E. (2007). Brief intervention for alcohol use by pregnant women. *American Journal of Public Health*, *97*(2), 252–258. https://doi.org/10.2105/AJPH.2005.077222

O’Keeffe, L. M., Greene, R. A., & Kearney, P. M. (2014). The effect of moderate gestational alcohol consumption during pregnancy on speech and language outcomes in children: A systematic

review. *Systematic Reviews*, *3*(1), 1-11. https://doi.org/10.1186/2046-4053-3-1

Olivier, L., Curfs, L. M. G., & Viljoen, D. L. (2016). Fetal alcohol spectrum disorders: Prevalence rates in South Africa. *South African Medical Journal*, *106*(6), S103–S106. https://doi.org/10.7196/SAMJ.2016.v106i6.11009

Pajulo, M., Pyykkönen, N., Kalland, M., Sinkkonen, J., Helenius, H., Punamäki, R.-L., & Suchman, N. (2012). Substance-abusing mothers in residential treatment with their babies: Importance of pre- and postnatal maternal reflective functioning. *Infant Mental Health Journal*, *33*(1), 70–81. https://doi.org/10.1002/imhj.20342

Pajulo, M., Suchman, N., Kalland, M., & Mayes, L. (2006). Enhancing the effectiveness of residential treatment for substance abusing pregnant and parenting women: Focus on maternal reflective functioning and mother-child relationship. *Infant Mental Health Journal*, *27*(5), 448–465. https://doi.org/10.1002/imhj.20100

Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology*. Routledge.

Parker, I. (1994). Discourse analysis. In P. Banister, E. Burman, I. Parker, M. Taylor, & C. Tindall (Eds.), *Qualitative methods in psychology: A research guide* (pp. 92–107). Open University Press.

Parry, C. D. (2005). South Africa: Alcohol today. *Addiction*, *100*(4), 426–429. https://doi.org/10.1111/j.1360-0443.2005.01015.x

Patra, J., Bakker, R., Irving, H., Jaddoe, V. W. V, Malini, S., & Rehm, J. (2011). Dose-response relationship between alcohol consumption before and during pregnancy and the risks of low birthweight, preterm birth and small for gestational age (SGA)-a systematic review and meta-analyses. *BJOG: An International Journal of Obstetrics and Gynaecology*, *118*(12), 1411–1421. https://doi.org/10.1111/j.1471-0528.2011.03050.x

Pei, J., Tremblay, M., McNeil, A., Poole, N., & McFarlane, A. (2017). Neuropsychological aspects of prevention and intervention for FASD in Canada. *Journal of Pediatric Neuropsychology*, *3*(1), 25–37. https://doi.org/10.1007/s40817-016-0020-1

Peltzer, K., & Ramlagan, S. (2009). Alcohol use trends in South Africa. *J Soc Sci*, *18*(1), 1–12. https://doi.org/10.1080/09718923.2009.11892661

Penberthy, J. K., Hook, J. N., Hettema, J., Farrell-Carnahan, L., & Ingersoll, K. (2013). Depressive symptoms moderate treatment response to brief intervention for prevention of alcohol

exposed pregnancy. *Journal of Substance Abuse Treatment*, *45*(4), 335–342. https://doi.org/10.1016/j.jsat.2013.05.002https://doi.org/10.1016/j.jsat.2013.05.002

Pengpid, S., Peltzer, K., & Ramlagan, S. (2021). Prevalence and correlates of hazardous, harmful or dependent alcohol use and drug use amongst persons 15 years and older in South Africa: Results of a national survey in 2017. *African Journal of Primary Health Care & Family Medicine*, *13*(1), 1–8. https://doi.org/10.4102/phcfm.v13i1.2847

Peràkylà, A. (2005). Analyzing talk and text. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 869–886). Sage.

Petrenko, C. L. M., & Alto, M. E. (2017). Interventions in fetal alcohol spectrum disorders: An international perspective. *European Journal of Medical Genetics*, *60*(1), 79–91. https://doi.org/10.1016/j.ejmg.2016.10.005

Pfinder, M., Kunst, A. E., Feldmann, R., van Eijsden, M., & Vrijkotte, T. G. M. (2013). Preterm birth and small for gestational age in relation to alcohol consumption during pregnancy: Stronger associations among vulnerable women? Results from two large Western-European studies. *BMC Pregnancy and Childbirth*, *13*(49), 1-10. https://doi.org/10.1186/1471-2393-13-49

Popova, S., Lange, S., Probst, C., Gmel, G., & Rehm, J. (2017). Estimation of national, regional, and global prevalence of alcohol use during pregnancy and Fetal Alcohol Syndrome: A systematic review and meta-analysis. *The Lancet Global Health*, *5,* e290–e299. https://doi.org/10.1016/S2214-109X(17)30021-9

Postow, B. C. (2008). Care ethics and impartial reasons. *Hypatia*, *23*(1), 1–8. https://doi.org/10.1007/sl0869-007-9037-x

Potter, J. (2004). Discourse analysis. In M. Hardy & A. Bryman (Eds.), *Handbook of data analysis* (pp. 607–624). Sage.

Rabinow, P. (1997). Introduction: The history of systems of thought. In P. Rabinow (Ed.), *Michel Foucault: Ethics, subjectivity and truth* (pp. xi-xlii). The New Press.

Rendall-Mkosi, K., Morojele, N., London, L., Moodley, S., Singh, C., & Girdler-Brown, B. (2013). A randomized controlled trial of motivational interviewing to prevent risk for an alcohol-exposed pregnancy in the Western Cape, South Africa. *Addiction*, *108*(4), 1-11. https://doi.org/10.1111/add.12081

Reynolds, J., Wetherell, M., & Taylor, S. (2007). Choice and chance: Negotiating agency in narratives

of singleness. *Sociological Review*, *55*(2), 331–351. https://doi.org/10.1111/j.1467-954X.2007.00708.x

Romaioli, D., & McNamee, S. (2021). (Mis)constructing social construction: Answering the critiques. *Theory and Psychology*, *31*(3), 315–334. https://doi.org/10.1177/0959354320967757

Roth, W.-M., & von Unger, H. (2018). Current perspectives on research ethics in qualitative research. *Forum: Qualitative Social Research*, *19*(3), 798-809. https://doi.org/http://dx.doi.org/10.17169/fqs-19.3.3155.

Russell, B. S., Eaton, L. A., & Petersen-Williams, P. (2013). Intersecting epidemics among pregnant women: Alcohol use, interpersonal violence, and HIV infection in South Africa. *Current HIV/AIDS Reports*, *10*(1), 103-110. https://doi.org/10.1007/s11904-012-0145-5

Rutman, D., Callahan, M., Lundquist, A., Jackson, S., & Field, B. (2000). *Substance use and pregnancy: Conceiving women in the policy-making process*. Status of Women Canada. https://www.researchgate.net/profile/Deb_Rutman/publication/264870539_Substance_Use_and_Pregnancy_Conceiving_Women_in_the_Policy-Making_Process/links/544c76c10cf2d6347f43adad.pdf

Rutman, D., & Hubberstey, C. (2019). National evaluation of Canadian multi-service FASD prevention programs: Interim findings from the co-creating evidence study. *International Journal of Environmental Research and Public Health*, *16*(1767), 1-21. https://doi.org/10.3390/ijerph16101767

Rutman, D., Hubberstey, C., Poole, N., Schmidt, R. A., & Van Bibber, M. (2020). Multi-service prevention programs for pregnant and parenting women with substance use and multiple vulnerabilities: Program structure and clients' perspectives on wraparound programming. *BMC Pregnancy and Childbirth*, *20*(441), 1-14. https://doi.org/10.1186/s12884-020-03109-1

Salmon, A. (2004). "It takes a community": Constructing Aboriginal mothers and children with FAS/FAE as objects of moral panic in/through a FAS/FAE prevention. *Journal of the Motherhood Initiative for Research and Community Involvement*, *6*(1), 112–123. https://jarm.journals.yorku.ca/index.php/jarm/article/view/4889

Salmon, A. (2011). Aboriginal mothering, FASD prevention and the contestations of neoliberal citizenship. *Critical Public Health*, *21*(2), 165–178. https://doi.org/10.1080/09581596.2010.530643

Sampson, E. (2001). Of rainbows and differences. In T. Sloan (Ed.), *Critical psychology: Voices for change* (pp. 1–5). St Martin’s Press.

Santona, A., Tagini, A., Sarracino, D., De Carli, P., Pace, C. S., Parolin, L., & Terrone, G. (2015). Maternal depression and attachment: The evaluation of mother-child interactions during feeding practice. *Frontiers in Psychology*, *6*(1235), 1–11. https://doi.org/10.3389/fpsyg.2015.01235

Schechter, D. S., Coots, T., Zeanah, C. H., Davies, M., Coates, S. W., Trabka, K. A., Marshall, R. D., Liebowitz, M. R., & Myers, M. M. (2005). Maternal mental representations of the child in an inner-city clinical sample: Violence-related posttraumatic stress and reflective functioning. *Attachment & Human Development*, *7*(3), 313–331. https://doi.org/10.1080/14616730500246011

Schegloff, E. A. (1984). On some questions and ambiguities in conversation. In J. . Atkinson & J. Heritage (Eds.), *Structures of social action: studies in conversational analysis* (pp. 28–52). Cambridge University Press.

Schegloff, E. A. (1997). Whose text? Whose context? *Discourse & Society*, *8*(2), 165–187. https://0-www.jstor.org.wam.seals.ac.za/stable/pdf/42888107.pdf?refreqid=excelsior%3Aed87256a147b234a33a9cf4fd2a1724c

Schneider, M., Norman, R., Parry, C., Bradshaw, D., & Plüddemann, A. (2007). Estimating the burden of disease attributable to alcohol use in South Africa in 2000. *South African Medical Journal 97*(8) 664–672. https://doi.org/10.7196/SAMJ.658

Seidman, S. (2013). Defilement and disgust: Theorizing the other. *American Journal of Cultural Sociology*, *1*(1), 3–25. https://doi.org/10.1057/ajcs.2012.3

Shefer, T., & Munt, S. R. (2019). A feminist politics of shame: Shame and its contested possibilities. *Feminism & Psychology*, *29*(2), 145–156. https://doi.org/10.1177/0959353519839755

Shield, K., Manthey, J., Rylett, M., Probst, C., Wettlaufer, A., Parry, C. D. H., & Rehm, J. (2020). Burdens of disease from 2000 - 2016 attributable to alcohol use.pdf. *The Lancet*, *5*, e51-e61. https://doi.org/doi.org/ 10.1016/S2468-2667(19)30231-2

Smith, B. J., & Bonfiglioli, C. M. F. (2015). Physical activity in the mass media: an audience perspective. *Health Education Research*, *30*(2), 359–369. https://doi.org/10.1093/her/cyv008

Solberg, C. T., Sørheim, P., Müller, K. E., Gamlund, E., Norheim, O. F., & Barra, M. (2020). The devil's

in the DALY: Prevailing evaluative assumptions. *Public Health Ethics*, *13*(3), 259–274. https://doi.org/10.1093/phe/phaa030

Stockings, E., Hall, W., Lynskey, M., Morley, K., Reavley, N., Strang, J., Patton, G., & Degenhardt, L. (2016). Prevention, early intervention, harm reduction, and treatment of substance use in young people. *The Lancet Psychiatry*, *3*(3), 280–296. doi: 10.1016/S2215-0366(16)00002-X.

Stoler, A. . (1995). *Race and the education of desire: Foucault's history of sexuality and the colonial order of things*. Duke University Press. https://doi.org/10.2307/j.ctv11319d6

Strong, T. (2005). Understanding in counselling: A preliminary social constructionist and conversation analytic examination. *British Journal of Guidance & Counselling*, *33*(4), 513–533. https://doi.org/10.1080/03069880500327538

Symons, M., Pedruzzi, R. A., Bruce, K., & Milne, E. (2018). A systematic review of prevention interventions to reduce prenatal alcohol exposure and fetal alcohol spectrum disorder in indigenous communities. *BMC Public Health 18*(1227), 1-18. https://doi.org/10.1186/s12889-018-6139-5

Taylor, S., & Littleton, K. (2006). Biographies in talk: A narrative-discursive research approach. *Qualitative Sociology Review*, *II*(1), 22–38. https://doi.org/1733-8077

Toerien, M. (2014). Conversation and conversation analysis. In U. Flick (Ed.), *The Sage handbook of qualitative data analysis* (pp. 327–340), Sage.

Toerien, M., & Jackson, C. (2019). Seeing silenced agendas in medical interactions: A conversation analytic case study. In A. J. Murray & K. Durrheim (Eds.), *Qualitative studies of silence* (pp. 38–58). Cambridge University Press.

Tomlinson, M., O'Connor, M. J., le Roux, I. M., Stewart, J., Mbewu, N., Harwood, J., & Rotheram-Borus, M. J. (2014). Multiple risk factors during pregnancy in South Africa: The need for a horizontal approach to perinatal care. *Prevention Science*, *15*(3), 277–282. https://doi.org/10.1007/s11121-013-0376-8

Törrönen, J. (2001). The concept of subject position in empirical social research. *Journal for the Theory of Social Behaviour*, *31*(3), 313–329. https://doi.org/10.1111/1468-5914.00161

Treharne, G. J., Mnyaka, P., Marx, J., & Macleod, C. I. (2018). Traversing ethical imperatives: Learning from stories from the field. In *The Palgrave handbook of ethics in critical research* (pp. 429–

453). Springer International Publishing. https://doi.org/10.1007/978-3-319-74721-7_28

Trnka, S., & Trundle, C. (2014). Competing Responsibilities: Moving Beyond Neoliberal Responsibilisation. *Anthropological Forum*, *24*(2), 136–153. https://doi.org/10.1080/00664677.2013.879051

Tronto, J. C. (1995). Care as a basis for radical political judgments. *Hypatia*, *10*(2), 141–149. https://doi.org/10.1111/j.1527-2001.1995.tb01376.x

Van den Berg, W., Makusha, T., Richter, L., Rabe, M., Ratele, K., Nduna, M., Khunou, G., Human, L., Zoheb, M. M., & Smith, C. (2018). *The state of South Africa's fathers, 2018*. Sonke Gender Justice and Human Sciences Research Council.

van der Wulp, N. Y., Hoving, C., & de Vries, H. (2014). Dutch midwives' experiences with implementing health counselling to prevent prenatal alcohol use. *Journal of Clinical Nursing*, *23,* 3286-3289. https://doi.org/10.1111/jocn.12525

van der Wulp, N. Y., Hoving, C., & de Vries, H. (2015). Partner's Influences and Other Correlates of Prenatal Alcohol Use. *Maternal and Child Health Journal*, *19,* 908-916. https://doi.org/10.1007/s10995-014-1592-y

Van der Wulp, N. Y., Hoving, C., & De Vries, H. (2013). A qualitative investigation of alcohol use advice during pregnancy: Experiences of Dutch midwives, pregnant women and their partners. *Midwifery*, *29*(11), e89–e98. https://doi.org/10.1016/j.midw.2012.11.014

Walker, M. J., Al-Sahab, B., Islam, F., & Tamim, H. (2011). The epidemiology of alcohol utilization during pregnancy: An analysis of the Canadian Maternity Experiences Survey (MES). *BMC Pregnancy and Childbirth*, *11*(52), 1–9. https://doi.org/10.1186/1471-2393-11-52

Wang, Y., Feltham, B. A., Eskin, M. N. A., & Suh, M. (2021). Differential effects of maternal diets on birth outcomes and metabolic parameters in rats after ethanol consumption during pregnancy. *British Journal of Nutrition*, *126*(8), 1130–1139. https://doi.org/10.1017/S0007114520005152

Warren, Z., & Moghaddam, F. M. (2018). Positioning theory and social justice. In P. L. Hammack (Ed.), *The Oxford handbook of social psychology and social justice* (pp. 319–330). Oxford University Press.

Wassenaar, D. R. (2006). Ethical issues in social science research. In M. Terre Blanche, K. Durrheim, & D. Painter (Eds.), *Research in practice* (2nd ed., pp. 60–79). UCT press.

Watt, M. H., Eaton, L. A., Choi, K. W., Velloza, J., Kalichman, S. C., Skinner, D., & Sikkema, K. J. (2014). “It’s better for me to drink, at least the stress is going away”: Perspectives on alcohol use during pregnancy among South African women attending drinking establishments. *Social Science and Medicine*, *116*, 119–125. https://doi.org/10.1016/j.socscimed.2014.06.048

Watt, M. H., Eaton, L. A., Dennis, A. C., Choi, K. W., Kalichman, S. C., Skinner, D., & Sikkema, K. J. (2016). Alcohol Use During Pregnancy in a South African Community: Reconciling Knowledge, Norms, and Personal Experience. *Maternal and Child Health Journal*, *20,* 48-55. https://doi.org/10.1007/s10995-015-1800-4

Wetherell, M. (1998). Positioning and interpretative repertoires: Conversation analysis and post-structuralism in dialogue. *Discourse and Society*, *9*(3), 387–412. https://doi.org/10.1177/0957926598009003005

Wetherell, M. (2001). Debates in discourse research. In M. Wetherell, S. Taylor, & S. Yates (Eds.), *Discourse theory and practice: a reader* (pp. 380–399). Sage.

White, M. (2007). *Maps of narrative practice*. Norton.

Wilkinson, S., & Kitzinger, C. (2003). Constructing identities: a feminist conversation analytic approach to positioning in action. In R. Harré & F. M. Moghaddam (Eds.), *The self and others: Positioning individuals and groups in personal, political and cultural contexts* (pp. 157–180). Praeger.

Wilkinson, S., & Kitzinger, C. (2007). Conversation analysis, gender and sexuality. In A. Weatherall, B. Watson, & C. Gallois (Eds.), *Language, discourse and social psychology* (pp. 206–230). Palgrave Macmillan. https://doi.org/doi.org/10.1057/9780230206168_9

Wilkinson, S., & Kitzinger, C. (2017). Conversation analysis. In C. Willig & W. Stainton Rogers (Eds.), *The Sage handbook of qualitative research in psychology* (2nd ed., pp. 74–92). Sage.

Willig, Carla. (2008). Discourse analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 160–185). Sage.

Willig, Carla. (2013). *Introducing qualitative research in psychology* (3rd ed.). Open University Press.

Wilton, G., Moberg, D. P., Van Stelle, K. R., Dold, L. L., Obmascher, K., & Goodrich, J. (2013). A randomized trial comparing telephone versus in-person brief intervention to reduce the risk of an alcohol-exposed pregnancy. *Journal of Substance Abuse Treatment*, *45,* 389-394. https://doi.org/10.1016/j.jsat.2013.06.006

Witte, K., & Allen, M. (2000). A meta-analysis of fear appeals: Implications for effective public health campaigns. *Health Education & Behavior*, *27*(5), 591-615. https://doi.org/10.1177/109019810002700506

Wood, K., & Jewkes, R. (2006). Blood blockages and scolding nurses: barriers to adolescent contraceptive use in South Africa. *Reproductive Health Matters*, *14*(27), 109–118. https://doi.org/10.1016/S0968-8080(06)27231-8

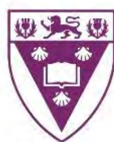
World Health Organisation. (2018). *Global status report on alcohol and health 2018*. http://www.who.int/ substance_abuse/publications/global_alcohol_report/en/

Wowk, M. T. (2007). Kitzinger's Feminist Conversation Analysis: Critical Observations. *Human Studies*, *30*(2), 131–155. https://doi.org/10.1007/s10746-007-9051-z

Young, B., Lewis, S., Katikireddi, S. V., Bauld, L., Stead, M., Angus, K., Campbell, M., Hilton, S., Thomas, J., Hinds, K., Ashie, A., & Langley, T. (2018). Effectiveness of mass media campaigns to reduce alcohol consumption and harm: A systematic review. In *Alcohol and Alcoholism, 53*(3), 302–316. Oxford University Press. https://doi.org/10.1093/alcalc/agx094

Yüksel-Kaptanoğlu, İ., & Adalı, T. (2021). Intimate Partner Violence During Pregnancy in Turkey: Determinants From Nationwide Surveys. *Journal of Interpersonal Violence*, *36*(15–16), 7802–7831. https://doi.org/10.1177/0886260519837652

Appendix A: Ethical clearance for overarching project



RHODES UNIVERSITY
Where leaders learn

Rhodes University Ethical Standards CommiΣee, Rhodes University, P O Box 94, Grahamstown, 6140

Tel: +27 46 603 7366 • Fax: +27 46 603 8934 • Email: ethics-commiΣee@ru.ac.za

11-Jul-2016

Dear Carol (Katlego) Molokoe (Temp)

Ethics Clearance: Alcohol use during pregnancy in the Eastern Cape: Research in support of [Organisation] interventon

Principal Investigator: Carol (Katlego) Molokoe (Temp)

This letter confirms that a research proposal with tracking number: RU-HSD-16-05-0001 and title: **Alcohol use during pregnancy in the Eastern Cape: Research in support of [Organisation] intervention** was given ethics clearance by the Rhodes University Ethical Standards CommiΣee.

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 or not 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.

Yours Sincerely,

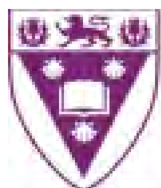
Dr J. Marx: Chairperson RUESC.

Note:

1. This clearance is valid from the date on this letter to the time of completion of data collection. 2. The ethics committee cannot grant retrospective ethics clearance.

3. Progress reports should be submitted annually unless otherwise specified.

Appendix B: Ethical approval for Project 3



RHODES UNIVERSITY
Where leaders learn

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

16 November 2016

Nicola Graham
Department of Psychology
RHODES UNIVERSITY
6140

Dear Nicola

ETHICAL CLEARANCE OF PROJECT PSY2016/63

This letter confirms your research proposal with tracking number PSY2016/63 and title, 'A critical discursive and formative evaluation of two aspects of an alcohol and pregnancy intervention in the Eastern Cape', served at the Research Projects and Ethics Review Committee (RPERC) of the Psychology Department of Rhodes University on 26 October

2016. The project has been given ethics clearance.

Please 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

Dr Jacqui Marx

CHAIRPERSON: RPERC

Appendix C: Permission from Organisation to collect data

24 January 2017

[Letterhead branding deleted to preserve anonymity of Organisation]

To whom it may concern

"I hereby give permission for Nicola Jearey Graham, and assistant researchers, to examine training materials, record training sessions, conduct and record interviews, and record mentoring sessions which are conducted by FASfacts in the Buffalo City municipality.This is for the purposes of gathering data for the research project entitled 'A critical discursive and formative evaluation of two aspects of an alcohol and pregnancy intervention in the Eastern Cape.'

"I understand that all data gathered will be treated confidentially. Electronic recordings and transcriptions will be kept in password protected files. Paper transcriptions will be kept in a locked cupboard. Only researchers of the Rhodes CSSR research team, and translators and transcribers who are bound by rules of confidentiality, will have access to these files. Reports written will mask the identities of the individuals involved, to the extent that this is possible. Formative feedback reports and a copy of the final thesis report will be provided to FASfacts."

We wish Nicola Graham and her assistant researchers all strength with their research project. Thank you so much that [Organisation] can be part of this project which we believe will be beneficial to the participatory communities.

Best wishes,

[Signature deleted to preserve anonymity]

CEO and founder

Appendix D: Information on the research into the training sessions

RHODES UNIVERSITY - DEPARTMENT OF PSYCHOLOGY

INFORMATION ON THE RESEARCH INTO THE [ORGANISATION] TRAINING SESSIONS

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

2. The researchers are interested in helping [Organisation] to become even more effective. They are NOT going to evaluate anyone's individual performance.

3. Participation will involve:

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

   b. Filling out a questionnaire after the training sessions;

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

4. Only Nicola, Nqobile, their supervisors, a transcriber/translator, and selected researchers in the CSSR research programme at Rhodes University will have access to the recordings and transcriptions. These people will not divulge your name or identity to others. Recordings and transcriptions will be stored electronically in password protected files. Paper copies of transcriptions will be stored in a locked cupboard.

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

6. You are free to withdraw from the study at any time – however, if you agree to participate, you need to commit yourself to full participation unless some unusual circumstances occur, or you have concerns about your participation which you did not originally anticipate.

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

8. If you are a trainee and do NOT wish to participate, then the training session in which you are taking part will still be recorded, but any of your contributions will be erased from the transcriptions of the recordings.

IDYUNIVESITHI YASE RHODES – ISEBE LEZIFUNDO ZESAYIKHOLOJI

IINKCUKACHA EZIBALULEKILEYO NGOPHANDO LWEESESHINI ZOQEQESHO ZE-[ORGANISATION]

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

2. Abaphandi banomdla wokunceda i-[Organisation] ibe neziphumo eziluncedo, ezintle, nezinokunceda abanye. **Abazokuvavanya indlela namnye umntu asebenza ngayo**.

3. Ukuthatha kwam inxaxheba kuzakuquka oku kulandelayo:

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

    b. Ukwenza okanye ukugcwalisa iphepha elinemibuzo emva kweeseshini zoqeqesho;

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

4. UNicola, noNqobile, umongameli wabo, umntu oqeqeshelwe ukukhuphela oko ndikuthethileyo/umtoliki okanye umguquleli nabaphandi abakhethiweyo kwinkqubo yophando e-CSSR eDyunivesithi yaseRhodes ngabo bodwa abazakufikelela koko kurekhodishiweyo nokukhutshelweyo bendikuthethile. Aba bantu abazokulichaza igama lam okanye bandazise kwabanye. Oko kurekhodishiweyo noko kukhutshelweyo bendikuthethile kuzakugcinwa kwiifayile ezinenombolo yokuvulwa. Iikopi zoko kukhutshelweyo bendikuthethile zizakutsixelwa ekhabhathini.

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

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

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

8. Ukuba ungumqeqeshi kwaye **awufuni** ukuthatha inxaxheba, iseshini yoqeqesho othatha inxaxheba kuyo isezakurekhodishwa kodwa, igalelo obunalo wena okanye izinto ubuzithethile zizakususwa koko kurekhodishiweyo kukhutshelweyo.

Appendix E: Agreement between researchers and participant

RHODES UNIVERSITY - DEPARTMENT OF PSYCHOLOGY

AGREEMENT BETWEEN STUDENT RESEARCHERS AND RESEARCH PARTICIPANT (training sessions)

I ____ (participant's name)

agree to participate in the research project of Nicola Jearey Graham and Nqobile Msomi on the [Organisation's] programmes.

I understand that:

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

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

11. My participation will involve:

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

    b. Filling out a questionnaire after the training sessions;

    c. Possibly being interviewed by Nqobile after the training sessions. This interview will be audio recorded and will last between 30 and 60 minutes. Questions will be asked about how I experienced the training sessions, and how I got involved with [the Organisation]. 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.

12. Only Nicola and Nqobile, their supervisor, a transcriber/translator, and selected researchers in the CSSR research programme at Rhodes University will have access to the recordings and transcriptions. These people will not divulge my name or identity to others. Recordings and transcriptions will be stored electronically in password protected files. Paper copies of transcriptions will be stored in a locked cupboard.

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

14. 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.

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

Signed on (Date):

Participant : ________________________________

Age : ________________________________

Researcher : ________________________________

IDYUNIVESITHI YASE RHODES – ISEBE LEZIFUNDO ZE-SAYIKHOLOJI

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

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

Ndiyaqonda ukuba:

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

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

11. Ukuthatha kwam inxaxheba kuzakuquka oku kulandelayo:

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

    b. Ukwenza okanye ukugcwalisa iphepha elinemibuzo emva kweeseshini zoqeqesho;

    c. Mhlawumbi ndithathe inxaxheba kudliwano-ndlebe oluzakwenziwa nguNqobile emva kweeseshini zoqeqesho. Olu dliwano-ndlebe luzakurekhodishwa ngeteyipu kwaye luzakuthatha phakathi kwemizuzu elishuni elinesithathu (30) ukuyokutsho kwimizuzu elishumi elinesithandathu (60). Imibuzo ezakubuzwa iyakuba ngamava am ngeeseshini nangendlela endiye ndaba yinxalenye ye-

[Organisation]. Ndingacelwa ukuba ndiphendule imibuzo ngam nobomi bam kodwa ndingakhetha ukungayiphenduli imibuzo edibene nento ethile ngobomi bam endingafuni ukuyichaza.

12. UNicola, noNqobile, umongameli wabo, umntu oqeqeshelwe ukukhuphela oko ndikuthethileyo/umtoliki okanye umguquleli nabaphandi abakhethiweyo kwinkqubo yophando e-CSSR eDyunivesithi yaseRhodes ngabo bodwa abazakufikelela koko kurekhodishiweyo nokukhutshelweyo bendikuthethile. Aba bantu abazokulichaza igama lam okanye bandazise kwabanye. Oko kurekhodishiweyo noko kukhutshelweyo bendikuthethile kuzakugcinwa kwiifayile ezinenombolo yokuvulwa. Iikopi zoko kukhutshelweyo bendikuthethile zizakutsixelwa ekhabhathini.

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

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

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

Isayinwe ngo (Umhla):___________________ Iminyaka: _______________________

Umthathi-nxaxheba: ____________________ Umphandi: ______________________

Appendix F: Use of video and audio recordings for research purposes

RHODES UNIVERISTY - DEPARTMENT OF PSYCHOLOGY

USE OF VIDEO & AUDIO RECORDINGS FOR RESEARCH PURPOSES PERMISSION AND RELEASE FORM

Name of participant	
Participant's contact details	Email: Cell number:
Name of researcher	Nicola Jearey Graham
Level of research	PhD
Title of project	A formative evaluation of [Organisation]
Name of supervisors	Prof. Catriona Macleod

DECLARATION

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

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

Signature of participant :

____

Date :

____

Witnessed by researcher :

____

Date :

____

IDYUNIVESITHI YASE RHODES – ISEBE LEZIFUNDO ZESAYIKHOLOJI

UKUSETYENZISWA KWEZINTO EZIREKHODISHIWEYO NGEVIDIYO NETEYIPU KUPHANDO – IFOMU YOKUNIKEZELA IMVUME YOKUSETYENZISWA KOKO KUREKHODISHIWEYO

Igama lomthathi-nxaxheba	
Iinkcukacha zonxibelelwano zomthathi-nxaxheba	I-imeyile: Inombolo yefowni:
Igama lomphandi	Nicola Jearey Graham
Izinga lophando	PhD
Isihloko sophando/seprojekthi	A formative study of [Organisation]
Amagama abongameli	Njingalwazi Catriona Macleod

UBHENGEZO

(Tikisha iibloko eziqulathe oko kufenelekileyo)

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

Isayiniwe ngumthathi-nxaxheba :

____

Umhla :

____

Ingqinwe ngumphandi :

____

Umhla :

____

Appendix G: Use of audio recordings for research purposes

RHODES UNIVERISTY - DEPARTMENT OF PSYCHOLOGY

USE OF AUDIO RECORDINGS FOR RESEARCH PURPOSES PERMISSION AND RELEASE FORM

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

DECLARATION

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

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

Signature of participant :

____

Date :

____

Witnessed by researcher :

____

Date :

____

IDYUNIVESITHI YASE RHODES – ISEBE LEZIFUNDO ZESAYIKHOLOJI

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

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

UBHENGEZO

(Tikisha iibloko eziqulathe oko kufenelekileyo)

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

Isayiniwe ngumthathi-nxaxheba :

____

Umhla :

____

Ingqinwe ngumphandi :

____

Umhla :

____

Appendix H: Semi structured interview schedule

Semi-structured interview schedule for facilitators and participants who took part in the training programmes

- Filling out of demographic and occupational details
- Going over consent form (already signed before training session)
- Setting up recording device
- Thank participant for agreeing to interview and recording
- Ask participant what questions s/he has for you before the interview

1. Please tell me your primary occupation (e.g. job, housekeeping, child minding, looking for employment etc.)

2. What are some of your hopes for your own life?

3. How did you hear about [Organisation]?

4. What made you decide to get involved in [Organisation]?

5. (For facilitators) What have you learnt since becoming a facilitator and running training courses for [Organisation]?

6. What was your experience of this week's training course?
    a. What aspects do you think went well/you enjoyed?
    b. What aspects do you think need improving/did you not enjoy?

7. What has really made an impact on you from this week's course?

8. (For facilitators) Is there anything you would like to do differently next time?

9. (For trainees) What have you learnt about alcohol and pregnancy through doing this course?

10. Tell me about alcohol use and pregnancy in your community.

11. How do you think [Organisation] can help to reduce alcohol use during pregnancy?
12. What role do you hope to be able to play in reducing alcohol use during pregnancy?

Show two different pictures depicting pregnancy from the training materials

Picture 1

This was the logo of the Organisation, which is not reproduced here to protect the identity of the Organisation. It depicts a stylised syllouette of a woman, with a foetus in her abdomen. The foetus is mature, almost ready for birth, and is depicted in detail, unlike for the woman. The woman is drinking from a blue bottle, and a blue line goes from her mouth to the foetus, indicating the passage of alcohol. The bottle is crossed out with a prominent red cross. The woman's one hand is holding the blue bottle, and her other is throwing away an empty bottle.

Picture 2

13. What do these pictures say to you about pregnancy/the foetus/women/drinking/smoking?

Appendix I: Transcribers' confidentiality agreement

CONFIDENTIALITY AGREEMENT:

Transcription Services

I, ________________________, (name of transcriber) agree to maintain full confidentiality in regards to any and all audio recordings and documentation received from ______________ (name of researcher) related to his/her (circle appropriate) research study on

____
____(title of research)

Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents;

2. To not make copies of any audiotapes or computerized files of the transcribed interview texts, unless specifically requested to do so by _______________________(name of researcher).

3. To store all study-related audio recordings and materials in a safe, secure location as long as they are in my possession;

4. To return all audio recordings and study-related documents to __________________ (name of researcher) in a complete and timely manner.

5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audio recordings and/or files to which I will have access.

Transcriber's name (printed)

____

Transcriber's signature

____

Date ____

Appendix J: Information on research into mentoring programme (mentors)

RHODES UNIVERSITY - DEPARTMENT OF PSYCHOLOGY

INFORMATION ON THE RESEARCH INTO THE [ORGANISATION] PREGNANT WOMEN MENTORING PROGRAMME

(Mentors)

1. Nicola is a student conducting the research as part of the requirements for a PhD degree at Rhodes University. She may be contacted on 076 259 2303 (cell phone) or g09g6311@campus.ru.ac.za (email). The research project has been approved by the relevant ethics committees, and is under the supervision of Prof Catriona Macleod in the Psychology Department, who may be contacted on 046 603 7377 (office) or c.macleod@ru.ac.za (email).

2. Nicola is interested in helping [the Organisation] to become even more effective. She is NOT going to evaluate your individual performance.

3. Your participation will involve audio-recording some of the mentoring consultations that you conduct as part of the mentoring programme.

    a. You will need to explain the research to the pregnant woman that you are mentoring, then ask for her consent to be recorded.

    b. If she agrees, then you must go over the information sheet with her. If she still agrees, then she must sign two consent forms (one for participation and one for recording).

    c. You must record how many previous sessions you have had with this woman (e.g. is this your first session? Third? Fifth? Etc.)

    d. Only after she has signed the consent forms can you switch on the recorder and conduct the session.

e. If she doesn't agree, then you can't record the session. Just continue with your mentoring as normal. It is very important that she doesn't feel forced to agree.

4. Only Nicola, her supervisor, a transcriber/translator, and selected researchers in the CSSR research programme at Rhodes University will have access to the recordings and transcriptions. These people will not divulge your name or identity to others. Recordings and transcriptions will be stored electronically in password protected files. Paper copies of transcriptions will be stored in a locked cupboard. All information will be confidential.

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

6. You are free to withdraw from the study at any time – however you need to commit yourself to full participation unless some unusual circumstances occur, or you have concerns about your participation which you did not originally anticipate.

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

IDYUNIVESITHI YASE RHODES - SEBE LEZIFUNDO ZESAYIKHOLOJI

IINKCUKACHA NGOPHANDO LWENKQUBO YE[ORGANISATION] YOKUCETYISWA KWABAFAZI ABAKHULELWEYO (Abacebisi)

1. UNicola ngumfundi owenza uphando oluyinxalenye nemfuneko yedigri ye*PHD* kwiDyunivesithi yase Rhodes. Angatsalelwa umxeba ku 076 259 2303 (iinombolo yefowni) okanye ku n.graham@ru.ac.za (nge-imeyile). Oluphando luvunyiwe ziikomiti zemikhwa esesiskweni kwaye longanywelwe nguNjingalwazi uCatriona Macleod kwisebe lezifundo zeSayikholoji kwiDyunivesithi yaseRhodes, ongatsalelwa umxeba ku 046 603 7377 (iinombolo ye-ofisi) okanye ku C.Macleod@ru.ac.za (nge-imeyile).

2. UNicola unomdla ekuncedeni iFASFacts yenze izinto bhetele iphumelele. **Akazokuvavanya indlela wena othi wenze ngayo umsebenzi wakho.**

3. Ukuthatha kwakho inxaxheba kuzakuquka ukurekhodisha iingxoxo zengcebiso othi uzenze njengenxalenye yenkqubo yokucetyiswa kwabantu abakhulelweyo (mentoring programme).

    a. Kuzakufuneka ucacise oluphando kumfazi okhulelweyo omcebisayo emvakoko ucele imvume yakhe yokuba arekhodishwe.

    b. Ukuba uyavuma, kuzakufuneka umcacisele iphepha leenkcukacha. Ukuba usavuma, kuzakufuneka asayine iifomu zemvume ezimbini (enye yeyokuthatha inxaxheba enye yeyokurekhodisha).

    c. Kuzakufuneka ubhale phantsi ukuba zingaphi iiseshini ezidlulileyo osele unazo nalomfazi (Umzekelo: Yiseshini yenu yokuqala? Yeyesithathu? Yeyesihlanu? Njalo njalo.)

    d. Emva kokuba umfazi ezisayinile iifomu, irekhoda ungayilayita uqhubeke neseshini.

e. Ukuba akavumi, awuzukwazi ukuyirekhodisha iseshini. Ungaqhubekeka nokucebisa kwakho njengesiqhelo. Kubalulekile ukuba umfazi angaziva enyanzelwe ukuba makavume.

4. UNicola, umongameli wophando lwakhe, umntu oqeqeshelwe ukukhuphela oko kuthethiweyo/ingququli kwakunye nabanye abaphandi abakhethiweyo kwiyunithi yophando i-*CSSR* kwiDyunivesithi yaseRhodes ngabo kuphela abayakufikelela koko kurekhodishiweyo noko kukhutshelweyo uzakube ukuthethile. Aba bantu abayi kuxelela abanye igama lakho okanye batsho ukuba ungumntu onjani. Oko kurekhodishiweyo noko kuyakube kukhutshelwe uzakube ukuthethile kuzakugcinwa ekhompyutheni kwiifayile ezinenombolo yokuvulwa. Iikopi zamaphepha zoko kukhutshelweyo uzakube ukuthethile zizakugcinwa kwikhabhathi ezakutixwa. Zonke iinkcukacha zizakuba yimfihlo.

5. Uyamenywa ukuba ubuze uNicola imibuzo ngokuthatha kwakho inxaxheba koluphando, okanye ngeziphumo ongathi ujongane nazo ngokuthatha kwakho inxaxheba, kwaye ezizinto ziphendulwe ngokweemfanelo zakho waneliseke. Ukuba ukuthatha kwakho inxaxheba kukwenze wakhathazeka, waba neentloni, okanye wakhubeka nangeyiphi na indlela, ungafumana inkxaso kube kanye kuNicola oyi-*Counselling Psychologist*. Ngenye indlela, ungathetha nonontlalontle weFASfacts okanye uNicola angandikungiselela ukuba ufumane iingcebiso kwa*FAMSA* (EMonti) okanye *eMasimanyane Women's Support Centre* (enamasebe eDuncan Village naseMdantsane).

6. Ukhululekile kwaye uvumelekile ukuba urhoxe koluphando nokuba kunini na – kodwa uyazinikela ukuba uthathe inxaxheba ngokupheleleyo ngaphandle kokuba kwenzeke into obungayilindelanga okanye uye wakhathazeka ngento okanye wakhathazwa yinto ethi yenzeke ngenxa yokuthatha kwakho inxaxheba obundingayilindelanga.

7. Ingxelo ngoluphando ingaba neenkcukacha ngamava, izimvo, nokuziphatha kwakho kodwa lengxelo izakubhalwa ngendlela ezakwenza abo bayifundayo bangabi nolwazi lokuba oko kubhaliweyo bekuthethwe nguwe.

Appendix K: Agreement between researcher and mentor

RHODES UNIVERSITY - DEPARTMENT OF PSYCHOLOGY

AGREEMENT BETWEEN STUDENT RESEARCHER AND RESEARCH PARTICIPANT (consultations – mentors)

I ____ (participant's name) agree to participate in the research project of Nicola Jearey Graham on the [Organisation] programmes.

I understand that:

1. Nicola is a student conducting the research as part of the requirements for a PhD degree at Rhodes University. She may be contacted on 076 259 2303 (cell phone) or n.graham@ru.ac.za (email). The research project has been approved by the relevant ethics committees, and is under the supervision of Prof Catriona Macleod in the Psychology Department at Rhodes University, who may be contacted on 046 603 7377 (office) or c.macleod@ru.ac.za (email).

2. Nicola is interested in helping [the Organisation] to become even more effective. She is NOT going to evaluate my individual performance.

3. My participation will involve audio recording some of the consultations that I engage in, as part of the mentoring programme.

4. Only Nicola, her supervisor, a transcriber/translator, and selected researchers in the CSSR research programme at Rhodes University will have access to the recordings and transcriptions. These people will not divulge my name or identity to others. Recordings and transcriptions will be stored electronically in password protected files. Paper copies of transcriptions will be stored in a locked cupboard. All information will be confidential.

5. I am invited to voice to Nicola any concerns I have about my participation in the study, or consequences I may experience as a result of my participation, and to have these addressed to my satisfaction. If my participation causes me any distress, embarrassment or offence, I may seek once-off emotional support from Nicola, who is a qualified Counselling Psychologist. Alternatively, I may speak to the [Organisation] social worker,

or the researcher can arrange for me to have counselling at FAMSA (in East London) or the Masimanyane Women's Support Centre (which has branches in both Duncan Village and Mdantsane).

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

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

Date: ____

Participant signature: ______________________________

Researcher signature: _____________________________

IDYUNIVESITHI YASE RHODES - SEBE LEZIFUNDO ZESAYIKHOLOJI

ISIVUMELWANO PHAKATHI KOMPHANDI NOMTHATHI-NXAXHEBA (IINGCEBISO ZE-MENTOR – ABACEBISI)

Mna (igama lomthathi-nxaxheba) _______________________ ndiyavuma ukuthatha inxaxheba kuphando luka Nicola Jearey Graham ngeenkqubo zika [Organisation].

Ndiyaqonda ukuba:

1. UNicola ngumfundi owenza uphando oluyinxalenye nemfuneko yedigri ye*PHD* kwiDyunivesithi yase Rhodes. Angatsalelwa umxeba ku 076 259 2303 (iinombolo yefowni) okanye ku n.graham@ru.ac.za (nge-imeyile). Oluphando luvunyiwe ziikomiti zemikhwa esesiskweni kwaye longanywelwe nguNjingalwazi uCatriona Macleod kwisebe lezifundo zeSayikholoji kwiDyunivesithi yaseRhodes, ongatsalelwa umxeba ku 046 603 7377 (iinombolo ye-ofisi) okanye ku C.Macleod@ru.ac.za (nge-imeyile).

2. UNicola unomdla ekuncedeni iFASFacts yenze izinto bhetele iphumelele. **Akazokuvavanya indlela wena othi wenze ngayo umsebenzi wakho.**

3. Ukuthatha kwam inxaxheba kuzakuquka ukurekhodishwa kwezinye iingxoxo endithi ndibe yinxalenye yazo kwinkqubo yokucebisa abantu abakhulelweyo (Mentoring Programme).

4. UNicola, umongameli wophando lwakhe, umntu oqeqeshelwe ukukhuphela oko kuthethiweyo/ingququli kwakunye nabanye abaphandi abakhethiweyo kwiyunithi yophando i-*CSSR* kwiDyunivesithi yaseRhodes ngabo kuphela abayakufikelela koko kurekhodishiweyo noko kukhutshelweyo ndizakube ndikuthethile. Aba bantu abayi kuxelela abanye igama lam okanye batsho ukuba ndingubani. Oko kurekhodishiweyo noko kuyakube kukhutshelwe ndizakube ndikuthethile kuzakugcinwa ekhompyutheni kwiifayile ezinenombolo yokuvulwa. Iikopi zamaphepha zoko kukutshelweyo ndizakube ndikuthethile zizakugcinwa kwikhabhathi ezakutixwa. Zonke iinkcukacha zizakuba yimfihlo.

5. Ndiyamenywa ukuba ndibuze imibuzo kuNicola ngokuthatha kwam inxaxheba koluphando, okanye ngeziphumo endingathi ndijongane nazo ngokuthatha kwam inxaxheba, kwaye ezizinto ziphendulwe ngokweemfanelo zam ndaneliseke. Ukuba ukuthatha kwam inxaxheba kundenze ndakhathazeka, ndaba neentloni, okanye ndakhubeka nangeyiphi na indlela, ndingafumana inkxaso kube kanye kuNicola oyi-*Counselling Psychologist*. Ngenye indlela, ndingathetha nonontlalontle we[Organisation] okanye umphandi angandilungiselela ukuba ndifumane iingcebiso kwa*FAMSA* (EMonti) okanye *eMasimanyane Women's Support Centre* (enamasebe eDuncan Village naseMdantsane).

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

Umhla: ______________________

Isignitsha yomthathi-nxaxheba: ____________________________

Isignitsha yomphandi: ____________________________

Appendix L: Use of audio recordings for research purposes

RHODES UNIVERISTY - DEPARTMENT OF PSYCHOLOGY

USE OF AUDIO RECORDINGS FOR RESEARCH PURPOSES

PERMISSION AND RELEASE FORM

Name of participant	
Participant's contact details	Email: Cell number:
Name of researcher	Nicola Jearey Graham
Level of research	PhD
Title of project	Formative evaluation of the [Organisation's] intervention
Name of supervisors	Prof. Catriona Macleod

DECLARATION

(Please 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	
11.	I agree to allow recordings to be made of the mentoring session that I am taking part in.		
12.	The audio recordings may be transcribed only by the researcher and a transcriber, both of whom will maintain the strictest confidentiality.		
13.	I give permission for the audio recordings and transcriptions to be retained after the study and for them to be utilised by the researchers of the Rhodes CSSR research team for future research.		

Signature of participant :

____

Date :

____

Witnessed by researcher :

____

Date :

____

IDYUNIVESITHI YASE RHODES – ISEBE LEZIFUNDO ZESAYIKHOLOJI

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

Igama lomthathi-nxaxheba	
Iinkcukachazonxibelelwano zomthathi-nxaxheba	I-imeyile: Inombolo yefowni:
Igama lomphandi	Nicola Jearey Graham
Izinga lophando	Uphando lwenzelwa PhD
Isihloko sophando/seprojekthi	*Formative evaluation of the [Organisation's] intervention*
Amagama abongameli	Njingalwazi Catriona Macleod

UBHENGEZO

(Tikisha iibloko eziqulathe oko kufenelekileyo)

1.	Isimo sophando nesokuthatha inxaxheba ndisichazelwe kwaye ndisicaciselwe:	Ngokuthethiweyo ☐ Ngokubhaliweyo ☐
2.	Ndiyavuma ukuba iiseshini zengcebiso endithatha inxaxheba kuzo zirekhodishwe	
3.	Oko kurekhodishiweyo kungakhutshelwa ngumphandi nomntu oqeqeshelwe umsebenzi wokukhuphela okuthethiweyo kuphela, bobabini aba bantu bayakugcina konke oko kubuthethile njengemfihlo, bangaxeleli mntu.	
4.	Ndinika imvume kwaye ndiyavuma ukuba okurekhodishiweyo noko kukhutshelweyo bendikuthethile kugcinwe emva kokuba uphando luphelile zize ezizinto zisetyenziswe ngababaphandi beqela le-CSSR kwiDyunivesithu yase Rhodes kwixesha elizayo.	

Isignitsha yomthathi-nxaxheba :

____

Umhla :

____

Ingqinwe ngumphandi :

____

Umhla :

____

Appendix M: Information on research into mentoring programme (pregnant women)

RHODES UNIVERSITY - DEPARTMENT OF PSYCHOLOGY

INFORMATION ON THE RESEARCH INTO THE [ORGANISATION'S] MENTORING PROGRAMME

(Pregnant women)

1. Nicola Jearey Graham is a student conducting the research as part of the requirements for a PhD degree at Rhodes University. She may be contacted on 076 259 2303 (cell phone) or g09g6311@campus.ru.ac.za (email). The research project has been approved by the relevant ethics committees and is under the supervision of Prof Catriona Macleod in the Psychology Department at Rhodes University, who may be contacted on 046 603 7377 (office) or c.macleod@ru.ac.za (email).

2. The research is about helping [the Organisation] to become even more effective. It is not about you, your individual relationships, or your lifestyle.

3. Your participation will involve being audio recorded during a mentoring consultation that you engage in, as part of the mentoring programme.

4. Only Nicola, her supervisor, a transcriber/translator, and selected researchers in the CSSR research programme at Rhodes University will have access to the recordings and transcriptions. Recordings and transcriptions will be stored electronically in password protected files. Paper copies of transcriptions will be stored in a locked cupboard. All the information gathered from you (like your name and personal details of your life) is confidential; none of it will be disclosed to others.

5. You are invited to ask the [Organisation's] Social Worker or your mentor about any concerns you have about your participation in the study, or consequences you may experience as a result of your participation, and to have these addressed to your satisfaction. The Social Worker or your mentor will communicate any concerns to Nicola. Alternatively, you may call/message Nicola directly on 076-259-2303. If your participation causes you any distress, embarrassment or offence, you may seek once-off emotional support from Nicola, who is a qualified Counselling

Psychologist. Alternatively, you may speak to the [Organisation's] Social Worker, or Nicola can arrange for you to have counselling at FAMSA, or Masimanyane Women's Support Centre.

6. You are free to withdraw from the study at any time – however you need commit yourself to full participation unless some unusual circumstances occur, or you have concerns about your participation which you did not originally anticipate.

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

IDYUNIVESITHI YASE RHODES - SEBE LEZIFUNDO ZESAYIKHOLOJI

IINKCUKACHA NGOPHANDO LWENKQUBO YE[ORGANISATION] YOKUCETYISWA KWABAFAZI ABAKHULELWEYO

(Abafazi abakhulelweyo)

1. UNicola ngumfundi owenza uphando oluyinxalenye nemfuneko yedigri ye*PHD* kwiDyunivesithi yase Rhodes. Angatsalelwa umxeba ku 076 259 2303 (iinombolo yefowni) okanye ku n.graham@ru.ac.za (nge-imeyile). Oluphando luvunyiwe ziikomiti zemikhwa esesiskweni kwaye longanywelwe nguNjingalwazi uCatriona Macleod kwisebe lezifundo zeSayikholoji kwiDyunivesithi yaseRhodes, ongatsalelwa umxeba ku 046 603 7377 (iinombolo ye-ofisi) okanye ku C.Macleod@ru.ac.za (nge-imeyile).

2. Olu phando lungokunceda iFASFacts yenze izinto bhetele iphumelele. Alukho ngokukhulelwa kwakho okanye indlela yakho yokuphila.

3. Ukuthatha kakho inxaxheba kuzakuquka ukurekhodishwa kwengxoxo yengcebiso othatha inxaxheba kuyo njengenxalenye yenkqubo yokucetyiswa kwabantu abakhulelweyo (mentoring programme).

4. UNicola, umongameli wophando lwakhe, umntu oqeqeshelwe ukukhuphela oko kuthethiweyo/ingququli kwakunye nabanye abaphandi abakhethiweyo kwiyunithi yophando i-*CSSR* kwiDyunivesithi yaseRhodes ngabo kuphela abayakufikelela koko kurekhodishiweyo noko kukhutshelweyo ozakube ukuthethile. Aba bantu abayi kuxelela abanye igama lakho okanye batsho ukuba ungubani. Oko kurekhodishiweyo noko kuyakube kukhutshelwe uzakube ukuthethile kuzakugcinwa ekhompyutheni kwiifayile ezinenombolo yokuvulwa. Iikopi zamaphepha zoko kukhutshelweyo uzakube ukuthethile zizakugcinwa kwikhabhathi ezakutixwa. Zonke iinkcukacha eziqokelelweyo kuwe (ezifana negama lakho kwakunye neenkcukacha ngobomi bakho) ziyimfihlo; akukho nanto ezakuthi ixelelwe abanye.

5. Uyamenywa ukuba ubuze imibuzo kunontlalontle weFASfacts okanye umcebisi wakho ngokuthatha kwakho inxaxheba koluphando, okanye ngeziphumo ongathi ujongane nazo ngokuthatha kwakho inxaxheba, kwaye ezizinto ziphendulwe ngokweemfanelo zakho waneliseke. Unontlalontle okanye umcebisi wakho uyakuthetha noNicola ngayo yonke imibuzo. Ngenye indlela, ungafowuna okanye uthumelele uNicola umyalezo ngqo ku 076-259-2303. Ukuba ukuthatha kwakho inxaxheba kukwenze wakhathazeka, waba neentloni, okanye wakhubeka nangeyiphi na indlela, ungafumana inkxaso kube kanye kuNicola oyi-*Counselling Psychologist*. Ngenye indlela, ungathetha nonontlalontle we[Organisation] okanye uNicola angakulungiselela ukuba ufumane iingcebiso kwa*FAMSA* okanye *eMasimanyane Women's Support Centre*.

6. Ukhululekile kwaye uvumelekile ukuba urhoxe koluphando nokuba kunini na – kodwa uyazinikela ukuba uthathe inxaxheba ngokupheleleyo ngaphandle kokuba kwenzeke into obungayilindelanga okanye uye wakhathazeka ngento okanye wakhathazwa yinto ethi yenzeke ngenxa yokuthatha kwakho inxaxheba obundingayilindelanga.

7. Ingxelo ngoluphando ingaba neenkcukacha ngamava, izimvo, nokuziphatha kwakho kodwa lengxelo izakubhalwa ngendlela ezakwenza abo bayifundayo bangabi nolwazi lokuba oko kubhaliweyo bekuthethwe nguwe.

Appendix N: Agreement between researcher and pregnant woman

RHODES UNIVERSITY - DEPARTMENT OF PSYCHOLOGY

AGREEMENT BETWEEN STUDENT RESEARCHER AND RESEARCH PARTICIPANT (mentoring consultations – Pregnant woman)

I ____ (participant's name) agree to participate in the research project of Nicola Jearey Graham on the [Organisation's] programmes.

Name of mentor: ___________________________________

Number of previous mentoring sessions: ________________

I understand that:

1. My mentor is obtaining this consent on behalf of the researcher, Nicola.
2. Nicola is a student conducting the research as part of the requirements for a PhD degree at Rhodes University. She may be contacted on 076 259 2303 (cell phone) or n.graham@ru.ac.za (email). The research project has been approved by the relevant ethics committees, and is under the supervision of Prof Catriona Macleod in the Psychology Department at Rhodes University, who may be contacted on 046 603 7377 (office) or c.macleod@ru.ac.za (email).
3. The research is about helping [the Organisation] to become even more effective. It is not about my individual pregnancy or lifestyle.
4. My participation will involve being audio recorded during one or two of the consultations that I engage in, as part of the mentoring programme.
5. Only Nicola, her supervisor, a transcriber/translator, and selected researchers in the CSSR research programme at Rhodes University will have access to the recordings and transcriptions. Recordings and transcriptions will be stored electronically in password

protected files. Paper copies of transcriptions will be stored in a locked cupboard. All the information gathered from me is confidential, and will not be disclosed to others. This includes my name, identity, and personal details of my life.

6. I am invited to ask the mentor about 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. The [Organisation] Social Worker or mentor will communicate any concerns to Nicola. Alternatively, I may call/message Nicola directly on 076-259-2303. If my participation causes me any distress, embarrassment or offence, I may seek once-off emotional support from Nicola, who is a qualified Counselling Psychologist. Alternatively, I may speak to the FASfacts Social Worker, or Nicola can arrange for me to have counselling at FAMSA (in East London) or the Masimanyane Women's Support Centre (which has branches in both Duncan Village and Mdantsane).

7. 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.

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

Signed on (Date): ______________________________________

Participant signature: ____

Age: ______________________________ Number of children: _____________

Mentor signature: ____

Researcher signature: ____

IDYUNIVESITHI YASE RHODES - SEBE LEZIFUNDO ZESAYIKHOLOJI

ISIVUMELWANO PHAKATHI KOMPHANDI NOMTHATHI-NXAXHEBA (IINGCEBISO ZE-MENTORING PROGRAMME – UMFAZI OKHULELWEYO)

Mna (igama lomthathi-nxaxheba) _______________________ ndiyavuma ukuthatha inxaxheba kuphando luka Nicola Jearey Graham ngeenkqubo zika [Organisation].

Igama lomcebisi wam: ____

Inani leeseshini zengcebiso ezidlulileyo: ________________________________

Ndiyaqonda ukuba:

1. Umcebisi wam wakwa[Organisation] ufumana imvume yam endaweni yomphandi.

2. UNicola ngumfundi owenza uphando oluyinxalenye nemfuneko yedigri ye*PHD* kwiDyunivesithi yase Rhodes. Angatsalelwa umxeba ku 076 259 2303 (iinombolo yefowni) okanye ku n.graham@ru.ac.za (nge-imeyile). Oluphando luvunyiwe ziikomiti zemikhwa esesiskweni kwaye longanywelwe nguNjingalwazi uCatriona Macleod kwisebe lezifundo zeSayikholoji kwiDyunivesithi yaseRhodes, ongatsalelwa umxeba ku 046 603 7377 (iinombolo ye-ofisi) okanye ku C.Macleod@ru.ac.za (nge-imeyile).

3. Olu phando lungokunceda iFASFacts yenze izinto bhetele iphumelele. Alukho ngokukhulelwa kwam okanye indlela yam yokuphila.

4. Ukuthatha kwam inxaxheba kuzakuquka ukurekhodishwa kwengxoxo enye okanye ezimbini endithatha inxaxheba kuzo njengenxalenye yenkqubo yokucetyiswa kwabantu abakhulelweyo (PWMP programme).

5. UNicola, umongameli wophando lwakhe, umntu oqeqeshelwe ukukhuphela oko kuthethiweyo/ingququli nabanye abaphandi abakhethekileyo kwiyunithi youphando i-*CSSR* kwiDyunivesithi yaseRhodes ngabo kuphela abayakufikelela koko kurekhodishiweyo noko kukhutshelweyo ndizakube ndikuthethile. Oko kurekhodishiweyo noko kuyakube kukhutshelwe ndizakube ndikuthethile kuzakugcinwa

ekhompyutheni kwiifayile ezinenombolo yokuvulwa. Iikopi zamaphepha zoko kuzakube kukutshelwe bendikuthethile zizakugcinwa ekhabhathini ezakutixwa. Zonke iinkcukacha eziqokelelweyo kum zizakuba yimfihlo kwaye azizokuxelelwa abanye. Oku kuquka igama lam, ukuba ndingumntu onjani, kwakunye nezinye iinkcukacha ngobomi bam.

6. Ndiyamenywa ukuba ndibuze imibuzo kumcebisi wam ngokuthatha kwam inxaxheba koluphando, okanye ngeziphumo endingathi ndijongane nazo ngokuthatha kwam inxaxheba, kwaye ezizinto ziphendulwe ngokweemfanelo zam ndaneliseke. Unontlalontle weFASfacts okanye umcebisi uyakuthetha noNicola ngayo yonke imibuzo. Ngenye indlela, ndingafowuna okanye ndithumelele uNicola umyalezo ngqo ku 076-259-2303. Ukuba ukuthatha kwam inxaxheba kundenze ndakhathazeka, ndaba neentloni, okanye ndakhubeka nangeyiphi na indlela, ndingafumana inkxaso kube kanye kuNicola oyi-*Counselling Psychologist*. Ngenye indlela, ndingathetha nonontlalontle weFASfacts okanye uNicola angandilungiselela ukuba ndifumane iingcebiso kwa*FAMSA* (EMonti) okanye *eMasimanyane Women's Support Centre* (enamasebe eDuncan Village naseMdantsane).

7. 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.

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

Isayiniwe ngo (Umhla): ______________________

Isignitsha yomthathi-nxaxheba: ____

Iminyaka: _________________________________ Inani labantwana: ________________

Isignitsha yomcebisi: _____________________________________

Isignitsha yomphandi: ____

Appendix O: Transcription notations

you::	Colons represent lengthening of previous sound; the more colons, the longer the lengthening
=	This indicates no pause between the end of one speaker's utterance and the beginning of the other's.
[positive]	Addition of word by transcriber to aid meaning, or to describe tone
(.)	Slight pause
(2)	Pause of two seconds. The number indicates the length of time of the pause in seconds
Belly	Underlining indicates emphasis
CONSUMED	Capital letters indicate loud tone
I didn't know	For interview transcriptions, italics indicates speech translated from isiXhosa. Non italics is for speech in English
lento because *lanto yenziwa*	For mentoring transcriptions, isiXhosa is in italics, and English is in non italics
….	Text omitted
/yes/	Backchannel response from listener during the flow of speaker's talk
(for)	Possible understanding of unclear word
<	Rising volume of speech
>	Falling volume of speech