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Biopower and the Reproductive Autonomy of Childfree Women in South Africa

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Word count: 26 311

Declaration

I declare that this research report is my own, unaided work. It has not been submitted before for any other degree or examination at this or any other university.



Elize van Zyl _____ 09 November 2020_____

Student name and signature Date

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Abstract

The current research sought to examine the discourses employed by medical practitioners regarding women's reproductive autonomy, with specific reference to voluntary sterilisation. Furthermore, the researched aimed to investigate whether these discourses were in favour of pronatalist ideologies withing society. It also aimed to challenge the status quo by exploring the power inequalities that may exist within medicine, with specific attention paid to nuances concerning race, class, and gender within the context of semi-structured interviews. The semi-structured interviews conducted included questions regarding medical practitioners' views on women and motherhood in general, how the female body is viewed within medicine, and voluntary sterilisation. The research is situated within the critical theory paradigm and employs assumptions of social constructionism. The data were analysed by applying the critical discourse analysis approach within the Foucauldian tradition, utilising Parker's (1992) steps for analysing discourses. The major themes that emerged included Discourses of women and motherhood, Discourses surrounding the medical practitioners, and Discourses surrounding voluntary sterilisation, each with several subthemes. The emerging themes revealed that there exist many contradicting and interlinked discourses, both on a societal and medical level, through which women and motherhood are constructed and can be understood. Mainly, the research revealed that while women are constructed as having complete autonomy over their reproductive decisions, their choices are deeply influenced, controlled, and limited by the prescribed identities made available to them through discourse.

Keywords: *Biopower; pronatalism; patriarchy; heteronormative; women and motherhood; voluntary sterilisation; Habitus, discourse analysis; gendered discourse; medical discourse; medicine; feminine identities*

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Chapter 1
Introduction

1.1 Framing the Research

"I recognised the roles that were placed on me very early. One persistent concept that I observed, existing in our language, in our media, was that women are not only supposed to have children, they're supposed to *want to*" (TED, 2017, 0:14). This quote reflects the experience of many women today with regards to their reproductive autonomy.

An increasing number of women are choosing to lead childfree lifestyles (Basten, 2009; Bicharova, Lebedeva & Karabushchenko, 2015; Blackstone & Stewart, 2012; Doyle, Pooley & Breen, 2012; Settle & Brumley, 2012). Women have now entered the workforce and are choosing to either delay motherhood in favour of their education and careers or to forgo it altogether (Ulrich & Weatherall, 2000; Wilson & Huntington, 2005). However, despite significant shifts from traditional perspectives of femininity and motherhood, women who choose to be childfree are still perceived as the deviant group within a dominantly pronatalist and heteronormative society (Mollen, 2006; Morison, Macleod, Lynch, Mijas & Shiyakumar, 2015; Neyer & Bernardi, 2011).

Motherhood is perceived as a natural, inevitable part of being a woman and believed to provide women with identity status within society (Ulrich & Weatherall, 2000). Though women are perceived as having autonomy over their reproductive choices; discourses surrounding women and motherhood are tightly embedded within religious, gender, class, and socio-cultural beliefs, and socio-political norms (Donath, 2015; Doyle et al., 2012; Koeck, 2014; Settle & Brumley, 2012; Ulrich & Weatherall, 2000; Uzun, 2018). These discourses allow limited subject positions for women to occupy, contribute to societal pressures that are deeply engrained within identity, and are reinforced by power relations within society, such as doctor-patient relationships (Donath, 2015; Doyle et al., 2012; Koeck, 2014; Settle & Brumley, 2012; Uzun, 2018).

Medical practitioners operate within positions of knowledge and power, acting as the gatekeepers of women's reproductive decisions (Lalonde, 2018). Many women, especially younger women, who seek surgical sterilization in pursuit of a childfree lifestyle, are denied such procedures by medical professionals, justified mainly by the possibility of decision regret (McQueen, 2017; Mertes, 2017; Richie, 2013). Women under a certain age, or with

only one child, are encouraged to opt for less permanent contraception methods, rather than to make any "life-changing" decisions too soon (Denbow, 2014; McQueen, 2017; Richie, 2013). Emphasis is placed on the irreversibility of sterilisation, and the possible regret that might stem from not being able to have any (more) children, should one lose one's current children, or remarry and wish to have a child with one's new partner. Furthermore, the scrutiny that women who wish to be childfree endure is not imposed on women who choose to undergo fertility treatment to have children (Day, 2007; Dickinson, 2004; Kinloch, 2018; Lalonde, 2018).

The medicalization of issues such as infertility and the readiness to offer alternative pathways to pregnancy reinforce the idea that all women, at some point in their lives, will *want to* have children and should; therefore, delay (or avoid) making decisions that might render it impossible (Lalonde, 2018; McQueen, 2017; Mertes, 2017; Neyer et al., 2011; Settle & Brumley, 2012).

1.2 Chapter Organisation

Chapter 1 of this research report provides a brief introduction and context for the research. A summary of the relevant literature reviewed for this study is provided in Chapter 2, including an overview of the literature regarding Habitus, Gender, and the Female Body, Pronatalism, Parenting and Gendered Responsibilities. Following the literature review is a discussion of the Discourses Surrounding the Choice to Forgo Motherhood. Thereafter, a review of Reproductive Justice, Reproductive Autonomy, and Reproductive Control is provided, including discussions of coercive sterilisation, assisted reproductive technologies, and denied sterilisation. Chapter 3 provides the theoretical framework of the research, which is Biopower. The theory of Biopower is discussed in relation to the current research.

Chapter 4 provides a discussion of the methods employed in the current research, which includes the research questions, paradigm of the research, the participants, the sampling, the procedure, the data collection, the data analysis, the ethical considerations of the research, and reflexivity. A discussion of the data under analysis is provided in Chapter 5, presented through emerging themes and subthemes which arose from the data. The chapter highlights the dominant discourses brought about by the talk of the medical practitioners in the interviews, embedded in previous research and literature. Chapter 6 summarizes the findings, limitations of the current research, and recommendations for future research.

1.3 Rationale

The issues of motherhood and reproduction have been at the centre of women's rights discourses since the emergence of feminism (Neyer & Bernardi, 2011). Reproductive autonomy is especially crucial to women's rights and overall well-being, as pregnancy still occurs within women's bodies and because, in many cases, they are still primarily responsible for childcare (Purdy, 2005). Historically, views of motherhood placed women within the roles of maternal caregivers while being denied equal rights within society and the workplace (Neyer & Bernardi, 2011). Because it is women's biological ability to bear children, it was considered not only the ideal role of women but also their innate desire, a woman's *raison d 'être*; mandatory (Donath, 2015; Doyle et al., 2012; Neyer & Bernardi, 2011; Russo, 1976). This "motherhood mandate," as Russo (1976) put it, although no longer biologically based, still exists within the pronatalist social context, perpetuated by sex-role socialisation. The choice to lead a childfree lifestyle thus became the "ultimate liberation" of women (Neyer & Bernardi, 2011; Peterson, 2015).

Although societal structures have since changed significantly, women still associate their choice to remain childfree with more freedom, increased opportunities, and more autonomy over their other life choices (Peterson, 2015; Settle & Brumley, 2012). Besides the various, complex reasons women may have for choosing to be childfree, the most important 'freedom' it affords them may be that of escaping stereotypical gender roles (Basten, 2009; Blackstone & Stewart, 2012; Mollen, 2006). Nevertheless, childfree women, whether by choice or by chance, are still stigmatised within society (Mollen, 2006). The more traditionally synonymous view of women and motherhood is reflected in language. Women are labelled as "desperate" (in the case of involuntarily childless women) and "selfish", "immature", "egotistic", "cold" and "materialistic" (in the case of voluntarily childfree women), and as "deviant", "empty", "defective" or "abnormal" and "unfeminine" (in both cases) (Basten, 2009; Blackstone & Stewart, 2012; Doyle et al., 2012; Mollen, 2006).

It is essential to the advancement of women's empowerment that the discourses perpetuating these gendered views of women and motherhood be investigated and challenged. Furthermore, in addition to imbalances between genders, imbalances between different cultural and racial groups of women also exist and need to be explored and challenged. The majority of research thus far has focused on the reasons for and experiences of women to choose childfree lifestyles (Donath, 2015; Doyle et al., 2012; Settle & Brumley,

2012; Richie, 2013; Uzun, 2018), and the differences between childfree women across race, ethnicity and cultures regarding stigma, expectations of motherhood and medical practice (Chapman, 2018; Settle & Brumley, 2012; Uzun, 2018), prioritising the women's viewpoints in line with both the feminist and biopower theoretical frameworks.

However, to better understand the consequences that power dynamics within medicine hold for women's reproductive autonomy, the current research focused on exploring the discourses surrounding women, motherhood, and reproductive autonomy from a medical practice perspective. Medicine is value-laden, reflecting and reinforcing the values of a particular society (Coovadia, Jewkes, Barron, Sanders & Mdtyre, 2009; Shahvisi, 2019). Through practice and language, medicine becomes the medium through which societal norms are imposed and maintained (Craddock & Dorn, 2001; Shahvisi, 2019). Discourse not only influences how particular objects can be understood, but also creates restrictions on the subject positions that can be assumed, and what can be said or done from those particular subject positions (Willig, 2008). It is essential to explore how reproductive autonomy is constructed through medical discourse specifically, as medical discourse not only reflects but also perpetuates and legitimises societal norms (Craddock & Dorn, 2001; Shahvisi, 2019). It cannot be assumed that women's reproductive decisions are simply "their choice," but rather that it is influenced, controlled, and limited by the realities constructed for them through discourse, both on a societal and medical level (Lundquist 2008; Shahvisi, 2019).

1.4 Research Aims and Objectives

The current research aims to investigate the existing discourses regarding women's reproductive autonomy, particularly requests for voluntary sterilisation among medical practitioners.

The research further aims to challenge the status quo by exploring whether these discourses are in favour of pronatalist ideologies and therefore exercise power to maintain the pronatalist views of women and motherhood.

An additional goal of the research is to explore inequalities of power that may exist by paying special attention to possible changes in discourse regarding women of different age, class, and racial groups.

Chapter 2

Literature Review

2.1 Introduction

Provided in this chapter is the review of the relevant literature regarding the current research. The research is situated within the social construction paradigm. It relies on feminist theory underpinnings to conceptualise issues surrounding view of women and motherhood within society, as well as constructions of those women who choose to be childfree and wish to forgo motherhood through voluntary sterilisation. This chapter aims to highlight the overarching ideologies of women and motherhood and provide an overview of how requests for voluntary sterilisations are met within medicine and its relation to societal views of women and motherhood. This chapter explores issues regarding gender, pronatalism, intersectionality, and reproductive justice.

2.2 Habitus, Gender, and the Female Body

Habitus can be defined as "a set of acquired schemes of dispositions, perceptions, and appreciations, including tastes, which orient our practices and give them meaning" (Thorpe, 2009, p. 499). It is both the "embodiment of our social location" (i.e., race, class, gender, ethnicity, sexuality, nationality and generation), and the "structure of social relations that generate and give significance to individual likes (or taste) and dislikes with regard to practice and action" (Thorpe, 2009, p. 499). Habitus is, however, not only composed of attitudes and perceptions but is also "embodied," in that it is located within the physical human body and also affects the manner in which individuals express themselves through stance, gesture, etc. (Reay, 2004; Thorpe, 2009). Bodies are socially informed, and it is through the body that the taken-for-granted dispositions of life is learnt, and the deepest dispositions of the habitus are revealed (Doucet, 2009; Warin, Turner, Moore, & Davies, 2008). Thus, the "traditional," taken-for-granted norms, rules, expectations, and forms of authority of a given society are embodied along the axes of race, class, and gender; internalised and reproduced via habitus (Adkins, 2003; Reay, 2004; Thorpe, 2009). As such, habitus may reveal how gendered norms, and especially gender inequality, become embodied (Thorpe, 2009).

Broadly put, gendered habitus refers to "the social construction of masculinity and femininity that shapes the body, defines how the body is perceived, forms the body's habits

and possibilities of expression, and thus determines the individual's identity – via the body – as masculine or feminine" (Thorpe, 2009, p. 500). Gendered expectations and values are imprinted on the body, through early life experiences, and retains its constancy through the embodiment of these gendered dispositions within the social "field" (Doucet, 2009; Adkins, 2003; Thorpe, 2009). The "field" refers to "a structured system of social positions occupied by either individuals or institutions engaged in the same activity" and "is structured internally in terms of power relations" (Thorpe, 2009, p. 496). Within each field occupied by the social agent, the agent holds a certain form of power, referred to as "capital" (Thorpe, 2009).

Women are considered "capital bearing objects" within the groups they belong to, such as the family (Thorpe, 2009). Not only is femininity embodied, but it also operates as a learnt competency. Therefore, it operates as a form of cultural capital – a discursive position that women are expected and encouraged to inhabit – informed by a network of social positions of race, class, gender, and sexuality, available through gender relations (Thorpe, 2009). However, it is important to note that femaleness and femininity, and their relating capitals, are distinguishable (Thorpe, 2009). Female capital is derived from being perceived as and having a female (although not necessarily feminine) body. At the same time, femininity is socially constructed, its manifestation and capitalisation most powerfully represented by the recognition of the body as being feminine, associated with the capacity to produce food within the woman's body during pregnancy and lactation, and the pursuit of certain occupations such as caring (Deveaux, 1994; Thorpe, 2009; Warin et al., 2008).

The ability of the feminine body to bear children has historically pushed women towards motherhood. According to feminist writers such as Beauvoir (1953), this has ultimately resulted in the marginalisation of women as the "second sex," denying them equal social and economic positions within society (Fraser, 1998; Neyer & Bernardi, 2011). Within patriarchal structures of sexual difference, motherhood became both valued as a central part of the woman's nature and purpose, while simultaneously devalued as a lesser social position (Fraser, 1998; Neyer & Bernardi, 2011). Such conditions reduced women to their childbearing and maternal "nature," and determined relationships between men and women by "sexual contracts" (such as the patriarchal marriage), in which women's bodies and children were surrendered to men and society (Neyer & Bernardi, 2011). Traditional ideals of femininity were so profoundly internalised by women that rejecting their supporting practices

may very well amount to the rejection of their very identities (Deveaux, 1994; Lundquist 2008).

However, although the encouragement for women to conform to the traditional feminine ideals persists, notions of femininity are evolving. They differ across fields, and female and feminine forms of capital are innovatively exerted by women within different social fields (Thorpe, 2009). When habitus encounters a field (social world) of which it is a product, there is a match between field and habitus and the field becomes taken-for-granted (Reay, 2004; Thorpe, 2009). However, when the habitus encounters an unfamiliar field, there occurs a dissonance, a disjuncture which may generate transformation or change (Reay, 2004; Thorpe, 2009). Social agents may become more reflexive of the social conditions of their existence and to change them accordingly as societies are being modernised (Adkins, 2003). Thus, for many women, the traditional "model" of motherhood - which encourages women in heterosexual relationships to first tend to others' needs and be nurturing, placing them at the centre of the domestic "field" - is no longer relevant, but should they wish to change their positions within the various fields in which they operate, it would require them to first recognise and critically reflect on prevailing norms and structures (Adkins, 2003; Warin et al., 2008).

Habitus generally operates at the unconscious level. However, reflexivity arises due to tension arising from an individual moving across new and unfamiliar fields of social action, which may result in ambivalence and a double perception of self, or a "split habitus" (Adkins, 2003; Reay, 2004; Thorpe, 2009). Habitus may then be either reinforced or challenged (Thorpe, 2009). The questioning of traditional notions of femininity, or "gender reflexivity," could thus be considered the product of these tensions and negotiations between conflicting female roles as women move across various social fields, such as family and work. (Thorpe, 2009). However, while choice is at the centre of habitus, it is also limited by the opportunities and constraints of the external circumstances the individual is in (Reay, 2004). While individuals are actively engaged in creating their social worlds, the structures of those social worlds are also predefined by broader, racial, class, and gender relations (Reay, 2004). Thus, the empowerment of women may not only depend on the objective possibilities for resisting power, but also on whether or not they feel empowered within their specific contexts (Deveaux, 1994).

2.3 Pronatalism, Parenting, and Gendered Responsibilities

Societal values are primarily pronatalist, meaning that it values and encourages the choice of childbearing and parenthood (Doyle et al., 2012; Uzun, 2018). Enclosed within pronatalism are the key assumptions that childbearing is a) a natural, instinctive part of human biology, b) a significant marker of "normal" gender development and progression into heterosexual adulthood, and c) personally fulfilling and essential for a happy, meaningful life (Morison et al., 2015). Pronatalism "reinforces the socio-political, familial and religious obligations of producing children for the good of the country and future generations" (Doyle et al., 2012, p. 3), providing "a powerful mandate for the value of parenthood as a cultural norm" (Doyle et al., 2012, p. 3). Pregnancy is commonly considered a deeply meaningful and valuable experience and is associated with contributing to personal fulfilment and self-identity (Hall & van Niekerk, 2016). Not only are there socio-cultural and socio-political pressures to become a parent, but also to parent in a certain way (Doyle et al., 2012; Uzun, 2018). What it means to be a "good" parent is socially and culturally influenced and reinforced by the pronatalist mandate. For example, it might be expected of women in heterosexual relationships to be the primary caregiver and sacrifice their own careers in favour of the father's career (Russo, 1976; Uzun, 2018).

Despite the fact that more women now hold influential positions within professional, political, and social spheres, they continue to be shunned for choosing to forgo motherhood (Chapman, 2018). Furthermore, despite the increase in father involvement in childcare during recent years, the idea of the mother being primarily responsible for childcare and the father being the breadwinner, especially in earlier years, persists (Doucet, 2009). Such gendered responsibilities are, unfortunately, profoundly ingrained into the habitus, as it is closely linked to the expectations and capabilities of the body (Doucet, 2009). The pregnant embodiment of women reifies the reality and meaningfulness of parenthood, while men have a more ‘disembodied’ experience of parenthood, especially during the prenatal stage (Doucet, 2009). Even in the case of fathers who stay home with their children, where parental responsibilities are embodied through play, this is still a gendered embodiment, in that the father portrays himself differently than the mother would, reinforcing these gender differences in parenting (Doucet, 2009). However, women are increasingly maintaining full-time careers, while still being expected to be ‘good mothers’ and to embrace this expectation

as a central feature of their feminine identities (Chapman, 2018; Donath, 2015; Doyle et al., 2012; Russo, 1976; Uzun, 2018).

Society has become increasingly critical of those who make the "wrong" reproductive decisions, especially with regards to "responsible motherhood" (Hall & van Niekerk, 2016). The idea of a unified, "normalised" experience of motherhood exists for all women has caused discrimination towards those women not considered "true mothers," such as stepmothers, single mothers, mothers of colour and different ethnic or national backgrounds (Neyer & Bernardi, 2011). Furthermore, if one should be a "good mother," then feeling that motherhood is unworthy is not allowed (Donath, 2015). Interestingly, it is often these very pressures on women to wish to become parents, to find it fulfilling, to accept it as their identities and above all to do it well, that deter them from motherhood in the first place (Donath, 2015; Doyle et al., 2012; Russo, 1976; Settle & Brumley, 2012; Uzun, 2018).

2.4 Choosing to be Childfree: The Discourse Surrounding the Choice to Forgo Motherhood

Before discussing the discourses surrounding the choice to remain childfree, it is essential to first establish what childfree means. While the terms "childless" and "childfree" are sometimes used interchangeably within the literature and society, it is vital for the purpose of the current research (as in previous research) to make the distinction between the two as their underlying connotations are very different (Basten, 2009). The term "childless," as in "homeless" or "friendless," refers to the explicit lack of something that is naturally expected, or in other words, to be without something (Basten, 2009). The term "childfree," however, as in "care-free" or "disease-free," implies freedom or liberation from something (Basten, 2009). The nature of the current research suggests that women who choose not to have children should be considered liberated rather than lacking. Therefore, the term "childfree" is the preferred term that will be used to refer to such women throughout this research report.

Although motherhood is the expected norm for women, increasingly, more women choose not to become mothers (Basten, 2009; Bicharova et al., 2015; Blackstone & Stewart, 2012; Richie, 2013). The reasons for this decision are complex and may vary widely. However, many women make the decision based on their certainty that they simply "never want children" (Richie, 2013, p. 36). They also choose their childfree lifestyles in rejection of

traditional gender norms in pursuit of personal fulfilment by having more freedom to pursue education, careers, and travel, among others. (Doyle et al., 2012; Richie, 2013). While the discourses surrounding such decisions are generally negative, some groups of women may face more pressure to become mothers than others, as beliefs and values regarding motherhood are embedded within religion, race, ethnicity, and culture (Chapman, 2018; Uzun, 2018). Some cultures may be more willing to accept alternative roles for women. In contrast, others may not, and previous research suggests that the consequences of choosing to be childfree differ significantly for women of colour than for their White counterparts (Chapman, 2018; Settle & Brumley, 2012; Uzun, 2018).

For example, in a study interviewing 15 African American, Hispanic and Latina women, all participants reported experiencing expectations of motherhood from their societies, cultural and community groups, and families (Uzun, 2018). Expectations of motherhood were communicated to them by family members, through media, in church, and within their local neighbourhoods, all of which reinforced the idea that women are, first and foremost, supposed to be mothers (Uzun, 2018). For some, having children was even communicated as essential to having successful marriages (Uzun, 2018). Even being a 'strong woman' necessitated having children according to one of the participants (Uzun, 2018). African American women reported experiencing expectations of motherhood specifically linked to their race, receiving comments such as "Oh… you're a black woman, you must have children running around!" (Uzun, 2018, p. 36), and responses to their choices such as they were "Whitewashed" and "You don't understand Blackness" (Uzun, 2018, p. 37). In addition to cultural and racial differences in expectations of motherhood, differences in reproductive autonomy are also reflected within socio-political and medical practices (Frohmader & Ortoleva, 2014; Morison et al., 2015; Nixon, 2013; Purdy, 2005).

2.5 Reproductive Justice, Reproductive Autonomy, and Reproductive Control

Although the meaning of women and motherhood has been a contentious issue within feminism, the struggle for women's reproductive rights and freedom to gain control over their bodies and reproductive choices has bridged the differences among various women's movements and feminist discourses (Neyer & Bernardi, 2011). Reproductive autonomy can be defined as the capacity for self-determination regarding reproductive decisions, such as choosing when (if at all), and with whom to have children, free from discrimination, stigma,

coercion, and violence (Frohmader & Ortoleva, 2014; Hall & van Niekerk, 2016; McQueen, 2017; Purdy, 2005). Although reproductive rights are fundamental human rights, certain groups face major challenges regarding gaining autonomy over their reproductive decisions. This is especially true for women (especially marginalised groups, including women with physical and intellectual disabilities, women of colour, or members of the LGBTQ+ community) (Frohmader & Ortoleva, 2014; Morison et al., 2015; Nixon, 2013; Purdy, 2005; Uzun, 2018).

The theory of reproductive justice has provided avenues for examining the intersectionality between reproductive politics, race, class, and gender (Ross, 2017). Thus, reproductive justice has gone beyond the binary pro-choice/pro-life frameworks to give voice to the struggles of women of colour in fighting for their human and reproductive rights (Ross, 2017; Smietana, Thompson & Twine, 2018). Reproductive justice is intersectional in that it posits that human rights are both universal and indivisible (Ross, 2017). Both sexual freedom and bodily autonomy are included in the intersectional praxis of reproductive justice, making the material consequences of embodiment visible (Ross, 2017). Through reproductive justice, undiscovered vulnerabilities regarding fertility and childbirth can be addressed by paying special attention to the racial ideologies, heteronormativity, gender-specific logics and neo-colonial practices that underlie them (Ross, 2017; Smietana et al., 2018). Although all women should have the right to autonomy over their reproductive decisions, the control over what occurs within their bodies instead lies within the political discourses of gender, class, race, and religion. (Donath, 2015).

2.5.1 Coercive sterilisation

The science of eugenics was developed as a by-product of Darwinism and can be traced back to Britain in the early 1880s (Naicker, 2012). Since then, the main preoccupations of eugenics were European superiority and the need for human heredity. This gave rise to "scientific racism," which can be defined as "the belief that variables of phenotype, intelligence, and ability to achieve in terms of civilisation and/or culture are not only genetically determined but also genetically linked (Naicker, 2012, p. 210). Scientific racism was supported by 18th century Europe, as it was a means of supporting the absolutist system that enforced patriarchal dominance on newly discovered continents (Naicker, 2012). Because it was believed that social problems were the result of social defects, coercive

sterilisation practices were employed on the "socially undesirable" population as a means of race control (Fraser, 1998; Roberts, 2009). According to American authors, Shreffler, McQuillan, Greil and Johnson (2015), between the 1920s and the 1970s, medical practitioners engaged in coercive sterilisation practices based on the logic of eugenics.

From the 1950s, these practices were particularly aimed at marginalised groups of women, specifically African American, Native American, and Hispanic women, as well as all racial groups of poor women, including White women (Fraser, 1998; Shreffler et al., 2015). African American women were more likely to be victims of governmental control over their reproductive autonomy because they were more likely than White women to be below the poverty line. They were also stereotypically viewed as being sexually promiscuous, thereby devaluing them as mothers (Fraser, 1998; Roberts, 2009). It has been estimated that over 60 000 individuals were subjected to forced sterilisation to eliminate social problems such as "poverty, mental illness, mental retardation, disease, and criminality" (Fraser, 1998, p. 200). The theory of eugenics would later be adopted by the British Colonial medical profession in South Africa (Naicker, 2012).

The eugenics theory was first present in South Africa shortly after the First World War (Naicker, 2012). According to Klausen (1997), who examined eugenic beliefs and practices in South Africa from 1903 to 1926, the English-speaking medical profession in South Africa placed a great emphasis on eugenics in the first three decades of the English settlement in the country. A common concern for South African eugenics scientists was the health of the White race, who saw a link between the health of the White population, White women as the "mothers of the nation," and the health of the South African state (Naicker, 2012). 'Coercive pronatalism,' meaning the encouragement of procreation among the privileged and reducing procreation among the less privileged, was also utilised during the apartheid regime in South Africa (Morison et al., 2015).

Furthermore, women with disabilities are at increased risk of coerced sterilisations or forced contraception (Frohmader & Ortoleva, 2014). Disabled women are often seen as either asexual or hypersexual, unable to make their own reproductive decisions (Frohmader & Ortoleva, 2014). These negative perceptions result in women with disabilities being denied their basic reproductive rights, often not receiving the necessary information to give informed consent to reproductive choices, which are also often made on their behalf (Frohmader & Ortoleva, 2014). Disabled women and girls are often victims of forced contraception, which

is used to suppress menstruation or sexual expression, for reasons such as population control, menstrual management, personal care, and pregnancy prevention (Frohmader & Ortoleva, 2014). This same ‘coercive pronatalism’ that has undermined the reproductive autonomy of less privileged women by forced sterilisation, has also created challenges for more privileged women to exercise their rights to forgo motherhood, such as terminating pregnancies or avoiding it altogether (Fraser, 1998; Morison et al., 2015). For instance, medical advancements such as Assisted Reproductive Technologies (ART) have provided a means to overcome obstacles to childbearing for some individuals who did not previously have the option but may serve as reinforcement of the notion that childbearing is something to be pursued and not avoided (Neyer & Bernardi, 2011).

2.5.2 Assisted Reproductive Technologies

ART has made it possible to overcome biological boundaries when it comes to childbearing for certain groups for whom it was previously not an option, including infertile and menopausal women, men and women with other health problems, same-sex couples, and transsexual individuals (Neyer & Bernardi, 2011; Smietana, et al., 2018). However, such technologies, while meant to provide equal opportunities for parenthood and starting families, actually contributed to the existing inequalities along the axes of race, class, gender (Fraser, 1998; Neyer & Bernardi, 2011; Smietana et al., 2018). Women who have the means to afford ART, such as in vitro fertilisation (IVF), are pushed towards reproduction due to the options available to them. In contrast, women who cannot afford such technologies are pushed away from reproduction (Fraser, 1998).

Moreover, due to the value placed on heteronormative, nuclear families within society, IVF and other ART were initially not available to the LGBTQ+ community (Smietana et al., 2018). Early ART treatments were regulated and granted access to in terms of heterosexual parents who were unable to conceive through unprotected sex or surrogates and donors who stood in for heterosexual parents unable to conceive (Smietana et al., 2018). Treatment protocols only gradually shifted towards the needs of LGBTQ+ parents in the 2000s (Smietana et al., 2018). The ability to have biological children was especially important in the fight for gay men's parental rights, as they could not draw upon the same dominant scripts of gender norms and femininity that lesbian mothers could (Smietana et al., 2018). Therefore, despite societies becoming more accepting of fluid sexualities, gender

identities, and non-nuclear families; the persistent association between typical gender norms and parenthood, particularly the synonymity between motherhood and the feminine body, may undermine reproductive autonomy instead of supporting it, regardless of the advances towards reproductive rights brought about by ART (Neyer & Bernardi, 2011; Smietana et al., 2018).

Some feminist writers have argued that ART may actually limit women's freedom of reproductive choice because it may pressure women to conceive, as well as diminish their feelings of control over their bodies (Fraser, 1998; Neyer & Bernardi, 2011). Women who turn to ART, such as IVF, do so to overcome a defect that exists within their bodies, placing the control over their bodies in the hands of medical practitioners and technology (Fraser, 1998). This creates an unequal power dynamic between the patient and medical practitioner, as the medical practitioner, who "owns" the technology, is seen as the source of granting life, which the patient is unable to (Fraser, 1998, p.190). Women undergoing IVF treatments become mere vessels of childbirth, and failure to conceive is internalised as failure to comply with treatment protocols, causing guilt and anxiety and further reducing their autonomy over their reproductive identities (Fraser, 1998; Neyer & Bernardi, 2011). Furthermore, technologies such as egg freezing are being advertised as a means for women to "safeguard themselves against potential future infertility and to keep their attraction as prospective mothers for men" (Neyer & Bernardi, 2011, p. 171). Ultimately, while ART makes it possible for every woman to wilfully plan their futures and become mothers at their own pace, it reinforces the assumption that motherhood a universal desire and a fundamental part of a woman's nature (Neyer & Bernardi, 2011). Therefore, women who choose to abstain from motherhood may find themselves being questioned at any stage of their lives (Neyer & Bernardi, 2011).

2.5.3 Denied sterilisation

Many women who have sought sterilisation have been turned away by medical practitioners (Denbow, 2014; McQueen, 2017; Mertes, 2017; Richie, 2013). This is especially the case with younger women (under the age of 30-35 years) as well as unmarried women without children and women of higher social class (Denbow, 2014; McQueen, 2017; Shreffler et al., 2015). These women were generally told to return when they were older or married (with children) (McQueen, 2017; Mertes, 2017; TED, 2017, 4:38). In most cases,

younger women seeking sterilisation would only be granted such procedures after several attempts and years, reporting that at first, their requests would not be taken seriously (Denbow, 2014; TED, 2017, 4:15; Richie, 2013). The literature suggests that there may be gender differences in granting or denying sterilisation procedures, with men being more likely than women to gain access to such procedures (McQueen, 2017). This may suggest that gendered discourses that define women in terms of motherhood and reproduction may influence attitudes towards the sterilisation of women (McQueen, 2017).

Furthermore, although not thoroughly researched yet, considering the evidence of coercive sterilisation among certain groups, there may be differences in voluntary sterilisation within race and class (McQueen, 2017; Mertes, 2017; Morison et al., 2015). Some research suggests that sterilisation rates seem to be higher among minority racial groups and lower socio-economic groups than among middle-class white women. However, it is not fully known why (Shreffler et al., 2015). It is suggested that this "stratified reproduction," as it is named, is the aftermath of the inequalities caused by earlier eugenics movements within the fertility industry, which still values the reproduction of some, more than the reproduction of others (Shreffler et al., 2015; Smietana et al., 2018). However, it is also important to remember that differences in sterilisation and fertility technology rates also occur because there is no universal experience of being a woman or of motherhood. The need to become a mother (or abstain from it permanently) is also a product of habitus, in terms women's histories, attitudes, experiences, cultural backgrounds, and thus internalised notions of gender norms (Adkins, 2003; Reay, 2004; Thorpe, 2009; Shreffler et al., 2015). Whatever the reasons for stratified sterilisation, it is important to explore these differences with historical hierarchies and habitus in mind (Thorpe, 2009; Shreffler et al., 2015).

2.6 Conclusion

This chapter provided an overview of the issues surrounding how women and motherhood are viewed within broader discourses. Historically motherhood has been conceptualised as a woman’s entire purpose. Although this is no longer necessarily the case, the importance and joy of motherhood prevail within discourse. Women who are unable to conceive or who choose to forgo motherhood are deviants from the norm. Furthermore, this chapter provided an overview of intersectionality as it relates to reproductive justice, and how women’s reproductive autonomy (or lack thereof) is also a product not only of discourse, but

also of power as it relates to race, class, and gender. Lastly, this chapter provided a discussion of how voluntary sterilisation is usually denied, especially to certain groups of women, and how it fits into the broader ideologies regarding women and motherhood. The next chapter concerns the theoretical framework in which this research was undertaken.

Chapter 3
Theoretical Framework

3.1 Introduction

This chapter provides a discussion of Biopower as the theoretical framework which underpins the research. First, it provides an explanation of Biopower as a theory in relation to the power exercised within a given population. A brief history of reproductive autonomy within the framework of Biopower is also discussed. In addition, this chapter provides a discussion of how the current research is framed within the theoretical framework and how Biopower relates to the issues discussed in Chapter 2, specifically with regards to reproductive autonomy and voluntary sterilisation.

3.2 Biopower

According to Foucault, modern power is defined as " …situated and exercised at the level of life, the species, the race and large-scale phenomena of the population" (Hubbard-Mattix, 2017, p. 6). Biopower emerged from what Foucault termed the *bio-politics of the population* (Cisney & Morar, 2015). Biopolitics can broadly be understood as "the extensive complex of ideas, practices, and institutions focused on the care, regulation, disciplining, improvement and shaping of individual bodies and the "collective body" of national populations" (Dickinson, 2004). It is inherently concerned with aspects of power that are centred around the species-body; such as tracking and regulating birth, death, fertility and infant mortality rates, economic statistics and statistics on poverty, disease, average longevity, and the various factors by which these aspects are influenced. Biopower operates in favour of the production of life and populations, and is exercised by normalising biological, social, and psychological technologies to optimise it (Ojakangas, 2005). The advancement of the natural sciences provided humanity with the capacity to understand the world through separating, differentiating, defining and analysing, resulting in powers to control and shape the world that were previously unimaginable (Koeck, 2014).

Thus, power has evolved from being concerned with the population as such to being concerned with the exertion of power over the individual body in order to control the characteristics of the population (Hubbard-Mattix, 2017, p. 7). The medical sector has been given vast resources in order to exert a power over the human body that no other profession can; "to open the human body, to prescribe potentially lethal substances, and to cut, pierce,

and replace organs and body parts" (Koeck, 2014, p. 1). Illness, the inevitability of death, and the promise that modern medicine holds to postpone or even avoid it has created a dependency on medical professionals that inevitably leads to unequal power relations between doctors and patients (Koeck, 2014). Power is yielded to the knowledgeable doctor, who therefore makes the decisions, by the apparently ignorant patient, who therefore follows (Koeck, 2014). However, the internal rationality of power and the mindset and values of those involved, along with the roles each plays in a given institution, determines how power circulates in a given society and how it is exchanged among individuals (Iliopoulos, 2012).

"Power cannot be exercised unless a certain economy of discourses of truth functions in, on the basis of, and thanks to, that power" (Cisney & Morar, 2015, p. 1). The fathers of modern medicine were mostly White, heterosexual, cisgender men (Sharma, 2019). The culture of modern medicine is thus created (and recreated) in this image, with most medical education firmly rooted in biomedicine (Sharma, 2019). Biomedicine itself is inherently rooted in male dominance, or patriarchy (Sharma, 2019). Patriarchy does not only relate to cultural contexts referring only to men ((Bleakley, 2013). Rather, it also refers to a dominant cultural form based on a particular type of logic that embraces "heroism, rationalism, certainty, the intellect, distance, objectification, and explanation before appreciation" (Bleakley, 2013, p.62-63). Thus, the historically racist and gendered nature of medicine prioritises particular types of knowledge and how that knowledge is produced (Naicker, 2012; Sharma, 2019). Interpersonal power differentials and discriminatory practices may still exist, despite the inclusion of members of marginalised communities (Naicker, 2012; Sharma, 2019).

In the South African medical field specifically, ideologies that inform practice stem from a history permeated by discrimination based on race and gender (Coovadia et al., 2009; Naicker, 2012). Pre-democracy policies structured the country along race, gender, and age-based hierarchies, which greatly affected social life and health policies and services (Coovadia et al., 2009). Furthermore, the western biomedical framework, which conceives of failure to enter motherhood as a physical or psychological illness, acts as a mechanism of power in which patriarchal, stereotypical gender-roles are reinforced and perpetuated (McQueen, 2017; Neyer & Bernardi, 2011; Russo, 1976). Indeed, women's bodies, as well as childbirth have increasingly been medicalised and subjected to control by the patriarchal

medical profession, estranging women from their bodies and reproductive lives by losing control over what was once a "natural" process, as in the case of ART (Fraser, 1998).

The medicalisation of issues such as infertility ultimately renders the inability to conceive as problematic and in need of medical intervention, further placing the power of reproduction in the hands of medicine (Kinloch, 2018). Women who cannot conceive become all the more "desperate" to conform to reproductive and gendered norms because infertility places them outside of the desired norm, marginalising them through the negative connotations within the medical discourse (Gillespie, 2000; Ulrich & Weatherall, 2000). However, medical power over women's reproductive decisions does not only exist in knowledge and language but also practice (Dickinson, 2004; Lalonde, 2018). This utilisation of power is further reflected in the high refusal rate of sterilization, especially among younger, unmarried women, despite them being of legal age, acting of their own accord free from coercion and with due consideration of the risks and consequences of such procedures (McQueen, 2017; Richie, 2013).

The main reason for the refusal of sterilisation to women is the possibility of regret (Denbow, 2014; McQueen, 2017). Medical practitioners swear an oath not to cause harm and are therefore obligated to discuss the possibility of future regret with their patients. (Mertes, 2017; Richie, 2013). However, the paternalistic positions that they take toward these women may be more reflective of pronatalist ideologies rather than a wish not to cause harm. There is evidence to suggest that it is the minority of women who regret sterilisation later in life, not the majority (Mertes, 2017; Richie, 2013). Thus, as Russo (1976) claimed, the idea of women being anything other than mothers is unthinkable – the *nonconscious ideology*. The discrepancies between sterilisation and fertility practices call into question the legitimacy of possible regret as a justification for the dismissal of the patient's current wishes and needs (Denbow, 2014; McQueen, 2017; Richie, 2013). Throughout history, medical practitioners have acted as the gatekeepers of women's reproductive autonomy, in favour of the political economy (Denbow, 2014; Hubbard-Mattix, 2017).

What is meant by *political economy*, is what Foucault (2010) considered a *mechanics of power* which determined the power that one may hold over the bodies of others so that they may operate within the parameters and in the manner established by said power (Hubbard-Mattix, 2017). Thus, medicine becomes the mechanism of power that, through discourse, determines the subject positions available to women, and so also the parameters in

which their bodies may operate. During eugenic campaigns, which originated in Europe, sterilisation was forced onto women who were considered "unfit" for reproduction, in particular those who were considered more vulnerable to abuse, the poor, those with a mental disability, and minority groups (Naicker, 2012; Richie, 2013). Conversely, sterilisation was denied to women who were deemed "fit" for reproduction, in other words, those who were socially desirable within the eugenic ideology (Hubbard-Mattix, 2017; Richie, 2013).

Colonial authority in the Cape was constructed on the notion that Europeans in the colonies were socially superior to indigenous groups (Naicker, 2012). The South African medical profession became concerned with the preservation of "White purity" in the 20th century as scientists attributed "feeblemindedness" among the White race to racial mixing South African eugenic scientists believed that it was their duty to intervene in social relations, in both the public realm of policy development and in the private realm of sexual reproduction (Naicker, 2012).

Subsequently, the 120 rule was established, which allowed sterilisation only for those women whose age multiplied by the number of children she already had yielded a total of at least 120 (Hubbard-Mattix, 2017; Richie, 2013). However, even after sterilisation became legal practice (provided a woman meets all the legal requirements for the procedure), medical practitioners still hold the freedom to choose their patients and to either provide or deny sterilisation based on their perceptions of the patient's best interest (Hubbard-Mattix, 2017). Even today, despite women being of legal age (at least 18 years in South Africa), medical practitioners prefer women being at least 30-35 years of age before considering doing a sterilisation. Even when women are the preferred age, should they only have one child, medical practitioners are still reluctant towards sterilising. Although the reasoning behind this is not clear, one could argue that decisions surrounding voluntary sterilisation are still reflective of archaic rules of reproductive practice.

Due to the difficulties that women face in obtaining sterilisation and the reasons provided by medical practitioners, it is reasonable to question whether the best interest of the patient is the only concern (McQueen, 2017; Mertes, 2017; Richie, 2013). As McQueen (2017) and Mertes (2017) point out, decision regret only becomes a concern when a woman is seeking sterilisation and is not of any concern for those seeking treatment to become parents, even though both decisions could lead to regret. Women who wish to become mothers are supported and not required to reconsider their decisions, while women who

choose not to become mothers are scrutinised (McQueen, 2017; Mertes, 2017). Furthermore, anecdotal evidence suggests that men have more success in obtaining sterilisation than women (Richie, 2013). The fact that women younger than 30-35 are denied sterilisation, despite being of legal age to request such procedures, suggests that the decision to either provide or deny sterilisation is more at the discretion of the medical practitioner than governed by law (McQueen, 2017; Mertes, 2017; Richie, 2013). Therefore, it stands to reason that the decision-making processes regarding women's reproductive autonomy and the voluntary sterilisation of childfree women, are rooted deep within traditional ideologies which consider motherhood as the preferable, desired path for those women who are considered ideal candidates for reproduction (Denbow, 2014; Hubbard-Mattix, 2017). However, "where there is power, there is resistance" (Deveaux, 1994, p. 231).

Women now contest fixed identities of motherhood – it is now seen as merely one identity a woman can acquire that is equal to many others (Deveaux, 1994; Neyer & Bernardi, 2011). Biopower is not only prohibitive but also productive. It not only acts in ways that subordinate women, but allows them to act upon the power exercised over their bodies and choices, either by reinforcing traditional notions of feminine and maternal identities or resisting them (Deveaux, 1994; Neyer & Bernardi, 2011). The *reflexive self*, brought about by late modernity, allows for the detraditionalization of gender, as the feminine habitus moves into different fields of social action (Adkins, 2003). Specifically, a lack of fit between habitus and the field may arise as women enter previously masculine-dominated fields (Adkins, 2003). The lack of fit between the gendered habitus and the field has led to increased possibilities for critical reflexivity as well as social transformation vis-à-vis gender (Adkins, 2003).

For example, female medical practitioners may experience a disjuncture between their personal expectations and dispositions (resulting mainly from their experience within the domestic field) and the "objective requirements of the workplace" (Adkins, 2003, p. 30). This may lead to a greater critical awareness of the shortcomings of the previously patriarchally defined system of employment (Adkins, 2003). Female medical practitioners' attitudes towards the feminine body and voluntary sterilisation, formed by their gendered habitus, may conflict with the mainly paternal medical habitus they are expected to embody within the field of medicine. However, it is not to say that even though gender reflexivity may occur due to tensions arising from the dissonance between the gendered habitus and the medical field, it

will lead to identity transformation (Thorpe, 2009). Masculine domination is not necessarily undermined by gender reflexivity, and women entering male-dominated fields may adopt strategies to "manage the masculine culture into which they are entering" (Thorpe, 2009, p. 506).

This is exhibited by even the female medical practitioners' refusal to grant sterilisation, even if they rejected motherhood, as will be seen in the next chapter of this report. Thus, biopower not only exerts power of the bodies of women, but also produces bodies that either maintain or challenge the status quo (Deveaux, 1994). Although women can reject traditional feminine identities through gender reflexivity, there are still a limited number of feminine identities for them to occupy (Agrillo & Nelini, 2008; Mannay, 2015). Despite women entering previously male-dominated fields, such as medicine, the values portrayed through language and practice may not be altered through gender reflexivity. Rather, they remain a product of the *masculine culture* in which discourse is situated. In other words, by paternalistically limiting reproductive options available to women, medicine still acts as a tool for the persistence of patriarchy, albeit implicitly (Sharma, 2019; Thorpe, 2009).

3.3 Conclusion

Biopower is concerned with exercising power over the population and is situated within the broader framework of Biopolitics. Biopower does not only constrain certain realities but also produces them. The current chapter provided an overview of how issues surrounding voluntary sterilisation are situated within the Biopower framework and how constructions of reproductive autonomy within the Biopower framework have produced and reproduced certain subject positions that can either be conformed to or challenged through reflexivity. The following chapter will provide a discussion of the methods employed in the undertaking of this research.

Chapter 4
Methodology

4.1 Introduction

The current research aimed to identify the medical discourses surrounding motherhood and voluntary sterilisation, situating these discourses within the broader, dominant discourses and ideologies within society. This chapter aims to indicate how the study was structured. Firstly, the research is located within the critical paradigm. Secondly, a discussion of the particular research design is provided, as well as a motivation for the use of the selected design. The participants, sampling, procedure, and data collection methods follow. Thereafter, the chapter describes the method of data analysis chosen and is then concluded with ethical considerations and reflexivity.

4.2 Research Questions

4.2.1 What are the discourses among medical practitioners surrounding motherhood?

4.2.2 What are the discourses among medical practitioners surrounding the voluntary sterilisation?

4.3 Paradigm

The current research was undertaken within a qualitative framework. The function and aim of a qualitative research design are to "understand human action by describing the inherent or essential characteristics of social objects or human experience" (Jackson, Drummond & Camara, 2007; p. 23). Unlike in quantitative research, where responses are elicited and analysed from a set of finite, closed-ended questions, within the qualitative framework, the researcher relied on open-ended questions in order to gauge how participants constructed their experiences through their responses (Jackson et al., 2007).

The current research was undertaken within the critical theory paradigm (Özkan & Murphy, 2010). Critical theory "seeks to not just study and understand society but rather to critique and change society" (Karataş-Özkan & Murphy, 2010, p. 456). Critical theorist writings focus on themes surrounding ideology and power, among others, emphasizing the social, historical, and political construction of knowledge, people, and social relations (Karataş-Özkan & Murphy, 2010). Critical theory and postmodern thought gave rise to social

constructionism, which can be described as a genus of various theories, disciplines, and traditions (Houston, 2001; Karataş-Özkan & Murphy, 2010). Social constructionism is gathered around a number of epistemological (related to knowledge) and ontological (related to existence) assumptions (Houston, 2001).

First, there is the notion that the social world, as we know it, is constructed through human interaction and language (Houston, 2001; Karataş-Özkan & Murphy, 2010). Society is not pre-existing but produced by people engaging with one another, where such interactions are externalised, objectified, and internalised (Houston, 2001). Secondly, social constructionists posit that individuals' understanding of the world is historically and culturally specific (Houston, 2001). Symbolic and cultural elements play an important role in the construction of different realities. Therefore, scientific "truth" and knowledge arise from the construction and reconstruction of language within a given context (Karataş-Özkan & Murphy, 2010). Third, the notion of essential structures existing within society (or the individual) is denied by constructionists (Houston, 2001). Fourth, according to constructionism, one's narratives about the world will shape one's response to it (Houston, 2001). These assumptions can be categorised into two major perspectives (Houston, 2001). The first emphasises the role of "human agency" in constituting the social world, and the second emphasises the role of "discourse" in shaping experience (Houston, 2001). The current research was undertaken within the latter perspective.

4.4 Participants

Due to difficulties in gaining access to willing participants and finding suitable times to conduct interviews with them, the sample only consisted of nine private specialist medical practitioners. All participants have knowledge in assisting patients with reproductive queries, issues, and procedures. The sample included specialist obstetrician-gynaecologists and a family physician. Of the nine practitioners, four were male, and five were female. In terms of ethnicity, five of the practitioners were White/Caucasian, two were Black/African, and two were Indian. The ages of the participants ranged between 34 and 93 years. Participants were pooled from private practices in the following areas: four practitioners from the Parklane and Brenthurst areas in Northern Johannesburg, one practitioner from the Dobsonville Soweto area, one practitioner from the Flora area in Roodepoort, one practitioner from Krugersdorp, and one practitioner from the Groenkloof area in Pretoria.

4.5 Sampling

The sample was obtained using non-probability sampling. Non-probability sampling was used as it is difficult to gain access to the entire population. Due to the qualitative nature of the study, the researcher did not intend to generalise findings. Therefore, random sampling methods were not necessary (du Plooy-Cilliers et al., 2014; Maree, 2012). The method of non-probability sampling was a combination of purposive sampling and snowball sampling (du Plooy-Cilliers et al., 2014; Maree, 2012). Initial participants were sought out using purposive sampling, based on the characteristics mentioned in the sample section above. This was done by visiting the private rooms of practitioners at private hospitals around the Johannesburg, Roodepoort, Soweto, and Krugersdorp areas, and via Google searches for private practitioners/specialists online.

More than twenty practices were approached. Some of these practices belonged to a single medical practitioner, while multiple medical practitioners shared others. These practices were approached either by phone to make an appointment, visiting the rooms in person, via email, or by a combination of these methods. From all these visits, calls, or emails, twelve initial appointments were granted to speak to participants about the study and invite them to participate in the research. Of the twelve appointments made, eight successfully led to actual interviews. Others were unsuccessful, either because the appointments were cancelled, or (in most cases) because the medical practitioners were unavailable upon arrival for the appointment without prior notice. In some cases, alternative appointments were attempted but also unsuccessful.

Once initial interviews were completed with willing participants, the researcher employed snowball sampling by asking the participants for referrals to more potential participants. The reason for this choice of sampling method was that medical practitioners who are willing and able to participate in the study were extremely difficult to locate. Of all the referrals provided by initial participants, contact and a subsequent interview could only be established with one of the referrals. Others were contacted but did not respond, or the researcher was unable to gain appointment times with them by visiting their private rooms.

4.6 Procedure

The researcher approached the practitioners' private rooms and asked for permission to conduct the study at their facilities. All practices (whether in person or via email) were

provided with the relevant information regarding the study. In cases where the medical practitioners themselves were unavailable and the researcher unable to make an appointment, the study information was left with receptionists, who were asked to pass it on to the medical practitioners so that they may accept or decline to participate in the study.

Thereafter, in some cases, the researcher was able to access the practitioners themselves by making an official appointment to see them. In other cases, no appointments were granted, and the researcher was required to return to the rooms and wait until all patients have been attended to in order to speak to the practitioner, or until the practitioner returned from theatre. Unfortunately, after waiting for several hours at many practices, and in many cases returning to the same practice several more times, contact could not be established in that manner. Only official appointments lead to interviews, and not in all cases. Many appointments could also not be kept by practitioners due to high demand or other unforeseen circumstances.

In the successful cases, face-to-face interviews took place with willing participants, mostly at their private practices and in one case, at the medical practitioner's private residence. Participants were then asked to provide contact details of more potential participants. The researcher then made use of the contact information given to approach new potential participants in the same manner in which the initial participants were approached. Due to time and other constraints, some of the referred potential participants' rooms were visited, while others were emailed or phoned. The subsequent procedure followed the same steps as with initial participants.

4.7 Data Collection

The data were collected, making use of individual, in-depth, semi-structured interviews (see Appendix E for interview schedule). The duration of the interviews ranged between 20 and 95 minutes, depending on the medical practitioners' availability and time-constraints. The nature of the interviews was standardised and open-ended, with the same open-ended questions for all participants, to ensure ease of analysis (du Plooy-Cilliers et al., 2014). The interviews were also semi-structured, in that it began with defined questions, but allowed a more conversational style to unfold as the interview progresses (Maree, 2012). Prompts were used to ensure the interviewee did not deviate too far from the topic, as well as

to follow up on interesting issues raised by the interviewee that the researcher may not have considered previously (Cassell, 2015).

Interviews were chosen as it allowed the researcher to gain insight into the world of the participants. However, the researcher understands that in the case of interviews, real understanding may sometimes be elusive (Qu & Dumay, 2011). Although the interviewer and the interviewee may speak the same language, the meaning that is given to the same words spoken may differ completely based on culture and a difference in world views (Qu & Dumay, 2011). A few other strengths and weaknesses of interviews are considered below.

One of the main concerns about qualitative research in general and the interview process is the researcher's impact on the data (Diefenbach, 2009; Hofisi, Hofisi & Mago, 2014). By engaging with the interviewee, through the type of questions asked, responding to answers given, sometimes sharing experiences, what is chosen to select from the data to analyse, interpret and describe, the interviewer becomes a part of the "interviewing picture" and therefore cannot be separated from the data (Hofisi et al., 2014, p. 62). The theoretical position, personal interests, and political perspective of the interviewer will affect, if not determine the research process (Diefenbach, 2009). This concern is addressed in the reflexivity section of this chapter.

Another concern regarding interviews is that the selection of interviewees does not happen systematically and objectively, as is mainly the case with purposive and snow-ball sampling used in the study (Diefenbach, 2009). The risk is that the selection of interviewees may be dependent on the goodwill of powerful or influential individuals within the targeted population who know the stakes of the research and therefore, may view the interview process as an opportunity to put forward their worldviews, thus influencing the outcome of the research (Diefenbach, 2009). However, due to the nature of the research, this was less of a concern, as it is precisely such cultural scripts and stereotypes (in this case, ideologies surrounding women and motherhood) that the researcher focused on answering the research questions (Diefenbach, 2009).

During the face-to-face interviews, the researcher was able to probe and seek clarification on what was said to uncover hidden, more profound meanings (Hofisi et al., 2014). In face-to-face interviews, non-verbal cues were observed to illustrate meanings further and provide depth to the data that will otherwise have been difficult to obtain with different methods (Hofisi et al., 2014). Lastly, the open-ended nature of semi-structured

interviews allowed for richer, more nuanced data than that derived from other methods, and contributed to the overall quality of the data (Choy, 2014).

4.8 Data Analysis

The data were analysed within the Foucauldian discourse analysis tradition, however not as strictly, as it was not concerned with the genealogy of the discursive constructions of a particular discourse (Willig, 2008). The data were therefore analysed utilising Parker's (1992) seven criteria for distinguishing discourses which state that discourses are: a) realised in text, b) are about objects, c) contain subjects, d) are coherent systems of meaning, e) refer to other discourses, f) reflect on their own way of speaking, and g) are historically located (Macleod, 2002). Specifically, the analysis focused on how language is central in constituting and reproducing behaviour and relations of power that result in forms of inequality (Blackledge, 2012; Lea, 2007).

After the data collection process (gathering information employing interviews and recordings of said interviews), data analysis occurred in the following steps: First, the audio recordings of the semi-structured interviews were transcribed verbatim. Second, these transcriptions of the data were read and re-read and broken down into smaller parts, which subsequently led to the identification of emerging themes. Keeping Parker's (1992) criteria for discourse analysis in mind, the current research made use of the 20 steps of critical discourse analysis created by Parker (1992), which Willig (2008) has integrated into six stages of analysis. These are discussed below.

First, the researcher identified all objects of discourse, as they were both implicitly and explicitly referred to in the text, and all references to these objects were highlighted (Willig, 2008). Furthermore, from the data elicited by the semi-structured interviews, discursive objects were also investigated in light of the dominant discourses that reproduce them. The medical practitioners, their patients, and voluntary sterilisation are all objects of discourse, constructed in various ways through language and practice.

Once the discursive objects and all sections related to them were identified, the second stage of analysis shifted the focus from these "discursive objects" to the different ways they were constructed. Any single discursive object may be constructed in various ways, leading to different subjectivities that come into being (Willig, 2008). Medical practitioners may employ several discourses when referring to motherhood and patients who

wish to undergo voluntary sterilisation. For example, they may employ the individual/personal choice discourse to emphasize that becoming a mother (or not) is the woman's own choice. Alternatively, they may employ the decision regret discourse, which claims that women who undergo sterilisation will ultimately regret their decision to do so. These broader discourses were intertwined with several other societal, gender, and medical discourses as well.

Third, the analysis was concerned with identifying what can be achieved by constructing these discursive objects in particular ways, which Willig (2008) called "action orientation." The specific discursive objects and the functions that different constructions serve were examined (Willig, 2008). Then, the relationships between the constructions and their surrounding constructions within the text were determined (Willig, 2008). Thus, the research sought to determine what could be achieved by the particular constructions of women, motherhood, and voluntary sterilisation employed by the medical practitioners and the broader societal discourses they reinforce.

Once discursive objects were identified and situated within broader discourses, the fourth stage of analysis involved identifying subject positions by determining how these locations and constructions position the subjects of discourse (Willig, 2008). Not only do discourses construct objects, but also subjects, and particular positions are made available and can be taken up, which determine "discursive locations from which to speak and act" (Willig, 2008, p. 116). Individuals' subjectivities are influenced by the subject positions available to them.

The fifth stage of analysis referred to as "practice," involved an exploration of the relationship between discourse and practice, specifically how certain opportunities for action are opened up by the subject positions taken (Willig, 2008). Subjects are positioned in certain ways in certain realities and ways of understanding the world, which determines what can and cannot be done. Particular practices and behaviours are manufactured and become legitimate within certain discourses, reproducing, and legitimating such discourses (Willig, 2008).

Finally, the sixth stage of analysis was concerned with "subjectivity" (Willig, 2008). Different ways of being and seeing the world come to be through different discourses employed, influencing social and psychological realities. In this final stage, what can be felt and experienced from different positions within different discourses was questioned (Willig,

2008). The aim was to investigate the different subjective experiences that result from the particular subject positions taken up. For example, when medical practitioners employ the discourse that motherhood is a woman's choice, they contradict their paternalistic positions over their patients' autonomy and decisions.

4.9 Ethical Considerations

The ethical considerations will be discussed in relation to the four elements of quality of qualitative research, namely dependability, credibility, confirmability, and transferability (Moon, Brewer, Januchowsky-Hartley, Adams & Blackman, 2016; Tracy, 2010). Dependability refers to "the consistency and reliability of the research findings and the degree to which research procedures are documented, allowing someone outside the research to follow, audit, and critique the research process" (Moon et al., 2016, p. 2). The researcher attempted to ensure dependability to the highest degree possible by outlining in detail the procedures and methods followed while conducting this research in the section above.

Furthermore, throughout the research process, all ethical considerations were adhered to. Medical ethics clearance was obtained from the University of Witwatersrand's Medical Human Research Ethics Committee (see Appendix F). Once ethical clearance was obtained, the aforementioned practitioners/practices were approached and asked for permission to conduct the study (see Appendix A). Participants were provided with information sheets (see Appendix B) to inform them about the topic and nature of the study and what will be required of them as participants, as well as the responsibilities of the researcher. Participants were also provided with informed consent forms. Prior to commencing with the interviews, each participant signed two consent forms, consent to the interview (see Appendix C), and consent to the audio recording of the interview (see Appendix D). Also, prior to data collection, the participants were provided with the introduction, rationale, and goals and aims of the study, as well as a copy of the ethics clearance certificate (see Appendix E).

To ensure confidentiality and anonymity to the highest possible degree, the participants' true identities are not revealed in the published data, using pseudonyms whenever direct quotations are reported. Moreover, any other identifying information about the medical practitioners (such as their race/ethnicity, gender, area, and age) were omitted in the analysis of the data. In some instances, revealing certain details (race, culture, and gender) was essential to the analysis of certain themes and, therefore, were included. Even in such

cases, such identifying details were mentioned in the analysis, but not added to the pseudonyms. Each medical practitioner was provided with a coded abbreviation, for example, MP1. Participation was voluntary, and participants were given the option to withdraw from the study should they no longer wish to participate.

The researcher also took steps to ensure the credibility of the research. Credibility refers to "the degree to which the research represents the actual meanings of the research participants" (Moon et al., 2016, p. 2), and was demonstrated through member checking (Tracy, 2010). A summary of the findings was sent to all participants via email prior to submitting this research report. Participants were given the option to ask questions or to withdraw from the study formally should they have any concerns. No queries, concerns, or withdrawals were received. The research was also not of a sensitive nature, and therefore, no psychological harm or discomfort was expected to be of concern.

Transferability refers to "the degree to which the phenomenon or findings described in one study are applicable or useful to theory, practice, and future research" (Moon et al., 2016, p. 3). Regarding transferability, the qualitative nature of the study does not allow for the generalisability of the findings to other contexts. However, it is critical that the researcher fully explains the extent to which the findings may or may not be relevant in other contexts (Moon et al., 2016). This will be further addressed in the limitations of the study in Chapter 6.

Lastly, to achieve confirmability, the researcher must report on "researcher disposition, beliefs, and assumptions" (Moon et al., 2016, p. 3), to ensure that the results of the study truly reflect the experiences and preferences of the participants and not that of the researcher. This is done through reflexivity. Although reflexivity cannot necessarily remove bias, it can explain the researcher's position within the research, while still yielding useful insights (Moon et al., 2016; Tracy, 2010). Thus, confirmability is addressed through the reflexivity section below.

4.10 Reflexivity

Throughout the research process, due to the feminist underpinnings and my personal position regarding the topic, reflexivity was crucial. First, I must acknowledge my personal lens through which I conceived the research and brought into the research process. The topic of reproductive autonomy, especially regarding choosing to be childfree, is of great personal

interest to me. Although I am a mother myself (and happy to be one now), I could not help but remember my own experience of pregnancy and the expectations imposed on me that came with it.

When conceptualising this research, I was not neutral in how I viewed motherhood as a social construct, because of personal experience, something that I remained cognisant of throughout the research process. Yet, the idea that there are certain expectations of women, especially with regards to having children, is not a concept that is new or imagined. I set out to do my research using a feminist lens, which I also considered throughout.

I remained aware that due to my personal experiences, and the feminist underpinnings of the research, that I would necessarily affect the research process as a researcher. Additionally, the discursive nature of the research also necessarily means that the data does not necessarily reflect reality, but more reflects a certain way in which certain constructs are spoken about and analysed within a specific context, at a particular point in time.

With regards to Biopower, it was necessary to stay cognisant of my theoretical framework and how it would affect the way I navigated the research process, specifically with regards to the participants. I had to remain diligent to not attribute certain aspects of the research to power because of my preconceived notions that medical practitioners necessarily exert power over patients.

Nevertheless, I can definitely speak of unequal power relations within the medical field, particularly, which made the task of undertaking my research all the more difficult. First, with regards to gaining ethical clearance, the obstacles in obtaining ethical clearance – not only from the Wits medical ethics committee but the ethical committees of the hospitals I wished to approach as well – proved much more complicated than initially thought.

Second, it proved no easy feat to gain access to participants, even when I changed strategies from approaching hospitals to approaching medical practitioners in their private capacities. Simply making it past the receptionists at most of the practices I visited was difficult, as they serve as the gatekeepers of the medical practitioners' precious time. I spent hours sitting in waiting rooms with patients in hopes of getting five minutes of the medical practitioners' time, mostly to no avail. In other cases, I was told to come back another time, which I did many times at some practices, with no success.

Other times I was simply told that the doctor is "not in" or "booked full", in which cases I simply had to leave my stack of papers with my research information with them in the

hopes that they will actually show it to the medical practitioners. Most of the time, I never heard back. Some receptionists were even rude, and I had to be satisfied with them reluctantly giving me a business card.

At one practice, I sat waiting for a chance to speak to the receptionist while she was having a conversation with someone. I waited patiently for the opportunity to be noticed and spoken to, while they continued with their conversation. I only later realised that it was the specialist having a conversation with the receptionist, all the while ignoring my presence. Eventually, the medical practitioner simply left, not asking me what I wanted. When I finally got to speak to the receptionist, I learned that the doctor had just left, and I had to ask for a later appointment. After about a day, the receptionist phoned, saying the doctor was not interested in participating in the study. It poses the question; would I have been treated any differently had I been a patient?

After spending hours in many waiting rooms, along with many (pregnant) patients, I have gained some insight into how much control the medical practitioners have. Not only do they control their own schedules, but also their patients' schedules. Notwithstanding my experiences, one needs to ponder the cost to patients.

In cases where I was fortunate enough to gain access to the medical practitioners, I was very aware of the power dynamics at play. During interviews, I had to take great care to remain impartial to what participants were saying, especially with regards to how they spoke about individuals my age, when motherhood should occur, etc. I assumed that participants were unaware that I had a teenage pregnancy and was a mother myself. I am not certain whether this affected the type of data I got from the interviews or not.

As for my social positioning, I am situated within society as white, female, and with a relatively high degree of education. Therefore, in terms of differences between me and my participants, race, age, and gender were the only differences of concern. In terms of education, all participants had more advanced degrees than I do, which might have further contributed to the power dynamics at play, situating them in a more knowledgeable position. I was also considerably younger than even the younger participants, which may also have affected the power relations. The interview process differed significantly between younger and older practitioners.

Older practitioners, in particular the male practitioners, tended much more toward a paternalistic dynamic. I had to take care not to let these differences in power dynamics affect

the data. However, by virtue of the nature of the research alone, I understood that it would necessarily affect my analysis of the data. Therefore, I took extreme care to remain cognisant of my personal biases and social positioning and aimed to analyse the data as objectively as possible within a qualitative paradigm.

4.11 Conclusion

This chapter provided a motivation for the particular research methods utilized in this study. The chapter also elaborated on the characteristics of the participants of the study, the sampling procedures, and described the data collection method of semi-structured interviews. Following this, the chapter discussed the method of data analysis utilized, as well as the ethical considerations. The chapter then concluded with a discussion of the reflexivity employed by the researcher throughout the research.

Chapter 5
Findings and Discussion

5.1 Introduction

This chapter will provide an in-depth discussion of the themes and discourses identified within the data. Subsequent to the initial collection and transcription of the data, the researcher immersed herself in the data by reading and re-reading the transcripts until a broad overview of the data was achieved. The data was then analysed by applying the critical discourse analysis approach within the Foucauldian tradition, utilising Parker's (1992) steps for analysing discourses (Willig, 2008). The themes that emerged from the data are interrelated. With regards to answering the research questions, three major themes emerged, each with several subthemes.

The first major theme is Discourses of women and motherhood, with the following subthemes: The medicalisation of gender, Cultural expectations of motherhood, Motherhood as a natural progression, and Motherhood as part of the female identity. The second major theme is Discourses surrounding the medical practitioners, with the following subthemes: The field of medicine in South Africa, The nature of Obstetrics and Gynaecology, and Gendered interactions between the medical practitioners and their patients. The third major theme is Discourses surrounding voluntary sterilisation, with the subthemes: The "completed" family, Decision regret, Infertility vs choosing to be childfree, and Male sterilisation. Each of these themes with their respective subthemes is discussed below.

5.2 Discourses of women and motherhood

Political economies are strengthened through the discourses that reinforce their political beliefs and standards (Leite, 2013). Language, and therefore discourse, become the tool through which power and dominance are exercised (Leite, 2013). The overarching contemporary discourses surrounding women and motherhood range along two poles: women have no choice, and women are entirely free to choose (Donath, 2015). The former speaks in the name of nature (Donath, 2015; Neyer & Bernardi, 2011). Pronatalist and patriarchal ideologies produce discourses of motherhood in which having children is constructed as a natural, inevitable part of being a woman (Agrillo & Nelini, 2008; Day, 2007; Leite, 2013; Ulrich & Weatherall, 2000). On the other hand, neoliberal, feministic discourses hold that women have the right to choose whether to become mothers (Donath, 2015). Both these

discourses were employed by the medical practitioners. Four inter-related subthemes emerged, the medicalisation of gender, cultural expectations of motherhood, motherhood as a natural progression, and motherhood as part of the female identity.

5.2.1 The medicalisation of gender

Medical discourses play a large role in shaping the standard definitions of race, gender, social location and citizenship (Craddock & Dorn, 2001). Medicine, as Canguilhem and Foucault have recognised, is a powerful constituent in the formation of perception and practice (Craddock & Dorn, 2001). Medical discourses of gender reify the traditional link of gender to the physical body (Schuh, 2006).

> MP1 – "Within medicine it's science. it's, what's on paper and it's black and it's white…But then when you start looking into the psychological part, that's a completely different story. But, from a physical point of view, it's either one, or the other."
>
> MP4 – "Only medical and scientific, there's no… uhm… 'mushy' side of this."
>
> MP9 – "I think, within medicine… one would have a very, strong, biomedical view of masculinity and femininity- of- of gender, because of, the different diseases there are, and the difference in- differences in anatomy… so I think with your, medical training, it will actually reinforce, your – your view on gender… much more strongly, because it is so- what we do is so biological. And if you're treating disease, it's very biological. Uhm, if you tr- if you're treating physical disease, it's- it's very biological, so I think that would, entrench… if you want to call it stereotypes, but your biological view of gender, very much, because it's just… how it is, practical."

In the excerpts above, gender is constructed as purely "scientific" and "biomedical". It is localised within the anatomy of male and female bodies and instructs how these bodies are treated accordingly. The medicalisation of gender, therefore, holds a very binary view, based on physiological differences, and is completely separated from the subjective experience of gender. This is reflected in the excerpt by medical practitioner number 4, in which it is said that there is no "mushy" side to it within medicine. Similarly, in the excerpt by medical practitioner number 9, gender is constructed as biological differences between femininity and masculinity, therefore taking binary subject positions of either male or female, on which treatment is based. As medical practitioner number 9 strongly implies, this does not leave

much room for interpretation of other gender identities and may aid in perpetuating gender stereotypes.

This fits into the larger societal ideal feminine embodiment discourses in which women are perpetually seen "as their bodies," in which they are judged by their willingness or failure to embody the feminine ideal, of which there are many competing discourses (Malacrida & Boulton, 2012). Furthermore, it reinforces taken-for-granted notions of femininity and motherhood, localised within the feminine body and the meanings attached to it, such as the ability to bear children. Frequently, women's bodies are referred to as having the capacity to reproduce and to nurture life into existence (Solinger, 2007). Yet, women often do not feel in control of this process (Solinger, 2007). The biologically reductionist language used within the medical field may reinforce and affirm the concept of "biological determinism" - the idea that genetically inherited traits determine an unchangeable hierarchy between men and women (Leite, 2013; Neyer et al., 2011).

By virtue of their physiology alone, women are subjectively placed along the more "naturally" inclined roles within society (i.e. reproductive roles) and have historically been marginalised by this biological distinction (Donath, 2015; Leite, 2013; Neyer et al., 2011). Men, by contrast, are placed in more productive roles, and it is through this biological distinction that social dominance has been practiced over women in society (Leite, 2013). In such contexts, representations of femininity are reduced and circumscribed by motherhood (Leite, 2013). Thus, language has become a tool for the persistence of patriarchal dominance and the "othering" of women through motherhood (Leite, 2013; Neyer et al., 2011).

5.2.2 Cultural expectations of motherhood

The next theme discusses cultural expectations of motherhood, which is broadly rooted in the notion that motherhood is seen as both a moral and social construct (Malacrida & Boulton, 2012; Morison et al., 2015). Motherhood is argued to act as a certain rite of passage, giving one status from child to becoming a woman (Malacrida & Boulton, 2012; Morison et al., 2015). Moving into motherhood from the "impotence of childhood" provides a woman with a higher social status (Malacrida & Boulton, 2012; Morison et al., 2015). Furthermore, the role of women and mothers within the family differ widely according to culture and the given society (Agrillo & Nelini, 2008).

> MP2 – "If you're sort of like us it's part of your life you know, sure. But if you're part of a religious Jewish community, they-they start having babies at the age of 21 and carry on having six babies, till they're 38, 40. Their purpose in life is to have children and bring them up. So every culture's different."

> MP5 – "It's not the same, for a woman and I have had to experience it, when… I had to take o- my wedding ring off. I lost a bit of uhm…what is it? Place… in society, right? You're not heard, because you're not married. Now this- I was coming from a place where I'm not heard, because I'm not a mother… motherhood gives you a Ranking! That's the word I'm looking for… there's a little bit of wisdom that's reserved for mothers, out there…"

As can be seen above, certain cultures have very strong expectations of motherhood, particularly the Jewish and African Black cultures (as described by participants). Within the Jewish community specifically, having many children is described as a "purpose", which reinforces earlier discourses of motherhood being the purpose of a woman. For African Black communities, as described by medical practitioner number 5, motherhood gives you "place" or "ranking" in society. For a woman to be "heard", she has to become a mother. Motherhood is constructed as having finally achieved maturity. "Wisdom" is believed to be "reserved" for mothers only. Therefore, not becoming a mother means one has not yet moved into adulthood and will not be taken seriously (Ulrich & Weatherall, 2000). Being a mother means one is wise; one has social standing and is to be revered by society. Not being a mother implies immaturity and is belittling of one's knowledge and social standing. Not becoming a mother is to not live up to expectations. This is not only the case from the medical practitioners' perspectives, but from their patients' as well:

> MP5 – "I've had, an 18-year-old come here, from… I think it's Ethiopia…recently gotten married. And, she's like, two months married. Married as a virgin. And she was here to say, 'I'm not falling pregnant.' And… my gut was like, what the heck? You're 18 - and there's so much to life! But in her society, achievement is through motherhood. And it was- it would be wrong for me, to just nullify that, and say 'Go get an education, doesn't matter, you're still'- you know, so…"

Furthermore, patients seem to have the same expectations of medical practitioners. Patients were described as being surprised to find out that two of the medical practitioners are not mothers themselves:

> MP5 – "It's wisdom, and rank that comes with motherhood. So then… I've had to navigate myself… through that, and I still get patients who

> say to me… when I take them through… what to expect in labour… and then they say 'Do you have a child?' Like what's that got to do with anything? I've studied… I've helped women labour. I know what to expect. And, that- and when I say 'No I don't'- they're like mmm (making an uncertain face). 'Then you don't know what labour pains are like?' 'No I don't. I haven't experienced it, but I've studied.'"

> MP4 – "The patients get a surprise when they ask me if I have children and I tell them no. Especially the pregnant mommies, they're very surprised… They expect, me being an obstetrician that I should have a child. So I told them my treatment is not gonna change because I don't have a child."

According to these quotes, to share an experience is to have knowledge of the experience. In the absence of shared experience, patients had doubts about medical practitioner nr 5's ability to truly understand and give sufficient guidance on what they could expect from child-birth. Additionally, in medical practitioner nr 4's case, it is assumed by her patients that she would be a mother because she chose this specific medical field to specialise in. When it comes to motherhood, it is expected that only mothers would know and understand what it means to be a mother, regardless of medical training. This reiterates the fact that there is a certain standing reserved for mothers in broader society. That, at least by societal standards, mothers have more wisdom and knowledge (Ulrich & Weatherall, 2000).

5.2.3 Motherhood as a natural progression

It is widely assumed that whatever path a woman decides to take in her life, that (eventually) she would want to become a mother. It is described as a "trend" that women now pursue motherhood later in life, in favour of education and careers. Pronatalism dictates that motherhood is a "natural, instinctive" part of a woman's identity, as well as a "marker of normal gender development" of the heterosexual woman into adulthood (Morison et al., 2015). Ideas of pronatalism can be observed in the excerpts below.

> MP1 – "I think there's still a trend to, kinda predict, that uhm, that you should have babies."

> MP3 – "I leave it to them, I… do not project, any thoughts on them. If they want to, be uh, domestic, and be at home, and look after the kids, and not, uh, go out into the world, that's up to them. If they want to go and work, and they, put the children in childcare, or there's somebody looking after them, I have no issues with that either. Uh… my personal life, my wife is a social worker, and she-she did- she worked, while we raised the kids, and, uh… my daughters at the moment are in the

> same, position. They're all professionals and they're all working, and they're raising their children as well."

Motherhood is "predicted" by "trends" within society. Although the medical practitioners in the extracts above did not explicitly position themselves as necessarily having these values themselves, they situate certain expectations and norms within the broader society. It can be argued that while they may not have personal opinions on this "trend" themselves, they do recognise it and therefore within their positions of power within medicine legitimise it. Although it is acknowledged that women may not all prefer being "stay-at-home" parents, there is still the underlying assumption that despite having professional careers, raising children will still be a part of their roles. One is either a full-time mother, or a professional and a mother, but a woman is rarely described as being only a professional or even just a woman in her own right. Even women who choose to first pursue careers are assumed to have children later in life. These findings are in line with previous research which was aimed at measuring students' perceptions of childless couples and individuals (Koropeckyj-Cox, Romano & Moras, 2007).

The study found that students had no biases towards infertility or childlessness, but that such perceptions were highly influenced by gender and occupation (Koropeckyj-Cox et al., 2007). Women who occupied roles that are traditionally perceived as male roles were judged more harshly than women who occupied traditionally female roles, revealing critical insights into views surrounding gender, family, and work (Koropeckyj-Cox et al., 2007). Furthermore, although childlessness in and of itself was not necessarily perceived negatively, temporary childlessness was more positively perceived than when it was a permanent decision (Koropeckyj-Cox et al., 2007). This indicates that there is an acceptance of delayed motherhood as the norm and that it is still more favourable than permanent child-freeness (Koropeckyj-Cox et al., 2007).

5.2.4 Motherhood as part of the female identity

From the discourses surrounding motherhood as part of the female identity, it seemed that the overarching discourse is now in favour of the more positive female identity – one that is separated from motherhood (Agrillo & Nelini, 2008). In line with previous research, an increasing number of women are rejecting and resisting the pronatalist cultural imperatives of femininity (Agrillo & Nelini, 2008). New-found professional possibilities are the main reason

for women to delay or forgo motherhood (Agrillo & Nelini, 2008), which is reflected in the discussions below.

> MP1 – "It-it, in the older generation, yes. But I do find that the younger generation is not so, so centred. And, uhm, a lot of them, even if they do have kids, they, are not stay at home parents, or moms, let's put it that way. So, you do still have, your job and, doing your own thing. Uhm, and motherhood is kinda secondary to all that, where with the older generation it was more, you know, you stay at home, you bring up your kids and that's…"

> MP6 – "I don't think it's very central at all. I mean my mother had, us as children and my- I mean- all of my, aunts and uncles, had children, but it doesn't- certainly has never been- dis- in my family, certainly… it has never been discussed that you, that it means that you're a woman or it's a… I don't know like a… (sigh) like a… whatever of your femininity. I don't think that it makes any difference, so I move… It's …personal choice whether you want to or not, and it doesn't mean that you're not… a woman if you, haven't had a baby. Not central at all, that's how I'm gonna put it."

As can be seen from the excerpts above, both medical practitioner number 1 and 6 contend that the idea of motherhood as being part of the female identity is not relevant today, as it was for older generations. To them, even though they come from backgrounds that might have pushed women into becoming mothers, they do not feel that these expectations were imposed on them. Motherhood is constructed as much more a choice today than it was for women years ago. However, it can be argued that motherhood or parenthood as the ideal, is not explicitly, but more implicitly communicated. The mere fact that this is the "norm" in which these medical practitioners grew up - although not explicitly discussed as medical practitioner number 6 pointed out – implicitly, there exists within their families a normative example of family life, which includes children, and is the case for most family members.

Although motherhood is not constructed as "central" to the female identity, it is still a naturally assumed part of it, even if it is "secondary" to other desires or goals such as having a career, as medical practitioner number 1 points out. What these discourses do not reflect, is a way of constructing feminine identities outside of motherhood. Rather, they merely construct motherhood as a choice. Not having children does not mean that one is not feminine or not a woman, yet no alternative subjective meanings of being feminine or a woman are offered. Rather, it can be argued that instead of offering alternative female identities, these

discourses contribute the increasingly complex "having it all" female identities, which include having successful careers as well as still being primarily responsible to childrearing (Mannay, 2015; Oliver, 2010). However, despite women now "having it all" and being able to enter the professional field, women are still subject to "acceptable female identities", thus still operating within gendered spaces (Mannay, 2015).

The themes discussed above exemplify how embodied experiences of gender and motherhood are deeply entrenched within the habitus and not easily extricated (McNay, 1999). While motherhood is portrayed as a "choice," the autonomy of that choice should be questioned (Mannay, 2015). As Lundquist (2008, p. 152) stated, "…to assume the autonomy of such decisions would ignore the powerful social forces, many of them internalised, that condition reproductive choices."

5.3 Discourses surrounding medicine and the medical practitioners

"Medicine, as a cite of social power, reflects the contours of power in society at large, and patriarchal values are prevalent in healthcare provision as a structural trend which is also mediated through injustices within individual encounters" (Govender & Penn-Kekana, 2008, as cited in Shahvisi, 2019, p. 101). From this major theme, three inter-related subthemes emerged, the field of medicine in South Africa, the nature of Obstetrics and Gynaecology, and gendered interactions between medical practitioners and their patients.

5.3.1 The field of medicine in South Africa

South Africa has a particularly disturbing history of racial and gendered oppression (Coovadia et al., 2009; Thackwell et al., 2016). Despite efforts to racially diversify the medical profession in South Africa, it largely remains mainly dominated by White, male medical practitioners, especially at higher levels (Thackwell et al., 2016; Umoetok, Van Wyk & Madiba, 2017). The exclusion of minorities from certain parts of the workforce during South Africa’s Apartheid regime gave rise not only to discrimination, poverty, health problems, and the disruption of family life; but also several competing discourses regarding gender and sexual socialisation (Coovadia, et al., 2009). Medicine is value-laden, and thus, practice and health-related issues within society are shaped by medical discourse, informed by the values of certain eras and certain agents of power (Coovadia, et al., 2009; Shahvisi, 2019).

> MP3 – "So the… interesting time when, I graduated, uh and went into practice…There were no private clinics available to us, because of the apartheid era. They wouldn't allow, uh, non-white- I don't like to use that word 'non-white' but. Uh-uh, black uh, doctors, at any of the private institutions. It was the law. So, we had to deliver uh, or operate on our patients in government hospitals. So the nearest one to Lenasia… because we couldn't live anywhere in Johannesburg, they moved us to Lenasia which was an Indian, proclaimed area…There were no clinics nearby. The nearest clinic was in (Krugersdorp), (name of hospital omitted), which is about 20/30 kilometres away. So I had to, take the patients in my car, to the hospital there, have them admitted, because they were private patients nobody would want to help them…And, we had to admit them, operate on them, deliver them there. And because it was so far, I had to wait and… sleep on the floor until the patient's delivered, before I could get back to my rooms. I, used to finish my rooms at about 10/11 at night, sometimes past midnight. And, often after midnight if I had a delivery… I had to take my family with me…Ja. They were too scared to stay alone, so, my kids and my wife, I had to put them in the car and take them to the, hospital. Do the delivery and come back. So it was uh, it was, quite a horrendous time in my life."
>
> MP5 – "There's… there's still a lot of transformation that has to happen. Women are still, disadvantaged. Particularly Black women, and…we- we tend to shy away from it, and- and tiptoe around it, but it is what it is. I still, to date… get to the, doctors' dining room and, the male, white, old, doctors will still ask me for… to dish up something for him because the assumption is that I am there to cater for them. I cannot possibly be there as a doctor, and this took two years, of me coming in… and sitting in their dining room- they don't even look at me…And… I had to say, okay, this is- you can choose t- which fights you want to fight. You can, pu- stomp your feet and say, 'I am a doctor as well!', or you can politely pass him what he wants, and just move along."

In the quote above, medical practitioners 3 and 5 highlight the struggles that some medical practitioners have faced and may still be encountering today, especially medical practitioners of colour, and female medical practitioners of colour (Umoetok et al., 2017). Despite the racial diversification of the medical (and other) fields in South Africa, there still exists an overarching ideology of White male dominance. Not only did minorities and women (and especially minority women) struggle to gain access to the same level of medical training as their White counterparts (Thackwell et al., 2016; Umoetok, et al., 2017), but once they have, it is assumed to occupy lower positions within the field. If this is the state of medicine in South Africa today, then it holds certain implications for the practice itself. If the medical field is founded in racial and gender disparities, then the values of the field must be

considered when determining what informs medical practice, especially with regards to gender, race, and class.

It was often wrongly assumed that the female medical practitioners would display more empathy and understanding for women's choices, suggesting that they operate more within the medical field's masculine culture, rather than their own gendered habitus (Thorpe, 2009). Despite their active engagement in creating their social worlds, the predefined racial and gender relations within medicine may strongly influence how female practitioners operate within the medical field (Adkins, 2003; Reay, 2004; Thorpe, 2009). As female medical practitioners move through the predominantly patriarchal medical field, they may encounter what is called a "split habitus" (Adkins, 2003), as they grapple with the demands of the field and their own gendered habitus:

> MP4 – "I don't have children… Because I'm not a broody type either. I don't want children… No I grew up, I was busy studying, and then working, and then I realised my job doesn't- wouldn't allow me time to have, children. Or I won't- I won't be able to… give those children, the time and the care that I would want to give them, and I'm at this point where I feel no. Not anymore… I've always had this feeling, I don't want children. *Always*."

In the quote above, medical practitioner number 4 states that she had always known that she did not want to become a mother and that she is not the "broody" type. Although she also mentions that her studies and career did not allow for children, she did not attribute not becoming a mother to that, but rather to her personal preference. This indicates a type of gender reflexivity, which questions traditional notions of femininity and motherhood (Thorpe, 2009). Yet, when interacting with her patients, she (like all other medical practitioners, discussed in subsequent themes) is reluctant to perform sterilisations on younger female patients, especially if they have not had any children yet. Therefore, as her own gendered habitus moves through the field (which in itself is value-laden and informs practice), there seems to be a conflict between habitus and the field (Adkins, 2003; Reay, 2004; Thorpe, 2009), which can then be reinforced or challenged. She further explains that the age at which "they" would start to consider sterilisations is when the patient is at least 35 years of age:

> MP4 – "35 is our cut-off. Our cut-off…I don't know we were taught that at, varsity. 35. Because most people at 35 are economically stable, they've gotten to their job, that- that's gonna see them through till, wherever… and they know financially I'm secure at this, at this age. And at this age, you will realise okay I want more children/I don't want more children. So that's how I looked at it, at that age, you're… economically stable, or, you are where you're gonna be. You're not gonna be better or worse-off from there…You know, ja. That's why…I don't know, everybody uses 35. I don't know if it's a legal thing. I should actually find out."

In this excerpt, the medical practitioner seems to operate within the values of the field, which is typically against voluntary sterilisation in women younger than 35. Her use of the word "our" in various instances when asked when she would consider performing sterilisation suggests a collective consciousness of medical practitioners, or rather the field of medicine – specifically with regards to reproduction. She continues to explain, "we were taught that at varsity," which indicates that the specific age at which to consider granting sterilisation is a standard within practice, taught to medical practitioners at university level. When asked the specific reason for the specific age, the medical practitioner gave a mixed response, both saying that she is not entirely sure what the specific reason was, just that "everyone uses 35," and one claiming that it is the reasonable age at which one would expect to be "financially secure" and "economically stable" and know that one does or does not wish to have *"more"* children.

While these assumptions about a patient's life course may be true, it is interesting to consider where such values come from, especially considering the history of South Africa and South African medicine. Although strides have been made toward inclusivity and democracy, it is not clear whether what the medical practitioners have been "taught" to practice still comes from previous values. It might very well be that the values portrayed here are in line with how medical practitioners themselves feel about sterilisation, but what is interesting to consider is how values of motherhood within the medical practitioners themselves (their gendered habitus) interact with the field and its values, which are rooted in patriarchal and racist ideologies. While medical practitioners are not passive in how they operate within their social worlds (including their own lives and the medical field), and one cannot ignore the structures of these social worlds, which are predefined by broader, racial, class, and gender relations (Reay, 2004). Choice is at the centre of habitus. However, choice becomes limited to the opportunities and constraints of the external circumstances the

individual is in (Reay, 2004). Culture and socio-economic class are also deeply intertwined with medical and personal values, which could also influence practice. Therefore, the values portrayed here, although intertwined with the nature of the medical field itself, are also indicative of what these medical practitioners experience within their practice, as seen in the following extracts:

> MP3 – "Uhm, those are the patients who are state- uh, who go to the state institution. So my patients are mainly, middle income… uh, professional, semi-professional, people with medical aid and who can afford, to be seen so-so it' s-it' s-it's a certain market, it's a certain…group of patients, that I see. So it's not all encompassing."
>
> MP4 – "All kinds. It's not only, uhm… White, Black. All kinds, whoever can afford it, can come…Not medical aid. I charge cash in my rooms- it's a cash practice. So, patients can arrive if they don't have medical aid. But mostly medical aid patients and the working class. The middle-income group that have- the medical aid. So we don't have, too excessively rich patients, we're not working in Sandton. And, nor do we have the severely poor patients that come in that can hardly afford a consult. Those will go to the government hospital. So in the middle range."

With this in mind, it also becomes necessary to consider how socio-economic class influences contraceptive choices and practice. Because the patients in these particular are of more middle-class, affluent status, they are able to afford other contraceptive options besides sterilisation. This is not the case for less affluent patients who require government medical assistance, as described below:

> MP2 – "Educated patients, it's a, it's a much more complicated decision. If you, got somebody from Baragwanath, you know who's, husband just wants to make babies all the time, she wants her tubes tied, sure. Come in and do the tubes, coz then she doesn't have to worry about pregnancy anymore. She doesn't have to carry the sixth baby. And look after the sixth baby…Of course if you've had your tubes tied- if you've got no money, and you go to a government hospital and you have your tubes tied, that's it. Done. No more worries. But if you're in the Northern Suburbs and you've got money and you like s-swimming and you go on holidays and you like traveling and so on and your periods are a pain in the arse, that's the answer for you (tapping on the Mirena)…Everything depends on the type of patient. The age, the social class, the degree of education. Everything."
>
> MP9 – "So if you're in a- in an area where you- you're less well off…uhm sterilisation is such an affordable, forever solution. But I don't work in an area like that. So that's probably also why I'm not

> confronted with that so much. I think it's the demographics. So, uhm, most patients are easily able to afford a Mirena. And that then opt for a less permanent- in case they decide otherwise…I don't work in an area where, it's not affordable. Uhm, so I haven't been- I haven't been consulted, for that in years… For someone asking for a sterilisation."

In the extracts above, medical practitioners 2 and 9 highlight the cost discrepancies that exist within medical practice when it comes to contraception. In their private practices, their patients are able to afford less permanent contraceptive options, such as the Mirena (a hormonal intrauterine device that is replaced every five years). In contrast, patients who cannot afford other contraceptive options due to their cost, need to seek sterilisation from government hospitals. As medical practitioner number 2 further points out, there is a clear intersectionality between socio-economic class, education, and reproductive health. Although it is possible that government hospitals also offer other (affordable) contraceptive options, to determine that was outside of the scope of the current study. It is, however, interesting to note the choices available to women from different socio-economic groups in terms of their reproductive choices.

5.3.2 The nature of Obstetrics and Gynaecology

The field of Obstetrics and Gynaecology is described as a joyous and "happy" field, mainly because it deals with life, rather than illness and death. For most of the medical practitioners, Gynaecology is a field which they do not necessarily enjoy, but rather seen as just part of the work. Obstetrics seemed to be the preferred field for all the medical practitioners. The journey taken with the patients through pregnancy and delivering healthy babies at the end of pregnancy are the main reasons why most of the medical practitioners have chosen this specific field of specialisation. Others prefer it because they enjoy the surgical aspect thereof, or they find it fits well into their top skill sets. Regardless of the reasons why the medical practitioners chose this specialisation, how it is described places the field and the medical practitioners within the normative views of motherhood as "joyful" and "miraculous" (Donath, 2015; Hall & van Niekerk, 2016).. Thus, normative views of motherhood and pregnancy are reinforced.

> MP1 – "…and you walk, a journey with them, but, being healthy patients. There's no illness involved, nobody dies at the end of the day… ja. And it's always just a- a wonder, seeing that small little spec on the ultra sound growing into a, into a, complete human being. And delivering, and everybody's happy and…"
>
> MP3 – "Well, rewarding in the sense that I see so many happy faces. I see, when mothers give birth, the… the joy, that it brings to the family. Uhm, I like caring for… women, who are, looking forward to increasing the family. I enjoy, having the whole family come in, the father, the children, looking at the ultrasounds and the scans. And… the little bit of surgery is usually… uh, healthy women…"
>
> MP5 – "…to take through- to take, a woman from, six weeks' pregnancy, to the end of- of a pregnancy. That is a miracle. That is awesome."
>
> MP6 – "…I love Obstetrics, coz it's very rewarding, it's fun for everybody, it's lovely to be part of that experience. It's miraculous, in a totally like non-religious way, if you know what I mean - to see a little baby and then you- they come and they see it's extremely joyous, you know it's a very, very emotive time, and I like being part of that…"

Motherhood, and specifically pregnancy, are constructed as a positive experience, which reinforces wider discourses of motherhood as the norm and the idea that describing it in any way other than positive and fulfilling is considered taboo (Donath, 2015; Hall & van Niekerk, 2016). This further normalises the heteronormative, taken-for-granted language stating that motherhood is a positive and natural occurrence which contributes to the happiness and "completeness" of a woman and the family (Donath, 2015). The field of Obstetrics is constructed as a "happy" field, as it does not deal with terminal illness or death. Rather, it deals with families who are taking a journey through pregnancy, which is considered "a miracle," "awesome" and "extremely joyous". Pregnant mothers are constructed as "happy" and "healthy," which not only reflects the typical patient these medical practitioners treat in their everyday practice but also signifies wider ideals of pregnancy, motherhood and expanding the family as something to be celebrated.

This discourse serves as the normalisation of the typical nuclear, heteronormative family, which situates non-pregnant women outside of the norm, implicitly suggesting deviance or failure to conform to the norm. The choice of the medical practitioners to specialise within this particular field may be reflective of their own ideals and values

regarding having children and family, positioning them (those who do have children) within the norm as well.

5.3.3 Gendered interactions between medical practitioners and their patients

As mentioned previously, through the scientific investigation of bodies and their functions, the medical field is a powerful component of shaping practice as well as perceptions (Craddock & Dorn, 2001; Koeck, 2014). This investigation of bodies and their functions becomes an authoritative exercise of power, in which medical practitioners are perceived to know more about one's body than oneself (Craddock & Dorn, 2001; Koeck, 2014). Through the medical gaze, not only is scientific language legitimised, but claims of knowledge about the body also extend to claims of knowledge about the individual within society (Craddock & Dorn, 2001).

> MP2 – "I look after lots of women, and I look after them nicely, and… guide them and help them and… you know, clarify problems…for them. Uhm, so I'm kind of more of a, I'm a bit older, so I'm also a, a bit more of a… directive person. You see what I'm saying, hey? They tell me where they're living, I tell them what the good schools are, I tell them where to send their kids, coz I get a good idea of what, somebody's like, after having had a consultation here. You see what I'm getting at, hey?"
>
> MP8 – "(pause) Basically… it's, the way that my patients see me. (pause) Some of them, see me as a father figure… They- they'll, talk to me about problems, and so on… And some see me as a- a doctor, they can confide in me."

The excerpts above reflect the paternalistic nature of the practice of medicine, especially in the case of White and Jewish male medical practitioners. Both these medical practitioners positioned themselves as "directive" within their practices or even "father figures" that are there to "look after" their female patients. The medical practitioners know best, not only in matters pertaining to their patients' health but also in their personal lives. In other words, female patients are positioned as more vulnerable, and medical practitioners are positioned as more knowledgeable along the axis of power (Koeck, 2014). Female patients are described as looking to the medical practitioners for advice and a place to confide in, placing a certain degree of power over their decision making and autonomy in the hands of

medicine and the medical practitioners. Through these interactions, unequal distributions of power continue to exist between medical practitioners and their patients.

5.4 Discourses surrounding voluntary sterilisation

The dominant medical discourse surrounding voluntary sterilisation is that medical practitioners should consider these procedures with great caution before performing them, as patients will often change their minds after having the procedure done (Denbow, 2014; McQueen, 2017). Patients must "qualify" for such procedures by proving they are sound of mind and that they are certain they do not want (*more*) children (Denbow, 2014; McQueen, 2017; Richie, 2013). Patients must be strongly encouraged first to consider less-permanent solutions to contraception, in case they might decide to have (*more*) children in the future (Denbow, 2014; McQueen, 2017; Richie, 2013).

This is particularly true for patients under a certain age (usually ranging between anything from 35 to 40), as they are constructed as "not mature enough" to make such final decisions (Richie, 2013). This is also true for women who have only one child or a few children, as they are reminded that they might want to have more children in the future, should they lose their existing children or get a new partner who might want children. Voluntary sterilisation is constructed as a finality – a last resort to be turned to only if the reproductive cycle of a woman is coming to an end or is jeopardised for whatever other reason, including a natural decline in fertility or severe illness (Denbow, 2014; Hubbard-Mattix, 2017). For as long as a woman is fertile and able to bear children, however, the possibility must be preserved at all costs, for a woman (*or her partner*) would surely *want* to have the option (McQueen, 2017; Mertes, 2017; Richie, 2013).

These discourses are produced by and reproduce the dominant pronatalist ideologies that inform them, and aid in the regulation of women's reproductive choices and what can (and should) be done with their bodies (Denbow, 2014; McQueen, 2017; Richie, 2013; Solinger, 2005). It is further legitimised by the power held within medicine (Deveaux, 1994; Lalonde, 2018; Neyer & Bernardi, 2011). Four inter-related subthemes emerged: the "completed" family, decision regret, infertility vs choosing to be childfree, and male sterilisation.

5.4.1 The "completed" family

In this analysis, as in previous research examining the medical discourses regarding the ideal patient for sterilisation in medical textbooks, women are considered fit for sterilisation as a form of contraception once she has "completed her family" (Day, 2007). Women may be considered for voluntary sterilisation only if they are absolutely sure they do not wish to have any *more* children (Day, 2007). More so, the act of sterilising a woman is related to pregnancy itself, as women are described to typically undergo sterilisations during the birth of their last child (typically during a Caesarean section) (Day, 2007). The timing of the sterilisation (when it is granted) is thus informed by the completion of the family as well (Day, 2007). However, the definition of the "completed" family is ambiguous and problematic (Day, 2007). Thus, the "completion" of a woman's reproductive activities as defined by herself is rendered invalid by medical discourse (Day, 2007).

> MP3 – "There are considerations. Certain uh, (clears throat) procedures would not be appropriate for certain, patients. If a-p- if a mother is young… and has only one child, I would try and dissuade her… from having a permanent procedure, and recommend, uh, contraception,- long-term contraception, because often they change their minds, uh over a period of time…"
>
> MP4 – "But most of the time they come, if, uhm, they've had their children. They've finished they- they've completed their family. And, then they come with their partners and we do it for them."
>
> MP6 – "No I mean they obviously need to have finished their family… and they obviously need to be sure, and they also need to be sure that if they lose a child, or if they, change their partners, that… they're still gonna want to be… irreversibly- irreversibly, infertile. Because, you know- we don't know what's gonna happen in this life and I just tell them that things are- you know the future is never certain. And, I- it's a very, very, very final step"
>
> MP9 – "Uhm, I wouldn't… advise it, if… the person wasn't sure that they've finished with their family. That they- that they, w-whether they- so- they must be sure that they do not want to have children, or that they've finished their families. That they' ve- that they've completed their families. Uhm, to reverse the operation is very difficult, so, I'd want to be sure that the patient is sure. Uhm, and then I would refer them to- to a gynae that can do the sterilisation for them. Uhm… it must be that person's decision. It's not for me to decide… Uh, as long as they- they understand the permanence, of their decision. But I'm, I think it's, w-wrong, for a doctor, to push, one way or the other. Because it's not my life."

As can be seen in the quotations above, the "completed" family is constructed in various ways, giving rise to conflicting discourses. Although the choice lies with the patient, the mere construction of a "completed" family holds certain meanings, for both patient and medical practitioner. For the patient, the implication is that there is a certain point to reach before a family is considered "completed". This subjective interpretation of "completed" is a choice, but also needs to be verified by the medical practitioner. The medical practitioner, therefore, holds the position of either validating or invalidating the patient's decision of what it means to have a "complete" family, based on the medical practitioner's idea of the patient's best interest. At the same time, as medical practitioner number 9 points out, the decision is the woman's, not the medical practitioner's decision.

However, medical practitioners take a more directive position in the decision-making process (Lalonde, 2018). As medical practitioner nr 3 states, "I would try and dissuade her". In other words, the patient's own perception of what she considers a complete family at a certain point in time is placed under scrutiny by the medical practitioner, based on her age and the number of children she already has. Therefore, as the gatekeepers of sterilisation, it is for the medical practitioner to verify, and ultimately, decide whether or not a woman "qualifies" for sterilisation (Lalonde, 2018). This conflicts with the opinion of the medical practitioners that the choice remains the patients'.

The language surrounding the certainty of one's family being complete is strongly biased towards the possibility of wanting to expand the family in the future due to circumstances in life that may change. This is legitimised through the power exerted by the medical practitioners, in how they communicate with the patients about what might happen if they "lose their children" or "change their partners."

5.4.2 Decision regret

Contraceptive guides instruct medical practitioners to warn against the possibility of decision regret following sterilisation (Day, 2007; Lalonde, 2018). Decision regret has been cited as the main reason for medical practitioners to deny sterilisation procedures (Lalonde, 2018).

> MP5 – "Because the biggest thing that these women have is regret and I've seen it too many times, in my training, for me to just say 'Okay,

> you want to sterilise, let's go'. Right? A woman who's 40, and says to me they want to sterilise, happy. That is, we counsel her, and then off we go. Within, a week, I can do a sterilisation of that woman. Easily. A woman, who has children, a woman- a 40-year-old with three children, it's easier for me… Right? But a 25-year-old, who says to me 'I want to sterilise'- I struggle. And I will, most, often, find, another route for, term- uh for a contraceptive, before I get to a sterilisation. And so…shoe…uh- this is gonna sound bad, but, a young woman kind of like has to 'earn' her sterilisation. And how do I say so? Let's put in a Mirena for you- a Mirena is an intrauterine device- keep it for five years. After five years, coz then- then after five years we have to pull it out and insert another one. If after five years you still come to me and say, 'Can I still sterilise? I don't want to have children, I told you this five years ago.' Then I'll say okay, fair enough."

The discourses surrounding decision regret are closely interlinked with the discourses surrounding the "completed" family. Although medical practitioners contend that the choice to be voluntarily sterilised is the patient's and not their own, the autonomy of choice is placed outside of the patient's individual desires and needs at a given point in time, and within the broader, taken-for-granted idea that eventually all women will want a child or more children, and that they will inevitably change their minds following sterilisation (Lalonde, 2018). The occurrence of decision regret within medical practices serves as justification for the medical practitioner to exert power over the patient's decision. Less permanent options of contraception are preferred and offered to the patient instead, as a means to delay the permanent procedure in case the patient changes her mind, which it is assumed that she will.

Patients must prove themselves and their certainty in their decisions before medical practitioners will comply with their wish. As medical practitioner number 5 states: "you have to 'earn' your sterilisation", and the patient must do this by opting for a long-term form of contraception. After five years, the patient will have to try and convince the medical practitioner again. This takes the autonomy from the patient and places it within the hands of the medical practitioner, legitimising and normalising the dominant discourse that women should *want* to become mothers (eventually), and should, therefore, preserve the option to be able to do so (Lalonde, 2018). Regret following the decision to sterilise, although reasonably so, is constructed as the worst possible outcome, and should therefore be avoided at all costs.

Furthermore, these discourses serve to legitimise and validate certain constructs of women and motherhood over others. Being 40 years of age renders one fit for sterilisation,

while any age younger than that means that one is not ready to make such a decision. Although the discourse of age when it comes to sterilisation centres around maturity and autonomy, it is also known that with age, fertility starts to naturally decline (Stoop, Cobo & Silber, 2014). Therefore, the reproductive cycle of a woman's life needs to run its natural course and is not to be interfered with until such time in which pregnancy begins to pose a threat rather than a positive experience. For as long as a woman is considered fertile, she should preserve the option to stay that way.

Related the "completed" family discourse, the number of children that a woman has also served as a legitimiser of the power exercised over a woman's reproductive autonomy. For example, medical practitioner number 3 mentions that a patient should also be dissuaded from sterilisation should she only have one child and is very young. The legitimacy of motherhood when a woman only has one child and considers her family "complete" is discredited by the implicit and explicit suggestions that a woman would eventually want more children once she is older. The death of a child or children is also portrayed as a strong determinant of wanting to have sterilisation reversed (Day, 2007).

> MP2 – "I mean you get some girls, some doctors on the East Rand… eh, deliver a third baby, of somebody who's 32 years old, say… Tie the tubes immediately, and then they want more babies after that and they find their tubes have been tied. They haven't thought it through. Or… please God it doesn't happen… your kids are killed in a car accident, you still can have babies. So I only ever, which is the right thing to do, discuss that with patients into their late thirties, forties."

The possible death of a child or children is constructed as the ultimate loss, and therefore the ultimate reason for remaining fertile. However, this further invalidates the patient's autonomy of decision and also reiterates the idea that women need to become mothers in order to be complete or have a social standing in society. Even patients who wish to undergo voluntary sterilisation at an age above 30, after having had their third child are constructed as not having "thought it through". It seems that the criteria needed to "qualify" for sterilisation are more a product of the overarching ideologies and subjective positions of the medical practitioners themselves than of a woman's personal choice. As with previous forms of persuasion against sterilisation, the death of one's family is constructed in such a way that it should inform women's reproductive decisions, in favour of having the option to reproduce naturally should they inevitably want to later in life, or due to tragedy.

The underlying doctrine that both these themes point to is informed consent. Medical practitioners use the doctrine of informed consent to guide their practice (Laufer-Ukeles, 2011; Shahvisi, 2019). From the data, it seems as though medical practitioners use informed consent to justify and rationalise the paternalistic stance taken in patients' decisions. According to the doctrine of informed consent, medical practitioners are only obligated to convey medical knowledge to the patient, in order to provide the patient with the necessary and correct information and possible alternatives (Laufer-Ukeles, 2011; Shahvisi, 2019). It is meant to increase the individual autonomy of the patient regarding medical decisions by allowing them to make up their own minds regarding any such decisions (Laufer-Ukeles, 2011; Shahvisi, 2019).

However, while medical practitioners take great care to ensure that they not only provide their patients with the necessary information regarding all forms of contraception (including sterilisation), they simultaneously attempt to sway their decision into a particular direction. The use of hypothetical situations (such as the death of children or new partners) should act merely as additional information for the patient to autonomously make up her own mind, not for the medical practitioner to attempt a persuasion of any kind (Laufer-Ukeles, 2011).

5.4.3 Infertility vs choosing to be childfree

The overarching aim of all the disciplines within the framework of biopolitics and biopower is to maximise health and efficiency in favour of creating a prosperous society (Dickinson, 2004; Lalonde, 2018). Through the "medicalisation" of issues previously seen as non-medical – such as infertility – it is now socially constructed as a problem in need of medical assistance and intervention (Kinloch, 2018).

> MP4 – "But… uhm… when in doctors it's not stuff, but infertility in patients… there… it's a big problem. It's a big problem, uhm… they feel, degraded, they don't feel, they're woman enough, why are they, not having a child? Is there something wrong with them, even if there's something wrong with their partner…They feel it's their fault. The burden is placed on the woman. Even if it's the male problem. It's a big problem with patients. I don't think so much with doctors. Within the doctors, but with patients it's a problem."

> MP6 – "… I think that you empathise, more towards the ones that are-obviously because they're having, you know like loss of their

> reproductive rights- if you like say like well we are trying and we- we can't, I mean obviously you feel a bit of sympathy for them but, the… I mean, I don't think that there's any prejudice against people who don't want to have babies- I- I don't feel it, but- then again I have babies, so it's hard for me to tell, what other people are feeling."
>
> MP7 – "I feel like those who, who are infertile and are looking for, uhm, for fertility… They are, kind of, uhm… Most of them are very- if I can use the word desperate. They sound desperate, when you hear them, an- I've been to this doctor, I've been to this doctor, and I've tried this, and I've tried that… You can see how much this person wants the- the, fertility."
>
> MP8 – "… some women… become almost pathological, in the- in that they cannot fall pregnant. So it- it's… it's a very difficult problem where, you gotta be… sympathetic… and, try and help them, refer them, to… specialist uh… specialist uh, colleagues who… who's main interest is, to try and… and… uh… assist them… and they have to, decide which is the best, method of assisting them to fall pregnant."
>
> MP9 – "Willing but unable is very, difficult. Uhm, because it puts so much pressure on a marriage, and so much hope. If you're able but unwilling, why is that a problem? U-uh- if you don't want children, you don't want children- then you shouldn't have children. … whereas if you, want to but you can't… it starts becoming a huge trauma, for the whole family. So I have a lot of patients like that who- goes for In Vitro, after In Vitro, and it's this cost, and they're picking up weight, and it's hormones, and, the terrible sadness of not having- being able to have children, if you really want to."

From the excerpts above, infertility and choosing to be childfree are constructed very differently within medical discourse. Infertility is constructed much more emotively from choosing to be childfree within the medical discourse. As medical practitioner number 6 points out, you "empathise" more towards women who struggle with infertility and show "sympathy" towards them. Similarly, medical practitioner number 8 also points out that one needs to be "sympathetic" towards these women. Such constructions of women who wish to have children but cannot fit into larger discourses which normalize a woman's desire (and even need) to fall pregnant as the natural and healthy "norm" (Gillespie, 2000; Ulrich & Weatherall, 2000). Motherhood is so normalized and deeply entrenched within the female/feminine identity that women who "fail" to fall pregnant may feel like they are "failing" as women (Gillespie, 2000; Ulrich & Weatherall, 2000). As stated by medical practitioner number 4, female patients who cannot fall pregnant feel "degraded" and that "they're not woman enough", which is in line with previous literature indicating deeply entrenched cultural and societal ideologies that view the female identity and motherhood as

synonymous constructs (Ulrich & Weatherall, 2000). While this normalization of motherhood and pathologizing of infertility occurs on a societal level and not necessarily a medical one, it is reflected in how infertility is constructed by medical practitioners.

The constructions of infertility as a "terrible sadness" and a "huge trauma" offer limited subject positions to be occupied by women with regards to their reproductive rights. Discourses that construct involuntary childfree women as "desperate" reflect broader normative discourses regarding motherhood which feminist theorists have deemed problematic, as it makes it difficult for alternative discourses of motherhood and infertility to exist (Gillespie, 2000; Ulrich & Weatherall, 2000). Women who want to fall pregnant but are unable to are considered stripped of their reproductive rights, while CFBC women are not.

The language surrounding the choice to forgo motherhood is far less emotive. Being childfree by choice is not constructed as a "problem," as medical practitioner number 9 states, "If you're able but unwilling, why is that a problem?" Similarly, medical practitioner number 6 states, "I don't think that there's any prejudice against people who don't want to have babies." Thus, women who choose to undergo sterilisation are not constructed in the same way as women who struggle with infertility with regards to their reproductive autonomy. This is likely due to the many contraceptive alternatives offered to CFBC women besides sterilisation. It is not considered that women who are denied certain procedures such as voluntary sterilisation may experience trauma and frustration as well because they can simply opt for another option instead, while infertile women cannot. These constructions of infertility thus reflect women who are desperate to fit into the norm of expected motherhood, which in turn reifies practice policies that are biased towards producing pregnant women and constraining non-pregnant women in their reproductive choices (Gillespie, 2000; Ulrich & Weatherall, 2000).

ART, where available, while previously considered to grant women freedom over their reproductive choices, thus becomes an additional form of pressure on women to conform to reproductive expectations (Neyer et al., 2011). Medical discourse is strongly biased towards ART to support fertility, rather than to provide voluntary sterilisation services to prevent it. When asked if women who wish to undergo ART undergo the same scrutiny regarding their as CFBC women and if medical practitioners also consider hypothetical future

situations and possible decision regret with infertile women in the same way as with CFBC women, medical practitioners 6 and 9 explained:

> MP6 – "You mean like when you want a baby an- does- do people sit you down and go like they're gonna cost you lots of money… the reverse of it, is that what you're saying? so like we counsel strongly, against, the sterility, but do we counsel strongly against fertility? No, because it's a… natural progression. It's viewed as like- if you don't want it, it's not a problem, but it's, I mean everybody wants, everybody wants a baby. Everybody wants to- it's like an instinctual thing. People wanna continue their gene pool. I've definitely have never sat anyone down when they come to me and say okay, so,- unless they've got a severe medical condition. Then it's different. Unless it's gonna threaten their life, or unless they've got a problem- I've never sat down and be 'Have you thought about how much, time you're gonna take up, and, have you thought about how much money they're gonna cost you?'- no. Seems unfair, but…
>
> MP9- "I want to say, no. No, you don't. I- I think it's, v-ve- pretty one-sided… I hear what you're saying, if you, opt not to it's ooh, but what if, but if you opt to it's not but are you sure?- Ja, I think you're right. I think it's biased towards the… "what if you want to"-side… much more than…Yes, I think so. I don't think you explore with them are you sure you want to have children?...Whereas if- if they're coming for a permanent solution not to have children, then you do explore it... it's definitely biased towards, uhm… the- the normality- that the normality is wanting, to have children. And if you don't, are you sure, are you sure, whereas if you go for the In Vitro you don't have all the same discussions. I don't know though, whether the, uhm… fertility practices, don't refer to psyc- to psychologists as well. I'm not sure. Because, usually the, In Vitro is done at the fertility clinics, and I'm not sure whether they, whether they have that facility, whether they do, advise…and go through all the- the reasons, why you want children. I don't know whether they do that."

Arguably, this relates to the assumption that every woman, regardless of her life-course, age or even health, *wants* to become a mother (Neyer et al., 2011). The juxtaposition of how women who seek to reproduce are "empowered" through ART and how women who wish to abstain from motherhood are questioned for their choices reproduces a "normative" situation in which the notion of reproductive rights is skewed towards motherhood, albeit in the far future (Neyer et al., 2011). Women who wish to become mothers through fertility treatment are not scrutinised or treated in the same manner as women who wish to forgo motherhood through voluntary sterilisation (Lalonde, 2018), at least not within the practice of gynaecology or family medicine. As mentioned, it is possible that fertility clinics may have

such discussions with infertility patients, which may be a worthwhile consideration for future studies.

While the overarching discourse of a woman's freedom to choose is evident in both infertility and sterilisation discourses and practices, women who wish to undergo voluntary sterilisation are much more scrutinized than women who wish to undergo fertility treatments, creating a conflict of subject positions. Women are free to choose not to become mothers, but motherhood is still considered the norm. Despite the option of voluntary sterilisation being depicted as a choice, the possibility for women to exercise this choice over their reproductive process is limited by the options made available to them by medical "authorities" (Lalonde, 2018; Neyer et al., 2011). However, it is important to note that it is not only through medicine that women's choices are limited, but that broader societal and gender-related values which also impose limitations on their reproductive autonomy.

5.4.4 Male sterilization

When asked whether male sterilizations were offered instead of the female sterilizations as an alternative option for contraception, most of the medical practitioners said that male sterilizations were offered and even recommended as the more desirable procedure. The medical practitioners confirmed that male sterilizations were not only less invasive than female sterilizations but hold far fewer risks (Hofmeyr & Greeff, 2002; Shih, Turok & Parker, 2011). Nevertheless, male sterilization is highly stigmatized among certain groups of men, giving rise to conflicting discourses of masculinity. On the one hand, men show scepticism regarding the influence of vasectomies on male sexual satisfaction reinforces hegemonic ideas of masculinity, where male sexual capability interlink with masculinity and positions of power within the family. On the other hand, resistance towards these views of masculinity gives rise to more egalitarian discourses of gender, where both partners in the heterosexual relationship share the responsibility of family planning and contraception (Hofmeyr & Greeff, 2002; Terry & Braun, 2011).

> MP5 – "And I… am more than happy to sit with a woman and for us to find that which is- that suits her. And…I am, one of those people who will bring, a vasectomy… to the table… when my patient is fed-up of taking pills, fed-up of injectables, fed-up I- can we bring him?"

> MP7 – "The male procedure can be done under local anaesthesia. It's simple. The female procedure needs, general anaesthesia, needs theatre. Yes, and then… So they- if, people understood it in that way, but- we do try to tell them but they still are reluctant to do it. But the easier one is the male one…Coz you do it under local, small cut, you find whatever s- you wanna tie, you tie. For females, you have to put in a camera inside, and, you know? S- so it's a p- uh, long process… which, also has got more risks."

However, although vasectomies are less invasive and generally more accepted (and preferred) than female sterilisation procedures, most of the medical practitioners reported that most men were unwilling to undergo vasectomies.

> MP2 – "Men hardly ever do it. Because they're scared it's not gonna work once they've had the vasectomy done…Easy as that… They're scared, men are *bang*…they just don't like people fiddling with their, private parts. That's the answer, end of story."

> MP5 – "Have I, in all my training, have a couple arriving and, requesting that- vasectomy? No. Because men, still don't want to- to do the vasectomy, but they don't want to have these children. So you are left with the burden of, the contraception…I think I've only had one successful counselling, but I still offer it. And I still bring it to attention that, contraception is not only your problem in this relationship. But unfortunately, that… an- and I realise the shortcomings of it, is that… you can save it, from your feminist point of view, but I'm the one who ends up with a foetus inside my womb."

> MP7 – "They are not willing, they- I mean, u-uhm… you find, they- the idea of sterilisation comes, with the lady. And then they are like you are the one who said you wanna sterilise. So go ahead and sterilise. And then- that's what, I find from most of them. And then, when we discuss with some of them, they're just not willing to do that. They're like… I'm not going for it. You know? And some are not cooperative at all, you know?"

> MP8 – "We can say to the patient, your husband can be sterilised. But, none of them want to be, most of them don't want to be…*Hulle is bang*...I think they may… also be scared that they may not, be able to have intercourse- they may not be able to get an erection or so on… You try and tell them they don't have to be scared about that, but… t- they… often the patient comes, without the husband…and I say, well perhaps your husband should have it. They say he won't. They've discussed it with them. And he won't have it."

> MP9 – "… I've got one patient now that I actually referred he's- he's very good, with verbalising, what he's feeling so he said to me he's worried about his masculinity and I said okay. Let's refer you to a, psychologist, and she's seeing him and they probably will still go for the- for the vase- he says, he knows it's best for his wife, but- and they,

> have two kids al- two or three kids already, so they've finished their family, and she's not doing well on contraception- she doesn't want to do anything permanently… Uhm, so, they decided he's going to do the vasectomy but they're first gonna go for counselling, because he's not so sure that that's what he wants to do. Yes, I do- I think, it might- it must be the demographics."

As can be seen above, despite the rise of more egalitarian discourses surrounding women and parenthood, there still seems to be an imbalance of responsibility when it comes to reproductive matters such as contraception (Terry & Braun, 2011). The "burden" of family planning is still seen as the responsibility of the woman, even if men agree that they do not wish to have any more children. As medical practitioner number 7 quoted: "you wanna sterilise, so go ahead and sterilise." In some cases, the medical practitioners confirmed that the men are not even part of the procedure of discussing contraceptive options, leaving it entirely to the women. These constructions of reproductive and contraceptive responsibility offer limited gendered subject positions to both men and women, where men are sexually driven, and women are domestically inclined (Terry & Braun, 2011). Men are generally sceptical about vasectomies because they believe that it would interfere with their sexual ability or satisfaction. However, research does not indicate any changes in male sexuality after undergoing a vasectomy (Hofmeyr & Greeff, 2002).

These discourses are reflective of a broader, underlying ideology regarding masculinity at a societal level, rather than a medical level. However, such views of masculinity seem to be significantly influenced by culture and the area in which patients reside. As can be seen below, in some cases, men were quite willing to undergo sterilisation.

> MP6 – "Lots of people, I get lots of patients who, after they've finished their family, men go- I say 'What are you gonna do for contraception?'- and I offer them the Mirena because it's also- it stops your bleeding, so you don't have a period for five years, it's fabulous. And then they're like no, they'd rather… they'd rather that the hubby goes for the vasectomy and they all go…it always surprises me also. Coz you don't think that men are gonna be willing to do it, but they do."

> MP9 – "Uhm… I think it must be the demographics, because I've got the- if I think of it, I've got very few, patients who were sterilised- would- it's- it's a stable practice, and a family practice, so… often the husband has had a vasectomy, so then the wife doesn't have to, do anything. And it's a much smaller procedure, and I would advise that. So if it's a- if it's a settled couple, then, why have a her have the anaesthetic risk, versus him having a much smaller procedure? Then

> we often advise for the vasectomy- we'd rather do the vasectomy. Or refer for the vasectomy."

The scepticism or willingness to undergo vasectomies are closely tied with views of masculinity - specifically the distinction between masculinity and fertility - which seem to be culturally dependent (Hofmeyr & Greeff, 2002). In cases where masculinity is tied to the idea of sexual prowess and ability to reproduce, vasectomies are perceived as an obstacle to men exercising their power within the family (Hofmeyr & Greeff, 2002). Previous research suggests that both internationally and locally within South Africa, these views of masculinity are particularly prevalent within the Black communities (Hofmeyr & Greeff, 2002; Shih, Turok & Parker, 2011). South African Black communities are among those who tend to value larger families, and South Black men are positioned as figures of authority and power within their families based on their ability to reproduce (Hofmeyr & Greeff, 2002). Based on previous research, they also believed that the inability for women to fall pregnant would result in infidelity (Hofmeyr & Greeff, 2002). In contrast, White, Indian and Coloured South African men do not hold the same views of vasectomies and masculinity (Hofmeyr & Greeff, 2002; Shih et al., 2011). Within the current study, it is not easy to pinpoint the more hegemonic views of masculinity to a certain ethnic or racial group, as all the medical practitioners reported seeing a wide demographic of patients.

However, particular areas may be considered more traditional or conservative than others. For example, the one medical practitioner mentions the "settled" couple, reflecting a more conservative demographic of patients where the traditional, nuclear family is still the desired norm. In such societies, having only one marital partner and children with only that one partner may be more highly valued than in other, more urbanised areas where the nuclear family is not as prevalent. Despite the stigma surrounding vasectomies for all groups of men, that men in such circumstances tend to be more willing to share the responsibility of contraception and resisting the more hegemonic discourses of masculinity (Pomales, 2013).

5.5 Conclusion

In many cases, discourses surrounding the same discursive objects were contradictory and co-occurring. Therefore, the constructions of women and motherhood and voluntary sterilisation are extremely complex and cannot be understood in a singular manner. Furthermore, the discourses within the medical field and of the medical practitioners

highlight the value-laden nature of medicine, and how the subject positions of the medical practitioners themselves play a crucial role in societal structures. As such, there was some difficulty in distinguishing between major themes and subthemes clearly, as these were all interrelated to one another, and with broader societal views and discourses. The main discourses employed to describe constructs included medical and societal discourses, all explored within the framework of biopower and also through a feminist lens.

The main findings were that motherhood, although not explicitly stated that way, is still considered an essential part of a woman's life and that there still exists within society the assumption that all women should *want* to become mothers eventually. This is legitimised and reinforced by the medical discourses surrounding infertility, which play a crucial part in reinforcing societal standards that view infertility as a problem in need of medical intervention. This medicalisation of previously non-medical problems highlights the role of biopower in reifying ideological norms and ways of continuing the normative constructions of realities through language and power relations existing within medicine between the medical practitioner and the female patient. This research aimed to challenge the status quo by identifying discourses within medicine surrounding women and motherhood and voluntary sterilisation and how these discourses serve the overarching ideologies which exist within society. The subsequent chapter will provide a conclusion to the research, as well as the limitations of the current research and directions for future research.

Chapter 6
Conclusion

6.1 Introduction

The current research was aimed at investigating the existing discourses regarding women's reproductive autonomy, particularly requests for voluntary sterilisation among medical practitioners. The research further aimed to challenge the status quo by exploring whether these discourses are in favour of pronatalist ideologies and therefore exercise power to maintain such ideologies. Data were collected making use of semi-structured interviews, conducted with a sample of 9 participants in total, ranging between 20 and 95 minutes each. Three major themes with several subthemes each were extracted from the data, the results of which are discussed in Chapter 5. This chapter provides an overall conclusion to the research and attempts to answer the research questions posed in the study. Furthermore, this chapter provides an evaluation of the study by including the limitations thereof and recommendations for future research.

6.2 Conclusion

Womanhood and motherhood have long been synonymous constructs. Motherhood is seen as a natural and inevitable progression in a woman's life, and therefore normalised within a mainly heteronormative, pronatalist, and (still) patriarchal South African society. Two main discourses arose regarding women and motherhood. Firstly, biological determinism dictates that women inevitably become mothers due to their natural ability to do so. Secondly, more egalitarian discourses contend that women are entirely free to choose. These constructions of women and motherhood, however contradictory, are both reflected in medical discourse. Participants employed both these contradicting discourses in the talk elicited through the interviews.

Participants contended that their patients' reproductive choices are entirely their own. However, by engaging in biologically reductionist speech regarding gender, medical discourse localises gender within the female body, contributing to the "natural" discourses regarding motherhood and the limited subject positions it offers women. Thus, the "natural" desire to fall pregnant and to have a family is legitimised through the language used by participants in the reflecting wider discourses that proclaim the heteronormative, nuclear family as the ideal. Furthermore, motherhood is considered a moral and social construct and

grants women a place within society that childless and childfree women are not afforded. Although it is no longer the case that women are viewed primarily as mothers, no alternative feminine identities are constructed through the discourse. Women are still (eventually) mothers, but they seek out education and careers first. Motherhood, although implicitly, is still considered the norm and ultimate goal for women. Thus, women still operate within gendered spaces, both in society and medicine.

The field of medicine is still mostly dominated by White males, reflecting societal values permeated by race and gender inequalities. The values reflected within medical discourse are inherited by past regimes that have influenced conflicting discourses of gender and sexuality. Such discourses, in turn, inform practice and are reinforced and reflected through language. Notwithstanding the medical practitioners' personal values and relationships with their patients, the larger values in which these agents of power operate cannot be ignored. Thus, the socio-historical context in which South African medicine is founded, will inevitably influence the subject positions available, both for the medical professionals and their patients, and what can be said and done within those subject positions. Through these values, and the language employed to construct particular identities, and therefore realities, women's reproductive autonomy is threatened and controlled.

The denial or delay of voluntary sterilisation in favour of becoming a (future) mother, reinforces these positions of women through medical discourse and power. Voluntary sterilisation is strongly discouraged within medical discourse, reflecting ideologies of pronatalism. It is constructed as a drastic measure and last resort, only to be turned to if a woman's reproductive cycle has concluded, due to age-related decline in fertility, abnormalities, or illness. Furthermore, voluntary sterilisation is reserved for those deemed "fit" for sterilisation, which is determined by medical practitioners and validated by medical discourses surrounding decision regret. Under doctrines such as informed consent, medical practitioners aim to "ensure that the patient is sure" before agreeing to a sterilisation, thus taking a paternalistic stance in women's reproductive decisions. The medical practitioner serves as the producer of knowledge while providing alternative contraceptive choices and attempting to dissuade women from seeking voluntary sterilisation. Broader societal values and norms are thus legitimised by medicine.

The controlled contraceptive options influence women’s reproductive choices, but so too does how both fertility and infertility are perceived and constructed. Infertility is

constructed as a problem in need of medical intervention, and infertile women are sympathised with, while childfree women are not. The language used to describe infertility, and infertile women is extremely emotive, and the language engaged in when describing voluntary sterilisation is distanced from subjective experience. Women who seek fertility treatment are constructed as stripped of their reproductive rights, while women who seek sterilisation are not. Although the latter is constructed as being completely in charge of their reproductive decisions; what is not considered, is that their *autonomy* of choice is influenced by the options made available to them — both by the medical practitioners and their partners.

Though sterilisation through vasectomy is an available option to couples who do not wish to have (more) children, men are often unwilling to have vasectomies. This further limits women's freedom of choice by completely placing the responsibility of contraception on them, yet eliminating another avenue toward childfree-ness. However, there are also competing discourses with regards to vasectomies, which are deeply entrenched within culture. Views of masculinity and male sexual satisfaction further contribute to the available subject positions women can occupy and are products of socio-cultural and socio-historical influences. Therefore, women are still mostly responsible for their reproductive decisions, yet not as in control of those decisions than assumed.

The themes highlighted in the current study revealed gendered medical discourses surrounding women, motherhood, and voluntary sterilisation, which serve to produce female patients who either adhere to or challenge the norm through their choice to forgo motherhood though their choice of contraception. Through these medical discourses, broader ideologies existing within society were identified by applying the Foucauldian tradition of discourse analysis through a feminist lens. These contrasting and interrelated discourses suggest a society in which motherhood is still expected and assumed, although not as the sole role of the woman, and indeed not explicitly stated. The research further highlights the still heteronormative expectations of femininity and its relationship to motherhood, both situated within the traditional, biological construction of the female body. Moreover, what this research mainly reveals, is that although women are no longer seen purely as mothers, and perceived as having complete autonomy over their reproductive choices, these choices are limited through the subject positions made available to them by discourse, determining what can be said and done from those positions.

Biopower does not only prohibit, but also produces bodies which either resist or reinforce traditional identities. Through resisting or even rejecting prescribed feminine identities, women act as social agents who contribute to creating their social worlds. However, even while resisting power, embodied notions of femininity and motherhood are arguably so deeply ingrained within the habitus, that it becomes difficult to act upon in ways that do not reflect traditional gender roles. For change to occur, these taken-for-granted positions require gender-reflexivity, which dominant discourses may not necessarily allow. Indeed, it seems that the most prevailing discourse of all, is that women are not only supposed to have children; they are supposed to *want* to.

6.3 Limitations of the Research

One limitation of the study is that the final sample of participants, while sufficient in providing quite rich data and enabled the researcher to address the aims of the research, was quite small. A larger sample might have yielded more themes and richer data.

Another limitation is that the sample only consisted of medical practitioners from areas around the Gauteng province, which means that although the research aimed at investigating discourses within South Africa, the data may not be reflective of all areas in South Africa. Additionally, while the researcher attempted to pool participants from as extensive a range of areas in Gauteng as possible, most of the participants in the final sample came from the same area, limiting the generalisability of the findings to other areas in Gauteng and the rest of South Africa. However, due to the qualitative nature of the research, the aim was not to generalise the findings but rather to gain an in-depth knowledge of the discourses arising from the selecting participants. The researcher, therefore, contends that this limitation is not of too much concern.

The main concern is that the sample comprised private medical practitioners only and that medical practitioners from the public sector could not be included. This was due to ethical considerations concerning public hospitals in Gauteng and the time constraints of the research project. This is considered a limitation because the demographics of patients did not vary so widely within the private sector, at least in terms of socioeconomic class. All the patients of private medical practitioners either have medical aid or are able to pay the co-payments of the practice, which places them in a different class than those patients who rely on public/government medical care. Comparison in this regard was therefore limited.

Lastly, due to the medical practitioners' time constraints, some of the interviews were extremely short in length. Longer interviews might have yielded richer data. However, because of the difficulty the researcher had in obtaining willing participants for the study and in order not to inconvenience the participants, time constraints were adhered to, and shorter interviews were also taken into consideration in the analysis of the data.

6.4 Future Recommendations

Future research might want to address the limitation of not having participants from the public medical sector. However, it should be noted that the ethical processes regarding obtaining medical practitioners from public hospitals are extremely lengthy, so time constraints of the research project should be considered beforehand.

Future research might also consider involving women in the study - both mothers and childfree women - as they were both objects and subjects of discourse and may offer valuable insights to discourses outside of the medical field.

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Appendix A: Permission Letter to Heads of Hospitals/Clinics

Psychology
School of Human & Community Development
Private Bag 3, Wits 2050, South Africa.
Telephone: +27 11-717-4500/2/3/4
Fax: +27-11-717-4559

To whom it may concern

Good morning/afternoon

My name is Elize van Zyl and I am currently a Masters student enrolled at the University of Witwatersrand and I am conducting a study on the reproductive health women in South Africa. This research is required for the completion of my degree in Psychology.

I would kindly like to request your permission to conduct research at your hospital and assistance in retrieving potential participants for my research project. My cohort should consist of one to two medical practitioners who practice at the hospital, specialising in reproductive health.

Participation in this study is voluntary and none of the participants will be forced to participate against their will. Participants can also withdraw from the research at any point. Participation in this study will involve one in-depth interview where I will be asking the participants questions about their experiences and expertise regarding women's reproductive health, with a particular focus on fertility choices.

Ethical clearance has been approved and granted for this research which means that my project does not pose any harm to participants in any way. Willing participants who accept to partake in this study will be contacted at the end of the study to be given a summary of all the findings and a full research report is available to participants upon request. I am available for questions and queries and I can be reached telephonically on 062 208 3247 or via email on evanzyl90@gmail.com.

Your assistance will be greatly appreciated. You are welcome to contact me directly or alternatively contact my supervisor using the details below.

Yours truly,
Elize van Zyl

Research supervisor: Ruby Patel
Ruby.Patel@wits.ac.za

Appendix B: Information Sheet for Participants

Psychology
School of Human & Community Development
Private Bag 3, Wits 2050, South Africa.
Telephone: +27 11-717-4500/2/3/4
Fax: +27-11-717-4559

INFORMATION SHEET

Good morning/afternoon

My name is Elize van Zyl and I am currently a Masters student enrolled at the University of Witwatersrand. I am conducting a study on biopower and the reproductive autonomy of childfree women in South Africa. This research is required for the completion of my degree in Psychology and I would like to invite you to participate in this research study.

Participation in this study will involve one in-depth interview where I will be asking you questions about your experiences and expertise regarding sterilisation requests made by women who choose to remain childfree. I am hoping to understand what the discourses surrounding voluntary sterilisation are among women of different age, class and racial groups and the role that medicine plays women's autonomy in choosing to remain childfree. In taking part in this research, you will assist us in questioning and perhaps even challenging traditional and/or stereotypical views of women and motherhood by providing insight into existing ideologies and how they are formed and reinforced.

Because it is of utmost importance that what you say to me, the researcher, is not misconstrued, I would like to request your permission to use a tape recorder during our interview to aid me when writing up my report. Your identity will be protected by using pseudonyms/fake names and only my supervisor and I will be permitted to listen to the audio-recordings. I may use direct speech in writing up my final report but even in those cases, fake names will be used. Confidentiality will be maintained at all times throughout the interview process and afterwards when data is being transcribed and reported on in the form of my research report. All recordings will be kept locked away in a safe room on my computer which requires a password to gain access. After the recordings have been transcribed verbatim, original recordings will be destroyed. The transcripts will be kept until my degree has been completed, after which they will be destroyed as well.

The interview will be approximately 45-60 minutes and is not sensitive of nature, so it is not expected that any discomfort should arise when answering the questions. Although information regarding patient requests for sterilisation will be asked, the questions will abide by doctor-patient confidentiality and will not require any identifying information about patients to be shared by you. You have the right to withdraw from the study at any time

without offering any reasons and/or you may refuse to answer any question that you are not comfortable discussing. Your participation in this study is voluntary and warmly welcomed.

Willing participants who accept to partake in this study will be contacted at the end of the study to be given a summary of all the findings and a full research report is available to participants upon request. I am available for questions and queries and I can be reached telephonically on 062 208 3247 or via email on evanzyl90@gmail.com.

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee"). A principal function of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concern over the way the study is being conducted, please contact the Chairperson of this Committee who is Professor Clement Penny, who may be contacted on telephone number 011 717 2301, or by e-mail on Clement.Penny@wits.ac.za. The telephone numbers for the Committee secretariat are 011 717 2700/1234 and the e-mail addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za

Your participation will be greatly appreciated. You are welcome to contact me directly or alternatively contact my supervisor using the details below.

Yours truly,
Elize van Zyl

Research supervisor: Ruby Patel
Ruby.Patel@wits.ac.za

Appendix C: Consent form for in depth interviews

Psychology
School of Human & Community Development
Private Bag 3, Wits 2050, South Africa.
Telephone: +27 11-717-4500/2/3/4
Fax: +27-11-717-4559

I, _____, hereby agree to participate in the research to be undertaken by Elize van Zyl for her study about biopower and the reproductive autonomy of childfree women in South Africa with the full understanding that:

- Participation in this study is voluntary
- Refusal to participate will involve no penalty
- I have the right to refuse to answer any questions that I prefer not to answer
- I may withdraw from the study at any time without giving reasons why
- The information I provide will not be traced back to me and my identity will not be disclosed in any report, presentation, or other forms of dissemination
- I understand that the fake names will be used to protect my identity
- No information that may identify me will be used in the research report. While direct speech from the interview will be included in the researcher's research, the researcher will keep all responses as nameless as possible

Date: _____

Participant Signature_____

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee"). A principal function of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concern over the way the study is being conducted, please contact the Chairperson of this Committee who is Professor Clement Penny, who may be contacted on telephone number 011 717 2301, or by e-mail on Clement.Penny@wits.ac.za. The telephone numbers for the Committee secretariat are 011 717 2700/1234 and the e-mail addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za

Appendix D: Consent form for recording

Psychology
School of Human & Community Development
Private Bag 3, Wits 2050, South Africa.
Telephone: +27 11-717-4500/2/3/4
Fax: +27-11-717-4559

I, _____, hereby give consent for the in-depth interview (described in the information sheet attached) by Elize van Zyl to be audio-recorded, with the full understanding that:

- The tapes will be heard by no other person other than the researcher and her supervisor
- All tapes and transcripts will be destroyed after the completion of the research and the qualification has been obtained
- No identifying information will be used in the transcripts or the research report
- Pseudonyms/false names will be used to identify different participants to maintain privacy
- I further give consent to the researcher, Elize van Zyl, to use direct speech that will not have any identifying information

Date: _____

Participant signature: _____

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee"). A principal function of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concern over the way the study is being conducted, please contact the Chairperson of this Committee who is Professor Clement Penny, who may be contacted on telephone number 011 717 2301, or by e-mail on Clement.Penny@wits.ac.za. The telephone numbers for the Committee secretariat are 011 717 2700/1234 and the e-mail addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za

Appendix E: Ethics Clearance Certificate

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R14/49 Miss Elize van Zyl

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M190531

NAME: (Principal Investigator)	Miss Elize van Zyl
DEPARTMENT:	School of Human and Community Development Private Medical Practitioners: Gynaecologists and Obstetricians Ubuntu Health Care Clinic in Cosmo City
PROJECT TITLE:	Biopower and the Reproductive Autonomy of Childfree Women in South Africa
DATE CONSIDERED:	31/05/2019
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Ruby Patel
APPROVED BY:	Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	09/10/2019

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the Third Floor, Faculty of Health Sciences, Phillip Tobias Building, 29 Princess of Wales Terrace, Parktown, 2193, University of the Witwatersrand. I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in **May** and will therefore be due in the month of **May** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix F: Interview Schedule

Themes:

The medical practitioner as an object of discourse (Who are they? Where do they come from?)

- Tell me a little bit about yourself? (with probing for more information regarding the background of the medical practitioner – which may include race, class and gender, to get a sense of how and where they position themselves within the discourse and their social fields)

The habitus of the medical practitioner (Their gender, culture, etc.) and their views of women and motherhood

- Can you tell me a bit more about your culture? (Asking about how they might have grown up, family structures/hierarchies, views of the positions of men and women, etc.)
- In your culture/family, what are the views around women and motherhood? (How central is motherhood to be a woman, what does it mean to be a woman/mother within their specific culture/family?)
- As a man/woman, tell me about your views of the female/feminine body? (Getting a sense of not only how they view the female body personally, but how they position themselves along the axis of gender – their own gendered habitus)

The objectification of reality as constructed within the medical profession (How medical practitioners make sense of the world and reality within their profession/practice)

- Tell me a little bit about your training? (What do you specialise in, how long was your training, where did it take place?)
- Tell me about your decision to specialise in this area? (Is this what you always wanted to do? What made you decide to specialise in this field?)

The medical practitioner as a subject of discourse (as being able to take on other subject positions due to their profession, e.g. being the paternal decision maker, the expert, etc.)

- What does it mean to you to specialise in this field? (What do you find rewarding/challenging about it? Tell me about some of the experiences you've had in your field?)

The gendered habitus within the medical field (How do medical practitioners reconcile their gendered habitus with the medical field – what are the views of motherhood and the feminine body in biomedicine and are there discrepancies between the habitus and the field?)

- Can you describe how the feminine body is viewed by medicine? (How were you trained to see and treat the feminine body? What is the meaning that medicine attaches to the feminine body?)
- Can you tell me about how valued motherhood and fertility is within the medical field? (What are the medical views around motherhood and fertility? Are there

discrepancies between how they see/value motherhood from their medical habitus versus their gendered habitus?)

The reproductive decisions of women as the subject of discourse (from the view of the medical practitioner)

- Can you describe some of the reproductive/fertility issues and/or procedures that you assist patients in?
- Do you assist many patients with voluntary sterilisation? (Providing patients with information, assisting with the actual procedures, providing them with alternatives, etc.)
- Can you tell me more about how you would go about consulting patients who ask to undergo fertility treatments and sterilisation procedures? (What do they need to consider? – probing for issues such as age, marriage, possible future regret, etc. - What are some of the risks/legal requirements involved?)
- Can you tell me about any specific factors, such as illness and/or other factors, that would make you more or less likely to assist patients in certain procedures, be it in order to be able to have children or to not have children? (Again, probing for demographic factors that might illuminate race, class, gender, disability factors, etc. and also to probe more specifically for difference in discourse regarding patients who want children vs patients who don't)

Women as both objects and subjects of discourse (Who are they? Where do they come from? How are they being positioned/contrasted against the medical practitioners? What are the subject positions they occupy? E.g. autonomous decision makers, selfish, ignorant patients, etc.)

- Tell me more about the type of patients you deal with or assist in reproductive/fertility issues? (Probing for more information about the 'type' of women and the procedures they ask for, looking for patterns of positioning within race, class, gender, perhaps even for discourses around LGBTQ+ individuals/couples)
- Can you tell me a little bit more about some of the experiences you've had with patients in the field regarding reproductive/fertility issues? (Have there been any cases which stood out? How did you deal with those experiences? How have these experiences shaped your view of the patient and of reproductive/fertility matters?)
- Would you imagine that women, who are able to have children but who want to undergo voluntary sterilisation, would regret their decision later in life? (Again, probing for a specific 'profile' associated with regret, in terms of age, race, class, unmarried)
- Would you imagine that men, who are able to have children but who want to undergo voluntary sterilisation, would regret their decision later in life? (Probing for a gendered discourse)