Introduction

Elite Birthing Care in South Africa

The floor to ceiling wall made entirely of glass offered a clear, expansive view of the ocean. The living room was open-plan, and bright as light streamed in through the glass walls and ceiling. The dining table, with a fresh flower centrepiece, was contemporary and surrounded by Scandinavian modern chairs, scattered with sheepskins, a fashion in 2015. Sandy, as I call her, welcomed me into her home, offering me filtered water infused with cucumber; she showed me where her private, one-to-one Hypnobirthing classes were going to take place in the living room. She explained that her husband travelled for work much of the time and fitting in birthing classes was easier if these took place in their home, at a time that suited the couple. Participating in Hypnobirthing classes was a common activity for women using private midwives; they understood the classes as a method that would help facilitate the 'natural' births they desired.

Sandy's home and her aspirations are typical of the circumstances and birthing desires of women using private midwives who I would come to know and observe over my year in the midwives' practices. Yet these women and their socio-economic contexts are atypical in South Africa. The group of women with whom I worked are unusual in South Africa's birthing sector for two reasons. The first reason is that they are able to access private health care, a form of care that is only available to South Africa's (largely white) financially elite class. This means that they are able to 'choose' how to birth. The second reason these women are unusual is that even though they would be birthing using private birthing services, they hoped for 'natural births'. This is uncommon in South Africa's

private sector as most women able to access private health care birth via caesarean section (C-section).

This is an ethnography about the constellation of care, race and privilege as they materialise in middle-class women's birthing practices. It traces privilege as choice, privilege as isolation, privilege and capital, and privilege and race as these emerge in relation to recognition and care. Care and being able to make choices about it form the central themes running through the book. This, in a South African setting with State health services under strain, understaffed and underequipped, is not a given but a kind of entitlement and an option for only a few. This is because South Africa's medical care is divided between private and public sectors. Where and how one births is largely determined by the sector a woman is able to access.

Birthing in South Africa

Rachel and I sat in her home in Somerset West, a small town on the outskirts of Cape Town, three weeks after the birth of her son. It was still chilly in the early days of spring but it was sunny so we sat near the window and Rachel spent most of her time speaking with me, breastfeeding or holding her baby. Rachel told me how she had gone into labour three weeks early and the speed of events had caught her and her husband, Dan, off guard. She had still been working (indeed she believed her annoyance at a work situation had contributed to the early onset of her labour) but was now completely focused on her baby, commenting on how she could not believe how she had made work such a priority before the arrival of her son. Rachel described her experiences and reasons for choosing a midwife-led birth. She explained what her friend had said:

> My friend, Dina, she's one of the smallest woman I've ever met and she had all three of her children naturally. She said you have to find the right practitioner that believes in the *power of a woman's body*. She said that's what you need to do and stay away from paternalistic men who believe it's unnatural and that they are doing you and your husband a favour by cutting the baby out of you cos you're going to be so damaged afterwards.

This was a common theme amongst my informants. Strong views on birthing highlight ideas of paternalism and feminism in my study. The overlaps on opinions of birth are also significant: I will explore

these themes. How such opinions emerged is framed within South Africa's approach to health care.

Private Sector Settings and Defining the Middle Class

There are two means of accessing medical care in South Africa: private and public sector led care services. Women with medical aid or enough money to pay out-of-pocket who are therefore able to use private care have the 'option' of how they give birth. Private care obstetricians offer vaginal birth and elective C-sections (and emergency C-sections) and medical aid covers the costs of a C-section more readily than a midwife-led vaginal birth (Macdonald 2008). Despite the fact that birth is unpredictable, women using private medical care are able to plan and think around how they birth as a choice-based practice.

As a woman living in Cape Town, South Africa, Rachel was included in a socio-economic bracket that allowed her to pay for monthly medical aid cover and she accessed private health care. The majority of the women in my study had medical aid and were either working or had partners who earned enough money so that they were able to not work and could afford private care as a family unit under their partner's medical aid scheme.[1] I refer to these women as middle-class but the definition and criteria for a middle-class population is complex. Visagie and Posel (2011) argue that South Africa's middle class is hard to define. Being middle class may be classified as having reached a particular level of affluence and lifestyle. It can also be defined on a comparative basis, relative to the economic position of other members of a population. A middle income in relation to the general populous is not adequate in South Africa where the average middle income places people at or just below the poverty line. Using criteria of affluence and lifestyle, such as being able to afford private health care, having housekeeping services (caring for children and household), owning a car and having tertiary education provides a means of defining women in my study as middle-class that is congruent with definitions in developed countries.[2] Having said that, while women in this study mainly had to work in order to maintain their lifestyles, the gap between the rich and poor in South Africa is enormous; inequality is still largely racially stratified, and South Africa remains one of the most unequal countries in the world in terms of income distribution.[3]

The women with whom I worked in this research subjectively defined themselves as middle-class and fell into categories of being middle-class in terms of the definition offered above, but the care they were able to access and their lifestyles, by the standards of the majority of South Africans, were elite. My study thus concerns an elite version of formal care, the meaning of care in this context and how women accessed and navigated particular versions of birth and care. As I will show, where and how one accesses care in South Africa determines how one is cared for. The elite quality of care is significant.

Rachel had access to various options of care and intended to birth in a private medical institution but she faced challenges in opting to birth 'naturally' (that is, vaginally) as this meant finding a health care provider who was willing and able to offer support for a vaginal birth.[4] While this may seem simple, 72 per cent of women in South Africa's private sector birth via C-section, with some private hospitals reporting C-section rates of 90 per cent (Fokazi 2011, Smith 2014). The World Health Organization (WHO)has stated that C-section rates should be between 10 and 15 per cent in any country, and in the light of new research on the benefits of vaginal delivery to infants, WHO states that vaginal birth should be the way that most women birth.

Patients using private sector medical services in South Africa have become more litigious. Obstetricians pay approximately R40 000 (about $3500) per month on medical malpractice insurance as more legal cases have emerged with adverse birth outcomes (Roux and van Rensburg 2011). Women are given the 'choice' of how they birth and the statistics suggest that many choose to have an elective C-section. Concurrently, higher monthly costs for doctors mean that obstetricians fit in more deliveries via C-section, where allotted times and days are set, and surgery takes less time than assisting labouring women over hours, potentially through the night (Fokazi 2011). The merging of financial imperatives, convenience, medical aid willing to cover C-sections more readily than midwife-led care home or hospital based births (although more providers of medical aid are becoming willing to cover midwife-attended birth) (MacDonald 2008) contributes to high C-section numbers. The midwives in my study established themselves as the caring alternative to obstetric-led birth which was criticised for scaring women and overriding patient decision-making. These factors, together with the desire for C-sections by many South African women, have produced the high C-section statistics in South

Africa's private sector (Fokazi 2011). Indeed, WHO released a statement on the rise in C-section rates globally and in all health care sectors (WHO 2015). WHO has reviewed the data and finds no benefit from a C-section birth to women or baby at the population level of rates higher than 10 per cent.[5]

The rising global C-section rates and high C-section rates in South Africa's private sector are not the only concern for pregnant women accessing private care. Women in the private sector reported not getting ideal care and being forced into C-sections when they did not believe they needed one (Roux and van Rensburg 2011). Concomitantly, women in the public sector also report inadequate care (Vivian et al. 2011, Jewkes et al. 1998). The question of what defines adequate and inadequate care is apposite. In both sectors of medical care there have been reports of inadequate care but it is mainly middle-class women who use the private sector and largely working-class women who receive public sector care. The public sector provides care for 82 per cent of South Africa's population but only accounts for 40 per cent of health expenditure in South Africa. There is a wide gap between care and resources in the different health care sectors (Pillay 2009). The question of whether definitions of adequacy in care differ by class warrants attention. My study focuses on a version of care available largely to middle-class women; therefore, care and its adequacy across sectors is important.

The Western Cape Government website on maternal and women's health offers a description of birth/labour services. The website recommends that labouring women bring a birthing partner (partner, friend or doula) to accompany them during labour. A birthing partner is encouraged as the website states that women feel more supported and need less pain medication (indeed epidurals are not an option in Midwife Obstetric Units [MOUs] where low-risk births in the public sector occur). In public sector birthing venues, mainly MOUs, midwives work on shifts and labour care consists of checking the progress of labour and monitoring the wellness of women and babies. Continuous, one-to-one labour care is not offered as there are not enough midwives on duty to support the number of labouring women individually each day. Conditions in public sector hospitals are difficult. Staff are overburdened and Vivian et al. (2011) and Jewkes et al. (1998) report patient abuse. Overburdened midwives and nursing personnel were reported to have shouted at labouring women and scolded young unmarried women for being pregnant. Adequate care in the public sector context was defined as

women receiving care that facilitated healthy women and babies, 'adequate' stay time in hospital (six or more hours) and no patient abuse (Jewkes et al. 1998). By contrast, the women in my study saw adequacy of care as predicated on continued close attention and extended interpersonal relations between women and carers over time, rather than on whether or not they survived childbirth and delivered live babies.

Women using private care defined adequate care on a spectrum of quality of care and continuity thereof because they were approaching care as consumers. Women in private care were given rest-in periods in hospital as medical aid covers the cost of a hospital stay for three days for a vaginal birth and up to five days for a C-section (women who birth in MOUs in contrast are given a few hours to rest as there are not enough hospital beds for longer rest-in periods). Women in my study had private rooms but reported a lack of one-to-one care while in labour as obstetricians mainly only assist women and enter the labour room at the second stage of labour (delivery). Particular expectations of care and accompaniment held by different groups of women define the parameters of adequate care and differentiate conceptualisations of 'adequate care' for various classes of South Africa's population. It is important therefore, to explore what care means in specific contexts. It also makes space for examining care in relation to race and privilege.

Accessing Independent Midwifery Care

Desiring a vaginal birth and a particular version of care rather than an obstetric-led birth that she believed could easily lead to a C-section, Rachel looked to a small number of independent midwives operating in nearby suburbs who were willing to support what she understood to be her choice of a 'natural' birth. At the time of my research, there were eight independent midwives working in the leafy middle-class suburbs of Cape Town, providing women with midwife-led care and offering vaginal, 'intervention-free' 'natural' birth where possible. Seven of these eight midwives and their clients are the focus of my work. The midwives in the study had been in private practice for between fifteen and twenty years, building a reputation for offering desired versions of birth ('natural birth') in the context of rising C-section rates in the private sector in Cape Town. Even though the midwives were all biomedically trained

and relied on obstetric back-up and medicalised versions of safe practice, they explicitly contrasted their work with what they described as technocratic/obstetric models of birth. Indeed, the team midwives (explained below) in my study had a C-section rate of 17 per cent.[6]

Midwives in South Africa were part of and were influenced by broader international debates on birth. Like the United States-based Midwifery Model of Care™ (MMC), they set their model of birth against medicalised versions of birth, particularly those that involved surgical intervention or medication. The midwives worked from the perspective that birth is normal and natural and that too much 'unnecessary' intervention is detrimental to a pregnant woman and her baby. Yet these versions of birth and the associated training of professionals were not all that different from one another. There were also overlaps in training depending on which sector of care one used.

Overlaps between Private and Public Sector Settings

The birthing context in South Africa is highly medicalised. Most births occur in a medical facility, and 84.4 per cent of women have a skilled attendant assisting at their delivery (Tlebere et al. 2007). South Africa is in fact well provided in terms of obstetric care. There are six basic essential (defined as providing sufficient medical care for low-risk women and births) obstetric care facilities per 500,000 people (well above the recommended rate internationally of four per 500,000 people). Despite this, there are challenges to birthing (Tlebere et al. 2007). South Africa has committed to the Sustainable Development Goals (SDG). These include reducing the maternal mortality rate to 38 per 100,000 live births and the infant mortality rate to 18 per 1000 live births.

Given that half of women in developing countries do not get the health care they need, SDG goals include improving maternity care. Strategies to implement such goals include improving access to skilled birth attendants via dedicated obstetric ambulances and maternity waiting homes. In 2015 maternal mortality had been reduced to 138 per 100,000 live births but infant mortality is still high (World Bank 2015). While these numbers are contested due to underreporting and misclassification, there is general agreement that there is still work to be done in preventing maternal deaths in South Africa, and Bradshaw and Dorrington (2012) indicate that

the maternal mortality rate is increasing despite the fact that 92 per cent of women receive antenatal care (WHO 2015, Bradshaw and Dorrington 2012). Strategies to improve these rates include access to immunisation, nutrition, increased maternal care, antenatal classes, encouraging breastfeeding, parenting classes and Kangaroo Mother Care, amongst others (Berry et al. 2013, Tshwane Declaration of support for breastfeeding 2011).

Public sector obstetrics care is provided through Midwife Obstetrics Units (MOUs) for low-risk births. These are staffed by public sector midwives. Training includes degree and diploma training. Both options consist of theoretical biomedical learning with a practical component taking place in hospitals throughout the four-year training period, providing clinical experience. Should the training for low-risk birth be insufficient due to complications in pregnancy, women are referred to second- and third-tier hospitals, depending on the severity of the complication(s). Unlike in the private sector, where women may use an array of specialists, including obstetricians/gynaecologists, general practitioners, independent midwives (and sometimes doulas) or another combination of carers, women in public sector care are usually attended to by nurses and midwives. As such, like the private sector, the kinds of care and levels of medicalisation available can vary widely depending on the level of health care tier and how high or low risk a pregnancy might be.

While independent midwives and public sector midwives working in MOUs are all registered with the South African Nursing Council as nurses/midwives, and have the same biomedical training, private sector midwives with whom I have worked made use of a particular model of care, The Midwives Model of Care™ (MMC). Monitoring the physical, psychological and social wellbeing of women and minimising surgical intervention are the benchmarks of this care model, a model that is not explicitly used in the state sector. Indeed, Chadwick et al. (2014) suggest that it is not implicit in public sector practice either. Midwives working in the public sector experience high volumes of labouring women without enough staff to offer continuous, one-on-one labour care. Vivian et al. (2011) described the abuses by midwives witnessed in a time pressured, overburdened public sector. Similarly trained but with different sets of concerns and challenges, independent midwives used the MMC in their practice.

According to Chadwick et al. (2014), difficulties faced in the public sector include a low standard of care, poor communication

between care-givers and patients, and poor interpersonal treatment in maternity care (see also Jewkes et al. 1998). Heavy workloads and institutional stressors were acknowledged as reasons behind maternity service challenges (Penn-Kekana et al. 2007). Abrahams et al. (2001) report that in a study on maternal service provision in the Cape, pregnant women described being 'scolded' for presenting 'late' at clinics and felt dismissed and unheard by staff (see Ferreira 2016 for an account of 'lateness'). 'Abuse' and 'neglect' were commonly used to describe experiences at maternity clinics (Chadwick et al. 2014, Jewkes et al. 1998, Fonn et al. 1998, Vivian et al. 2011). Due to service and institutional difficulties (heavy workload, a high number of women requiring care from a limited number of care-givers, interpersonal and communication challenges), the MMC is not practised by public sector midwives.

Although the same professions and institutions are used by women in the public and private health sectors, the form of care instantiated by the MMC and independent midwives is available mainly to middle-class women and their partners through private health care provision where medical aid that cover midwife-led birth pays for this service or women with medical aid that does not cover this version of care pay out-of-pocket. All of the midwives participating in my study of private midwife-attended birth offered home births and hospital births. Despite being part of the private sector of health care provision, almost all the midwives offered hospital births at both a private and a public hospital. This complicated and problematised the distinctions between public and private midwives and the care models used in institutions. Women who could afford an independent midwife could receive care practices based on the MMC but could birth their babies at a public hospital. Women using public sector care may birth their babies at the same hospital but receive a different kind of care even though their birth was being facilitated by someone of the same profession and in the same institution. Likewise, care within the public sector can also be highly varied. This blurs the boundaries, practices and definitions of institutions, institutional care and professions and raises the question of how care is constituted. I offer an ethnography of what I call 'a care world'. Thinking through care as a world draws attention to the multiple ways and factors that come to act on how care and care relations are made. It also places emphasis on the ways in which both carers and care-receivers actively produce care.

Elite Care, Race, Privilege and Apartheid

The women with whom I worked approached their births with particular ideas of birthing and choice that I explore throughout the chapters of this book. That they were able to approach birthing as a choice is shaped by race and racialised histories that come to bear on health care and its availability.

All aspects of South Africa's political, economic and social life are strongly linked to and moulded by its racialised beginnings, when white settlers began arriving in 1652, marking the beginnings of colonialism. South Africa was ruled as a colony, by the Dutch and later by the British, for almost 300 years before the solidification of institutionalised racial segregation of Apartheid in 1948. Apartheid was based on eugenic discourse and inherited colonial British laws, including those that separated non-white people from white people, and laws that required black people to travel with 'passes' when entering 'white areas'. Access to hospitals and medical care was segregated along racial lines. The availability of health care providers was also racially stratified. Therefore, South Africa's racialised nineteenth- and twentieth-century history (I explore this history more deeply in Chapter 1) produced a gendered, race-based stratification of birth attendants where the rural became conflated with women, lack of knowledge, lack of 'good care' and 'blackness' while civility, medical intervention, medical knowledge, 'whiteness' and men became the markers of urban, hospital-based birthing. Not only then were black people unable to access certain versions of care and facilities, but certain kinds of medical knowledge and care were conflated with race. I explore this theme in Chapter 1.

After years of discrimination, structural and physical violence and brutality, in 1994 Apartheid officially came to an end with the advent of the first democratic elections. The socio-economic effects still reverberate some twenty years later through all aspects of South African social life. Not only are economic inequalities still deeply entrenched; the devastating separation of people and discrimination towards black people have meant that the aspiration for an 'ordinary' suburban life is one that most South Africans are still unable to access (Ross 2010; see Burman and Reynolds 1986, Cock 1980 and May 2000 for a history of Apartheid and its consequences). Access to private health facilities and care is not available to most people. Yet, for many white South Africans, owning a home made of bricks and mortar, sending children to good schools and accessing private care is taken for granted. The disparities between

the rich and the poor, the white and black population, in South Africa remain deeply stratified. Many white South Africans are able to take their life worlds for granted, as a group for whom liberal democracy works. Yet the lives of most of the women in my study are ones of great privilege. Specific conflations of whiteness and biomedicine on one side and blackness and 'local, lay' knowledge on the other are presently not as clear cut as the historical stratifications, but perceptions of how one births are attached to 'unruliness' and lack of biomedical facilities, and civility is conflated with technology. Who does caring and how is therefore apposite to questions of privilege.

This book focuses on one aspect of privilege: the access of private birthing care and, therefore, the availability of a series of affects. Tracing the constitution of care, the chapters articulate the different ways in which women using private midwifery care come to seek recognition for enacting work they regard as part of the 'universal feminine' in relation to reproduction. Thus, themes centre on birthing practices and reproduction. As I have shown, the specific version of care I focus on is available only to a small group of women in South Africa. Therefore, as I describe the ways in which women plan their births, engage with pain, and expect a certain kind of care, they become part of a birthing model in South Africa that reproduces privilege. The book articulates how the reproduction of privilege instantiates the reproduction of race in a South Africa where resources are still largely accessed by white people. Care, the ethics of care, resources and being able to make choices about these are themes to which I draw attention.

Framing and Theorising Care

My work offers an account of care, a subject to which anthropology has recently turned its attention. Indeed, the ethics of care come to inform and expand (as a set of ethics that are practised) within the models and modes of life that edify the ways in which pregnant women in my study wanted to be cared for. I look closely at the practices of care and how care is made (as a practise): this is broadly framed within a conversation with the ethics of care, offering an ethnographic account (see Tronto 1989, 1993, 2005, Sevenhuijsen 1998, 2000, 2003, Han 2012, Ticktin 2011 and Torres 2015 for the ethics and anthropology of care). Care as a practice – one of the elements that defines the ethics of care – is carefully examined,

making care and its relation to the ethics of care an important aspect of this book. I examine how people access (via resources, language and myth) and co-produce their desired care, and how carers respond to care needs, arguing that the ways in which people desire and call for care – as a mode of recognition – is as much a part of the care dyad as are the care-giver's roles. I pay careful attention to the negotiated relationships that unfold in the client-midwife relationship and how these are shaped by and come to play out in the face of the models and myths that informed how women approached birth. I therefore draw attention to the ways in which care is part of broader influences (in this case birthing models, history and privilege) and how people constitute care in varied ways. Women wished to be seen as doing what they considered 'universally feminine work'; how they were cared for became part of how that work and birthing was understood. It also becomes one of the ways that privilege, and therefore race, is reproduced.

Getting to Know Midwives and Their Clients

When I began fieldwork in the spring of 2014, I worked with three midwives who were in private, single midwife practice (Alex, Alison and Bridget), as well as one team of midwives, The Cape Town Midwives, consisting of four midwives (Beth, Ingrid, Maggie and Tanya) who worked on a rotation basis of being 'on' and 'off' call, 'second on call', doing postnatal checks and antenatal consultations.[7] All the midwives had worked in public health at large teaching hospitals before moving to private care. The team versus single midwife approach was often spoken about because some pregnant women specifically chose their midwifery practice based on whether they would receive care throughout from one person or a team. For some women having a relationship with a single midwife was important as they felt they got to know her much better and believed that this was critical to the trust that they envisaged as being central to the birthing relationship they desired. For other women it was less important and they felt better knowing that there would always be a midwife available even if another women was in labour and they would get a 'fresh' midwife, not someone going to one labour straight after another labour (even though this was rare because 'single' midwives only took on four to six clients per month). The team approach meant women saw a different midwife at each consultation so that they had met and

seen each midwife at least twice before going into labour, but they did not know who would be on call on their labour day. The team midwives spoke about not getting to know women as well as when they were in single midwife practice but not always being on call made life more manageable, and it meant they could care for more women.

On Method

I worked in the midwifery clinics for a year, tracking closely the activities of seven midwives and their clients. I interviewed nineteen women over the course of their pregnancies. Of these, I met six regularly both during their pregnancies and after the births and so we were able to become comfortable speaking with one another, often talking about matters unrelated to pregnancy and birth. I gained insight into how they lived and, for those wanting home births, how and where they imagined birthing. As partners or older siblings came and went during our conversations, the daily experiences, nuances and chaos of life were animated. Rather than just asking direct questions about birth, I was given a small window onto these women's life worlds and the influences and processes that enfleshed their crafting and imagining of birth as a plan. Sometimes I sat on the floor while a woman breastfed in the nursery where there was only one chair, or women bounced up and down on physiotherapy balls, trying to get their baby into a 'good position' for birth as we spoke. At other times, siblings woke from naps or came home from school so the children and I had brief 'chats', some children being curious about the new person in their home. During postnatal visits, the new baby was given to me to hold while women attended to something and I became officially acquainted with the little person who I had seen grow via their mothers' expanding bellies over several months.

As well as interviewing these women, I sat in on consultations with their midwives. With permission from midwives and clients, I attended almost 800 consultations between August 2014 and August 2015, providing the project with rich observational data. The booking appointment was the first consultation in a client's care trajectory. Here, midwives got to know their clients, conducting a thorough 'history-taking' and doing blood tests. Starting between 8:30am and 8:45am and running through until after lunch (approximately 2:30pm), midwives saw between five and eight women per

day, with a few catch-up breaks between consultations as most of the midwives tended to spend longer with clients than scheduled.

I sat in the corner of the room during consultations so as not to be in women's lines of sight but women did often address me, asking for more details on the research. The women using the team midwives, whom I had seen each week in the last month of their pregnancy, would sometimes ask me if they were looking any different as labour approached (for instance, if their belly looked bigger or had shifted downwards slightly, which often happens as a baby engages). This was because I had seen them each week whereas the team midwives rotated consultations, meaning I saw some women more regularly than each team midwife. At new born four-day checks and six-week postnatal check-ups I was often (very pleasantly) tasked with holding babies while their mothers were physically checked.

Sitting in consultations three days a week for a year, and meeting with women outside the consulting rooms, gave me the opportunity to become deeply acquainted with the rhythms of midwifery. The consultation room of five of the midwives in the study (one single midwife used the team practice rooms) had white cotton curtains and light cream walls. The room had boards covered with pictures of babies the midwives had delivered and on the mantelpiece were thank-you cards from clients. Typically, midwives welcomed a client with a broad smile and a 'how are you?' Daily annoyances and work issues were talked about and the midwives wove these conversations into ones on the actual pregnancy. Women were asked how they felt and a discussion on ailments of pregnancy emerged along with a reassuring explanation from the midwife and a smile of sympathy. Physical checks often included a physical touch from midwives – a hand placed on a women's shoulder or on her belly. Checks were done between conversations; the only check no spoke at was during the blood pressure reading, where midwives concentrated on the various aspects that had to be recorded for an accurate reading. Listening to the heartbeat, many women commented on how reassuring it was to hear and the midwives smiled back, using both the Doppler (a hand-held device used to listen to a baby's heartbeat) and their own sense of what sounded normal (midwives sometimes looked at the window and did not talk for a few seconds before saying 'it sounds perfect!'), to assess that all was 'right'.

With the increasing medicalisation of birth, approaches to pregnancy have changed: how an unborn child is imagined and how bonding occurs through new reproductive technologies, especially

amniocentesis and scans. Rayna Rapp (1999: 119) describes how the signs of the progress of pregnancy are produced quickly when tracked via ultrasound and other kinds of medical technology. With visual technology, 'abnormalities' and seeing a baby for the first time in utero contribute to when pregnancy is known and how it is known and how a growing baby is understood and known by expecting parents and medical professionals (Han 2013). Yet, according to Rapp (1999) there are also (slower) embodied signs of pregnancy – slower to be made known in the course of a pregnancy as well as, perhaps, slower to recognise – such as changing scents, sore breasts, crying and dizziness. Signs of the progress of pregnancy may not occur in all pregnant women and may be subtle and not necessarily recognised, making the awareness of the progress of pregnancy slower. The question of temporality is important with regard to midwife-assisted births.[8] Midwives in my study did not use ultrasound or perform amniocentesis. They relied on tools that detect foetal heartbeat, feeling a woman's body, visual clues, counselling and listening to a women's experiences during pregnancy in order to track and monitor gestation. If problems were detected or women wanted further testing, the midwives would refer them for amniocentesis, although all women using midwives in this study had a back-up obstetrician who would perform an amniocentesis should it be required. Many of the women with whom I worked had chosen a midwife-attended birth because they did not want 'unnecessary' scans and felt that engaging with their baby did not need to happen visually, often reporting feeling more of a connection with their baby with the midwives who used tactile, embodied means of checking on babies – their hands, listening with a Doppler, which was not considered a form of technology aligned with obstetric-led birth (Morgan 2009: 25).

I witnessed how women changed over the course of the pregnancy, how they steadily became more comfortable with their midwife/midwives and how they went from enjoying pregnancy to wishing their babies out (despite the midwives regularly telling the women to be patient). I was able to observe the format of consultations and the ways in which conversations were held while physical checks were completed, and knew the routine so well that if a midwife was running a little late getting to the practice, I was jokingly asked when she arrived, why, instead of talking with clients, I had not sent women to do their urine sample. In between consultations the midwives and I spoke about the impressions we had of the women and who was likely to go into labour soon. It

was during these brief conversations between clients that I got an insight into how the midwives felt and responded to their work.

Evans' (2010) study on the independent midwives in the Cape Peninsula found that of 836 women using a midwife between 2003 and 2009, the majority (74.9 per cent) were white, 21 per cent were Coloured, 3.8 per cent were black and 0.2 per cent were Indian. She also found that the majority of women were aged between thirty and forty. These data are apposite five years later: ten of the women in my study were aged below thirty and only two were over forty years old. The midwife practices were all based in the Southern Suburbs of Cape Town so most clients lived in the City Bowl, Southern Suburbs and the 'deep south' Cape Peninsula region. A few women came from the Northern Suburbs – an area considered to be on the outskirts of Cape Town in terms of the position of the city centre and South Peninsula entailing a 40–60 minute drive to the midwives' rooms, and with a smaller concentration of wealth compared to the city centre and Southern Suburbs – but this was less common as the midwives did not do home births or home visits in areas that were that far away, meaning that the women had to birth in hospital and come to the practice if they lived outside the suburb parameters that the midwives serviced postnatally.

The sample of women in the study were largely university trained with thirteen of the nineteen women having attended university and of those six were medically trained. Women came to their birthing decisions with a high level of knowledge and the skill set required for engaged research. For middle-class women, good mothering was equated with intensive mothering (see Waltz 2014, Faircloth 2009 and Avishai 2007 for an account of the shifts in modes of mothering from the good enough mother to the good mother and its history). Good mothering was connected strongly with being well informed about pregnancy, birth, babies and parenting. Women researched in detail the physiological processes of pregnancy, birth, breastfeeding, hormones and anatomy and knew about these processes. They used highly technical language in tracing their pregnancies and asking questions: a discursive agility that I found surprising given that few of those whom the midwives called 'clients' were medically trained.

The women with whom I worked sought to be good mothers 'from the start': that is, from as soon as they were able. For them, good mothering was about more than reading expert knowledge, it required an ability to question critically and reflexively multiple

sources of information as an informed consumer (Murphy 1999 in Faircloth 2009). As Strathern (1995: 347) points out though, cultural life is lived via circulations of knowledge and, particularly, what is made known. Desiring a 'natural' birth, women were aware of the associated sets of knowledge at stake (they felt they had to be knowledgeable) and presumed (and were expected to know) in eliciting that birth. During the antenatal classes and doula training I attended, for example, I frequently heard that women needed to understand the physiology of birth in order to birth.

Insider/Outsider

As much as birth was women's work, it was work I had not done at the time of my fieldwork. Speaking with women and midwives who used their own experiences frequently to explain and describe pregnancy, birth and the early weeks of parenthood, I could only imagine these experiences. During the doula course, as the youngest participant, I was the only one not to have birthed. It was difficult to talk about birth when I could only relay my mother's or her close friends' experiences of birth and stories women had told me in fieldwork. I had a strong sense of how difficult the first few weeks of motherhood could be, how intense birth is and how easy it could be to miss postnatal depression, but I had not actually felt labour pain or found myself postnatally depressed.

I was an insider to beliefs about birth: I had internalised the natural/technical model of birth as binary. It was easy to have conversations with women about why birth was 'natural' and how particular ways of living and being appeared 'natural'. Internalising this model demonstrates how the natural/technical model is situated in wider forms of life that extend beyond birth choice. These were not personal stakes for me though: I was not pregnant and contemplating how I would give birth and so I was able to attend to the models in particular ways, turning a critical eye on how versions of birth were differentiated.

I found myself both insider and outsider. I am female and middle-class and that gave me relatively easy access into conversations with women. Most women were only a few years older than me, a few were my age. Yet the focus of the study, care in pregnancy and birth, were not experiences of my own. Narayan (1993) asks: how native is a native anthropologist? I was in many ways a native anthropologist: I lived ten minutes from the midwives' practice and

near most of the women I interviewed. Challenges existed in terms of what I saw and heard as these were often familiar and therefore easy to take for granted; turns of phrase, general musings and complaints of life. But I was also thoroughly unfamiliar: I do not know what it feels like to need to empty my bladder every ten minutes as a baby weighs down in my pelvis, or the feeling of being kicked from inside by a growing foetus, or the worry and concern that unfold in the limit experience of crafting life. But having not given birth was in many ways helpful to my study. When women described birth, I needed to ask multiple questions to try and understand what they meant. The pain of birth is in many ways unspeakable and so rich narratives and metaphors emerged in our conversations. The delicate balance of being part of a world that I was distanced from in significant ways came to bear on fieldwork and data production.

A Note on Intervention

Bridget, the midwife who attended Rachel's pregnancy and birth, frequently said 'you have to work to get the birth you want'. She meant that women needed to exercise, eat well and sit/kneel/stand in positions to help their baby into an optimal position for birth, and then continuously practise those forms of work throughout pregnancy. While it is presented as 'natural' and inevitable in much of the literature on birth, so-called 'natural' birth is, in the model Bridget and others use, something that must be achieved through careful preparation to lessen technocratic 'intervention'.

Intervention became a marker of how a labour could and would unfold. Each midwife was biomedically trained and worked within biomedical parameters of safety management. In the model used by Bridget and her fellow midwives and their clients, natural birth should not need to be worked towards: at some point a body goes into labour and a baby might or might not emerge healthy and well. Yet intervention in versions of birth categorised as 'natural' was indeed part of these births. Sets of parameters described the optimal situation for 'intervention-free' birth. The baby should be a singleton, cephalic (in a position so that the baby's head emerges before its body), preferably left occipital anterior (baby's back is facing away from the woman's and facing the left side of the woman's body), and delivered before forty-two weeks gestation. The baby should measure a certain size and women with diabetes with babies having estimated weights of more than 4kgs were closely

monitored as fat distributed on the baby's shoulders was an important factor in determining safe delivery. There needed to be a certain amount of amniotic fluid and women's blood pressure needed to be within a specific range. Blood glucose levels needed to measure below 11.1 mmol in a random blood glucose reading. The existence of safety parameters established a norm: there were physiological limits to whether or not women could have their desired 'intervention-free' births. The horizons of risk and safety were established, setting up the probabilities of intervention (free) births. The distinction between intervention and intervention-free rests on a particular idea and myth of what intervention is (as I will show) and establishes the binary of natural and technocratic/medicalised birth that is the basis upon which women make birthing 'choices'.

The myth, and its binary, were powerful in producing the versions of care made available by midwives. It also drew attention to birth rather than the baby during pregnancy and women spent hours working on their birth plans, imagining and envisaging their desired birth. As 'technocratic' (or, as it was more commonly termed, 'biomedical' or 'medicalised') and 'natural' birth myths existed as one another's other, the midwives worked to produce a kind of care that they, along with their clients, believed to be largely unavailable in the obstetrician-led and medicalised birth sector, despite the fact that the midwives were positive about the kind of care given by some obstetricians, especially the four who backed them up.

The Way Forward

My study provides an account of a desired version of 'everyday', 'personalised' care in which care-receivers were not ill or in economically precarious situations, but were receiving care in a clinical setting and a formalised quality of antenatal care. I draw attention to what care can mean and look like in this setting.

In the context of elite health care, women were paying for a kind of care. Not only did they want care that facilitated and materialised a version of their desired birth, they also wanted care to look and feel a certain way. Everyday familiarity and relationality were key markers of desired care. Care happens in the everyday with particular limits, fluctuations and boundaries; this book pays attention to a specific, temporally limited care relationship of pregnant women

and midwives, in which a version of care was modelled on everyday notions of 'familiarity' and 'personalised' care.

I look at how those relations are constituted. Generalised care that facilitated many births was simultaneously made specific as women called for flashes of midwives' personalities, hints of the everyday nuisances and joys of life, and companionability. I offer an account and an enrichment of the idea of care as an 'everyday problem' in a formalised setting of care work (Han 2012). In asking what makes care and a care-giver, I draw attention to how care-receivers were part of the crafting of the intimate life of care.

Noting Joel Robbin's (2013) suggestion that anthropology's focus on suffering in the forms of pain, poverty, violence and oppression, takes attention away from other aspects of daily life, and southern African anthropology has largely followed suit. In the aftermath of gross injustices, post-Apartheid cultural life is inflected with deep inequalities, violence, structural violence and for many people, is very hard work (Ross 2010). Southern African anthropologists have largely and necessarily turned their attention to engaging with the struggles and precarity of everyday life. My study came out of an interest in midwifery, and a concern about the reports of inadequate care in the public sector, as I have described above. There were plenty of reports and studies of inadequate and 'bad' care but this did not answer the question of what 'good', adequate or different versions of care might mean. By looking at a case study where women reported satisfaction with the care they received, I hoped to look at 'good' care and draw attention to a middle-class setting, an understudied aspect of anthropological enquiry; thus, my work offers an intervention into southern African anthropology and draws attention to questions of who anthropologists study and why. Southern African anthropology does not often turn attention to 'studying up' (Nader 1969), which is indeed the focus of this book. Francis Nyamnjoh (2015) critiques 'anthropology's object' – the pristine object of study in which questions of being an insider/outsider and how one studies one's 'own' is considered. The topic of study in this ethnography offers a move away from studying 'the poor' and draws attention to studying middle-class life and the questions of reflexivity and objects of study critical in contemporary anthropological debates.

Most importantly perhaps, my work offers an account of the spread of a global imaginary of positive birthing. The context of unique health systems and racial inflection in everyday life means that birthing in South Africa has its own nuanced concerns and

challenges. Yet the travelling of birth models settles locally and informs women's daily birth desires and affects the ways in which birth is spoken of, imagined and practised. My book offers an account of the local settling of a global imaginary in a local context. As Kelly (2013) writes of Han's (2012) work on care in Chile and the ways in which people care for one another and their drug-using kin in the everyday, it is not that privilege, inequality, jealousy and cruelty, amongst other factors and emotions, do not exist in life, but that generosity and care exist alongside and part of these aspects of life. My study focuses on such qualities in the midst of deeply racialised, stratified care networks.

An overarching myth informed by historical, political and economic discourse comes to bear on how women imagined and constructed cultural storylines that produced a myth-making process of dichotomised versions of birth. These models hinge on various understandings and definitions of intervention. In Chapter 1 I describe the myth of birth that was informed and crafted by women desiring 'natural' birth and the ways that 'natural' and 'medicalised' birth are one another's other. The chapter offers an account of how this was indeed a myth and not a discourse, an elaboration of models of birth and how the models come to bear on the ways pregnancy and birth were imagined. Chapter 2 attends to the ways in which women engaged with pregnancy as plan. I describe how women approached knowledge, risk and choice in terms of a plan and I argue that the pregnancy as plan operates as a method for instantiating a kind of visibility as women did 'good' women's work. The chapter examines how women were able to plan how they would birth, tracing the privilege of choice and planning. Chapter 3 offers an account of the language used and the pain stories women told as they anticipated birth. Using Faye Ginsburg's (1987) model of procreation stories, I argue that the moral dimensions inflecting birthing choices were defined by experiencing and mediating painful childbirth. A racial stratification along lines of rural and urban birthing was connected with pain and self, and the chapter explores these dynamics. Thus, the chapter describes the ways in which an ethics of the self was constituted as women accounted for pain as 'character-developing' work. Classes, preparations and metaphor are, I argue, techniques of the self that were part of the ethics of the self at stake in life-giving work. Chapter 4 provides an insight into how birthing relations are made and how women who are white in South Africa are able to choose their care providers and the series of affects that inflect their care. The

powerful moral underpinning of birth, and particularly 'natural' birth, reflects a construction of the self at stake. Care and birthing relations provided a means to self-care. In this chapter I look closely at how care relations such as trust, familiarity and intimacy are made in relation to the attentions and experiences women anticipated. I show how middle-class reproductive life is imagined as individual work rather than one shared in an extended social network. Thus, the chapter attends to the ways in which care offers intimacy in collective life, as a service. I show how the separations of the private and public sphere are offset in liberal democratic life. In the concluding chapter I draw together the themes of care, choice, privilege and race, to show how care and birthing practices are part of a broader network of privilege. Race and privilege remain closely connected in South Africa, and my study offers an ethnographic account of how race is reproduced in health care. To begin, I grapple with the myths of birth and the ways in which the boundaries of 'natural' and 'medicalised' birth are blurred.

Notes

1. Medical aid or medical insurance is a monthly payment plan offered by medical insurance companies in South Africa. One pays a monthly fee (which varies depending on what option is chosen in accordance with high or low medical needs), and when a medical procedure or medication is necessary, medical aid carries the cost. Some options require a shortfall payment as some hospitals and medical professionals practising in the private sector charge more than medical aid rates (determined each year), even up to 400% above these rates.
2. See study by Visagie and Posel (2011).
3. South Africa has a Gini coefficient of 0.63 according to the World Bank (2011), one of the highest in the world, with 1 being the measure of the greatest discrepancy.
4. In the book I use the term 'natural birth' to describe both how women defined a 'natural' birth (vaginal birth unmedicated) and the broad ideas informed by and informing the model of 'natural birth' as universally feminine, women's work. In Chapter 1, I elaborate on the model known as the 'natural birth' model.
5. The global call from health practitioners concerned about high C-section rates has, however, led to WHO affirming the need to review the 1985 statement on C-section rates.
6. This percentage is still above WHO's recommendations and may be linked to the older average age of clientele in my study as well as care

providers who take a more 'conservative' approach to birth due to high insurance costs.

7. All names have been changed in this study.
8. According to the webpage for the midwives at The Cape Town Midwives, 'consultations allow time for questions and are usually 30 minutes in duration. We always welcome partners to attend the consultations to stay as involved as possible throughout the pregnancy'.