FEMINIST ACTIVISM IN POST-APARTHEID SOUTH AFRICA: THE POLITICS OF POSTNATAL DEPRESSION

By

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by

Danielle Altman
For Jackie and Vicki
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ib</td>
<td>ACKNOWLEDGMENTS</td>
<td>iv</td>
</tr>
<tr>
<td>Ii</td>
<td>ABSTRACT</td>
<td>vii</td>
</tr>
<tr>
<td>1</td>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>METHODLOGY AND LITERATURE REVIEW</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Methodology</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Data Collection</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Data Analysis</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Literature Review</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>The Medicalization of Reproduction in South Africa</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Theoretical Orientations: Medical Anthropology and Feminist Interventions</td>
<td>20</td>
</tr>
<tr>
<td>3</td>
<td>THE SHAPING OF FEMINIST POLITICS IN THE GENDER REPORT TO THE TRUTH AND RECONCILIATION COMMISSION</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>The Gender Report</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>Sexual Violence, Feminism, and Consciousness-Raising: The Global Context</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>The Cipher of Gender in South African Historical Studies</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>Trauma and the Public Politics of Memory</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>45</td>
</tr>
<tr>
<td>4</td>
<td>FEMINIST ACTIVISM SURROUNDING POSTNATAL DEPRESSION</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>The Postnatal Depression Society of South Africa</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>What is Postnatal Depression? The Medical and Feminist Models of PND</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Making PND Universal: Narratives of Statistical Prevalence</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>Narratives of Cultural Causation and the Cultural Management of PND</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>Loss: career work and reproductive work</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>Physical and emotional reproductive work</td>
<td>71</td>
</tr>
<tr>
<td></td>
<td>Circulating Testimonials: The PNDSA Chat Room</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>84</td>
</tr>
</tbody>
</table>
This thesis opens up the thematic of how people are defining and shaping feminist politics surrounding reproductive rights in post-apartheid South Africa. It asks what types of communities and alliances different groups of feminist activists attempt to build, and what types of political strategies they use. I address these topics within the realms of national rhetoric, political activism, and medical research. The thesis illuminates how norms surrounding domesticity, class, language, and race are produced within these three arenas. I argue that two strategies are becoming standardized within contemporary, South Africa feminist politics surrounding reproductive rights: the pursuit of scientific and medical facts about gender inequality, and the pursuit of individual female testimony about personal experiences of gender inequality.

Specifically, I examine how a non-profit organization and its affiliated researchers organize around the issue of postnatal depression. I analyze information this organization presents on its Internet website, and the dialogue that occurs in its online chat room, in
order to show how the organization articulates postnatal depression as a pertinent national and transnational issue. In turn, I illuminate the type of feminist community that the organization is enabled to build through its use of the Internet. I then analyze how psychiatric researchers affiliated with the organization develop, carry out, and talk about their research concerning postnatal depression in the townships of Cape Town. The thesis thus traces how a reproductive issue is differentially defined and shaped in the hands of different activists working within the same national space. It also reveals how South African activists concerned with reproductive rights embed themselves in feminist and scientific communities that span national boundaries.
CHAPTER 1
INTRODUCTION

The 1990s ushered in a new era of feminist activism within South Africa (Bazilli 1991; Hetherington 1993; Horn 1991; Rosenthal 2001; Ross 2003). In 1991, as South Africa was in transition to majority rule, a conference entitled Women and Gender in Southern Africa was held at the University of KwaZulu Natal at Durban. It was the first conference of its kind to be convened in South Africa. Conference participants have noted what an important and controversial event it was for the public intellectuals, academics, and political activists in attendance, all who were concerned with ensuring that the creation of gender equality would become a major pursuit within government and civil society (Bazilli 1991; Horn 1991). Two scholarly papers that were critical of women’s organizations, which were charged with failing to engage in struggles for gender equality during the 1980s, became points of particular contention. Following the presentation of these papers, a group of activists concurred that an alternate meeting should be held “more for feminist political activists” and less for “intellectuals.” Patricia Horn writes of these events:

The activists were not a homogenous group. In the activists’ meeting (for the purpose of which “activists” were self-defined) there were: white academics who also belong to women’s or political organizations, academics who were black and felt that this distinguished them significantly from white academics, trade unionists, members of youth and civic organizations, returned ANC exiles, and foreign visitors from the USA, Canada, Zimbabwe, and Mozambique. The only thing they had in common was that they were all women. Unfortunately, this did not prove to be of much value. There was no real consensus between the activists as to what the problems with the conference were, and which of those were major or minor. (1991:85)
By the end of the conference, only two people continued to attend the activists’ meeting. The splintering of the conference into various camps, and the eventual unraveling of those divergent camps, demonstrates how contentious and fraught the process of building feminist coalitions in South Africa can be, just as it is in many other national and transnational contexts. It is also highlights how desirable it is, for some South Africans, that feminism should be made into a legitimate and powerful political loyalty—which can reach across the lines of language, race, and class—in the post-apartheid era. Moreover, the conference proceedings, as described by Horn, beg the questions: Who gets to describe themselves as a feminist and/or an activist, and who does not? What does it mean to label oneself as a feminist and/or an activist in the post-apartheid era? What types of loyalties and alliances do these designations invoke?

Horn also writes her own dissatisfaction as a conference participant:

I cannot help feeling that we are hearing a whole haphazard collection of facts which does not necessarily fit into any discernable pattern… I find this a bit unsatisfactory, because this collection of truisms does not really bring us any closer to an understanding of the political dynamics which were being played out at the conference. As a feminist I also find it unsatisfactory because all it offers us in our struggle is some basic practical tips of which we are probably aware already, namely, that we must do research in an accessible way; that we must search for feminist methods of conferencing; that we must avoid reproducing the racist and sexist structures of or society; that we must find a way to make our work accessible to the masses. Somehow one feels that there must be something more to be gained from the experience. (1991:82)

Horn finds this “haphazard collection facts” and “collection of truisms” insufficient, in and of themselves, for consolidating a feminist politics that will serve the unique situations and histories of South African women. This thesis opens up the thematic of how people are defining and shaping feminist politics in post-apartheid South Africa. It asks what types of communities and alliances different groups of feminist activists attempt to build. It addresses these topics within the realms of national rhetoric, political
activism, and medical research. The thesis does not take an approach that seeks to locate a representative sample of what a majority of South Africans believe feminist politics should consist of. Rather, it traces certain patterns in how various groups and individuals are going about the process of defining and shaping feminist politics. I center the thesis on two broad practices that manifest themselves in feminist organizing: the pursuit of scientific facts about gender inequality, and the pursuit of testimonials by individual women who have experienced gender inequalities.

A striking feature of post-apartheid feminisms is the extent to which some activists have articulated issues of sexual/domestic violence and reproductive rights as centerpieces of feminist politics. It is around these issues that some of the most impassioned pleas for facts and testimonials occur (Rosenthal 2001; Ross 2003). Through the increasing pursuit of facts and testimonials about sexual/domestic violence and reproduction, sexuality and reproduction are increasingly medicalized and politicized. This thesis examines the processes through which the medicalization and the politicization of sexuality and reproduction occur within three different sites of activism: within the Gender Report to the Truth and Reconciliation Commission, a document that emerged out of a meeting amongst activists at the University of Witwatersrand in 1996; within the political activism generated by the Postnatal Depression Support Association of South Africa (PNDSA), a Cape Town-based non-profit organization devoted to helping women who suffer from mental health problems associated with pregnancy and childbirth; and within a medical research project that sought to measure rates of postnatal depression (PND) in Cape Town townships.
The Gender Report is primarily concerned with making sexual violence into a major national issue. The PNDSA and its affiliated researchers are concerned with making PND into a major national and transnational issue. I bring the shaping of these two different issues under the aegis of this study in order to examine how feminist practices—in this case, the pursuit of facts and testimonials—are taken up by different individuals and communities. The thesis thus contributes to understanding the micro-processes through which feminist knowledge and feminist practice are fashioned.

I chose to study the Gender Report and PNDSA activities alongside one another for a few reasons. In the summer of 2003, I volunteered at a major NGO in Cape Town that organizes in part around gender issues. My work included compiling lists of free social services available to women living in the townships, as well as visiting program centers in townships and sitting in on meetings. Many of the activists I spoke with at the time cited violence against women as one of the most pressing issues facing women. Compiling my lists, it also became clear that this issue was relatively well represented amongst the various governmental and nongovernmental organizations that provide social services to women in Cape Town. Nearly every large organization I researched provided some type of support around rape and domestic violence. I believe the Gender Report crystallizes a few arguments about sexual violence that I heard consistently from people while I was volunteering in Cape Town—namely, the arguments that more empirical research needed to be done into sexual violence, and that individual women needed to be encouraged to come forward and talk about their experiences of such violence. That same summer, I also noticed that a few prominent South African women had published memoirs that explicitly detailed their experiences of sexual violence. It
seemed that most people I spoke with were urgently concerned about both rape and domestic violence, and urgently concerned about women’s silence on the matter. The latter concern—that women victims were not speaking out enough—and its attendant request, that victims do begin to speak, seemed to be standard among activists. The Gender Report crystallizes how and why demands for such testimony are made in South Africa. It thus provides a useful node for examining how an issue is made into a feminist issue in the post-apartheid era and normalized within activist communities. As such, I argue the Report provides insight into the political logics at work among many South African feminists.

While the Gender Report represents an issue that most South African feminists would probably agree upon as being an important one (even if their opinions differ on the way one goes about addressing such a problem at the societal level, see Rosenthal 2000), I chose to analyze the work of the PNDSA precisely because the content of what the organization argues may seem entirely marginal to many South African feminists. In the summer of 2004, during 10 days I spent in South Africa talking with activists and academics about postnatal depression, many of the people I spoke with stated that the PNDSA is a politically problematic and politically marginal organization. I argue that this makes the PNDSA a useful group to examine, from an anthropological perspective, precisely because it works incredibly hard to legitimize itself as feminist. To greatly simplify the matter, South African activists who organize around sexual/domestic violence do not have to consistently defend their positioning as feminist—it is taken for granted knowledge that ending violence against women in the townships is a feminist activity. For the PNDSA, this is not the case—because they mostly organize politically
for upper-class and middle-class women, and organize around an issue that has historically been much of less of feminist issue in South Africa than it is many other nations, they work very hard to be seen as truly feminist within South Africa. As a result, the style through which they organize can illuminate quite a lot about the practices that people believe they need to engage in to be considered feminist in South Africa.

Analyzing how two different issued are defined and shaped as feminist illuminates the diversity of feminist politics in post-apartheid South Africa. The thesis throws into relief how standard some practices have become, even amongst divergent activist individuals and groups. Examining two different issues that are presently being shaped as feminist ones, such as sexual violence and PND, alongside one another, allows me to interrogate Horn’s points above. She suggests that while no unified consensus has emerged about what feminism should do and look like in South Africa, there are numerous activists who are deeply engaged with work that they describe as feminist. Thus, this thesis is an inquiry into how various activists go about doing what they do.

I primarily relied upon medical anthropology literature and women’s studies literature to guide the research process and the questions I posed. As an investigation into the medicalization of sexuality and reproduction, this thesis is in dialogue with medical anthropology literature. I seek to follow the work of medical anthropologists who have examined how medical knowledge and practice become implicated in and generative of moral and political concerns (Martin 1994; Rapp 1997; Young 1995;). Scholars have analyzed how medical knowledge is deployed to buttress political claims outside of clinical settings, such as the media, in classrooms, in government, within civic organizations, or within everyday conversation (Ginsburg and Rapp 1991; Martin 1994;
Lock 2002; Lock and Kaufert 1998). Within clinics, anthropologists trace how practitioners and patients negotiate certain practices, such as ultrasound technology (Rapp 1997), or psychotherapy (Young 1995). I focus on the deployment of medical knowledge in three specific sites: within the Gender Report, an official document generated by a legal studies department at a university; on the website and chat-room of the PNDSA; and within scholarly and popular articles written by psychiatrists. In sum, I look at how activists mobilize medical knowledge within a legal context, civil society, and print and Internet media.

In conducting such an inquiry, this thesis enters into a few key debates within recent medical anthropology work, particularly that literature which has been inspired by feminist concerns: What impact does the medicalization of sexuality and reproduction have on those who are the subjects or objects of medical knowledge and practice? What norms of gender, sexuality, kinship, domesticity, class, and race are generated when sexuality and reproduction are medicalized? How do feminist activists use or not use medical knowledge to further feminist politics? The thesis follows the work of anthropologists who argue that medical knowledge and practice are implicated both in the production of new subjectivities and communities and in the production and naturalization of norms surrounding gender, race, class, and sex (Farquhar 2004; Lock and Kaufert 1998; Young 1995). Specifically, I trace how the authors of the Gender Report, and PNDSA activists, mobilize medical knowledge in efforts to build communities of women and make political arguments. Regarding PNDSA activism, I also examine the subjects and objects of medical knowledge that emerge through the political work they do and the psychiatric research they support. In doing this, I
illuminate the norms surrounding womanhood, race, class, and domesticity that are
generated through the Gender Report and PNDSA activities.

As an investigation into the feminist politicization of sexuality and reproduction,
this thesis is also in conversation with women’s studies literature. Feminist scholars have
examined the links and tensions between representations of women and the lived realities
of women (Mohanty 1991). In doing so, they open up key questions concerning power,
authority, and the practice of feminist politics. Namely, which women have the authority
to speak for or represent other women? How do certain representations of or discourses
about certain types of women become naturalized and reproduced within feminist circles
and society at large? Questions of representation, of what it means to speak, and of what
it means to speak in acceptable ways, lay at the heart of this thesis. In the chapter on the
Gender Report, I reveal how and why a group of women who do speak are nonetheless
represented as voiceless. In the chapters on the PNDSA, I trace the political effects of
representations of “Western,” “African,” “traditional,” and “indigenous” women.
Following Chandra Mohanty and Patricia Hill Collins, I analyze how feminisms based on
ideas of universal womanhood and a universal patriarchy may naturalize certain
configurations of womanhood, sexuality, and kinship as norms.

The thesis is based mostly on online research I began conducting in the fall of
2003. I also spent ten days in South Africa in the summer of 2004, conducting phone
interviews in Pietermaritzburg and Cape Town. In Chapter Two, I discuss the
methodology and literature I relied upon to conduct the research. In Chapter Three, I
analyze the Gender Report. I examine how the authors of the report represent sexual
violence and South African women, and why they call on women to provide testimonials
about experiences of violence. In Chapter Four, I focus on how the PNDSA fashions PND into a feminist issue. I study how the group mobilizes medical and feminist knowledge about PND on their website—namely, how they put fact and testimony to political use. In Chapter Five, I look at how PND is refashioned as a children’s rights issue by PND researchers working in the Cape Flats townships of Cape Town. A primary goal of the thesis is to better understand how feminism is put into practice in South Africa. Thus, it may seem odd to include a whole chapter on how an issue, PND in this case, ceases to be articulated as a feminist concern. Yet, I argue that this reveals quite a lot about the sometimes-fragmentary nature of feminist activism. In showing how an issue such as PND can so quickly become reshaped in the hands of different activists, working in the same city, I examine how politically malleable facts can be. Finally, in the conclusion, I reflect on larger questions the research draws up, and how they could be addressed.
CHAPTER 2
METHODLOGY AND LITERATURE REVIEW

Methodology

Data Collection

Data was primarily collected off the Internet. I also spent ten days in South Africa conducting phone interviews, visiting libraries, and talking with people about my research in general. Collecting most of my data online, my main method was to discursively follow the connections that appeared in the stories I gathered. A short description of how the PNDSA (my primary node of study) is organized and geographically distributed, throughout South Africa and in cyberspace, elucidates the shape of the ‘field site’ and how it impacted data collection.

The PNDSA has a chapter in each of South Africa’s major cities: Cape Town, Durban, Pietermaritzburg, Port Elizabeth, Pretoria, and Johannesburg. However, many women, even those who live in or near those metropolitan areas, often find it difficult to make it into a chapter headquarters on a regular basis (personal interview). There are two reasons for this. First, some live too far away from a city center to get into town easily. Secondly, many women who consult the PNDSA are housebound with children, or do not leave the house very often as a result of their depression. Thus, women often use phone, email, and website chat rooms to engage with the PNDSA and its services. By sitting at my desk, alone and in front of the computer, reading the PNDSA website, I was doing a kind of participant-observation. Many of the women who consult the PNDSA rarely meet to face to face, and interact with the organization just like I did.
The PNDSA website is a place to find information about the organization. It is also a place to find information about a host of affective disorders associated with childbirth and motherhood. It contains a lot of information which is directed at English-speaking women who have high-school educations or higher. It also contains basic advice and supportive messages geared towards women who live in upper class, single-family households.

The website provides links to online chat rooms—these chat rooms are the sites where people talk to one another about their PND experiences. The women who visit actual PNDSA chapters are limited in number and geographic scope. They all live directly in major cities and have the capacity to move around the city easily. The women who visit PNDSA chat rooms are still limited in number, in that they are people who have access to Internet services. Yet, their geographic scope is much wider. White South African women living in North America, Britain, and Australia all meet up in these rooms. As a website and a chat room were my primary field sites, I collected most of my data by sitting in front of my computer, gathering narratives off the Internet. My goal was to understand how PNDSA activists position PND as a medical and feminist issue. However, I also read narratives of women who were not activists, but PND sufferers. While my focus is not the subjective experience of illness, I found the latter type of narrative illustrative. The stories of this latter set of women reveal a host of social ideas and political anxieties that lie beneath individual cases of PND.

Another major source I used is a Masters thesis written by a South African psychology student, Linda Lewis. This thesis focused on PND survivors living in Cape Town. She worked closely with the PNDSA in producing this thesis, and it provides a
great deal of insight into how the PNDSA frames PND as a sociological and emotional problem. It also contains many narratives about the experience of PND.

I also spent 10 days in South Africa, after gathering most of the online data. I spent 5 days in Pietermaritzburg and 5 days in Cape Town, conducting three interviews by phone during that period. Because of difficulties with transportation, and people being out of town on winter holidays, I never had the chance to speak with any PNDSA members in person, or to visit a chapter of the organization. This is a weakness of the research. When I conducted my phone interviews, I used a list of open-ended questions as a guide. Broadly, I was interested in finding out how the interviewees raise awareness of PND, and their personal opinions on why PND is an important issue in contemporary South Africa.

Initially, the thesis was focused entirely on the issue of PND. After returning from South Africa, I thought it would be a good idea to analyze another type of narrative or document that indicated how and why the medicalization of sexuality and reproduction is becoming useful for feminist activists within South Africa. I felt that just focusing on the organization was insufficient for getting at larger questions. Namely, what does it mean to call oneself a feminist or an activist in post-apartheid South Africa? Are the practices of the PNDSA typical of other feminist organizations in South Africa, or atypical? Since the TRC Special Women’s Hearings were a watershed moment for the medicalization and feminist politicization of sexuality and reproduction, I found the Gender Report a useful node for interrogating those larger questions. Thus, I devote a chapter to analyzing the document. I do not argue that there are direct causal relationships between the Special Women’s Hearings and the organizing of the PNDSA. Yet, I think the Report
does illuminate a trend, in some parts of South African society, towards using secular and scientific language to articulate problems facing women.

In sum, the fieldwork was conducted primarily on the Internet, and included little face-to-face participation or observation. The research would no doubt have benefited from a greater number of interviews and time spent with PNDSA members. However, the goal was to gather stories in which the languages of psychiatry and feminism were used, and I was able to gather many stories with the methods employed.

**Data Analysis**

I primarily analyze three different types of narratives. First, I examine the Gender Report. It is an official document generated out of the Centre for Applied Legal Studies at the University of the Witwatersrand. I ask: How do the authors write of sexual violence? How do they represent South African women? How do they mobilize feminist arguments about shame, women’s silences, and empowerment? How do they conceptualize female liberation?

Secondly, I examine the narratives about PND that were generated through the work of the PNDSA. Some of these stories detail a personal experience of PND. Other narratives describe the medical facts of PND (gleaned from authoritative texts) in lay terminology. PNDSA activists and the women who turn to that organization for help generate these stories. I gathered the narratives from three sources: the PNDSA website and chat room (www.pndsa.co.za); Linda Lewis’ Master’s thesis (2002) about PND in Cape Town; and personal interviews.

Thirdly, I analyze the scholarly and popular articles produced by psychiatrists conducting PND research in Cape Town’s townships. Most of these researchers sit on the board of the PNDSA. Their articles appear in major journals, such as the *British
Journal of Psychiatry, as well as smaller online journals. I also analyzed British and South African newspaper articles, in which the PND researchers are interviewed. I examined these latter two types of narratives by asking the following questions. How do narrators make their case about what PND is? How do they argue that PND is a pressing social problem? What types of discursive tools do they use to make their arguments? When narrators cite authoritative texts, what are they and where do they come from? What larger sociological arguments do narrators make about South African life, the South African family, and South African women? How do they configure arguments about gender and racial difference in the process of making political and medical claims? What medical and political claims do they make?

Aside from examining narratives, I also analyze the research methodologies PND researchers employed in the studies they conducted in Cape Town’s townships. These studies consisted of intimate interactions between psychiatric technologies and new mothers. The medicalization of PND is enacted not just through discourse, but also through drawing actual bodies into research projects. Hence, I analyze the specific psychiatric research tools being used in South Africa.

Literature Review

The Medicalization of Reproduction in South Africa

Discourses, policies, and practices surrounding reproductive health are productive sites for analyzing how ideas about racial difference were produced, circulated, and sedimented throughout twentieth century South Africa (Burns 1994; Gaitskell 1983; Klausen 1997, 2000; Marks 1987, 1989). Ethnographers and social historians have analyzed how the state, missions, public health officials, medical practitioners, and civil society organizations medicalized women’s reproduction and mothering practices
throughout the twentieth century. However, most in-depth studies focus on the years between 1900 to around 1960. These studies reveal how reproduction was stratified throughout the twentieth century, and how the cultural logics of apartheid were developed through medical research into reproduction (Burns 1994; Klausen 1997, 2000).

A number of studies also examine how individual women were affected through their entanglements with biomedicine. For instance, Burns (1994) discusses individual women who told her how they benefited medicalized birth. Marks (1989) elucidates both the happiness and anxieties that women nurses experienced as part of a small core of medical practitioners in the 1930s and 1940s.

Marks and Andersson (1987) and Gaitskell (1983) assert that up to the end of World War II, there was no hegemonic control over reproductive health. For instance, during the first few decades of the twentieth century, liberal medical practitioners and missionaries often aligned to argue that the only way to lessen the high infant mortality rate among black women was to provide more health services to them and to increase the salaries of wage earning husbands. Yet, the end of the 1940s marked a turning point. Liberals and missionaries ceased to have much influence over apartheid-era public health policies.

Social historians have examined the political economy of reproductive health in segregationist and apartheid era South Africa (Brown 1987; Dubow 1995; Klugman 1990; Marks and Andersson 1987; Wright, Stein and Scandlyn 1988). They ask: How did the emergence of industrial capitalism—the development of the mining industry, shifts in agricultural production, urbanization, and the impoverishment of the countryside—initiate shifts in illness patterns and reproductive and mothering practices
among women in South Africa? How did the state, industry, and public health officials attempt to manage reproduction?

The social history of medicine literature cited here was produced in the 1980s, 1990s, and 2000s. One goal, apparent in part of the literature, is to explain how segregationist and apartheid state policies impacted the lives of women and their reproductive health. For instance, Burns (1994) and Wright, Stein, and Scandlyn (1988) document which women had access to biomedical maternal health facilities, and how infant mortality rates changed alongside the institution of apartheid era public health policies. Klausen (2000) shows that it in the 1910s, 20s, and 30s Afrikaner anxieties over the mingling of poor whites and black city-dwellers, particularly in Johannesburg, fueled segregationist policies that would have a massive impact on the provision of reproductive health services to urban populations.

Another goal of the literature has been to detail how segregationist and apartheid era ideologies about race coalesced within the field of reproductive health. For example, Brown (1987) analyzes how state and public health officials attempted to effect population control policies through the differential definition and control of white and black women’s fertility. Klugman (1990) reveals how such ideologies regarding population control were manifested in rhetoric and policy concerning contraception.

For this paper, the importance of the literature on the political economy of reproductive health is that it highlights how reproduction was economically stratified along racial lines over the course of the twentieth century. It also reveals that processes of medicalization were always fraught and uneven, and intimately related to the production of raced and gendered bodies. Gaitskell, writing about the years between
1900-1960, makes the important point that the structure of the economy (such as migrant wage labor) and specific apartheid policies (such as the Pass Laws) worked to disrupt black families. Because of this, staying home with children and being a mother became something many women were fighting for and not against, throughout the twentieth century (1983). Along these same lines, Burns (1994) shows that many women wanted more access to biomedical services for reproduction than they were being offered in the 1930s, 40s, and 50s. According to the literature cited here, the story about the medicalization of reproduction in South Africa is a story about most women wanting more access to biomedical services, and not less. However, this literature also reveals that ideas of racial difference emerged out of scientific research into black women’s reproduction. These ideas of racial difference were used as ideological justification for segregationist health policies (Burns 1994). Importantly, Marks and Andersson (1987) point out that one should not see pre-apartheid and apartheid health policies and discourses as mere reflections of larger national and political ideologies about racial segregation and economic stratification. Instead, they argue that health issues were a crucible where segregationist ideas coalesced, particularly in the early years of the twentieth century.

The political economy of health literature demonstrates how reproduction was raced and gendered at the levels of nationalist rhetoric and public health policy. It also documents the profound impact that segregationist- and apartheid-era health policies had on women’s health. Some works in this field also account for the intimate entanglements that occurred through the medicalization of women’s health (Burns 1994; Marks 1994).
These texts deal with the more micro-scale issue of how people who were the objects, subjects, or interpreters of biomedical practices/discourses in mission and government clinics made biomedical knowledge and objects meaningful in the context of their own lives. Women and men who could be called middle figures (Hunt 1999) worked to transform reproductive health, in the realms of both healing and policy\(^1\). Burns (1994) consideration of the Bridgeman Memorial Hospital in Johannesburg illustrates the types of therapeutic and policy transformations middle figures were engaged in. She shows how black nurses took on powerful roles in the hospital and in the community, shaping medical practice to the needs of the women who gave birth at the hospital. By interviewing nurses who worked at Bridgeman, and the women who used its services, Burns illustrates how medical knowledge and technology were transformed and reconfigured at Bridgemann.

In slightly different veins, Marks (1994) focuses on how the training of black medical professionals was productive of a black middle class in Natal, and Gaitskell (1983) analyzes the role of missions in introducing new ideas about motherhood and domesticity to women. In sum, the literature on the medicalization of reproduction in South Africa—whether it deals with macro-scale political economic issues, or micro-scale entanglements—demonstrates how reproduction was economically and racially

\(^1\) Hunt develops the concept of the “middle figure” in her study of the medicalization of birth in the Congo from about 1920 onwards (1999). She argues that the African men and women who took on roles as medical practitioners in mission clinics worked as translators and negotiators between biomedical knowledge/practice and local worlds. Yet, more than being simply translators/negotiators, these “middle figures” were integral to the emergence of “colonial lexicon”, in which biomedical objects and practices accrued powers and meanings (in plural and unexpected ways) within local practices and discourses. Hunt thus makes a larger point about how colonialism played out in some parts of Africa—that it was less an “encounter” between white and black, European and African, than a process of appropriations, accommodations, and refusals. Burns, examining the medicalization of reproduction in Johannesburg in the first half of the twentieth century, makes a similar point about the nature of segregation in South Africa. Her study provides a picture of the segregationist era (1910-1948) as a time marked not as an encounter between white and black, but rather as a time of shifting alliances and mutual accommodations.
stratified over the course of the twentieth century. It also details how women’s reproductive bodies were fashioned into objects of scientific knowledge, and used to articulate ideas of racial difference. It reveals the subjective experiences of individual women who worked as nurses or doctors, or those who received medical services. Finally, it throws the encounter between “biomedicine” and “Africans” into relief, by revealing the how ideas, discourses, and pieces of technology were appropriated, transformed, and made powerful in clinical settings.

Using this literature in conversation with a few key works about health and society in Africa in general (Feierman 1985; Feierman and Janzen 1992; Hunt 1999; Janzen 1978; Vaughan 1990) provides a context for understanding the historical conditions of possibility for psychiatric and feminist or humanitarian discourses analyzed in this thesis. For instance, it reveals that the PNDSA argument that white, black, Indian, and Coloured women all have different reproductive and mothering practices—and are thus each deserving of different political and therapeutic solutions to PND—is an articulation of a narrative that has been invoked by various sectors of civil society and government in South Africa since around the beginning of the twentieth century. Literature concerning health in Africa also highlights that calls to medicalize reproduction are often spurred by humanitarian desires to improve the lives and well being of women and their children. This literature also reveals that such humanitarian impulses often invoked ideas about difference or sameness between races².

² This point dovetails with one made by Ann Stoler (1989), in a piece coming not out of health literature, but out of a literature on empire and colonialism. She asserts that a central tension of the colonial project was that humanitarian efforts and desires were themselves productive of exclusionary ideas.
The PNDSA, in using a universalizing feminism as the grounds for making political claims, is not unlike earlier maternalist movements that also invoked universals about women and mother-child welfare, while simultaneously employing the rhetoric of stratified reproduction (Klausen 1997). The PNDSA, as well as the authors of the Gender Report, claim that there is a universal womanhood, a universal type of sexual difference, and a universal patriarchy. Mohanty has noted that invocations of a universal woman normalize one configuration of womanhood and liberation at the expense of others. A goal of the thesis is to examine how the idea of a universal woman is fashioned, within the Gender Report, and within PNDSA discourse, and how this claim to a universal woman establishes the ground for a feminist or humanitarian politics which de-politicizes some reproductive issues while politicizing others.

**Theoretical Orientations: Medical Anthropology and Feminist Interventions**

This paper addresses the medicalization of sexuality and reproduction. It is inspired by medical anthropology work that takes biomedical knowledge and practice as its object of study. A 1982 piece by Allan Young influenced the particular strand of medical anthropology literature that provides the theoretical backbone to this thesis. In “The Anthropologies of Illness and Sickness,” Young asserts that biomedical knowledge and practices are as socially determined as any other system of knowing about and healing the body (1982:277). He calls on anthropologists to analyze the underlying power relations that entrench certain healing systems as dominant over others, and “to critically examine the social conditions of knowledge production” (1982:277). The goal was not only to unpack the social construction of disease, health, and healing, but also to understand the social conditions that made certain ways of knowing about or healing the body possible (Lindenbaum and Lock 1993:xi).
In a later book, Young demonstrates such a study by analyzing the invention of post-traumatic stress disorder as a unique diagnostic category (1995). He illustrates how psychiatrists and Vietnam veterans developed and applied the diagnosis within clinical settings at VA hospitals. Moreover, he examines how the diagnosis displaces moral and political issues by bringing the focus onto individual pathologies. In this work, and other medical anthropology texts that share his epistemological and methodological standpoint, the authors employ a particular theoretical paradigm. Under this view, disease categories or medical entities are not treated as universal or homogeneous across time and space (Lock 2002; Martin 1994; Mol 2002; Scheid 2002). Diseases are not analyzed as natural entities, upon which illness categories and healing practices are constructed. Instead, they are seen as emergent out of intersections between bodies, technologies, and discourses.

This position holds implications for how research questions and objects of study are framed, and the types of methodology employed. For instance, this thesis does not analyze discourses about trauma or PND as local interpretations of a universal phenomenon. Instead, it analyzes the political work that people do to position trauma and PND as universal. My goal is not to discover how different groups in South Africa interpret PND or trauma, but to uncover why and how they pick up these terms, and the implications of that.

Some anthropologists who are concerned with understanding the deployment of biomedical knowledge and practice contribute to a strand of literature that examines the medicalization of the body and/or the medicalization of social issues. Medicalization refers to the escalating appropriation of bodies, souls, and populations by medical
discourses and practices. For instance, Rapp analyzes how ultrasound technology medicalizes the body (1997), while Kaufert and O’Neil examines how the deployment of statistics medicalizes birth (1990). Medicalization of both the body and of social issues is linked to the increasing specialization of the medical sciences in eighteenth and nineteenth century Europe (Foucault 1978), war (Young 1995), and shifts in global economic forces and structures (Petryna 2002; Scheper-Hughes 1992). Moreover, the medicalization of the body has been analyzed as a process in which gender (Franklin 1997; Ragone 2000; Rapp 1999), race (Comaroff 1993; Hunt 1999), and age (Lock 1993) are performed, produced, and/or sedimented.

Foucault’s concept of biopower is instrumental to many studies that focus on the medicalization of the body or social issues. Foucault argued that a burgeoning number of social institutions in the eighteenth and nineteenth centuries fashioned both bodies and populations into objects of knowledge. As bodies and populations were increasingly appropriated by medical discourses and practices, new categories of individuals and entities emerged—such as the patient and the expert, or social concepts such as poverty. Foucault argued that biopower was both individualizing and totalizing. Medical knowledge and practice are honed through the manipulation of bodies, and this process is productive of individual cases, such as the hysteric or the pervert. At the same time, the objectification of populations, through practices such as statistics, works to produce homogeneous groups. In this case, an individual can come to ‘stand in’ for a whole population group. For Foucault, the medicalization of the body or a social issue is normalizing and pathologizing. It produces ideas of what is normal and what is deviant.
While Foucault’s conception of biopower has fuelled and influenced research into the medicalization of the body and of social issues, anthropologists have reconfigured the concept, and intertwined it with other theoretical positions. For instance, Farquhar (2002), discussing a sex survey administered by the Chinese state, suggests that classic tools of biopower (the statistic, the survey) can shape or not shape people’s sexuality in unexpected ways. Like similar work carried out in Africa (Burns 1994; Kaler 2003; Thomas 2003), Farquhar shows that the medicalization of sex and reproduction does not always move in deterministic paths. This scholarship is important because it points research questions and methodologies into new directions. Lock and Kaufert, writing in regards of the medicalization of women’s bodies, point out that most researchers, when referencing medicalization, appear to be thinking about it in terms of authoritative power or direct control (1998:6). They state, “most of the literature on medicalization focuses on clinical settings, individual women, and the manipulation of their bodies” (1998:19). Whether unwittingly or not, some of this literature employs a conception of power that Foucault would call repressive, or negative. Lock and Kaufert state that to do this is to be in danger of a “gross oversimplification”—it ignores the productive power that manifests itself in the more mundane realms of tacit knowledge, aesthetics, ethics, and, importantly, medical knowledge itself (1998:6). Lock and Kaufert suggest that while much scholarly attention has been paid to the ways in which women’s bodies are objectified by or made into objects of medical knowledge, what has sometimes been oversimplified is the more complex ways in which medical power is productive of subjects. This thesis contributes to medical anthropology literature by taking up Lock
and Kaufert’s call to analyze mundane or “common sense” medical knowledge, showing how this knowledge may be productive of new subject positions.

Since this paper deals specifically with the medicalization of reproduction, it must be read against the backdrop of theoretical positions that have contributed to understanding such processes. In 1991, Ginsburg and Rapp reviewed the literature on reproduction in anthropology. They write that since the encounter between second-wave feminism and anthropology in the 1970s, “women’s reproductive experiences were analyzed as sources of power as well as subordination” (Ginsburg and Rapp 1991:312). They further write that researchers began using the methods of Foucauldian analysis and social history to “explore the dialectic between, on the one hand, the discursive strategies of the state, the market, and international medical institutions, and, on the other, resistances to them” (Ginsburg and Rapp 1991:314). Ginsburg and Rapp reveal one pole along which some anthropologists have thought about and analyzed women’s relationship to biomedical knowledge and practice. On one hand, biomedicine is seen as a power that exerts intense control over women’s bodies and minds. On the other hand, some biomedical practices were celebrated as expanding women’s agency over their bodies. In this conceptualization of the relationship between women and biomedicine—its institutions, practices, discourse, and knowledge—power is construed as something one has or does not have; women are either resisting power or wielding it.

Rapp (1997) usefully points out that much of this literature was inspired by feminist concerns over the dangers involved in the medicalization of reproduction. Writing of her own research into amniocentesis, she states that a large part of her own worries related to the way that powerful norms—norms regarding maternal-child health,
and what it means to be a woman, mother, and citizen—are inscribed onto women’s bodies and lives when reproduction is medicalized. This question—of how norms of womanhood or motherhood are mobilized at the intersection between medical technologies and bodies—lies at the very heart of feminist debates over the body, resistance, power, and subjectivity (McLaren 2002; McWhorter 2004; Valverde 2004).

Lock and Kaufert (1998), Ginsburg and Rapp (1991), and Rapp (1997) reveal that there is a tendency for some feminist medical anthropology to frame medicalization as inherently “bad” for women. This position is complicated by the work of other scholars (Franklin 1997; Thomas 2003; Young 1995). This paper centers on a group of activists who work to medicalize reproduction work precisely because of their feminist politics. Thus, this paper seeks to follow the work of scholars who argue that medical practice and knowledge are productive of subject positions, and not simply repressive. It contributes to the literature on the medicalization of reproduction by analyzing the intersection between medical knowledge and the development of liberal feminist politics. In tracing the effects of discourses about postnatal depression in South Africa, I hope to complicate the notion that the medicalization of reproduction is always either a positive or negative process. My goal is less to argue that is “bad” or “good,” than it is to perform a micro-scale analysis of the ideas and bodies it actually generates.

Rethinking how bodies and subjects are situated within regulatory norms (such as norms of motherhood produced through medical discourses and practices), and the way that power works through such norms, is a key concern within this context. Judith Butler (1993) argues that bodies and subjects never exist prior to or outside of regulatory norms. She asserts that the materiality of things, such as sexual difference, is effected through
performances, repetitions, and reiterations of discourses and practices that norms provide people with. Power works through these performances, and its effects can be traced—but power is not something a person can “have” or “lose.” Chandra Mohanty, writing from the perspective of women’s studies and cultural studies, makes a similar argument (1991). She also argues that persons do not exist prior to institutions, discourses, and practice, but are sculpted within those forces. Some literature concerning the anthropology of the body elucidates a similar point at a more ethnographic level. Feldman (1991), Seremetakis (1991), and Abu-Lughod (1990) analyze how people work within regulatory norms. Instead of looking for moments of blatant resistance or oppression, they look at how people live their lives inside of or on the edges of regulatory norms.

Mohanty and Butler are particularly concerned with the way that activists and researchers unproblematically situate “women” as an ahistorical, universal category of association. They argue that “women” are not already constituted as such. Thus, they argue that researchers should not assume that women always and already share some biological, sociological, or historical position that binds them together. Butler and Mohanty problematize research questions that assume “women” as an already constituted category. This paper follows from their points. Instead of taking the social location of “woman” for granted, it traces how people in South Africa are working to make it seem as if women constitute, or do not constitute, a universal group by virtue of their sex.

A final point, important for this paper, concerns the universalizing tendencies inherent to both psychiatry and liberal feminist politics. In the Gender Report, the authors argue that women are all universally alike because of their sexuality and their
reproductive capacities. The PNDSA universalizes postnatal depression as a universal category of illness and woman as a universal subject. Castaneda (2004), Haraway (1997), and Franklin (1997) argue that universals are always constructed out of particulars, and thus serve to naturalize certain experiences and positions. Likewise, feminists in the US (Butler 1991; Hammonds 1997; Mohanty 1991), Africa (Meena 1992; Gaidzwana 1992) and South Africa (Hassim 1991, 2001) argue that asserting woman as a universal category is dangerous because it tends to naturalize some women’s experiences (or some types of patriarchy) as more real than others. These points are important because it opens up the possibility for the questions pursued in this paper. Namely, how and why do some types of trauma become gendered as female? How exactly does the PNDSA position postnatal depression as a universal fact? How do these assertions of universals—both in the Gender Report, and by the PNDSA—enable certain avenues of subjectivity and activism but close off others? In the following chapters, I analyze the Gender Report and PNDSA discourses as rich sources for understanding how the medicalization of women’s health and feminist politics intersect.
CHAPTER 3
THE SHAPING OF FEMINIST POLITICS IN THE GENDER REPORT TO THE
TRUTH AND RECONCILIATION COMMISSION

Introduction
In March of 1996, one month before the public hearings of Truth and
Reconciliation Commission began, the Centre for Applied Legal Studies (CALS) at the
University of Witwatersrand held a workshop on gender and the TRC. Attendees
included prominent feminists, psychologists, lawyers, academics, TRC Commissioners,
politicians, and representatives of NGOs. The hearings had yet to begin, but the
workshop participants were concerned that women testifying before the Human Rights
Violation Commission (HRVC) would not speak openly about personal or private
violations they had experienced (Ross 2003:21). Sheila Meintjes and Beth Goldblatt, two
members of the CALS group, wrote and submitted the findings and recommendations,
named the Gender Report, to the TRC in May (in the second month of the public HRVC
hearings).

The Gender Report is centered on accounts of sexual violence experienced by
female political activists during the apartheid era, and it asks that women victims come
forward and publicly narrate personal accounts of violence. More broadly, it asks that
politicians, community leaders, and academics begin to take gender seriously as a unit of
analysis and as a point of legal or legislative intervention. The Report thus seeks to alter
a trend in twentieth century South Africa, in which issues of gender and sexuality were
muffled or ignored by various constituencies within civil society (Meintjes and Goldblatt 1996).

The dominant political and civic organizations of the twentieth century, both Afrikaner and African nationalist, had largely ignored or silenced sexual violence as a pertinent issue (Gaitskell and Unterhalter 1990). Likewise, many of the various women’s organizations that worked in concert with the liberation struggle during apartheid had not blatantly articulated sexual or domestic violence as issues of major concern (Walker 1990). During the segregationist and apartheid eras, political activists and community workers mostly sought to transform inequalities structured around race and class, and not those surrounding gender (Hassim 1991; Hetherington 1992; Seidman 1993; Walker 1990; Wells 1982). The Gender Report attempted to provide a corrective to this history. Its authors demand that political and academic attention begin to be paid to gender (broadly) and sexual violence (specifically) in the post-apartheid era, and it states that the stories of individual women victims are needed to further such a shift. The Gender Report was amongst the major attempts to put gender, sexuality, and sexual violence on a national political agenda following the transition to majority rule.

The TRC did not immediately act on the Gender Report, hesitating to name women a special category of victim until the "patterning of testimonial practices" (Ross 2003:22) was gauged after the first few months of hearings. Research teams analyzed the type of testimony women were providing, finding that women were not testifying about personal experience. That is, they were not testifying about violence committed directly against their own bodies. Instead, many were testifying on behalf of the dead, telling stories about loved ones who could not speak for themselves (Feldman 2004:176; Ross
At this point, the TRC took action on the Gender Report, calling two public discussion meetings in the summer of 1996 (Ross 2003:22). It invited journalists and representatives of women's organizations to offer up ideas of how to better "elicit statements about women's experiences of harm, particularly those of sexual harm" (TRC Volume 4:282-3; Ross 2003:22).

The Gender Report provides a lens for viewing how “women” came to constitute a specific type of gendered subject in post-apartheid South Africa. It also provides a window into which types of issues and concerns began to be defined as feminist in the post-apartheid era. This chapter examines the Gender Report in order to index how dominant researchers and activists began to articulate feminist politics in the post-apartheid era, and the type of gendered subjects that emerged out this process. I trace how the authors of the Report define a certain issue—namely, sexual violence and trauma—as feminist, and argue that it should be of immediate concern within mainstream, national politics. This section aims to show how a form of knowledge—that women are essentially different from men, and suffer differently from men, because of sexual and reproductive differences—was produced through the Gender Report. I argue that this truth about women generated another truth—that because of these differences, women are unlikely to speak about how they suffer differently.

While a history of civic and national-political silence about issues of gender and sexuality provided the impetus for the creation of the Gender Report, it was a transnational feminist/human rights movement that provided the model its authors relied upon to open up these issues. The Report demands two things that are standard within many feminist and human rights communities. It asks that scientists collect more
empirical data about inequalities, and it asks that individual victims of inequality come forward and narrate traumatic stories about the violence they suffered. This thesis is centered precisely on understanding how individual activists mobilize these two ‘standard practices’ in post-apartheid South Africa. Both of these practices are part and parcel of the increasing medicalization of sex and reproduction in South Africa, and of the efflorescence of new types of feminist politics in South Africa. In this chapter, by focusing on the Gender Report, I examine how these standard practices are put into effect at the level of national rhetoric.

In the first section, I examine what the Gender Report consists of and the arguments that it makes. In the second section, I touch on how the consciousness-raising movement of the 1970s initially articulated some of the demands laid out in the Report. Thirdly, I reflect on how the position of Sheila Meintjes, one of the primary authors of the Report, as a feminist historian, may have impacted the content of the document. Fourth, I use the work of Ian Hacking to further elucidate what underpins the demand for fact and testimony represented in the Report. In the conclusion, I reflect on what the Gender Report can tell us about what it means to practice feminist politics in post-apartheid South Africa.

**The Gender Report**

The primary objectives of the Gender Report are two-fold: to examine “the experience of human rights abuses through a gendered lens” between the 1960s-1980s (Meintjes and Goldblatt 1996:3); and, “to show how gender is an integral component of social analysis” while demonstrating that gender analyses are integral to a “fuller understanding of the past” (Meintjes and Goldblatt 1996:5). The Report is meant to work, on the one hand, as an evidentiary document providing a record of how
experiences of violence are shaped by gender. On the other hand, it is meant to work as a comment on what it will mean to carry out social scientific and historical research in the post-apartheid era. It argues that paying more attention to gender, and to women specifically, is integral both to the democratization of science and to the writing of South African history.

What do Meintjes and Goldblatt mean when they refer to gender, and how do they position their analysis? They state: “Gender refers to the social construction of masculinity and femininity, not to the sexual differences between men and women. The purpose of emphasizing gender relationships is to highlight the particular manner in which women have been subordinated and oppressed” (1996:4). As the authors note, South African women were subjected to a wide range of experiences that fall under the definition of being human rights violation. In order to conduct a gendered analysis, they make the torture of female political prisoners—particularly, experiences of sexual violence—the cornerstone of the Report. They embed numerous stories of sexual violence into the document, collected during oral interviews they or others collected. They also include excerpts from memoirs. They include quite lengthy quotes, letting the narrator speak for herself about what was experienced. Detailed and macabre accounts of what happened to women’s bodies in detention appear extensively throughout the Report.

In their analysis of women’s experiences in detention, Meintjes and Goldblatt put forward the argument that women and men experience torture differently because they each experience different types of socially constructed sexuality. The authors argue that women are capable of experiencing sexual and reproductive pain that men are incapable of (Meintjes and Goldblatt 1996:10). Meintjes and Goldblatt write (1996:10): "During the
1970s, combined with ordinary forms of physical torture, there were also quite specific and systematic sexual forms of torture which women found more difficult to cope with than simply being hit or battered." Meintjes and Goldblatt make this statement in order to point out that state agents systematically tortured men and women differently. They argue that state agents physically and psychologically tried to attack men’s sense of their manhood and women’s sense of their womanhood.

Arguments made by other researchers, as well as artists and writers, who detail the gendered nature of political violence in apartheid South Africa, dovetail with Meintjes and Goldblatt’s argument that women and men were tortured (and experienced torture) differently (see Cock 1993; Slovo 1997). The Gender Report thus illuminates an important point about women’s personal experiences of violation. Yet, the Report also genders women as “women” by emphasizing that their sexuality and reproductive capabilities make them different. It genders one type of suffering (ordinary torture) as male and another type of suffering as female (sexual torture). For instance, Meintjes and Goldblatt use the phrase “the combination of physical and sexual torture” to describe women’s experiences in detention.

Meintjes and Goldblatt write that they recognize men also experienced sexual torture (1996:10). However, it is only women’s experiences of sexual torture that are called for. The Report calls on women testifiers to talk both about “ordinary” torture and sexual torture—men were called on to talk only about the former. The Report emphasizes the imperative need for more female voices describing such torture by highlighting women’s general silence. For instance, in a section of the Report, Meintjes
and Goldblatt write of Albertina Sisulu and the way she speaks about herself in relation to past experiences of violence.

Even Albertina Sisulu, one of the most prominent fighters for justice who suffered a great deal of repression, was more able to talk about her husband and children's experiences than her own. She uses the second person to describe her experience because she finds it difficult to speak about herself as a suffering individual. She also locates her subjectivity within the collective – the nation. (1996:15)

Meintjes and Golblatt reveal in this quote what they know to be most important at the TRC, and in the eyes of the TRC’s global audience: the ability to speak about oneself as a suffering individual. Narrating the death of a husband, son, or other family member—the bulk of what women discussed when testifying—did not fit in to the TRC’s desire for stories of individual, bodily violation in the first person. As Meintjes and Goldblatt write, “We have already seen women in the TRC hearings emphasize men’s experiences of violence rather than their own. This distorts the reality which was that women too were direct victims of past abuses” (1996:3). Women wanted to talk about the effect of the Pass Laws, and the Group Areas Act, and they did, but those were not stories being elicited.

The Report consistently betrays an urgent worry that South African women are not speaking in the right way about their experiences, and this tells us quite a bit about what the standards and expectations are of how women should be speaking about their experiences. Namely, one should narrate a coherent story about oneself, to provide a personal testimony in which oneself is the central character in the tale being told.

Meintjes and Goldblatt write more generally of how women’s traumatic memories and stories are ignored in the post-apartheid era:

They themselves had been harassed and arrested, yet their stories were not probed and were treated as incidental. Our society constantly diminishes women's role and women themselves then see their experiences as unimportant. The TRC should
empower these women so that they are able to locate themselves not just in the private realm as supporters of men but in the public realm as resisters to oppression. There is nothing in the Act which prevents these types of questions from being asked by Commissioners. (1996:15)

Meintjes and Goldblatt note that people who are considered important, public actors are the same people who are “probed” for fuller stories at the TRC. The Report, in demanding that women speak, works at a symbolic level—in even making the request it functions as an indicator that women stories about their experiences should be taken seriously. At a practical level, this quote is clearly directed at Commissioners, advising them that women should be probed for personal stories of sexual violence at the Hearings. Here, we get a picture of why the Gender Report and the Women’s Hearings emerged as they did. “Women’s experiences” becomes equated with “women’s experiences of sexual violence.” This portrait reveals quite a lot about what the national and global expectations are of a “Gender Report” and a “Women’s Hearing”—namely, stories about sexual violence.

More broadly, we see that Meintjes and Goldblatt, in this section of the Gender Report, are concerned that the scores of women who participated directly or indirectly in the liberation struggle are going to get lost in the rewriting of history if they do not come out and narrate stories about themselves as public, political actors—that is, if former female political prisoners do not come forward and talk about sexual violence.

At the same time, this section also reveals two other practical concerns of prominent feminists in 1990s South Africa. South African women have been claiming themselves as public, political actors since 1912, according to standard South African women’s history. Yet, as the Gender Report shows, Meintjes and the CALS group had recognized and were clearly worried about the fact that TRC commissioners, and others
in positions of political power, were not publicizing this history. In making it seem as if women were much more silent than they actually were, the authors of the Report make a stronger case for the need for more “probing.” Secondly, violence against women, and other issues that often impact women in the home, were silenced at the civic and national levels throughout the twentieth century (Hetherington 1993). Meintjes and Goldblatt see the TRC as a chance for victims to give voice to the issue in a provocative way. They argue that these stories of violence are needed for the future democracy, in order to “construct a new society based on a human rights culture” (1996:10).

The Gender Report suggests that some of South Africa’s most prominent feminist activists were put in a unique bind after the transition. They wanted to ensure that South African women received as much global and local attention as possible, because this attention was imperative for placing South African women’s concerns on the national agenda. Seidman notes (1993) the extremely vulnerable position that women, as a constituency, held during the transition to democracy—specifically in terms of their representation in legislative and political battles. It is likely that it was in part this vulnerability that led the CALS group to emphasize sexual violence in the Report. Macabre stories of women’s experiences in detention were more likely to be provocative, and grab local and global attention, than a lengthy treatise on economic oppression. Describing women as silent and disempowered would give more weight to their claim that women need to be probed more for their stories. And, as suffering, and personal testimonies about that suffering, became increasingly valuable in the making of political claims, the authors of the Gender Report were in many ways compelled to demand that women start speaking within the norms dictated by civil society. This is why it was so
important that women be made into subjects explicitly marked by their sexuality within
the Gender Report; the Report positions the experience of sexual violence as something
that makes women different from men, and establishing this difference gives the authors
room to make special demands on commissioners.

A final point about the Gender Report concerns the way it positions race. While
the Gender Report emphasizes that men and women are inherently different, it is careful
to highlight that all women, despite their race, were subject to political violence. The
document includes the personal narratives of white, black, Indian, and Coloured women
who experienced sexual violence in detention. The authors write:

By the 1980s race was no longer a factor in brutality when Ruth First was murdered … Whilst white women may not have experienced the same level of physical
abuse, they were subject to continual harassment in other ways … Indian women,
too, experienced continuous police harassment and intimidation. (1996:8)

Here, we see how suffering may be employed as a racial leveler. While women’s
gender makes them different from men, it also unites women across races. The Gender
Report illuminates how women’s stories of torture are positioned in a post-apartheid
politics of public memory. Namely, they can be used to show that women of all different
races contributed to the liberation struggle, that their status as sexual beings makes them
all, on some level, the same. Moreover, women’s storytelling is used “to provide a fuller
understanding of our past,” an understanding that will “impact on the way in which we
shape gender relations in our society in the future” (Meintjes and Goldblatt 1996:8).

From a skeptical angle, the use of sexual violence as a racial leveler could be criticized
for using women’s stories of trauma in order to fashion a narrative of potential racial
reconciliation amongst all South African women. From a more generous perspective,
Meintjes and Goldblatt’s emphasis that all women were victims of violation could be
seen as a crucial attempt to provide a foundation off which future feminist alliances could be built across racial divides.

In the next two sections, I reflect on two different contexts that may illuminate why the CALS group chose to make sexual violence and the torture of female detainees the centerpiece of the Gender Report. First, the CALS group was composed of individuals who had extensive experience working within human rights and women’s rights communities in South Africa and abroad. Being experts of prominence in many fields—psychology, history, NGO work, and the law—it is safe to infer that they knew which “gender issues” were likely to incite the most attention within the human rights/feminist communities.

In the first section, I briefly discuss one context out of which the collection of facts and testimonies about sexual violence became standardized—the consciousness-raising movement of 1970s North America. I do not offer a comprehensive review or try to argue that there was a direct link between events that occurred within 1970s North American feminist circles and those that occurred during the writing of the Gender Report. Rather, I indicate a few points that shed some light on how producing a document such as the Gender Report became possible. Rosenthal (2000) provides a comprehensive review and analysis of how sexual violence has been shaped as a feminist concern since the late 1970s in South Africa; I don’t reiterate her points here.

In the second section, I look more closely at the context that Sheila Meintjes, in particular, is writing from—that of being a South African historian of women and gender in South Africa. As an individual who was among the first cohort of South African
historians to open up gender as an object of historical analysis, examining her position as an academic will further illuminate the Report.

**Sexual Violence, Feminism, and Consciousness-Raising: The Global Context**

In the early 1970s, North American feminist activists began to articulate and organize around issues of sexual and domestic violence. They began to deploy concepts of trauma to explain the effects of such violence on women, and to borrow psychotherapeutic techniques that emphasized talk as a form of therapy (Herman 1992:29). Activists organized consciousness-raising groups to define what this type of violence was, raise awareness of it, and to provide a space for individual women to speak about their own experiences of it (Herman 1992:28).

I provide a lengthy quote from Herman to highlight two points about the making of sexual violence into a major feminist concern. One, the quote remarks on the particular way in which activists borrowed from psychotherapy to develop feminist techniques of consciousness-raising. Two, it reveals how activists has commonly articulated consciousness-raising as a scientific endeavor. Herman writes:

> Though the methods of consciousness-raising were analogous to those of psychotherapy, their purpose was to effect social rather than individual change. A feminist understanding of sexual assault empowered victims to breach the barriers of privacy, to support one another, and to take collective action. Consciousness-raising was also an empirical method of inquiry. Kathie Sarachild … described it [consciousness-raising] as a challenge to the prevailing intellectual orthodoxy: “The decision to emphasize our own feelings and experiences as women and to test all generalizations and reading we did by our own experience was actually the scientific method research. We were in effect repeating the 17th century challenge of science to scholasticism: ‘study nature, not books,’ and put all theories to the test of living practice and action.” (1992:29)

Sarachild thus asks that women’s experiences and feelings—made manifest through spoken or written narratives—be regarded as empirical facts, facts which, when compiled, reflect or function as evidence of the social fact of sexual and domestic
violence. Secondly, Herman notes that while psychotherapy emphasizes the importance of sharing of individual stories of violation to achieve therapeutic ends, consciousness-raising emphasized the importance of such stories to achieve social and political ends—namely, to stop violence against women. Herman argues that consciousness-raising was thus absolutely crucial to making sexual and domestic violence key issues of scientific, academic, medical, legal, and social concern in the latter quarter of the twentieth century. Alternately, consciousness-raising—particularly the collection of testimony and fact—became important methods for feminists working to end gender inequalities.

The collection of women’s voices concerning sexual and domestic violence became intimately entangled with the collection of scientific facts about such violence, starting in the early 1970s US. Social scientific and medical inquiries into gender-specific violence proliferated alongside literary and social representations of it throughout the 1970s, 80s, and 90s. As new types of feminist movements sprung up over the globe and were internationalized during those decades, facts and confessionals about sexual and domestic violence became increasingly valued and valuable—politically, therapeutically, academically, and socially. The international human rights movement further mobilized the issue. The collection of fact and testimony seems to have traveled both easily and controversially, as activists brought those methods into articulation with different cultural and historical contexts (Azante and Lambek 1996; Caruth 1995; Felman and Laub 1992; Rogers, Leydesdorff, and Dawson 1999).

I suggest that the Gender Report to the TRC is in part a legacy of the consciousness-raising movement, transnational feminist movements, and the human rights movement. In 1970s South Africa, as in other parts of the world, activists began to
establish rape crisis centers (Rosenthal 2001). In 1980s South Africa, regional women’s associations began to organize around issues of sexual and domestic violence (Bernstein 1985; Rosenthal 2001;). It was during the transition to democracy that feminist activists initiated a much larger movement to stop violence against women in South Africa. This history elucidates why the Gender Report emphasizes the collection of both facts and traumatic stories as among the most important factors in opening up questions of gender and violence within the post-apartheid nation. The practices of collecting fact and testimony have become institutionalized over the years as standard within movements seeking end violence against women, both within South Africa and beyond. In calling for the collection of fact and testimony about sexual violence, the authors of the Gender Report were making a demand that fit into the norms of international feminist and human rights movements. As Ross (2003) has reviewed the controversy that the Gender Report and the Special Women’s Hearings became embroiled in—over the issue of demanding women to speak about sexual violence—I will not repeat her points at length here. What Ross highlights is the response the CALS group received from female testifiers—who decidedly did not want to speak about sexual violence—and from feminists who were decidedly anxious to encourage women to talk about sexual violence (Ross 2001:23-25).

The Cipher of Gender in South African Historical Studies

Sheila Meintjes is a South African who received a Ph.D. in African History from the School of Oriental and African Studies. Since 1989, she has been in lecturer in Political Studies at the University of the Witwatersrand. Since the 1970s, she has been involved as a women’s rights activist in South Africa. Since the transition, Meintjes has chaired and sat on the board of a number of prominent civic and governmental organizations.
Meintjes early academic work developed out of an intervention that feminist historians made in the academy in early 1980s South Africa. In an often-cited 1983 piece, Belinda Bozzoli charged that one failure of the Marxist approach in South African historiography was its treatment of the family as an ideological apparatus of the state. She suggested that this approach obscured struggles that occur within the family and the household. She also drew attention to the fact that historians had often elided issues of gender. Meintjes was part of a group of feminist historians who took up Bozolli’s call in the 1980s to conduct more critical analyses of gender and domestic life. Hetherington notes that this cohort tended to produce material that portrayed “black women as oppressed victims of a special kind of capitalism buttressed by the state” and/or celebrated “the heroic resistance of women against such oppression” (1993:261).

Meintjes work in the academy, civil society, and government has been intimately involved with ensuring that historically disadvantaged South African women are being represented—whether it within the written, English-language historical record or within politics. Hetherington, in her 1993 essay on the historiography of women and gender in South Africa, takes Meintjes and her cohort to task for representing women as either oppressed victims or heroic resisters. But it is highly illuminating that historians such as Meintjes—who have been trying to revise the written, English-language historical record as they work as feminists within civil society—are compelled to paint this image. Is it precisely these images of the resistor or victim that strike a cord with many (well-funded) national and international audiences? Is it these images that are most provocative for demanding that women be written into South African history? In the Gender Report, Meintjes and Goldblatt produces a document that reproduces both of these
representations of women. The Gender Report is an index of the types of representations of women that were valuable for making political claims in the mid 1990s.

**Trauma and the Public Politics of Memory**

Stories of sexual violence were in great demand around the time that the Gender report was submitted to the TRC (Ross 2003). Women’s testimony became entangled in politics of public memory, in which possessing a traumatic past and narrating it became a key way to make any number of claims. The authors of the Gender Report used the concepts of sexual violence and trauma to position women as different from men, so that TRC commissioners would be compelled to draw special attention to women. In deploying these concepts, the Gender Report medicalized and politicized sexuality. Ian Hacking has argued that this type of politics of public memory has its roots in the development of the ‘sciences of memory’ within nineteenth and twentieth century psychology.

Essentially, ‘memory’ was opened up as a site of scientific inquiry in the latter part of the nineteenth century (Hacking 1995:198-209). The sciences of memory articulate memory as a container that holds facts. Experts, such as a psychologist, are conceptualized as capable of mining these facts. Upon the emergence of the sciences of memory, a moral displacement onto the realm of memory occurred. “Memory, already regarded as a criterion of personal identity, became a scientific key to the soul, so that by investigating memory (to find out its facts) one could conquer the spiritual domain of the soul and replace it by a surrogate, knowledge about memory” (Hacking 1995:198). Thus, investigations into memory became politically charged and weighted with moral imperatives.

Hacking argues that the “politics of memory,” which are crucial to debates within nationalist and identity politics in the twentieth century, all rely on the depth knowledge that memory is a container for facts which can be scientifically deduced. Hacking distinguishes between two types of “politics of memory” or “memoro politics”: the personal and the communal (1995:210). He argues that the communal politics of memory have been practiced for thousands of years, particularly within religious communities. However, Hacking elucidates the personal politics of memory as an invention of the nineteenth century.

The liberal subject, the rights-bearing individual, is the central character in the personal politics of memory. She/he refers to certain facts about his/herself to make political claims. Importantly, the personal politics of memory make debates over traumatic memory possible. Likewise, Alan Young (1995), Ruth Leys (1996), and Judith Herman (1992) reveal in their work the centrality that debates over trauma had in
the development of the sciences of memory. They reveal how quickly scientific knowledge claims about traumatic memory became entangled in political claims to a specific identity or community. In the process, moral concerns are displaced onto the clarified world of science, stripped of their politics, and then remobilized as “facts” in claims to political legitimacy. Hacking writes, “Today, when we wish to have a moral dispute about spiritual matters, we democratically abjure subjective opinion. We move to objective facts, science … We do not examine, any more, whether incest is evil. To do so would be to talk about subjective values. Instead we move to science and ask who remembers incest” (1995:220). According to Hacking, when concepts of trauma are mobilized, political, societal, or historical issues are individualized and displaced into the world of scientific facts.

While I simplify Hacking’s arguments, his work contextualizes how the pursuit of facts and confessionals has become both politically normal and filled with serious political intensity. While the authors of the Gender Report were attempting to bring women into a politics of public memory, women’s responses to the Report’s demands were complex (Ross 2003). As Ross notes, many of the women, of who the Gender Report was calling on to speak, refused to testify about sexual violence and continued instead to speak about the death of loved ones (2003:27). While the Gender Report did bring women’s voices into the TRC, insofar as it spurred on the creation of special hearings for women, it did not entirely shape what women chose to speak of.

**Conclusion**

This chapter has examined why the Gender Report demanded that women testify about sexual violence. It revealed how and why the Report positioned women as a certain type of subject, inherently different from men. I briefly touched on some of the
processes which made the development of such a document possible at that particular moment in South Africa: the development of a politics of public memory, which has endowed traumatic stories with great meaning; the development of a global consciousness-raising movement which further mobilized the collection of stories and facts as meaningful; the solidification of sexual violence as a dominant, transnational feminist concern in the latter quarter of the twentieth century; and the unique place that South African feminist historians have come to inhabit, as they work to ally competing loyalties and alliances.

What, then, does the Gender Report tell us about feminist politics in post-apartheid South Africa? It shows how certain groups of feminists, such as the CALS group, are compelled to reproduce a certain set of globally and nationally standardized images/narratives (such as representing women as either victims or heroes, or fashioning women as first and foremost sexual beings) in order to garner attention for gender-specific issues. At the same time, the results of the Gender Report—a special hearing for women—revealed that individual women testifiers could, and did, refuse to partake in the reproduction of the ‘standard’ images or narratives. Once the hearings were instituted, each testifier could, and often did, refuse commissioners questions about sexual violence, and use their time on the stand in the way that they preferred.

The chapter argues that the practices of fact collecting and confessional-collecting are in themselves not inherently liberatory or oppressive. I have tried to highlight that these practices travel into specific historical and cultural contexts at the behest of specific individuals, who possess a host of competing loyalties. The chapter shows that some feminist activists working within certain realms of the new democracy—such as the TRC
and the law—are compelled to speak in a type of language, and deal in certain types of representations of women, that are have become globally normal but locally uncomfortable or unreasonable to the very women they seek to give voice to.

Finally, analyzing the Gender Report throws into relief the increasing medicalization of sex in South Africa. More precisely, it illuminates the growing usefulness of using psychiatric concepts, such as trauma, for feminists who are seeking to name, define, and solve problems facing women. In this, contemporary, South African feminist politics are possibly part of a broader trend in some parts of the world, in which making claims to trauma—or illness more broadly—is increasingly useful within a politics of public memory.
CHAPTER 4
FEMINIST ACTIVISM SURROUNDING POSTNATAL DEPRESSION

Introduction

This chapter explores in greater depth the increasing interconnection between the medicalization of sex and reproduction and the production of feminist activism in contemporary South Africa. As reproduction and sexuality come under the growing scrutiny of medical professionals and social scientists, post-apartheid feminist politics is flourishing around these issues. In this context, scientific facts and the confessionals of individual women become ever more valuable currency in the urgent effort to raise consciousness and effect social change; simultaneously, the deployment of facts and confessionals is in the process of becoming standard practice for organizations and individuals who wish to be taken seriously within civil society as legitimately feminist.

Chapter Three revealed how the CALS group and the Gender Report brought a global standard, regarding what feminism should do for women and society, into national politics. In this chapter, I examine the micro-process by which a specific organization within civil society brings feminist politics, defined around reproductive concerns, into community of their own making. Thus, while the previous chapter analyzed the mobilization of scientific facts and confessionals (concerning sexual violence) within feminist politics at a national level, this chapter examines a similar process (concerning reproductive rights) at the level of civil society. Specifically, I examine the narratives generated by one non-profit organization, the Postnatal Depression Support Association of South Africa (PNDSA). In doing so, I address a few questions. Which individuals
within civil society are participating in the creation of a post-apartheid feminist politics? What types of knowledge are being generated through this efflorescence of feminist activism? What norms of reproduction, motherhood, and domesticity are produced through this process? What types of “common sense” knowledge about race, specifically, are put into play through the mobilization of both scientific facts and confessionals?

**The Postnatal Depression Society of South Africa**

The PNDSA was organized in 1997, out of the home of its founder in the leafy green Cape Town suburb of Kenilworth. The PNDSA provides educational materials and a number of support mechanisms for women and families dealing with postnatal depression (PND) and other affective disorders associated with childbirth. It formed at a time when many other non-profit organizations devoted to defining and addressing women’s issues were starting up in Cape Town. Liz Mills, the woman who started the PNDSA, began organizing around PND in Cape Town in 1987. On the PNDSA website, Mills indicates that part of the reason the PNDSA officially formed in 1997 related to the democratization of South Africa (www.pndsa.co.za). Specifically, she suggests that openly discussing and organizing around ‘women’s issues’ was becoming a more widespread and socially acceptable practice.

Initially, the PNDSA consisted of a small group of mental health practitioners and survivors of PND. It opened up chapters in all of South Africa’s major cities, either in central business districts or out of someone’s home in the suburbs. Each chapter has a small structure of leadership. Many of the women and men who hold leadership positions experienced PND in the past, and/or are mental health professionals. A Board oversees the PNDSA, members of which include prominent psychiatrists affiliated with
the University of Cape Town. In terms of funding, individual donors and small grants support the PNDSA. It is a relatively small non-profit organization, in terms of the number of people needed to keep it running, and the number who use its services.

From its conception, the PNDSA began using the Internet as a crucial tool for making connections, both with potential PND sufferers, and with activists and researchers from other parts of the world. The PNDSA runs a chat-room in association with their website, where women can discuss their problems with new motherhood and receive advice. Women who do not live close to a city center, and who live in a nuclear family set-up, find it difficult to get into town because they are housebound with a new baby. Moreover, many say their depression keeps them further housebound, and less likely to leave the house. The form of the PNDSA, in which a lot of consciousness raising, healing, and community building occurs online, is strikingly conducive to helping certain women—those who have Internet access in their home, and those that are alone at home during the day. Aside from South Africans living at home and abroad, English-speaking women from many other nations talk in the PNDSA chat room. In addition to the Internet, the PNDSA also provides a popular phone-in support service. They also provide women with referrals for counselors, psychiatrists, general practitioners, and midwives. For women who can find their way to local chapter, the PNDSA also keeps a library of self-help texts, which women can borrow from. Finally, they run self-help meetings for women to attend. They estimate that over 4,000 women have contacted them through phone-ins, in the chat-rooms, for referrals, and in meetings.

Who are the women who tend to consult the PNDSA or engage with their materials? In terms of language, their educational materials and their support services
are primarily in English, and sometimes in Afrikaans. According to the PNDSA, most of the women that contact them are white, middle or upper class, and English or Afrikaans speaking (personal interview). Their emphasis on Internet education places a limit on which South Africans are likely to discover they exist—many South Africans do not fall into a class category that involves easy access to the Internet.

Different regional offices of the PNDSA work, to varying degrees, to cultivate contacts with NGOs and medical practitioners that deal with maternal and child health issues outside of the white/middle to upper-class/English or Afrikaans speaking realm of South African society. For instance, in KwaZulu Natal, the Durban and Pietermaritzburg offices do not have contacts with NGOs that work in the townships, but they do have one Indian counselor as a member, to whom Indian women are often referred (personal interview). In contrast, the Cape Town office has had long-term links with a few major NGOs and maternity clinics that service women who cannot afford private healthcare.

The PNDSA also embeds itself within a transnational network of NGOs and non-profit organizations that mobilize around PND. This network spans Western Europe, North America, Australia, and New Zealand.

The ideology of the PNDSA is informed by a liberal feminist politics, which is discussed more in-depth later in the chapter. The group is specifically concerned with overcoming patriarchy through consciousness-raising. The word patriarchy comes up often in PNDSA discourse, and it’s used to refer to constellation of structural inequalities and emotional issues, discussed below. The group also embraces psychotherapeutic healing techniques in its self-help and counseling activities.
The rest of this chapter primarily analyzes how the PNDSA articulates PND as a universal fact that all women who bear children are capable of suffering. First, I show how the PNDSA mobilizes medical and feminist knowledge of PND that emerge out of North America and Britain. I explain how the organization asserts PND as both a biological object and a sociological fact. While it is invoked as both, the PNDSA positions “culture” as a more relevant cause of PND than “nature.” Secondly, I show how that invocation of PND establishes a particular platform for activism. The PNDSA suggests certain political solutions to quell the problem of PND, and I examine what these are. I analyze how the political solutions deployed by the PNDSA articulate notions of racial difference. PNDSA discourse asserts white mothers and black mothers as different, and that the former demands different solutions for PND than the latter. Finally, I analyze what actually goes on in the PNDSA chat room. I examine what women talk about it, and how they come to establish themselves as PND sufferers.

**What is Postnatal Depression? The Medical and Feminist Models of PND**

How does the PNDSA establish or reassert PND to be a universal fact? Namely, by deploying facts about PND that are presented in authoritative psychiatric and feminist texts emerging from North America and Europe. These facts were generated relatively recently, beginning in 1950s North America and Europe. Since that time, a series of conversations between psychiatric researchers, PND sufferers, and feminist activists has produced PND as a biological and social fact. While psychiatric research into PND increased steadily through the 1970s, feminist interventions began to occur on a much larger scale in the 1980s.

In the late 1960s, and throughout the 1970s, PND emerged as a unique category of mental illness associated with reproduction, particularly through research conducted by
psychiatrists affiliated with the University of Edinburgh. This university was a hotbed of PND research, as its psychiatry faculty carried out definitive studies of the phenomenon. As more research was completed in North America and Western Europe, a medical model of PND coalesced. Psychiatric researchers now identify three different types of affective mood disorders associated with childbirth: maternity blues, postnatal depression, and puerperal psychosis.

Maternity blues, popularly referred to as the “baby blues”, is described as the least severe and most common. Researchers estimate that anywhere from 25% to 85% of women experience a mild case of depressed mood following childbirth (Kennerly and Gath 1989; Pitt 1968). Psychiatrists generally agree that hormone fluctuations and the psychical and mental stress that accompanies new motherhood are the cause for minor mood disturbances (Lewis 2002:8; Parry 1989). Maternity blues are thought to typically last for a few hours up to a few weeks, then to reside with few consequences (Lewis 2002:8).

Puerperal psychosis is the most severe and the least common of the disorders. Researchers estimate it occurs in about 1 out of 1000 women who give birth. It refers to psychosis accompanied by either bipolar depression or major depression, and is typically marked by delusions and erratic behavior.

Postnatal depression indicates cases of moderately severe depression. Psychiatrists estimate 10 to 15% of all women experience PND. Mental health researchers who study PND often comment on the lack of consensus on what causes PND (Lewis 2002). PND, like many other mental health diagnoses, is a category in the making. There is some consensus in the psychiatric literature on the following, however. First, its onset occurs
between two to four weeks following childbirth. Secondly, it usually lasts for about six months, but can last for up to four years. Finally, the symptoms are the same as listed under the category of depression in the DSM-IV: lowered mood; sleep, appetite, or psychomotor disturbances; feelings of exhaustion; guilt; suicidal thoughts; poor memory; anxiety; irritability; and loss of sex drive.

In the early 1980s, feminist activists in France, Britain, and North America intervened into psychiatric debates over postnatal depression. The two major transnational NGOs devoted to raising consciousness about PND, Postpartum Support International, and the Marce Society, were formed at this time. The people who organize within these groups include different types of mental health practitioners, interested feminists, and/or those who have suffered PND. While they come from all over the world, members tend to be concentrated in Europe and North America. For instance, the Marce Society organized first in France and uses French, German, and English languages to conduct their various activities—holding conferences, encouraging and influencing psychiatric research design and projects, and raising consciousness through educational materials. Postpartum Support International deals in the mainly English-speaking world of research and activism. The PNDSA draws heavily on English-language psychiatric literature about PND that comes from Britain and North America. PNDSA members see themselves as having a great deal of affinity with PND sufferers from Britain and its former colonies, particularly Australia, Canada, and New Zealand.

As a result of these feminist interventions in the 1980s and 1990s, many psychiatrists began to pay more serious attention to what are commonly called the ‘social’ or ‘cultural’ factors impinging on the development of PND (Parry 1989).
Psychiatrists and activists cited the patriarchal devaluation of reproductive work as a major influence on the prevalence of PND. They argued that patriarchy was structured into three different aspects of life in many countries—the national economy, the health care system, and family life—and that patriarchy was in large part to blame for the prevalence of PND.

First, they asserted that the unpaid work women did in the home was undervalued by national economies, in that mothering work comes without pay. They argued this led to many new mothers feeling depressed, as their mothering work went economically, politically, and socially unrecognized. Secondly, activists argued that some medical practitioners (such as general practitioners and nurses) and researchers (such as psychiatric researchers who saw PND as a purely biological issue) were insensitive to the needs of new mothers. European and American PND activists asserted that medical practitioners should be educated about the social and emotional changes women experience after giving birth, so that they could provide support to new mothers. Finally, many activists argued that the insensitive actions of individual husbands and other immediate family members were a root cause of PND. Within the home, women would suffer under the demands of taking care of a husband and a new child, while taking care of domestic chores in general. In sum, alongside the medical model of PND—which sees a mixture of biology and mental stress as the cause of PND—a feminist model of PND emerged. The feminist model of PND states that PND is normal social adjustment to an abnormal, patriarchal world.

In conclusion, there now exists a body of psychiatric knowledge about PND. Over time, it has become endowed with both scientific and feminist legitimacy. This body of
knowledge has been produced over the past 50 years, through particular networks of association—such as university departments, research projects, and transnational feminist organizations. All the researchers, research subjects, and activists who have contributed to the emergence of PND, as an object of knowledge, are not a homogenous group by any means. But they do form a transnational “circuit of exchange”—a network of association through which ideas, conversations, objects, and practices are transferred.

Castaneda’s notion of the circuit of exchange (2002:7-8) is useful for describing how the PNDSA puts itself in dialogue with the transnational network that organizes around PND. When PNDSA members select certain texts and standpoints from this circuit of exchange, and reframe these ideas, they also become part of the circuit. PNDSA members contribute to the production of PND as a “global” scientific issue, in that they extend the reach of that very circuit into South African cities. Thus, they are not simply mimicking discourses that come from other places, or borrowing from dominant narratives. They are integral to the production of PND as a “global” issue.

Making PND Universal: Narratives of Statistical Prevalence

The PNDSA draws on the feminist and medical models of PND outlined above. In this section, I analyze how the PNDSA positions PND as a biological fact. A key tension within the British-American feminist and medical models of PND relates to debates over whether PND is caused by biological or social factors. In Britain and North America, self-help texts typically dedicate a chapter or more to popularizing psychiatric knowledge about biological causes of PND. Writers typically provide accounts of the two most relevant biological issues thought to be implicated in PND—hormonal fluctuations and the behavior of neurotransmitters. A chapter or section devoted to pharmacological treatment options often accompanies these explanations (i.e., Aiken 2000; Huysman
Likewise, popular books published in Britain and North America detail the range of affective disorders new mothers might suffer. For instance, authors outline the different symptoms of major depression, bipolar disorder, dysthymia, generalized anxiety disorder, and obsessive-compulsive disorder (Dix 1987; Huysman 1998; Nicolson 2001; Sebastian 1998; Shaw 1998).

References to biological causes of PND appear on the Postnatal Depression Society of South Africa (PNDSA) website and in its newsletters, but in contrast to British-American accounts, there are very few consistent narratives about the biological basis of PND. One reason for this relates to the differences in suggestions for treatment and management of PND that appear in the South African versus the British-American literature. A hallmark of American, popular, feminist-influenced self-help texts about PND is a section on antidepressants. American writers position pharmaceuticals as a major avenue toward healing from PND (Aiken 2000; Huysman 1998; Nicolson 2001; Sebastian 1998). This in part explains why popular writers provide cartoons of synapses, serotonin, and nerve cells, or detailed descriptions of monoamine oxidase inhibitors, selective serotonin reuptake inhibitors, and tricyclics (Huysman 1998:84-92; Sebastian 1998:80-84). Nearly all such writers agree that pharmaceuticals are good option for most women with PND.

American writers fit their detailed accounts of brain chemistry and pharmacology into a larger feminist project within America, in which being well-informed about reproductive health means being in control of one’s reproductive health. Having control over reproductive health has been and is a dominant feminist concern in America. In this arena, a cartoon of a synapse and a neurotransmitter signals that the author is working as
an intermediary for women, translating arcane scientific or medical knowledge for them so that they can be knowledgeable and in control. The woman who is in control will know what drug her doctor is prescribing her and how it will work in her brain. In America, the women’s health movement was central to the development of second-wave feminism, and vice-versa. Reproductive rights—including the right to know about one’s body (“Our Bodies, Ourselves”—were centerpieces of second-wave feminism. In this context, the biological facts about PND are likely to be of great value to those who work to raise consciousness of the issue, and to women who are seeking help.

PNDSA discourse references biochemistry, hormones, and pharmaceuticals very little. Why is this? It is possible that its members do not see the deployment of biological facts about PND as either politically or therapeutically useful. However, the PNDSA does reproduce and mobilize a narrative about the statistical factuality of PND that appears in the British-American literature. The PNDSA uses two methods to assert the statistical factuality of PND: reiterating its ability to transcend time and place, and citing authoritative psychiatric texts that reiterate its ability to transcend time and place. Both practices have the effect of emphasizing the universality of PND. Importantly, the citing of statistics also produces ‘women’ as a universal category of association.

Castaneda (2002) and Haraway (1997) point out that the universality of an object or fact is often asserted through showing its ability to transcend time and place. They also state that citing authoritative scientific texts is an important tool for legitimizing a fact as a fact. The PNDSA repeatedly engages in these discursive activities. The PNDSA website, addressing depressed mothers, states: “At least 10-15% of all mothers feel like
you. They are all over the world, in all kinds of economic situations, from every social class and every nation; and this has been happening for thousands of years.”

In statements such as these, stressing two important qualities asserts the universality of PND as a natural fact: its timelessness and its transcendence of nation or class position. The notion of PND as timeless is echoed in other parts of the website. In a section devoted to explaining the history of psychiatric research into PND, entitled “Depression, Anxiety, and Childbirth”, PNDSA founder Liz Mills states, “Affective disorders associated with childbearing have been described since the time of Hippocrates.” Mills goes on to provide a citation of a citation. In a landmark psychiatric text Postpartum Psychiatric Illness: A Picture Puzzle, James Alexander Hamilton outlines a genealogy of the PND diagnosis, linking it back to Esquirol and Marce’s findings of postnatal mental illness in nineteenth century France. Mills cites Hamilton’s account of PND, further confirming PND’s existence across cultural and temporal boundaries.

In these descriptions two strategies are at work. First, citing the timelessness of psychiatric illness categories is a common practice in both biomedical and popular psychiatric literature (Young 1995:3). Medical anthropologists note that telling scientific stories about an object’s transcendence of temporal boundaries is integral to constructing its very status as a universal biomedical fact or object of knowledge (Mol 2002; Young 1995). Secondly, Mill’s citing of Hamilton, Esquirol, and Marce works as a legitimating tool because those authors’ texts have accrued great value as the ultimate authorities on the existence of PND. In trying to establish the existence of PND across historical time, it is important for the PNDSA to invoke the British-American medical model of PND.
Citing those texts evidences for local woman the “realness” of PND as a universal fact. It also evidences to local groups in government and civil society that PND deserves to be taken seriously. Citing the statistical factuality of PND reaffirms PND as truly legitimate biomedical disease.

Likewise, the PNDSA emphasizes PND’s ability to transcend differences in class and individual history. If assertions of timelessness help sediment PND as a legitimate illness category, then assertions of PND’s transcendence of class differences and individual history reiterate ‘women’ as a universal category of association. For instance, the “Depression, Anxiety, and Childbirth” section is immediately followed by a quote taken from one of the most popular American texts written for a lay audience, Carolyn Dix’s 1987 *The New Mother Syndrome*:

>PND is no respecter of persons ... It does not care about our income level, or social class, or happiness in marriage, number of cars or homes owned. Even if we have a happy history with one or two babies, it can strike us with a new one. We are all vulnerable.

In this quote, PND is represented as an equal opportunity employer—what is emphasized is not the timeless of PND so much as its ability to transcend all markers of class and individual history. In this quote, all women are vulnerable.

The anthropological literature on the medicalization of reproduction argues that such processes are productive of both individuals and populations. PNDSA discourse asserts ‘women’ as a universal population. Invoking the standard PND statistic (10 to 15% of all women will suffer), and asserting PND’s transcendence of time and social class, produces and stabilizes ‘women’ as a population group and sediments PND as universal. What larger effect does reiterating women as a universal category and PND as a universal illness have?
Fashioning PND as universal is both politically and therapeutically useful for the PNDSA. Asserting this fact allows the PNDSA to transform what had previously been seen as subjective experiences of pain into objective facts. Making claims to PND’s status as a statistically unavoidable fact provides one platform off which the PNDSA can assert that women should not be held responsible for PND. Psychiatric science becomes a strategic foundation off which feminist activists may work to assuage blame off new mothers. In statistical stories about PND, blame, guilt, and responsibility for PND are effectively displaced onto the realm of “nature.” Dumit (1997) shows how such processes works. He writes, regarding schizophrenia, that the diagnosis invents the “biological” self and the “personal” self, and then redistributes the relationship between the two. “The relations between the two selves are redistributed so that although the patient must continue to experience the illness and live with it, she or he no longer has to identify with it” (1997:96). This elucidates why the PND diagnosis is desirable for PNDSA members. The diagnosis fashions experiences of pain and guilt into a fact called postnatal depression, which is not of the personal self. PND becomes something both part of and separate from the woman. It makes her act and feel certain ways, but attributing those feelings and actions to postnatal depression allows her to distance herself from being held personally and socially responsible for those feelings and actions.

On the PNDSA website, the section entitled “Depression, Anxiety, and Childbirth” is preceded by the PNDSA’s Mission Statement. A section of this statement says that part of the PNDSA’s goal is “To spread the message to those who suffer from ante- and postnatal depression and anxiety that: a) You are not alone; b) You are not to blame.” PNDSA discourse often reiterates that “10 to 15% of all women will suffer from
PNP” and that “you are not to blame.” PNDSA assertions of the statistical
unavoidability of PND allow them to emphasize that women are not to blame. In this
world of statistics, suffering from PND simply comes down to random chance, and
responsibility is dealt back into the hands of nature.

The implication of this is that statistical stories about PND open up a new type of
subjectivity for women. These stories may not simply exert a negative power over
women (by marking them as deviant), but may also exert a positive power over women
(by allowing women to become a “PND sufferer” instead of a “bad mother”). Horacio
Fabrega (1993) states that psychiatric diagnoses activate a different type of
medicalization of health and healing than that of strictly medical or surgical practices and
discourses. He writes, “Whereas disease accounting in general medicine and surgery is
commentary about the physical body and indirectly about the self, disease accounting in
psychiatry is a direct commentary on the self and of the self” (1993:167). He argues that
psychiatry marks selves, not bodies, as deviant or normal. He furthers states that
“psychiatric diagnosis and treatment is controlling if not actually coercive and potentially
stigmatizing” (1993:167).

Lock and Kaufert (1998), observe that some medical anthropologists employ an
understanding of power as negative or repressive, what Foucault would call the juridico-
discursive model of power (1980). Fabrega analyzes psychiatric diagnostic categories as
tools that mark some selves as deviant, and psychiatric treatment regimes as controlling.
Fabrega’s position does little for furthering an understanding of the PNDSA, an
organization that works to liberate women precisely by forming them into objects of
psychiatric techniques. The work of Young (1995) and Dumit (1997) is more useful for understanding the activities of the PNDSA.

In his analysis of the emergence and solidification of post-traumatic stress disorder (PTSD) at a VA treatment center in the US, Young argues that diagnosis and treatment is both controlling and productive. Being marked as a PTSD sufferer produces a new subjectivity—the PTSD patient. Young shows that the men who inhabit this new subject position can use it to make claims to any number of things—better disability payments, more sympathy from friends, etc. At the same time, the deployment of the diagnosis is also engaged in by the state. It allows the US military and government officials to displace their own responsibility for veterans onto the realm of individual pathologies. Instead of having discussions about war as a social or political problem, the PTSD diagnosis encourages discussions about individual pathologies as psychiatric problems. While I have provided a simplified account of Young’s arguments, he ultimately suggests that the medicalization of social issues can be simultaneously politicizing and de-politicizing. In claiming PND as universal, the PNDSA politicizes it as a legitimate feminist concern—because it fashions all women as potential sufferers. However, as we will see in a following section, it also furthers the de-politicization of larger political, economic, and social issues that impinge on reproductive health in post-apartheid South Africa.

Dumit (1997:87) poses anthropological questions important to this paper: “Who takes facts up? Who does not? How are they produced and distributed?” This section has been concerned with showing how and why the PNDSA takes up statistical facts about PND. Before moving on to the next section, it is important to address Dumit’s
third question. How does the PNDSA distribute the facts it mobilizes? As mentioned earlier, the PNDSA performs a great deal of its political and therapeutic work through its website, over the phone, and in urban centers and suburbs of them. There are massive sections of the South African population to whom the PNDSA’s information is entirely inaccessible. Most people do not have computers, many cannot afford long phone conservations, many live in rural areas, and English is not the first language of most South Africans. It is easier for a student in Florida to access PNDSA materials than for the vast majority South African women the PNDSA claims to serve. Thus, there are striking contradictions in PNDSA discourse—namely, they invoke the experiences of a tiny minority of women as universal. The issue, for this paper, is not whether their discourses are sufficiently “representative” of most South African women. Rather, that PNDSA discourses are particularly productive for exposing how universals are fashioned, articulated, and put to political use.

In narratives regarding the statistical facts of PND, PNDSA emphasizes class as the sociological category that ceases to matter in the face of PND. In emphasizing the statistical unavoidability of PND, the PNDSA argues that middle- and upper class women are just as susceptible to suffer from it as poor women. In an interview with a member of PNDSA, it was emphasized to me that while English and Afrikaner women hold positions of economic privilege in South Africa, they are still prone to suffer from a host of cultural issues that exacerbate PND. On the PNDSA website and in conversation with members, a certain sensitivity emerges around class issues, but not race. The women I spoke with were defensive of their status as upper-class women but not of their status as white women. As the next section will show, it has become taken for granted knowledge
(among PNDSA members at least) that within South Africa each race has its own culture, and that each race is in need of its own political and therapeutic solutions for PND. While it is possible for PNDSA members to become defensive about their class position, they are not in the least defensive about being white—it is simply common sense to them that white women and black women are inherently different.

**Narratives of Cultural Causation and the Cultural Management of PND**

Cultural explanations of PND dominate PNDSA discourse and the stories provided by women who suffer from PND. When PND is reframed as having cultural origins, it is fashioned as being a normal response to an abnormal, patriarchal world. When the PNDSA invokes the terms patriarchy and culture, what are they referencing? Addressing this question illuminates the entire configuration of motherhood that the PNDSA invokes—the domestic arrangements and institutions—that lie beneath the surface of their narratives. For instance, every story of PND I located through the PNDSA articulates a single-income, nuclear family household. Behind almost every story is this: a wife and a husband who live in a house where the latter works a nine-to-five job Monday through Friday. The wife stays home, alone, with a new baby, after having taken maternity leave or quitting her own nine-to-five career. Sometimes there are insensitive mothers-in-law or mothers who visit the woman during the day, but many speak of being totally isolated in their home. Another story that appears in a number of narratives I collected is an angry one, about husbands who use their Saturday’s to play golf and rugby—who leave their wife home alone yet another day. Other issues and objects, which evoke a certain kind of domesticity and an entanglement with certain institutions (such as private health care), seep into narratives: lots of Barbie dolls and
teddy bears and tea sets strewn about the house; the quietude and isolation of suburban streets; the hormonal wreckage of in-vitro fertilization; or the loss of a career.

Exploring women’s narratives about the cultural causes of PND will shed further light on how the PNDSA defines patriarchy. Many women describe PND as an identity crisis. In this narrative of cultural causation, blame is displaced off of the mother and onto patriarchy (specifically) and culture (more broadly). In the world described by the PNDSA, husbands, immediate family, and patriarchal society place excessive expectations on new mothers in general. This society is patriarchal because it undervalues mothering work and the mother role. Moreover, it is patriarchal because it expects women to move immediately from highly valued roles, such as career-woman or student, and into the less valued role of mother, without allowing women room to express the difficulties they encounter. In this context, the PNDSA, and many women who suffer from PND, describe PND as an identity crisis.

**Loss: career work and reproductive work**

Within the discourse about PND as an identity crisis, the concept of loss emerges forcefully. Linda Lewis completed a psychiatric study of PND in Cape Town (2002), and devotes a large section to loss because so many of her informants named it as a central experience of PND. Likewise, the PNDSA website refers often to loss. Lewis separates out two different types of loss—loss of previous lifestyle and loss of identity. The two losses blur, however, as the women’s identities emerge as deeply embedded in their lifestyle, and vice versa. Importantly, when her informants talked about the loss of previous lifestyle, almost of all of them were referring to ending careers or putting them on hold. Thus, their narratives articulate a real and conceptual separation between career work and reproductive work. The former provided them the basis for performing an
identity and a lifestyle that made them feel valuable in the world. In contrast, they found reproductive work to be stifling. Ideas of freedom and responsibility, and what it means to exist in or be taken seriously by the world, predominant in the responses provided by Lewis’ informants. Thus, I use the following section to illuminate how ideas of domination and liberation are articulated by PND sufferers and by the PNDSA.

Understanding how the PNDSA conceptualizes liberation is central to discerning the types of feminist subjectivities and activism that their discourses open up or close off.

Ilana provides an account of the experience of loss she underwent as a new mother:

At the heart of it was the complete loss of freedom. And I am somebody who had lived an extremely free life. I’ve always done what I wanted to do … like I gave up a really lucrative job because I wanted to study literature … I didn’t have any dependents, I just did it. My husband and I are … people that are not bothered about how much money we have … So my freedom has gone in all sorts of ways … So I have no existential freedom at all. (Lewis 2002:68-9)

Here, freedom is defined as being independent, having a lot of money, and having a world of opportunities to pick and choose from. As Lewis writes, “For Ilana, the responsibilities associated with having to take care of her child and no longer just herself and her husband, sabotaged her previous sense of freedom” (2002:69). Likewise, Sandra, Fiona, and Gaby see the loss of freedom and independence as the cause of their PND. They articulate feeling as if new motherhood removed them from the swirl of living in the real world:

Sandra: I was always out doing stuff, I was involved in lots of different things and my work was really important to me, and I was very selfish with my time and incredibly independent and fought very hard for that. So that [new motherhood] was a big loss … that was a huge sacrifice. (Lewis 2002:69)

Fiona: My whole identity had changed. I missed the frivolity of actually waking up in the morning and getting really dressed up, and my suit, and my expensive cosmetics … and zooting off to work, and the appointments … people taking me seriously. Suddenly it was like, nothing I did was valued, or no-one really cared—
that I did my bloody … shopping and no-one cared about what I did—I was arbitrary. (Lewis 2002:71-2)

Gaby: I mean you got a lot of your identity from being out there in the world, and suddenly you are, well you feel like no-one remembers you exist. (Lewis 2002:72)

These women imply that certain actions or practices—being busy, being out of the house, pursuing degrees or careers—are taken seriously in the world. They were ‘valued’ when they did them. They see motherhood as a crisis because it cuts them off from those pursuits. They feel their stock falling in the eyes of the world, to the point where they feel as if they cease to exist. It is this experience of loss, and the identity crisis that accompanies it, that the PNDSA defines as the core experience of domination they are trying to overturn.

These narratives evidence certain conceptions of family, work, and value that Collins (1991) discusses in the context of Europe and North America. She writes of the elements that underpin dominant American and European ideologies about family, work, and value. First, wage labor occurring outside the home is marked off as the public sphere, and labor occurring within the home is designated as the domestic or private sphere. “Work and family emerge as separate, discreet spheres, with paid work done outside the home deemed more valuable than unpaid work performed for families” (1991:46). As Collins notes, it is this devaluation of domestic labor that fuelled many feminist struggles in North America and Europe, and this is precisely the type of feminist politics that the PNDSA is engaged in. Women who come to them for treatment options narrate stories about the identity crisis that new motherhood raises in them, and the PNDSA interprets and politicizes this as a larger problem, in which a patriarchal political economy does not value mothering work. (This interpretation appears in Euro-American feminist literature, in which the structure of the national economy oppresses women by
devaluing mothering work.) However, as Collins notes (1991:146-7), these types of struggles may be most pertinent to middle- and upper class women, who live in heterosexual, nuclear families with wage earning husbands. Collins points out that not all women reside within this type of family. For instance, she writes that within many African-American families, women do not have the option to not perform work outside the home because the survival of the family depends on more than one wage earner. Moreover, wage earners often provide support to family members that are not immediate sons or daughters. The liberal feminist activism the PNDSA engages in universalizes the nuclear family with a single wage earner as the norm—but this type of domestic arrangement is not exactly universal to all South African families.

Similarly, Collins problematizes a certain conception of work, one that is present in PNDSA discourse. She writes that people value work in their life in different ways. She reprints a quote of an informant from a study, conducted by Gwaltney which focused on inner city African-Americans:

One very important difference between white people and black people is that white people think you are your work … Now, a black person has more sense than that because he knows that what I am doing doesn’t have anything to do with what I want to do or what I do when I am doing for myself. (Collins 1991:47-8)

The women who contact the PNDSA, who suffer from identity crises during new motherhood, live in a world where work does play a large factor in creating feelings of social worth. But the quote of Gwaltney’s informant highlights the fact that not all women derive such social value from work. Moreover, structural inequalities forged around race, class, and gender often means that ideas about work and social value are linked up to people’s experiences as racialized, gendered, and classed beings. In medicalizing an identity crisis of new motherhood as PND, the PNDSA universalizes a
very particular conception of work as a primary source of social value. Because of this, PNDSA activism is limited—it will appeal to women who suffer identity crises because they must leave lucrative careers behind, but the bulk of South African women do not have lucrative careers. I am not arguing that black women and white women always and already have their own understandings of work and the type of social value that can be derived from it. Instead, the point is that PNDSA discourse naturalizes and universalizes one understanding of work and one conceptualization of the family as norms.

In sum, the core problem that women who contact the PNDSA articulate is that society values women in certain roles—career woman or student—but not as a mother. This is precisely where the PNDSA inserts it’s political argument that patriarchy exists in South Africa, and that it’s effects are pathological. While the PNDSA attests that they are committed to overcoming patriarchy, they also take a pragmatic standpoint that doing so is a long-term project. Medicalizing the patriarchal devaluation of reproductive work (and the identity crises that result from it) as postnatal depression is useful to their feminist project, which seeks to garner political and therapeutic benefits for women who suffer. However, while the PNDSA works to fight against the norms of a patriarchal political economy, they also reproduce certain norms about motherhood, work, the family, and value in their discourse. What is the implication of this?

Medical anthropologists who study the medicalization of reproduction argue that it is in implicated in producing and activating norms regarding maternal-child health (Franklin 1997; Rapp 1997). As Ginsburg and Rapp note (1991), many anthropologists influenced by second-wave feminism sought to understand how women resist these norms. However, other work complicates the idea that women are either entirely
subjected to or resistant to norms (Franklin 1997; Martin 1994). This work details how norms of motherhood or reproduction can be both repressive and generative of subjectivities. For instance, Franklin shows how new reproductive technologies, such as in vitro fertilization, reproduce ideas of proper kinship, citizenship, motherhood, and domesticity in 1990s England. But she also reveals the crucial ways in which these technologies generate new possibilities, even as they gender and racialize certain bodies. In medicalizing crises of new motherhood as PND, the PNDSA opens up new subjectivities for some women, such as PND sufferer, PND victim, etc. However, this process also naturalizes a configuration of motherhood that is experienced mostly by upper class white women. In the next section, I explain how PNDSA discourse reproduces ideas of racial difference.

**Physical and emotional reproductive work**

Reproductive work is separated into two different types in PNDSA discourse: emotional work and physical work. The PNDSA mobilizes popular psychiatric knowledge about child development to emphasize the importance and value of emotional work, both for the mother and baby. PNDSA discourse presents a very precise picture of mother, baby, and a mother-baby unit. The mother and the fetus or baby is each endowed with a unique, individual personality. They are two separate entities, but the latter is completely dependent on the former for its existence and development. Because of the child’s utter dependency on its mother, the mother and baby are described as being a hybrid unit, which form the “mother-child relationship” (www.pndsa.co.za).

The PNDSA stresses over and over again the importance of performing emotional work, both for the new mother and for the development of the child. The website states:
Babies need the sense from you that they are doing OK, even when they cry and wake at inconvenient times. They need you to look into their eyes and say “Hello—I see your unique little spirit there and we’re going to do fine together.” Everybody needs to be affirmed by his or her parents, even from early on. When they are tiny, babies really respond if you copy what they do, so that they know that you have noticed them and their actions. Sometimes, they don’t need food or sleep—but just need to be cuddled and smell and feel your skin. Each mother-child relationship is unique and you need to discover what feels right for you.

In the Euro-American literature, the importance of mothers developing unique relationships with their new babies is highlighted in similar ways. ‘Emotional work’ is represented as the attempts mother and baby make to get to know each other’s unique spirit or personality. The mother is seen as the creator of a new being and the curator of a new life. In PNDSA discourse, the mother is represented as holding such enormous power in this respect that even before giving birth she is haunted by guilt for making the mistakes that she has yet to make. For instance, the PNDSA website states, addressing the expectant mother:

You will have dreams about this baby, imagining how it will look, what talents it will have, worrying, perhaps about the possibility that it will not be perfect. More than anything, the woman will want to be the best mother in the world. To do it right. Even at this stage, the fear of making mistakes and the consequent guilt will probably haunt the pregnant mother.

This hypothetical woman is very concerned with perfection, with being the best mother. The perfection of the child is described as resting almost entirely in her hands. Endowed with such a great responsibility, she becomes riddled with fear and anxiety. Moreover, to recall the above discussion regarding PND as an identity crisis, the PNDSA constructs pregnancy and new motherhood as events that will forever alter the life of the mother. Anticipating this change adds to the anxiety over leaving a career behind. At times the baby is seen as slowly stealing away the previous identity of the mother, turning her into a new person:
Two bodies in one, one inside the other. A symbiotic relationship, with the mother as the life force for the child. Willy nilly, the mother is drawn into a union with another being, that literally feeds on her. It is a time of change, spiritual and physical. The mother’s body will never again be the same as it was before. Nor will her mind. The "silver cord" that binds her to her baby will never be severed. This is a time when fact and fantasy play together. As the woman’s body alters to accommodate the new life, she imagines the child she carries. When the child is born she has to relinquish the fantasy baby. The real and the unreal change places.

The story of PND as an identity crisis is crystallized, on the PNDSA website, under a subheading entitled “New Body, New Self” as this:

No longer can she [the new mother] call her life her own; she is the curator of another, the creator of new life. Her being has been taken over. Wondrous and scary, such responsibility limits with each passing day her freedom of choice. The baby is omni-present, affecting her biological and spiritual being at every level – what she eats, her thoughts, her sleep, all her activities … A new identity in every way. And with the new identity, the woman is herself reborn. New fears and anxieties are triggered, many of them dating back from her own pre-verbal experiences. And with these, inevitably, are concerns about the well-being and perfection of the unborn child, and apprehension about the birth experience, about doing it right, about being a good enough mother.

The PNDSA narrates an extremely anxious story about the death of one identity and the birth of another. The mother-to-be sees the unborn, omnipresent baby as so powerful that it controls her every waking moment. Yet, the woman imagines the new child as such a fragile thing that the impending responsibility of being the “curator of another” is overwhelming. The mothers who turn to the PNDSA feel as if they are the sole authors of their children’s lives, that the potentiality of the child is intrinsically bound up with their own mothering abilities. More specifically, their ability to emotionally connect with their child’s unique spirit is seen as particularly important.

The above passages invest a great deal in the emotional work of mothering. As elsewhere in PNDSA discourse, every gaze, feeding, cuddle, and touch is endowed with the power to make or break the perfection of one’s child. The passages isolate mother
and child into an inescapable unit—they will always be irrevocably bound. In that space, the emotional work of mothering is the most important work a new mother can do.

What of the physical work of mothering? So far, we see a division of differentially valued labor. According to the PNDSA and South African women who have PND, career work is valued more within South African society than reproductive work. Within reproductive work, however, the PNDSA highlights emotional work as the most important work a mother will do. Their stance on physical mothering work is as follows:

Ideally, one’s partner, mother, domestic or whoever else, should be doing cleaning, shopping, cooking, visitors, repairs, washing. It is best to get help with the housework and not the baby. Whatever one’s financial situation, it is enormously helpful to get the help you need over this initial period.

While the mother and partner of the mother are mentioned, the emphasis is on not letting finances get in the way of hiring a domestic. In Lewis' (2002) study of white, upper class South African women with PND, many women expressed anger at their mothers and husbands for neglecting to help them with the physical work of mothering. Some stated that no matter how many times they asked for help from their husbands, they were routinely ignored. Hence, hiring a domestic worker, or an additional one, is seen as the most pragmatic option (Lewis 2002; www.pndsa.co.za). Thus, a very precise division of labor is laid out as exemplary for the new mother. A domestic worker or two—women from historically disadvantaged sectors of the South African population—should be hired to do the physical work of mothering. This will allow the new mother to spend more time “developing your relationship with your child” (www.pndsa.co.za)—that is, to perform the emotional work of mothering. The PNDSA separates out two different types of mothering work, highlights the importance of doing one over another, and then suggests a best-case scenario division of labor for keeping PND at bay. In others words,
the PNDSA is advocating stratified reproduction as a worthy political solution for upper-
class women.

In Linda Lewis’ study of PND, previous psychiatric research and her own findings from interviews with South African women are used to back up the idea that women need physical support during the first few months of motherhood. She cites six British and American studies which found “lack of practical or instrumental support” to be a major cause of PND (Lewis 2002:49). Lewis also cites an interview she conducted with Sharon, a woman who attributed the lack of a domestic worker as a major cause of her PND. Lewis writes

Maintaining a family and home on a domestic level not only involves hard work but that work is also tedious, repetitive and, for the most part, unfulfilling. Sharon was desperate to escape from her domestic commitments … but … as a mother without domestic support she spoke about the fact that no-one else was going to get the job done for her.

This quote brings out one of the major feminist arguments explicit and implicit within PNDSA discourse, already discussed in the previous section. Namely, that the physical work of mothering is undervalued by society. (The PNDSA argues that the emotional work of mothering is inherently fulfilling—its reward is the love the infant shows for her/his mother, and the instances when the infant manifests its unique spirit to the mother. The PNDSA supports this view by citing psychiatric research and popular psychology texts that discuss the mother-infant bond. Mothering work is done without pay, and it is tedious, repetitive, and unfulfilling.) As noted above, in discussing Collins insights into the matter, this argument makes the most sense from the position of the middle or upper class nuclear family. The women who contact the PNDSA feel deeply entitled to performing work that is valued monetarily and symbolically by society. And this is precisely where the PNDSA inserts its feminist argument that women do deserve
to be fulfilled by their work. The PNDSA argues that women do deserve to have this expectation be fulfilled. And, for the PNDSA, one of the best ways to ensure that women be fulfilled by mothering work is to encourage women to get someone else to perform the unfulfilling aspects of that work—the physical labor. To repeat Mills advice, “It is best to get help with the housework and not the baby.”

In sum, then, the PNDSA separates out physical work and emotional work as two different aspects to mothering. Moreover, it places value on the latter and not the former—partly because the PNDSA argues that society itself does not value the physical labor of mothering. To put it another way, the PNDSA presents a certain vision of what society is and what it should be. It says that contemporary South African society does not value a certain aspect of mothering work. But instead of arguing that society should begin to value domestic labor, they argue that a certain class of women—upper-class women—should be exempted from performing that type of labor at all. They are not arguing for a shift in societal “values”—which jobs should garner which wages and what types of work are considered important—they are arguing for maintenance of those values. In this context, hiring domestic workers becomes an action one takes to be liberated from patriarchal domination. The PNDSA positions hiring domestics as part of their liberatory feminist politics. Their universalizing of one type of motherhood lays the foundation for their feminist activism. However, this type of feminist activism relies on an exclusionary politics.

Scholars in the US (Butler 1991; Hammonds 1997; Mohanty 1991;), Africa (Gaidzwana 1992; Meena 1992), and South Africa (Hassim 1991, 2001) argue that asserting woman as a universal category is dangerous because it tends naturalize some
women’s experiences of domination, social positions, or patriarchy. Mohanty’s insight into the real and discursive positioning of “Third World women” in Western feminist discourse reveals that while Western feminist discourses assert the universality of womanhood, they simultaneously construct “Third World women” as an other. A similar process is at work in PNDSA discourse.

PNDSA discourse implies that the use of domestic workers is a good solution for PND because South African domestic workers live in a different society, with its own set of values. One member of the PNDSA stated that black, Indian, Coloured, and white women in South Africa all have different cultural practices to deal with new motherhood. Race and ethnicity are the categories through which she understands cultural difference and practice surrounding childbirth and motherhood. In conversations with PNDSA members and in PNDSA materials, the words “African,” “traditional,” and “indigenous” are often used interchangeably to refer to non-white South African women. The PNDSA website reiterates its most common stance on PND in “other cultures”:

Less PND has been reported in some primitive tribes, where the extended family is intimately involved with the woman, and where she is treated as "special", and important, and it is understood that she is going through a "rite of passage."

Likewise, Lewis cites ethno-psychiatric research to state:

There is relative lack of adequate interpersonal support following the birth of a child in Western societies when compared to that of traditional indigenous cultures. Support in the latter involves mandated rest, instrumental help, and societal recognition through rituals and gifts marking the new status of mother. (Lewis 2002:48)

What does Lewis mean by “traditional indigenous cultures” and “Western”? She cites three studies—Cox 1988, Harkness 1988, and Sturn and Kruckman 1983. The Cox piece is an anthropologically inspired study of PND in Uganda. Cox, a British psychiatrist, went to Uganda to see if it was present there and to test rates of prevalence.
Harkness is a cultural anthropologist who assessed the impact of cultural practices surrounding childbirth and new motherhood on the development of PND among the Kipsigis. Looking at Lewis’ statement in relation to the research she cites and the larger context within which her assertion is made, “traditional” and “indigenous” peoples are equated with one another and white South Africans are “Western.” It is unclear how Lewis would categorize people who are not indigenous but may be considered traditional. Do Indian women get categorized as white or traditional? What about Coloured women? What about rural Afrikaner women? The point is not to criticize Lewis for using fuzzy terminology. Rather, it is to highlight the “common sense” categories through which some South Africans form alliances of sameness and difference.

Mohanty writes that one of the key questions facing feminist scholarship is how to understand the relationship between the representation of women in discourses and the material, lived realities of specific women. She argues that Western feminist discourses deploying Third World women

Discursively colonize the material and historical heterogeneities of the lives of women in the third world, thereby producing/re-presenting a composite, singular ‘third world woman’—an image which appears arbitrarily constructed, but nevertheless carries with it the authorizing signature of Western humanist discourse. (1991:53)

When the PNDSA invokes the “traditional,” “African,” or “indigenous” woman, they perform such a discursive colonization. As Mohanty argues, these discursive moves mark the traditional woman as different. PNDSA discourse invokes all non-white and non-Western reproductive practices as more naturally capable of sheltering new mothers from the harsh changes wrought by new motherhood. In Lewis’ quote, traditional woman are constructed as residing in a more comfortable past which technology and patriarchy have torn Western women out of. At this point in PNDSA discourse, we see a
positioning of traditional indigenous women as safe, or protected from, social ills because of their unique culture.

What are the effects of this discourse? How to best analyze the positioning of non-Western women in PNDSA discourse? While Mohanty remarks on the disconnect between discursive representations of third world women and their material, lived realities, understanding the PNDSA’s discursive situating of such women as mere representation does not take the analysis far enough. Specifically, Mohanty maintains a clear divide between the material (lived realities) and the semiotic (representation/discourse). Haraway (1997) and Castaneda (2002) introduce the concept of figuration to re-couple the semiotic and the material—they argue that materialities are forged through discourses, and that discourses are further forged through materialities. In Castaneda’s words, “a figure…is the simultaneously material and semiotic effect of specific practices” (2002:3). A figure can be an image, a character, or an object. As Haraway writes, it does not always have to be representational or mimetic, but it does have to be tropic. That is, it always references something other than itself—it calls up meanings, stories, and histories. Castaneda argues that figures accrue value over time, that certain figures become weighted down and sedimented with meanings. These figures are also “valuable,” in that they can be invoked to make truth claims, or to make claims to political legitimacy. From this point of view, the figure of the traditional woman articulated in PNDSA discourse is an effect of historically contingent intersections between bodies, technologies, and narratives. In drawing on the universalizing discourses of psychiatry and liberal feminism—which also invoke the figure of the traditional woman—the PNDSA is engaged in furthering figuring that
woman as such. This figure is invoked in PNDSA discourse because it is a valuable tool for claiming that Western women live in a society that has forgotten how to take care of its new mothers. This becomes more apparent in the next chapter, where we see how another figure of the African woman, the figure of the failed or suffering mother, is rendered out of actual psychiatric research in Cape Town’s townships.

**Circulating Testimonials: The PNDSA Chat Room**

The evidence I analyzed in the previous sections included the scientific facts presented on the PNDSA website, and the confessionals which appear on it and in Linda Lewis’ study. I analyzed why and how scientific facts about PND are mobilized by the PNDSA. In this section, I look more closely at testimonials which appear on the PNDSA website and in the PNDSA chat room. Why do they appear? What is their purpose, and who is writing, typing, or speaking them?

The testimonials which appear the formal PNDSA website are all written by South African women. These stories perform a few functions. Mills, the primary individual behind the website, uses them to illustrate, in story form, what the PNDSA means when it refers to certain symptoms of PND or the experience of it. Testimonials are useful because they are illustrative. Moreover, the website is specifically set up to reach out to sufferers. I argue that Mills and its other designers are trying to moderate the edges of hard, scientific facts, and testimonials help soften the edges of the website—as do the pale pink and blue drawings of mothers and babies, and the inclusion of remarks about the importance of faith and hope. Finally, the testimonials drive home the seriousness of PND as a problem, at a purely emotive level. While statistics and facts draw attention to and legitimate the issue, testimonials help make the issue “human”—they call on the reader to identify and sympathize with the sufferer. Similar to the way that confessionals
were used in the Gender Report, testimony appears on the PNDSA website as an emotional incitement to take either political or therapeutic action.

In the PNDSA chat room, the PNDSA mostly loses control over the testimonials that appear. The chat room is reached through clicking on a link posted on the PNDSA website. Aside from being bombarded by people trying to sell pharmaceuticals—and, oddly, poker and online gaming products—the chat room is mostly occupied by women who are suffering from PND. They typically post a note which reads like an update on their experience of PND, of their day, of their family life, of their doctors and medical problems, and the like. While many women never state the geographical location they write from, some do: New Jersey, Florida, South Africa, Britain, and the Netherlands are all represented. While some of the women state that they are South African ex-patriots, I infer from some of the posts that many English, Dutch, and North American-born women interact on the chat room too.

Many women appear often and write back and forth to one another, posting replies to one another’s messages. Here is a typical post. It is titled “Thanks for your support Sue, Carrie, and Pepper” (11/30/05 at 20:59 GMT):

I was on Celexa for about 3 years after a having a full-term stillborn baby and subsequent divorce. The first 3 days or so on Celexa I felt very strange; kind of dopey and very tired. I can't imagine being that tired from the meds and sleep deprived from a newborn. Anyway, that dopey / weird / tiredness wore off and I adjusted and Celexa was the best thing that I could have done for myself (in addition to counseling). I now have a newborn (6 weeks old) with a new husband. I went off Celexa during my pregnancy and now am going to the Dr. to discuss going back on. Please let me know if you are feeling better [directed at Sue]. I think your feelings are quite understandable given the amount of stress you are under with 3 young children. Much Love to You!! –Jean

This post is typical of most. It begins with the writer detailing a particular anecdote about the PND experience, and ends with a message of support directed at other chat
room members. The chat room functions primarily as a self-help forum, and a site where women can chat with other women under conditions of anonymity.

I would argue that it is precisely the secretive nature of the chat room that many women find comforting. A number write that they try to put on a mask of happiness at home, inferring the chat room is one of the few places where they can let themselves speak openly. For instance, Cyndi writes (7/24/05 2:03 GMT):

this is hard for me, but i am so not myself these days. I have a 2 1/2 year old daughter, 14 month old son and my sweet little newborn of 6 weeks today. I cry almost everyday. I love my kids like crazy, but i hate my family life. i hate my hate and anger. i hate that i feel sad and short. My kids probably think i'm psycho. Lord knows i do. But i am the "strong" one. The one who everyone thinks has it together. I always have a smile on my face and crack jokes at my crazy life. I have no help in my home. My husband and 2 step sons are as helpful as a square peg, and i have no family here. I'm so anxious writing on this web site i could just scream.

This message also reveals another commonality among many of the posts. Women often state that they have no one to talk to, or that they lack family where they are. In the lack of other supportive social or kin networks, the chat room becomes a place where sufferers can build an alternate community of belonging. Women often end their posts with messages of love and uplift to others in the chat room—part of the process of consolidating online friendships, and facilitating healing processes.

While most of the chat room participants appear to not be official PNDSA members, some PNDSA members often do enter the chat room to provide support and intervention. Colleen is the most represented PNDSA member on the website, and she uses her posts to do a few things. First, if a woman is having a crisis and does not know how to reach a doctor or counselor in her area, Colleen will respond with telephone numbers and other helpful information. In her posts, Colleen is often talking people down from an imminent psychological crisis. For instance, here is her initial post ("To
Ashley” on 6/20/05, 12:05 GMT) directed at Ashley, a woman who had called out for help in the chat room:

From what you describe you do seem to be very depressed. Depression during pregnancy is very common, so you are not alone and you are definitely not being selfish. What you are going through now is also not your fault. I would suggest that you seek some professional help… If you tell me where in the world you live, I will try and link you to some support. Take care of yourself and you will get through this!

After Ashley’s response that she was moving to Florida, Colleen wrote her again

(“Support in Florida”, 06/28/05 at 12:40 GMT)

I am not sure where in Florida you will be living but I have 2 contact people for you [she provides the telephone and email of a contact for South Florida and one for North Florida]. They are both members of Post Partum Support International and am quite sure that they will be able to help. Take care and let me know how you get on.

In the Ashley-Colleen conversation, we get a precise picture of how certain individuals become embedded in the “transnational circuit of exchange” that constitutes feminist activism concerning postnatal depression. Colleen, writing from within South Africa, provides contact information for Ashley, a woman in Florida, by deploying her connections with one of the dominant transnational non-profit organizations concerned with PND as a medical and feminist issue. The Ashley-Colleen conversation reveals how deeply embedded, and integral, the PNDSA is within this circuit of exchange.

Thus, the PNDSA has established itself as an important team of experts and activists within the PND circuit of exchange. In the previous sections of this chapter, I analyzed how the PNDSA mobilized information from the “West” to make certain arguments and establish itself as a legitimate organization. Examining the circulation of confessionals and advice in the PNDSA chat room provides another angle from which to view the PNDSA. Namely, it reveals how the PNDSA contributes to the making of PND
as a particular type of transnational feminist issue. Analyzing chat room activities, it becomes impossible to view the PNDSA as marginal to the global endeavor to define and quell a PND problem. The PNDSA chat room evidences that European and North American experts do not have hegemony over defining what PND is and how it should be managed.

Most importantly, the PNDSA chat room reveals in detail the type of community—and transnational feminist alliance that the PNDSA is building. It draws out educated, Christian, English-speaking women who have access to highly medicalized pregnancies and births. Many of the women are highly knowledgeable about various drug therapies, and have visited with a number of the counselors, therapists, and general practitioners. They all appear to have Internet access in the home. National identities and alliances mostly melt away in the chat room. Thus, the PNDSA chat room reveals how certain types of feminist knowledge are linked up specific types of feminist politics, and with the creation of certain types of communities of women. The PNDSA’s political position, its use of the English language, and its use of the Internet, allows it to build a transnational feminist alliance spanning North America, Europe, and South Africa. It disallows connections across race and class lines within South Africa, or connections with women in the rest of Africa, or Latin America or Asia. The here point has been to reveal the types of tacit knowledge that may buttress the development of certain types of feminist politics and communities.

**Conclusion**

What has this chapter illustrated about the interconnection between the medicalization of reproduction and the articulation of feminist politics in post-apartheid South Africa? On one level, it shows how the practice of feminist politics can become
segregated. The PNDSA mobilizes facts about PND that emerge out of “Western”
feminist and psychiatric texts. They do so, in part, in order to ground their claim that
PND is a universal reproductive illness, which transverses the boundaries of class. They
argue that economic comforts are not enough to shield them from PND. Upon
establishing the statistical factuality of PND, the PNDSA argues that women live in
patriarchal societies that devalue reproductive and mothering work. This initiates identity
crises in new mothers, who find themselves suddenly devalued, economically and
socially. The PNDSA medicalizes this identity crisis as PND, and defines the experience
of PND as female domination. Moreover, the PNDSA separates out physical and
emotional mothering work, and argues that the latter is more valuable than the former.
The PNDSA encourages the use of domestic workers, to perform the physical work of
mothering, to free up more time for some mothers to do the emotional work of
mothering. Thus, hiring domestic workers is suggested as a liberatory political action.
The PNDSA is able to take this position because it argues that Western and non-Western
women live in different culture, have different mothering practices, and are thus in need
of different therapeutic and political solutions for PND. In the process, the PNDSA
reproduces apartheid-era ideologies about racial and reproductive difference—it argues
that white South African women are “Western,” in contrast to “traditional,” “indigenous,”
“African” women. Analyzing PNDSA discourse, I argue that it has become “common
sense,” at least among PNDSA members, that each race has its own culture, and that each
race/culture is in need of its own political solutions to reproductive issues. This
“common sense” notion manifests itself in other spaces as well.
In 2003, an article entitled “Postnatal Depression: A Stark Reality” appeared in the South African newspaper *City Times*. In the article, Lynn Alexander, a young Coloured woman from the Cape Town township Mitchell’s Plain, discusses her struggle with depression following the birth of her first child. She states, “Depression is thought of as a white woman’s indulgence. Coloured mothers like me are supposed to pull themselves together and get on with life, as their mothers did.” Alexander’s comment reveals a trend in the way many South Africans I spoke with link up ideas about illness and society—namely, that membership in a particular cultural, racial, or class community determines what one is likely to fall ill with.

In texts I collected and in interviews, I read or heard the following: PND is a white woman’s indulgence; African women do not suffer from PND because they are natural mothers; African women are more likely to suffer from PND because they live in townships; African women living in other African countries (not South Africa) are probably less likely to get PND than black South African women; Afrikaner women are more likely than English women to get PND because Afrikaner culture is more patriarchal than English culture; Indian women are very likely to suffer from PND because their culture places high professional and maternal expectations on them. These myriad stories demonstrate that many South Africans share a tacit understanding that illness is structured along the lines of either race or class.

In analyzing PNDSA discourse, I have examined the implications this has on feminist politics—namely, segregation occurs within the realm of activism. Scientific language becomes one lexicon through which feminist concerns are articulated, and certain ideas about motherhood and race are naturalized. Yet, the language of the
testimonial provides another mode through which feminist politics are shaped. It is here that “Western” women emerge even more forcefully as a specific community. In the PNDSA chat room, middle and upper class women living in the predominantly English-speaking world contribute to the making of PND as a “Western” women’s issue. The end of apartheid enabled the opening up of sexual and/or reproductive rights as new types of feminist issues and national issues. Yet, the emergence of new types of feminist politics is being shaped—within some sections of civil society—by certain “common sense” knowledge about racial and cultural difference.

Encouraging the proliferation and circulation of scientific facts and traumatic stories is becoming standard practice amongst individuals who are trying to end gender inequalities in South Africa, as I argued in Chapter Three. In Chapter Four, I conducted a micro-scale analysis of one non-profit organization. I did so in order to illustrate the complexities that emerge when these standard practices are mobilized—namely, what types of alliances are forged amongst which types of women and how. I revealed how PNDSA discourse articulates a difference between “Western” South African women and “non-Western” South African women, and then absents the notion of alliances between those two groups. I then examined how the PNDSA does work to establish alliances with other “Western” women and organizations in North America and Europe, particularly through its use of Internet technologies. Putting these two chapters in dialogue with one another, different pictures emerge of how specific individuals and groups are shaping sexual violence and reproductive rights as feminist concerns in the post-apartheid era. The authors of the Gender Report make attempts to create alliances across racial divides, arguing that women of all races suffer sexual violence, and demanding that women of all
races come forward and tell their stories. The CALS group also demanded that the TRC fashion certain services for non-English speaking women, illiterate women, and poor women—for instance they demanded that legal experts and therapists who speak various African languages be available for women testifiers. In contrast, the PNDSA does not seek to create alliances across the lines of race or class—within South Africa—through the bulk of its political work; rather it seeks to create transnational alliances amongst a population of women that they actively define as “Western.”

As traumatic storytelling and the pursuit of scientific facts become increasingly normalized as global feminist practices, it is important to trace how these practices are being mobilized within particular nations and/or the civic organizations working within them. Moreover, as transnational feminist movements come into to dialogue with a broader, global human rights movement, it is important to trace how these practices (traumatic storytelling and the pursuit of facts) are taken up or not taken up by actors who define their work squarely within the latter movement. This is the object of the next chapter.
CHAPTER 5
THE OBJECTS OF POST-NATAL DEPRESSION RESEARCH

Introduction

This chapter works from the starting point that scientific facts about PND are incredibly malleable, and can be put to different political uses. This thesis is concerned with understanding how feminist politics is put into practice in South Africa, and this chapter will be used to illuminate how feminist knowledge about PND may disappear in the hands of different activists. The PND researchers and human rights activists, whose work I examine in this chapter, are intimately connected to the PNDSA. Mark Tomlinson, one of the primary researchers, sits in the board of the PNDSA. He writes articles for their newsletters, and discusses the work of the PNDSA in a few of his popular articles. The PNDSA cites the research findings of these PND researchers to back up their political claims about what an important issue PND is in South Africa. Thus, I argue that the work of the PND researchers can be seen as linked to the work of the PNDSA. While the PND researchers focused on here were inspired (in part) by feminist colleagues to take up PND as an important South African issue, the PND researchers refashioned PND into an entirely different kind of issue.

This chapter addresses how psychiatric discourse and practice fashion “township women” into objects of knowledge through analyzing PND research projects in the townships of Cape Town. Intersections between urban African women, psychiatric technologies, and humanitarian desires produce the figure of the township woman. I argue that when PND research moves into the townships, PND researchers and activists
cease to articulate PND as a feminist issue and instead reshape it as children’s rights and human rights issue. PND researchers conduct projects in the townships in an attempt to democratize psychiatric science and contribute to building a culture of human rights. In deploying their research methodologies, as well as humanitarian narratives, they generate the figure of the “township woman.” These PND research projects conducted in the townships often reproduce apartheid era ideas of the urban black women, the black family, and the black township.

The previous chapter examined how the Postnatal Depression Support Association articulates PND and politicizes it as a feminist issue. The mother with PND, suffering from an identity crisis brought about by a shift in social roles, is the primary character in the story the PNDSA tells about PND. She is the person who is experiencing patriarchal domination, and is thus the person who the PNDSA works to liberate. PND is constructed primarily as a women’s health issue and as a feminist issue. This chapter widens the scope for viewing some effects of PNDSA discourse. The PNDSA is part of a wider network of psychiatrists and activists who organize around and conduct research on PND in the Western Cape. When we move out of the internal world of PNDSA discourse—and out of the verdant suburbs and web-site chat rooms where the bulk of PNDSA activities occur—and into the townships of Cape Town, a shift takes place. Namely, PND researchers refashion PND as a children’s health issue. While the previous chapter focuses on the subjects and subjectivities produced in narratives about PND, this chapter asks who is made into an object of PND discourse. Why is PND a women’s health issue in the suburbs and children’s health issue in the townships? Why is it that women are the objects of research, and children the reason for conducting it? Psychiatric
research into PND in the townships provides an angle into viewing the malleability of psychiatric concepts, and how social reasons psychiatrists provide for caring about disorders can drastically shift and transform. Moreover, the PND research projects also illuminate how Capetonian and British researchers contribute to making of Western science by conducting PND research in South Africa.

The Hanover Park Project: Mother-Infant Attachment Research

Mark Tomlinson, a psychiatrist based at the University of Cape Town, is the key South African researcher of PND. He sits on the board of the PNDSA, and has directed two major studies of PND in Cape Town: The Hanover Park Project (1994-1996) and the Thula Sana Project (2000-2004). Tomlinson and his South African colleagues often work in concert with British researchers based at the University of Edinburgh. Tomlinson, as a member of the PNDSA and an employee of the University of Cape Town, situates himself in local and transnational circuits of exchange of psychiatric science. Tomlinson is an integral part of this transnational web—few studies of PND have been carried out in Africa, and his projects were the first conducted in Southern Africa. Like the PNDSA, Tomlinson and his colleagues are not merely mimicking “Western” science, but are actually realizing it through their research. Importantly, the production of this research depends on the women and infants who are at the center of the study. This chapter examines how researchers use these specific bodies to produce the more general concepts of the “township woman” or the “African woman.” I trace how specific research methodologies enable this figuration. While chapter two explained the discursive colonization of ‘traditional indigenous’ women in PNDSA discourse, this chapter analyzes the material production and colonization of “township women” in psychiatric research. How are specific bodies transformed into the figure of the township
woman? What types of narratives does this figure become entangled in? Why is this figure so central to realizing “Western science” as globally universal?

Between 1994 and 1996, Tomlinson, with a team of British and South African psychiatrists, conducted a mother-infant intervention project in the Western Cape township of Hanover Park. Hanover Park is predominantly Coloured and Afrikaans-speaking. The intervention included testing new mothers for postnatal depression, assessing mother-infant attachment, and teaching mothers skills to improve attachment. Mother-infant attachment research is based on the idea that mothers and their babies begin to bond from the moment of birth. Psychiatrists argue that the development of this bond—known as mother-infant attachment—is integral to healthy child development, at the cognitive, behavioral, and interpersonal levels. As investigations into both PND and mother-infant attachment became professionalized, particularly through research completed at the University of Edinburgh and major research institutions in the US and Europe in the 1970s and 80s, researchers increasingly highlighted PND as a major factor in impeding healthy attachment. Often, researchers concern over PND’s negative effect on attachment fuelled interest (and garnered national funding) for studies of both.

The Parent Centre, a Cape Town-based nongovernmental organization that mobilizes around child abuse, funded Tomlinson’s Hanover Park mother-infant attachment project. The basic aim of the project, adapted from the Hawaii Department of Health’s Healthy Start program (Tomlinson, et. al. 2003:207), was to “assist mothers in promoting nurturing relationships with their infants” through providing mother-infant interventions. (Tomlinson, et al. 2003:207). Tomlinson chose Hanover Park as the site of the project specifically because it had one of the highest rates of child abuse in the
Western Cape, according to the statistics of a local childcare agency (Tomlinson et al 2003:207). Twenty-five mother-infant dyads were chosen to take part in the study. Four women, community workers who lived and worked in Hanover Park, were trained to conduct the interventions by the psychiatrists. The psychiatrists delivered the training in English and Afrikaans. The training consisted of “providing information about parenting skills, counseling skills, child development, breast-feeding, postnatal depression, child abuse and the common concerns of the parent in the community” (Tomlinson, et al. 2003:208). These women were “paraprofessionals,” in that they had no previous training in the mental health field.

Tomlinson and his team chose the twenty-five mothers and infants because they had had previous contact with the Hanover Park public health obstetric facility. They received a weekly visit from a community worker beginning in the first week postpartum, continuing for a two-year period. These visits consisted of sharing information with the mothers on a range of topics, such as child development and disciplinary tactics (Tomlinson, et. al. 2003:207). The visit also included the counselor listening to the mother’s problems and teaching her skills that would help her manage those problems. Finally, the counselor worked as an advocate for the mother, most likely in terms of informing the mother on how to access social services.

The goal of the intervention was to provide support to the mothers through teaching them new skills, providing them with information regarding child development, and giving advice on how they could contribute to better child development. Moreover, the architects of the project “hoped that this assistance would translate into other important outcomes—for example, a reduction in child abuse and neglect” (Tomlinson, et. al.
The psychiatric and paraprofessional team used three psychiatric assessment tools to measure the outcome of the intervention. The Edinburgh Postnatal Depression Scale (EPDS), codified by Cox, Holden, and Sagovsky (1987), was used to measure “maternal mood” at two months postpartum, and again upon completion of the study (Tomlinson, et. al. 2003:208). This was used to determine which mothers were depressed and which were not, and to measure whether depression had an impact on mother-infant attachment. The Strange Situation, developed by Ainsworth in 1978, was used to assess mother-infant attachment after two years. Finally, the cognitive developmental level of the children was measured upon completion of the study using the Griffiths Scales of Mental Development, developed in 1976.

The EPDS and the Strange Situation are designed to test the extent to which women deviate from ‘normal’ mother-infant attachment. Thus, the Hanover Park project mobilized norms of motherhood and child development, norms that emerged out of psychiatric research carried in Britain and North America. The issue is not so much that Tomlinson and his team were holding Coloured women up to Western standards; rather, that Tomlinson was realizing global science through conducting the study. The mothers and infants in Hanover Park were not marginal to the project, but its absolute center.

An analysis of the EPDS and the Strange Situation reveal how psychiatrists figure universal knowledge about PND and mother-infant attachment from specific intersections between technology and research subjects. Karen Barad (1997) asserts that scientific knowledge is contingent upon the methods of observation which produce it, and by looking at the EPDS and Strange Situation, one can see how mother-infant “universals” are actually produced through these methods. These methods also reveal how postnatal
depression and child development came to be so intimately linked that it has become “common sense” within psychiatry to see the latter as dependent on the absence of the former.

Cox and his research team codified the Edinburgh Postnatal Depression Scale into its current form in 1987. In their article on the formulation of the EPDS, they state that research findings indicating a link between maternal depression and behavioral and cognitive dysfunction in children was a major impulse for its codification (1987:782). The EPDS is a ten-item questionnaire, which is administered to the mother. Cox mined two preexisting depressive indexes (the Irritability, Depression and Anxiety Scale and the Hospital Anxiety and Depression Scale) and came up with some of his own questions to form the EPDS. Cox’s discomfort with using depressive indexes already in existence surrounded two issues. One, many such questionnaires were developed to administer to people already hospitalized for depression. He saw his pool of potential postnatal depressives as being less obviously “abnormal,” and probably unwilling to admit that they were unwell. Secondly, he wanted to devise a survey that could be conducted in the home, without the need for a highly trained professional to administer it. For some methods of investigation, such as the EPDS and the Strange Situation, the home of the mother is seen as the key place to conduct mother-infant attachment research and intervention (Cox 1987:783; Tomlinson 2003). The home is a privileged site because psychiatrists see it as the “natural” environment of the mother and child. Mother and baby are more likely to be relaxed in the home, and psychiatrists feel research conducted there provides them a window into the everyday life of mother and baby.
Cox and his team carried out the initial validation of the EPDS in the homes of eighty-four Scottish women. The EPDS was immediately taken up in the psychiatric community in Europe and the US, and further validated. The development and acceptance of the EPDS provides a view into the peculiarly global-local configuration of PND, in which 84 Scottish women are used as the material out of which the “universal” normal mother is figured. The use of the EPDS, in numerous global locations, can be seen as a way in which British ideals of domesticity, kinship, and motherhood are produced, deployed, and naturalized. However, PND research projects in South Africa, and other locales, are by no means marginal to global PND research.

Castaneda points out that the production of the normal and the pathological is intimately wrapped up in the figuration of the child in nineteenth century physiology and twentieth century neuroscience. Likewise, the EPDS is a tool that produces the normal new mother and the pathological new mother within psychiatry. A number of qualities are codified as positive on the scale—happiness, the ability to laugh and sleep, being able to look forward to events. Likewise, the negative qualities emerge—blaming oneself unnecessarily, crying, and being worried. Importantly, the positive qualities delineate a universal idea of normal motherhood; the negative qualities are seen as universally abnormal.

The Strange Situation is another primary research tool deployed in the Hanover Park Project. With the EPDS, the lines of normal and pathological motherhood are defined solely forming the mother into an object of study and knowledge. In the Strange Situation, mother-infant attachment is the object of study, and the child is fashioned into an object as well. The interactions between mother and baby are studied through setting
up a series of three-minute separation and reunion episodes. Originally outlined by Ainsworth to be carried out in a laboratory setting, other researchers adapted the Strange Situation to be enacted in the home. Researchers typically codify the substance of mother-infant attachment, for the first three months of the baby’s life, in terms of the following factors: gazing, pre-speech, touching, and vocalizations. Psychiatrists are particularly concerned with gazing and facial expressions. Gazing refers to how the mother and baby will gaze in one another’s eyes. Sharing this kind of gazing while breastfeeding is seen as a particularly positive type of attachment. Pre-speech refers to how a baby will move his lips, smile in response to his mother’s smile, and so on.

Studying mother-infant attachment through these factors (measuring the duration and type of gazing) developed directly out of relying on film and video technology in the laboratory. This technology was used to refine psychiatric methods of studying child behavior, and this technology in turn produced new objects of study. Murray writes that since the 1970s, meticulous descriptions and observations of mother-infant attachment have been “greatly facilitated by advances in video and film technology.” Moreover, “These methods of recording ‘natural history’ have been accompanied by the development of increasingly refined and elegant experimental procedures for presenting the world to very young infants” (Murray 1997:165). Psychiatrists argue that they are granted special access into ‘nature’ through the refinement of technology. Film technology helps psychiatrists to see within nanoseconds how the expression on a child’s face changes when his mother leaves or enters the room. These observations and experiments provide the raw material out of which “normal” mother-infant interaction is figured.
Murray’s above statement reveals a tension within psychiatric knowledge production. Sarah Franklin examines a similar tension within scientific practice at large. Discussing assisted conception technologies, she describes a paradox—it is only through the helping hand of science (in vitro fertilization) that nature (having a child) can come to its full fruition. In assisted conception, as with mother-infant attachment, we see how scientific practices are enmeshed in progress-oriented projects, and in a certain type of temporality. Franklin writes that within scientific quests for knowledge and improvement, “humanity comes to be seen as both descended from and consanguineous with nature, at the same time that human society comes to be seen as modeled on a departure from the state of nature through the invention of social laws” (1997:98).

This point gets at the very heart of what mother-infant research and interventions are all about. Psychiatrists, through repeated experimentation and observation, discover the exact nature of normal mothering and attachment. Normal attachment is codified into a list of normal behaviors—gazes that last more than five seconds, mirroring the baby’s smile, talking to him as if he is a little adult. Technology—a video camera, a stopwatch—enable the psychiatrists to see this natural relationship. This technology also enables them to discover women who have lost their natural capabilities to mother. Then, the psychiatrists must intervene to educate her about how to mother. These interventions thus become part of an effort to not only save children from deviant mothers, but to improve upon natural mothering. Like athletes who take performance-enhancing drugs to become better than human, the mother can collect a slew of psychiatric techniques to improve mother-infant attachment beyond its natural state. Under this framework, researchers not only discover nature, but also become integral to improving it.
Tomlinson’s Hanover Park project and Thula Sana project are part of this framework. Tomlinson enters himself, his research team, and the mothers and infants he studies, into a transnational circuit of exchange that pivots around the issue of PND. On one hand, he is adding to the project of psychiatric knowledge production by showing how “Africa” fits in. On the other hand, he positions his projects as integral to democratizing South Africa, because it will help women living in townships to become better mothers. Looking more closely at Tomlinson’s reasons for conducting these projects illuminates how his project realizes Western science. It also sheds light on how the “township woman” is figured through his projects.

The Shape of Research: Indigenizing Global Psychiatric Practice in South Africa

Tomlinson and his team of psychiatrists state that they had two goals for conducting the Hanover Park Project: to quell child abuse, and to see whether mother-infant interventions developed in the UK and the US are implementable in South Africa (Tomlinson, et. al. 2003:206, 208, 210). That is, while the immediate goal within the sample was to improve mother-infant relationships, the psychiatrists carried out this project as a kind of pilot study to test whether mother-infant interventions developed in the West could be carried out at all in South Africa. Here we see the convergence between humanitarian desires to quell child abuse and the scientific pull to start defining what psychiatric research was going to look like in the post-apartheid era. For Tomlinson and his colleagues, defining the shape of psychiatric research is integral to stopping child abuse—only through the collection of psychiatric facts about mother-infant attachment could the humanitarian project to end child abuse be fulfilled.

The major problem facing the researchers in carrying out the Hanover Park Project, according to Tomlinson, is one of methodology. In the late 1970s, British researchers
established that depressed maternal mood had a negative impact on child development (Cox 1987; Murray and Cooper 1998). Olds (1997) and Olds and Korfmacher (1998) began pioneering mother-infant interventions in psychiatry in late 1980s North America. Regarding Olds’ research, Tomlinson et al. (hereafter, Tomlinson) write that his studies Were conducted in a context of active support for research in the social sciences, and in a country that is politically stable…Olds’ work assumes a degree of infrastructure that is not commonly available in developing countries. There is the difficult question of how to implement programmes where insufficient resources do not allow for a careful assessment of efficacy prior to implementation. Resources are constrained in terms of funding, personnel, assessment tools, and research experiences and expertise. The social scientist committed to both methodological rigour and to social change in a poorly resourced society is in a state of constant ambivalence. (2003:205)

Methodologies developed in transnational psychiatric practice and literature create the dominant experimental paradigm for conducting research into mother-infant interactions. However, carrying out these methodologies requires infrastructure and resources not present in South Africa, such as orderly mental health wards, psychiatric nurses, and filming equipment. Hence, Tomlinson sees a tension: the US and the UK have hegemony on scientific knowledge production, and researchers such as himself are located in a peripheral zone where scientific standards developed in the West simply cannot be met. Tomlinson narrates himself and his researchers as a group who struggle to conduct methodologically rigorous science in the face of lack. Throughout the article on the Hanover Park project, which Tomlinson published in the South African Journal of Psychiatry (2003), the reader is presented with all that South Africa lacks: infrastructure, well-kept patient records, and clean mental health clinics filled with professional psychiatric nurses. Other anxieties enter into the margins of Tomlinson’s scholarly articles. In 2002 British Journal of Psychiatry piece on another mother-infant project carried out by Peter Cooper, Mark Tomlinson, and others, Cape Town, the research team
writes that tracking down women as potential objects of study is difficult in South Africa, because women often lie about their address to receive services at obstetric facilities better than the ones in their own neighborhoods (Cooper, et al. 2002:77).

Thus, Tomlinson and his team are not robotically applying global standards of research in South Africa—he is trying to reformulate them and adapt them for South Africa, working around what it “lacks.” Despite methodological restraints and problems with locating research subjects, Tomlinson carried out his project. He consistently positions psychiatric mother-infant research and intervention as integral to South Africa’s democratization process and its building of a human rights culture. He states, “At this critical time in South Africa’s history—the first year of democracy—there was a strong feeling from influential players and activists in the child health and child rights fields that such a project, however small, should begin” (2003:207). Tomlinson specifically states that the value of the Hanover Park project does not lie in the scientific knowledge it produces. According to Tomlinson, the project cannot produce valid scientific knowledge anyway because of the methodological problems (money, infrastructure, etc., discussed above). Instead, he claims that it is valuable because it demonstrates to the government and local community that child abuse is a real issue of concern. He states: “When a non-governmental organisation enters a community and attempts to deal with a social problem—such as child abuse—it’s delivering a message about how seriously the problem is taken. This message is delivered regardless of the strength of the intervention design” (2003:208).

In a sense, Tomlinson sees the Hanover Park Project as a really important performance directed at a number of different audiences. He sees this demonstration as
targeting three different groups. First, it demonstrates to the mothers directly implicated in the projects that child abuse is not to be tolerated. Secondly, the community in general is a target. The ongoing surveillance of the community workers is meant to remind everyone in Hanover Park that child abuse is not acceptable (2003:208). Finally the state is an audience—by generating publicity about child abuse, the Hanover Park project became leverage for the psychiatrists’ demands for more funding.

Tomlinson recognizes that science functions as a powerful signifier regardless of whether the science being done conforms to international standards. Moreover, he argues that in the race for funding, it is better to go ahead with projects despite methodological problems. He writes:

If we wait until we have better data to advocate for resources in our area of interest, there is a strong chance that competing claims for resources will be heard and responded to, thereby sidelining early intervention work on an ongoing basis. Many of these claims, ironically, will be made by activists and lobbyists who rely even less on scientific knowledge than we do. (2003:210)

One of Tomlinson’s main concerns is the lack of government and international funding available to fund projects such as his. He links these problems South Africa’s democratic transition. He writes, regarding the shift from apartheid to liberal democracy:

Funding for innovative projects has been severely curtailed, especially as international agencies, regarding South Africa’s political transformation as sufficiently complete, have turned their attention to other areas perceived to be more in need of, or of greater strategic benefit to, their programmes. Budget cuts in the higher education and specialized health sectors, all of which are necessary for a more equitable distribution of resources, have led to decreased capacity in traditional areas of strength in terms of services and research. (2003:210)

Two points emerge from this quote. First, Tomlinson does not entirely blame the transition and the new government. He sees the lack of resources problem as directly related to the global political economy. He critiques international donors who drastically shift the amount of money they give to particular states because of cosmetic political
shifts. Tomlinson articulates a sudden international abandonment of South Africa. He also states that the anti-apartheid struggle—accompanied by the global circulation of images of a black proletariat—was a “sexy” political cause for international donors to take on. South Africa organizations affiliated with the struggle were haloed with symbolic power when it came to garnering funds. As Tomlinson puts it, “Many programmes that were initially funded on the basis of their commitment to transformation in South Africa currently have to reconfigure their way of working, as more emphasis is placed on outcomes rather than aims” (2003:207).

Tomlinson’s point reveals how civil society and NGOs within South Africa must drastically recast their work within new global and local configurations. While previously, affiliation with the liberation struggle was sufficient to receive international money, NGOs and researchers now must produce immediate outcomes. Tomlinson argues such emphasis on results can be destructive to the pursuit of scientific knowledge that happens within projects that are meant to garner societal benefits.

In a broad sense, Tomlinson is trying to indigenize global science to a local South African context in his article. He argues that South Africa is different from the US and the UK, and that sometimes in South Africa, the value of science lays in its social significance and not in the knowledge it produces. He cites historians of science to argue that science is often a local and social practice anyway. Interestingly, while Tomlinson asserts that scientific practices need to be refigured when they are used in South Africa and the rest of the ‘developing’ world, he does not question the methodologies themselves. Tomlinson believes that surveys such as the EPDS and the Strange Situation can be used anywhere in the world, since the “stuff” of mother-infant attachment—baby
and mother gazing into each other's eyes while breastfeeding, cooing at one another—are human universals.

In sum, Tomlinson explicitly narrates these projects as humanitarian interventions. His goal was twofold—to help end child abuse in the townships and to demonstrate that PND research can be carried out in Africa, as long as the researcher is able to deal with the methodological restraints. But the question remains—why were his projects carried out in Khayelitsha and Hanover Park, and not the suburbs? The next section addresses this issue, arguing that part of the reason lies in the ‘value’ of the figure of the African child.

Castaneda argues that figures accrue value over time, that certain figures become weighted down and sedimented with meanings. These figures are also “valuable,” in that they can be invoked to make truth claims, or to make claims to political legitimacy. Warwick Anderson writes, reviewing literature on colonial medicine, that the “third world body” has become one of the most salient representations constantly redeployed in scientific, political, and medical discourses. Similar to Mohanty’s treatment of the category “third world woman,” Anderson writes how these third world bodies were and are articulated:

Colonial medicine was a socio-spatial discourse that becomes reframed as a discourse on human rights and governmentality during the twentieth century. Medical experts continued to represent African and Asian bodies as diseased, lazy, and grotesque—as symbolic inversions a European social body—but they also began to hold out the hope that a colonial body subject to strict protocols of personal and domestic hygiene might reform itself, or rather, that an individual might use these technologies of self-care to acquire a generic citizenship. (1998:235)

It is useful to reread Anderson’s discussion of representation along the lines of Haraway and Castaneda’s concept of the figure. In this reading, the third world body is a
historically contingent figure that has been rendered out of medical, political, and scientific discourses and practices. The Hanover Park mother-infant attachment project can be analyzed a site where this third world body is figured and mobilized. But more specific figures emerge out of this project—the figure of the African child, the urban black woman, the black family, the black township, and the scientist as humanitarian hero.

Anderson argues that the ideologies underpinning colonial medicine are reproduced in discourses on human rights and governmentality. This is apparent in the Hanover Part project. At a moment of transition in South Africa, when nationalist rhetoric is celebrating the building of a human rights culture as the centerpiece of the new state, Tomlinson positions mother-infant attachment research as integral to such a project. He does this by invoking the figure of the African child, and fashioning mother-infant attachment intervention as a way to quell child abuse. Tomlinson succeeded in this, as the state did offer him a small grant. How did these research projects figure township women and their children?

**Figurations: The Township and its Women, Children, and Families**

Psychiatric mother-infant research and intervention is based on a fundamental concept—that “normal” mother-infant attachment (the mother-infant bond) is required for “normal” child development. Psychiatrists separate out biological and environmental factors in child development, and as psychiatrists, concern themselves specifically with how the environment negatively or positively influences child development. Importantly, the mother is literally seen as the sole environment of the infant. Murray (1997:159) writes, “It is in the postnatal period and the ensuing months, more than at any other time, that the infants primary environment will, in all probability, be the mother herself.”
When the child’s environment is isolated out so that the mother is the only environmental factor, maternal mood takes on paramount importance. Maternal mood is seen as one of the most important factors in securing a normal bond. If the mother becomes depressed, she compromises that bond, which in turn compromises the development of the child. As Jacobsen puts it, “the depressed or psychotic parent is the primary environment of the child,” and is such a pathological environment, the infant ceases to have access to normal developmental pathways (1998:19).

Importantly, it is the mother-infant bond that becomes the central object of study for psychiatrists. On the periphery, they conduct research singly on the mother and singly on the child. This is very apparent in the Hanover Park project. The mother is administered the EPDS at the very beginning and very end of the study, and cognitive tests are administered to the child upon completion of the study. But the substance of the project work is the 104 visits made to the dyads, to watch how they interact, and to intervene if necessary.

The primary reason psychiatrists give for the importance of the bond is that this bond will determine how the infant interacts with the rest of the world for the rest of his or her life. The major mother-infant attachment researchers see the infant as having only one environment—the mother—for the first few months of life. If the mother develops a normal bond with the child, then the child is empowered to explore other potential environments. Jacobsen writes, “From the outset, an available and responsive parent fosters the possibility for offspring to develop favorably and to engage in effective exploration” (1998:120). But if the child is neglected, and no real bond has been established, he will be less able to explore the world effectively (Jacobsen 1998:120). “It
follows that he or she may be at increased risk for taking a less favorable developmental pathway” (Jacobsen 1998:120).

Tomlinson and his fellow researchers adopt an idea of child development that is outlined in the work of Bowlby (1988, 1987) and Waddington (1957). Jacobsen summarizes this position (1998:131-132). Child development is understood is taking one of several distinct pathways—some which are considered to include “positive adaptation” and others that are marked by “negative adaptation.” From the moment of conception and onwards, the fetus and then the child face a narrowing range of potential pathways. Jacobsen writes, “Change becomes increasingly difficult after ‘sensitive’ developmental periods have passed” (1998:132). In the scholarly and lay literature that discusses the mother-infant attachment projects in the Cape, the child, the township, and the family are narrated as being caught up in a negative developmental pathway. While the township, the family, and the child are all articulated as malleable, the child is invoked as the most open to possibilities for transformation. On a continuum of which bodies are more changeable, the child emerges as having the greatest potentiality

This helps to make sense of the disappearances and reappearances of the mother in Tomlinson’s mother-infant research. In psychiatric literature on mother-infant attachment, the potentiality of the child becomes contingent on the potentiality of the mother. If “the depressed or psychotic parent is the primary environment of the child” then it is the potentiality of the mother that takes precedent within the confines of any particular intervention. Yet, in every popular and scholarly article that has been written by the psychiatric investigators of the Hanover Park and Thula Sana projects, it is the child that is most often invoked as the reason for conducting the studies. The psychiatric
teams invoke the figure of the child to make two claims. First, they invoke this child to legitimate their claim that more research on postnatal depression and mother-infant interactions should be conducted, so that better interventions can be designed and carried out. Secondly, they call up this child to argue that the economic conditions of the developed world, in general, should be improved. Cooper et al. write:

Not only is children’s developmental progress likely to be compromised by the extreme levels of social and economic adversity which obtain in the South African context (and in similar situations around the developing world), but it is likely to be further jeopardised the impact of such forces on the quality of care infants receive from their mothers. It is, therefore, of paramount importance that interventions are developed and evaluated to support mothers and families living in indigent peri-urban contexts in caring for young infants. (2002:79)

Here, postnatal depression is not mobilized as a woman’s issue, or a feminist issue, as it so apparently is in the discourse of the Postnatal Depression Support Association. Postnatal depression here becomes a (global) children’s issue. The 34% prevalence of postnatal depression in a South African township, which the psychiatrists discovered, is used as evidence that the global political economy endangers children through creating social and economic conditions that create bad families. The child quite literally comes to embody the failure of the world to protect Africa’s children. Yet, it is precisely the failure of the child that allows the status of its mother to rise as something worth investing in. At first the mother disappears; in her place, the global economy emerges as the primary actor in this drama of abnormal childhood development. Yet, she reappears as that which must be targeted if the problem, of being a developing child in the developing world, is to be remedied.

This disappearance and reappearance of the mother happens in other media as well. In 2002, a BBC News health report (UK online edition, May 19) on the Thula Sana project appeared. The article, topped by a photograph of a baby, is titled “When the baby
is no bundle of joy.” The woman in whose lap the baby is sitting has been cut out of frame—here, the baby is being invoked, not the caretaker. However, the community workers who are interviewed in the article do speak about mothers. One researcher states: “We mediate and help the relationship between mother and infant rather than treat depression.” Another reports: “Mothers distance themselves from their baby and might push other children around. We want them to see the babies as an individual with their own feelings. It’s not just a doll, it’s a person.” The community workers thus articulate their role as one of intervening into the relationship between mother and infant.

In the scholarly and popular articles about the Hanover Park and Thula Sana projects, visual and textual representations figure South African townships as quagmires of urban decay. In the BBC article, we read that Tomlinson’s findings of a 34% prevalence of postnatal depression among South Africa mothers in “black townships” is linked to the social problems of “unplanned pregnancies” and “poverty, unemployment and lack of education” amongst other factors. In another article, Leslie Swartz paints a similar picture of townships and the people who live in them. Swartz is a preeminent cross-cultural psychiatrist in South Africa. He was employed by the Truth and Reconciliation Commission, teaches at the University of Stellenbosch, and aided Tomlinson on the Thula Sana project. In his piece, there are three photographs of Khayelitsha, the township where the Thula Sana project was carried out. One photograph is an aerial view of Khayelitsha, revealing its "unplanned” collection of shacks. Another picture shows shoeless children standing on a dirt path in front of some shacks, and a third photo depicts yet more shacks. The captions include phrases such as, “Living in poverty leads to overcrowding,” and “The population of Khayelitsha is expanding rapidly
due to the rapid rural-urban migration.” In this text, the break down of the family is linked to urban decay, a “spiral of violence,” and the persistence of traditions such as bridewealth exchange. This article figures black township residents as a dysfunctional population, an organism that is breaking down and taking the family with it. Swartz narrates these people as caught “in a frightening and rapidly changing world” (2001:4).

Conclusion

This chapter analyzed psychiatric research into postnatal depression in Cape Town townships. It revealed how PND is fashioned as a children’s rights issue in the townships. PND researchers conduct projects in the townships in an attempt to democratize psychiatric science and contribute to building a culture of human rights. In deploying their research methodologies, as well as humanitarian narratives, they generate the figure of the “township woman.” They also circulate narratives and images of the “African child” as the reason for conducting their research. These PND research projects conducted in the townships often reproduce apartheid era ideas of the urban black family and the township, but they also mobilize the “African child” as a key figure in their political work. The research also powerfully contributes to fashioning PND as a truly global issue, just as it legitimizes science as having a universal applicability. At the same time, the PND researchers work to indigenize “Western” methodologies for South Africa. This chapter reveals how feminist knowledge of PND can disappear, as different activists take up the issue in different locales, even within the same city. The feminist knowledge that is mobilized by the PNDSA in cyberspace, among their community of “Western” women, is not deployed in the townships.
CHAPTER 6
CONCLUSION

A main goal of this thesis has been to examine in detail how the types of knowledge feminist activists mobilize are intimately connected to the types of communities that such activists are able to build. It has centered around two sets of questions, the first inspired by medical anthropologists (Young 1995) and science studies scholars (Dumit 1996), and the second inspired by women’s studies work (Mohanty 1991). First, I asked: Who takes facts up? Which facts, and why? Where do the facts that get taken up come from? Throughout the chapters, I trace which facts specific feminist and human rights activists mobilize. Employing Castaneda’s concept of “transnational circuits of exchange,” the thesis thus adds to understanding how knowledge moves across national spaces as people try to consolidate feminist communities. For instance, I show how the PNDSA deploys medical and feminist knowledge about PND, from British and North American texts, to create a community of “Western” women on their website and chat-room. The PNDSA, and its affiliated researchers, contribute to the fashioning of PND as both a South African and transnational feminist issue. However, who is enabled to partake in the community, which is created through the work of the PNDSA, is limited by the methods of consciousness-raising they use—i.e., primarily Internet-based; primarily English-language; and primarily informed by a cultural logic which naturalizes the experience of middle to upper-class women.
Donna Haraway and Ian Hacking have noted that a striking feature of the contemporary era is the extent to which scientific facts have become morally and politically valuable. I have put a few South African cases under a lens to provide a detailed snapshot of how certain individuals take up, produce, or pursue certain facts. Using these South African cases as examples, I address the question of what the implications are of this global trade in facts—namely, the types of differences and alliances that are generated through this trade. This brings me to my second set of questions: How are feminist alliances created—who gets brought in, and who gets left out? Who is called on to speak, and for what purpose? Why do certain representations, of certain types of women, persist over time and what is at stake in perpetuating them? I posed these questions, in order to get at the larger question of what it means to practice feminism in post-apartheid South Africa.

This paper has focused on feminist and human rights activists who hold positions of power within civil society, and who are also part of the middle to upper classes. The individuals who I focus on are first-language English speakers, many of them hold university degrees, and live in urban centers. I by no means try to paint a representative picture of what most feminist politics look like in South Africa—but I have examined how two methods common to many feminist activists are put to political use—the pursuit of scientific facts, and the collection of testimony. I hope the thesis raises some questions that could be pursued in much greater depth.

First, it is clear in the chapter on the Gender Report that the demand for certain types of testimony—such as traumatic stories about sexual violence—may be met by a refusal. The fact that so many of these women, who were called to speak, chose instead
to narrate stories about family members who were killed deserves consideration.

Respecting the reasons why the Gender Report emerged as it did, and moving out of the realm of the TRC, some feminist activists may want to ask: How can a broad-based, feminist coalition be built when the demands of one group anger or upset or another? Many South African feminists have already made this point (see Grey 1997). From an anthropological or historical perspective, however, the issue of what it means to speak and what it means to be silent also deserve further study.

For instance, the historian Deborah Gaitskell has examined the important role that Christian women’s associations have played in the lives of many Xhosa-, Zulu-, and Sotho-speaking women throughout the twentieth century (Gaitskell 1983, 1990, 1995, 2000). According to Gaitskell, from about 1880 onwards, these associations became one of the few realms where South African women could and would speak openly about sexual and domestic matters. In prayer meetings, women would wail and pray about errant husbands, and promiscuous sons and daughters. Likewise, members provided other members with a system of practical and emotional support if problems arose at home—if, say, a member was being abused by her husband, or if a member’s daughter fell pregnant outside of marriage. Gaitskell’s work reveals that many South African women do have institutional spaces where they are by no means “voiceless” about sexual and domestic matters.

However, to continue using Gaitskell’s work as an example, her research begs two questions—one that is very relevant to getting at the question of the politics of feminism in South Africa, and another that is important for anthropologists concerned with examining South African cultural politics. First, I anticipate a possible feminist response
to women’s Christian organizations. Namely, that making sexual and domestic violence into a *national* issue requires that women speak out about it in what is typically referred to as civil society—in civic organizations and within the national media—and within the legal system. From this perspective, churchly association is seen as possibly sufficient for aiding women therapeutically, spiritually, and sometimes practically, but insufficient for fashioning sexual violence into an issue of major national (and transnational) concern. How diverse groups of feminists within South Africa will attempt to reconcile such matters seems like a crucial area for feminist-inspired research. It is also draws attention to the question of how conflicting desires are to be managed by people who are articulating violence against women as a key obstacle to the larger democratization of South African society.

Secondly, how can anthropologists study these issues of speech and silence? The goal is not to simply say that “Zulu” and “Sotho” women all have their own separate cultures, which deal in their own separate way with matters such as domestic or sexual violence. This is precisely the type of argument that this thesis has tried to deconstruct. In fact, one issue I hope the thesis has thrown into relief is two extreme sides that some individuals may take around the issues of sexuality and reproduction. On one hand, I have shown how some—such as the authors of the Gender Report—argue that all women are all, at a basic level, the same because they share the same biological body and because they all experience the social fact of patriarchy. While the uses of the position are numerous, the danger of it is that it may elide historical and cultural contingencies. As Mohanty has argued, this universalizing position also typically serves to naturalize the experience of some as the experience of all—thus upsetting many people who cannot
identify with the experience of this “universal” woman. On the other hand, as I tried to show through my analysis of the work of the PNDSA, there is another extreme position that essentially claims women of particular races and cultures are all inherently different. “Western” women are articulated as inherently different from “African” women.

I have by no means tried to argue that most South African feminists would lay claim to either of these extremes. In the above paragraph I greatly simplified the complexity of the narratives presented by the authors of the Gender Report and PNDSA activists. Both the authors of the Gender Report have committed their academic and civic work to trying to open up dialogue about what feminism can do for all South Africans in general, and the Report is just one small piece of their research and writing. Likewise, individual members of the PNDSA have their own complex readings of what PND means, as an issue facing all South African women, which differs from stances presented on the website. The purpose of juxtaposing the groups and individuals I have—and in sometimes simplifying their arguments—has been to highlight some of the key tensions, and key practices, that underpin the practice of feminism in post-apartheid South Africa.
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BIOGRAPHICAL SKETCH

Born and raised in California, I attended the University of California at Santa Cruz, where I received a B.A. in anthropology in 2001. I have undertaken undergraduate and graduate coursework at the University of Cape Town and the University of KwaZulu-Natal at Pietermaritzburg.