"An interventional workshop"

Exploring the effectiveness of a government intervention using educational content from the First 1000 Days of Life Campaign

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Definitions

- Cortisol-stress hormone
- DOH-Department of Health
- First thousand days- The time from birth to age 2 years
- FTDLC-First Thousand Days of Life Campaign
- Infant –a child from birth to 12 months of age
- KESS- Khayelitsha Eastern Substructure
- Maternal and Child health – sector of health that deals with pregnancy and the infant
- PSG 3-Provincial Strategic Goal 3
- SG 3-Strategic Goal 3
- WCG-Western Cape Government
- WCP- Western Cape Province

Content Page

Introduction

The Western Cape Government (WCG) in partnership with the Department of Health (DOH), has placed maternal and child health care one of the top priorities to strategically invest in. Maternal and child health care has become priority are whereby urgent action is required as a gap was identified in service delivery (Maternal Care guideline,2015).In response to this the provincial government has decided to adopt the First 1000 Days Of Life Campaign (FTDLC) in educational workshops for a wide range of health care staff. This adoption of the FTDLC derived from provincial strategic efforts to achieve the goals of the Western Capes Governments Strategic Plan for 2014-2019 .This resulted from public health planners ensuring that the vision of the WCG wanting to create a better "open opportunity society" is put into action (Goeiman, 2016: 1). A society like this would be one whereby poverty is eradicated and individuals have sufficient and efficient resources to reach their full potential (Western Cape Government, 2014:2). There are five Provincial Strategic Goals, and game changers such as using the FTDLC have been prioritised for implementation. "Partnerships between government, other spheres of government, the private sector, civil society and individual citizens have been identified as key components for implementation "(Goeiman,2016: 1). DOH has been tasked to lead Strategic Goal 3, which is to "improve wellness and safety, and tackle social ills". According to public health planners, the goal will be achieved through the following objectives which is

- *"Build inclusive, safe and health communities, nurture resilient healthy families, ensure safe and healthy children (0-14 years), promote engaged healthy youth (15-25 years of age)".*
- *To achieve " safe and healthy children" the need to strengthen early childhood by holistic social and health services, including education with an emphasis on the first 1000 days of life was identified as one of the key initiatives to improve outcomes for children." (WCP-2014-2016).*

The FTDLC is a scientifically backed holistic educational approach to the wellbeing of a child's first one thousand days of life. Sufficient nutritional, emotional and support from caregivers in this period of a child's life is crucial to the child's ability to reach their full potential with regard to child's health and development (South African Child Gauge, 2013:44). "The initiative provides opportunities for lifelong health and wellness for children in the WCP through the implementation of health specific interventions, intersectorial interventions and effective communication" (Goeiman, 2016:2).

Although many policies have been put into place to try to improve service delivery, parenting information, support and training is not universally available to all South African parents(Parentcare.org:2016). Many South African parents are still trying to deal with the legacy of apartheid, which has created social issues such as; "degradation and poor self-esteem (Bond, 2005:18). Unfair economic opportunities resulting from the apartheid regime has led to high rates of poverty; violence; social fragmentation and family breakdown" (Parentcare.org,2016). The rate of maternal depression in South Africa is 35% i.e. one in three; 12% (i.e. one in eight) babies born in South Africa are to young mothers between the ages 15 and 19 and are often not yet ready to be a parent (Department of Social Development White Paper on Families in South Africa, 2012). This is a reflection from the Department of Social Development, therefore a reflection of the state's idea on child and maternal health. 2016 estimates indicated that close to 17% of South Africa's adult population was living with HIV; nearly eight percent of South

African children live in skip-generation households, where grandparents live with, and are responsible to care for, their grandchildren. Skip-generation households are described as "fragile" because the grandparents are struggling with their own personal health, custodial matters, financial constraints as well as the psychosocial and behavioural issues they face with their grandchildren (Department of Social Development White Paper on Families in South Africa, 2012)

Recommendations to improve the quality of the first thousand days' window are now known and governments in certain parts of the world have engaged with some of these (Majombozi, 2013:4). These include promoting good nutritional practices for mothers and young children (such as breastfeeding and appropriate, healthy complementary foods for infants), providing psychosocial support in maternal and child health services and a focus on early childhood development (1000days.org,2016). Some of these recommendations have translated into policy changes in South Africa, for example the, The Tshwane declaration of support for breastfeeding in South Africa. This was a policy which got formula banned from clinics so that mothers could exclusively breastfeed (Majombozi, 2013:5).

However, South Africa still has many challenges in sustaining efficient and sufficient maternal and child state health services during the first thousand days of life. Poor nutrition in life has had recognised effects on a child's neurological, immune and physical development (1000days.org,2016). However nutrition is not the only factor in child development to address the poor health and wellbeing of children affected by poverty (Agerholm., Arabena.,Kvernmo., Johnston., Panzonno., Rowley,2016:46) and a more broader approach is needed. The Western Cape Province has acknowledged these interrelated challenges and the WCP has taken steps and decided to use the broad holistic approach of the FTDLC in an educational interventional workshop. The goal of the FTD initiative is to ensure optimal, holistic wellness for children and families (Goeiman, 2016: 3).

This dissertation describes the engagement undertaken at a provincial level to raise awareness about the FTDLC amongst maternal and child healthcare service providers. This was done through educational workshops to raise awareness about the campaign for a broad range of healthcare staff. The approach was a first of its kind, with the aim of becoming a continuous process in engaging the FTDLC from a state perspective (Goeiman, 2016:3). The end goal is to develop a conceptual framework for the first 1000 days of life and to "improve interventions beyond the first 1000 days of life" (Goeiman, 2016:3). The engagement process was premised on the basis that no single policy could solve the increasingly complex social issues faced by poverty-stricken families in the Western Cape. The campaign would require an approach from multiple sectors, aligned to the common agenda of privileging the voices of vulnerable mothers and children (Goeiman, 2016:4). This was through educational workshops whereby their input was asked for on what is needed for the campaign to be implemented and improve maternal and child healthcare services in the Western Cape.

This initiative was built on an earlier decision: In 2011, at a Provincial summit a decision was made to include Wellness in health public health campaigns (Source,2016). By acknowledging the challenges, the WGC as taking steps by using the FTDLC to move " a society from illness to wellness by 2030"(Goeiman, 2016:3).The vision expressed within healthcare documents from the WCG was to create a society whereby citizens become responsible for their own health.

The first specific input regarding the First 1000 Days at a provincial level occurred in May 2013, when a senior dietician at Stellenbosch University presented this topic to WC DOH and

CCT colleagues in the Parent Infant & Child Health (PICH) provincial meeting. The paediatrician who chairs the PICH meeting and co-ordinates Child Health programmes in Metro East, Dr Elmarie Malek tapped into the growing international focus on the FTDLC when she attended a conference in Edinburg, and disseminated what she learned to the PICH committee amongst other fora (Source, 2016). She is part of the Provincial First 1000 Days working group, chaired by Hilary Goeiman (the Director of Provincial Nutritional services). The provincial colleagues have collaborated with Dr Virginia de Azevedo, (director of City Health services in Khayelitsha) and Janet Giddy (Maternal and child health programmes, KESS). This group provides clinical governance to city healthcare services, in planning maternal and child healthcare programmes and interventions. Through that capacity, City and Province have been working on various programmes, which provided content and connections for the First 1000 Days Roadshows to commence.

In response to key stakeholders raising awareness around the First 1000 Days, the Western Cape government launched an official First 1000 Days campaign in February 2016. This was intended to be an intersectoral campaign ("Working better together") as articulated by the Minister of health at the official launch:

> *"We realise that health and wellness requires a wider response than any one department can deliver, and that's why the Department of Health and Department of Social Development (DSD) have joined together on the First 1000 Days initiative"*(WCG.org,2016)." Said Minister Mbombo (2013)

As a result of Strategic Goal three (SG3) in the strategic plan, the WCG has the goal of improving state services in order to address maternal and child health care gaps within the health system. This has been a result of national policy aiming to improve the lives of South Africans who are vulnerable and in need of assistance from the state. National policy has trickled down into provincial strategic goals and objectives. In the Western Cape governments strategic plan, the first one thousand days of life is noted as a key period whereby the state will try to improve the lives of children in underprivileged areas in the Western Cape, i.e.;

> *"Children demand and deserve special attention. Their earliest experience has the potential to influence them positively or negatively as future active citizens in their communities later in life. To achieve this outcome, we will strengthen very early childhood development by providing holistic social and health services in the first 1000 days of life, from conception to 2 years old, to prepare children for pre-schooling and education. We will also ensure access to capacitated and quality partial care (including ECD and Aftercare), and access to education for all children with disabilities." (WCP Strategic Plan, 2014:44).*

A child who does not receive proper and efficient health care is at risk of facing health issues later in life such as mood instability, psychosocial issues and stunted growth (1000days.org,2016).This impact's and increases the burden of disease on the government (WCG, 2014:43). However, according to surveys done by Afrobarometer (2015), South African people feel that there has been insufficient action from the state to address these issues, despite policy frameworks been in place to address and shape the process of resolving social problems. South Africans feel that there is a gap between the state promises of service delivery and the actual service delivery (Afrobarometer, 2015). I was interested in exploring this gap by following the process of one government intervention aiming improve maternal and child health services address issues faced by vulnerable mothers, fathers and children. The gap between government and service delivery is important to address because of the huge amount

of resources been pushed into government attempting to improve service delivery since the states regime shift from apartheid (authoritarian) to a democratic state (Bond, 2008:55).

The workshop was part of an intersectional intervention, whereby participants had to make connections and contacts within the idea of holistic services from the campaign and government sectors such as the Department of Education and Social Development had common goals with health programmes based on the campaign. “Person centred quality holistic child health services that promotes child wellness are strived for underpinned by good governance that increases access to information, in partnership with internal and external stakeholders”(WCG strategic plan 2014-2019). Therefore the goal of the initiative was to “provide opportunities for lifelong health and wellness for children in the WCP through the implementation and effective communication”(Goeiman, 2016:2) . Following implementation plans, DOH involved the various sectors from the WCG to implement the FTDLC. This involved departments like communications where awareness strategies about the campaign was spread through various means. These included health messages for optimal maternal and child health on stationery, badges, and the popular minibus taxis wrapped in the campaign logos.

The public health planning team facilitating the workshops had approached Fiona Ross the head of the FTDLC in Cape Town, and the head of the Anthropology Department to ask if a student would be interested in doing a report on the workshops and analyse it in some way .I had responded to this, with interest on with the question in mind, how does policy translate into action? However, I soon realised that the question I was trying to answer how is the workshop and effective tool of the government to improve maternal and child health services. To answer this question I had to then find out what the aim of the workshops was and if they were effective. I wanted to find out what the experience of the workshops had on participants and through this analyse the effectiveness of establishing coordinating structures for the first 100 days initiative would be, as declared by the government (Goeiman, 2016: 4). I realised this after my fieldwork, as my main interest was looking into how effective the policy would be, namely in this case, the policy was the Western Cape strategic goal plan, in conjunction with the new antenatal policy released this year.

Ethics and Methodology

I met with Dr Janet Giddy, a member of the FTDLC public health planning team, and Fiona Ross the Head of the anthropology department to discuss what they needed from me in terms of the research. This was a result of Fiona sending out an email to anthropology to students requesting if anyone would be interested in a research questioning relating to following policy into practise. My fascination with South African politics immediately sparked my interest in the project. In order to analyse the process I needed to attend meetings with the planning team, attend the first round of 6 workshops and interview workshop participants. I needed to request permission from the City of Cape Town by submitting an online request to do research. I would then be traveling with Dr Giddy to all workshops, as I did not have my own transport. It was agreed that I would follow up this process, and analyse the workshops. My question at first was directed at how policy transforms into practise. However, there was no actually policy in place, which compelled health staff to use the FTDLC content in public health training interventions. However, the workshop initiative stemmed down from national health policies, aiming to improve maternal and child health care services. The Department of Health needed a student help then, and therefore I was allowed into all spaces without gate keepers. The need for monitoring and evaluation in the form of a report opened all sorts of doors for me.

I used participant observation to do my research by attending six workshops in the Khayelistha Eastern Sub Structure (KESS). I also attending three meetings with Dr Giddy which were all related to public health planning to improve maternal and child health care. I was also then given access to all workshop material, which was pre- and post-workshop tests, workshop evaluation feedback forms as well as workshop group activity feedback forms. I also then did six interviews with workshop participants and then four interviews with the public health planners from the workshop. The process and access to everyone I needed was given to me because I needed to write a report for DOH. After each workshop, I took home boxes of workshop documents with me

I had to submit an online request to the City of Cape Town, to do interviews with workshop participants. Dr Virginia De Savo helped facilitate this. The participants were asked if they were willing to be interview on the register forms they had to fill in at the workshop. I was allowed to take the registers home, and contact participants who said yes. The registers had all participants contact details on. This was private information that I had access to and decided to keep it confidential. Therefore, in terms of ethical considerations, I had all gates removed with ease, access to private government offices and spaces, private meetings with heads of public health departments in the Department of Health. I was helping DOH with the report and they were helping me with access to a field of my interest to study for my honours thesis.

As far as ethics were concerned, I remember wondering at the time, if I would be harming the government in some way, if the workshops received negative or unsuccessful feedback. Yet, I did not have capacity to physically or harm anyone through my research methods. I was in private public health planning meetings, as well as a private settings for healthcare workers receiving an intervention. Private stories were discussed from Heads of Departments which I could have access to and spread through my own personal capacity. However, I had agreed to keep all names anonymous, and instead of focusing on people, I shifted my focus to the practises of the state becoming spatialized through these meetings.

The main ethical consideration I had to consider was the public health planners, and their personhood. I was invited into their homes, vehicles and everyday jobs. I therefore had capacity to ethnographically analyze their everyday livelihoods, and their effort to improve maternal and child health. This was because they all held power to improve the livelihoods and essentially the potential of children within the Western Cape (based on the governmental goals from using the campaign). Therefore, using this experiences I could potentially and ethically damage the reputation of the government in the Western Cape with an analysis on government staff. However, this was not my intention as I was interested in critical analysis of the government system. This would have been done by been in the private spaces of the public health planners, as well as governmental staff and how they received the intervention. I was on two sides of the intervention- the giving and the receiving. Both dynamics I had access to throw a light onto the functionality of the government, as well as the livelihoods of government employees. The main ethical consideration was posing a negative eye on the government. However, for me, this ethical consideration was positive as it could potentially expose a gap within government public health planning, and therefore lead to more effective and efficient approaches.

The workshops were the first to use content from the FTDLC in an initiative to " establish and strengthen networks and because it was a collaborative project with two public health provincial institutions which have a lot of tension between them, people involved in the project were keen to speak to me and open up about the project. With little to no gatekeepers and a wide range of workshop participants, I was good to go, and off I went. Dr giddy facilitated the whole process of getting me to the workshops as well as introducing me to everyone I needed or wanted access to, to answer my research question. At each workshop, she introduced me to all public health planners involved in implementing the FTDLC initiative. The main question I had to keep in mind was what was the aim of the workshops and was the public health intervention effective in improving state service delivery? My focus changed from walking the map of powerful state documents as a tool of government, to focusing on effectiveness of the workshop as a technical tool of state governmentality.

My role in the process of analysing, consulting, and ethnographic study on the workshop meant I became part of the team, which was initiating the whole process. This meant that during the workshop, I could help in various ways. I handed out pamphlets, welcomed participants to the workshop. I became someone who could assist and help the team in the administration of the workshop. I welcomed participants, showed them where to find the register as well as where to sign it. The team as well as I needed the register to capture the participant's names and as previously mentioned, willingness to be interviewed. In addition, some participants had to sign the register and scan it to their bosses, as some had to request time off from work to attend the workshops.

Literature Review

The fieldwork I did examines concrete manifestations of modern government. Therefore, literature analysed focuses on the way authors have examined the way government becomes materialized in specific practises. Essays reflecting on the three themes of governmentality has often revealed an all too common theme of government, whereby interventions have failed because development is done without those needing development. These three themes include reasons, subjects and technics which are discussed later in this chapter. This is what Inda (2005) calls the "Foucauldian anthropologies of modernity". This analysis resulted in my understanding and watching the process of the technologies of government been put into practice.

Using Foucault's (1984) governmentality theory as a basis to understand and describe the intervention revealed gaps in the maternal and child health intervention using educational workshops. Foucault's (1984) thinking on modern government is articulated in a series of lectures named "Governmentality". These lectures provide a genealogical analysis of the art of government. Questions articulated from the series which was based on how best to govern, how to be governed and how to govern oneself and others (Inda, 2005:2). From the analysis, Foucault (1984) provides us with a major shift in understanding political rule, which lies in a sovereign notion of power to an art of government , i.e. the shift from authoritarian rule to democracy (Inda,2005:3). Inda (2005) argues that the key finding from Foucault's (1978) lectures is that what really counts in governmentality is the complexity of men and things, whereby it becomes the fundamental target of government (Inda, 2005:3).

According to Inda (2005) this means that, the target of government is no longer about imposing law on people but rather arranging things to produce an appropriate and convenient end for each thing that is governed. In the case of the workshops, public health service delivery was been governed through education based on a scientific campaign. The educational content was supposed to raise awareness to improve maternal and child healthcare services. Inda (2005) argues that for government, territory nor law hold much significance but rather that people and things be administered in an efficient way.

"The welfare of population and improvement of its condition, the increase of its wealth , longevity, health and so on, the means , whereby the key interest of the government becomes population"(Inda,2005:5). As this interest grows, a technology of power takes place which Foucault (2000) names *technology bio power*. Foucault (2000) argues that that biopower designates "what brought life and realm of explicit calculations and made knowledge power an agent of transformation of human life" (Foucault, 1984:143). My fieldwork allowed me to witness these happenings through meetings to plan for public health interventions. Each meeting and feedback from public health planners manipulated how health care service delivery will be provided to citizens.

Biotechnology plays out in two different forms, one is the biopolitics of whereby "citizen's bodies become imbued with the mechanics of life such as life and death. The other is through the power of the belief and inference that state health interventions are the best methodological interventions to improve wellbeing, as inferred by government (Inda, 2005:4).Through a biopolitical attempt to improve healthcare service delivery, a scientific campaign was used to increase awareness about the best journey for mother hood. Therefore biopolitics can be used as a basis to understand an attempt to regulate the phenomena that typify groups of human beings, in this case, vulnerable citizens who rely on state healthcare during their children's FTDL

The second form of is what Foucault (2000) calls anatomy politics, which is the management of population: "in its depths and details" (Inda ,2000:219). Simply put, biopower is state power centred on a person's body. The will of the state is carried out through interventional process centred on a person body. In the case of my research, it is centred on mother and children's bodies, through education using the FTDLC. Here, a person's body is objectified to be manipulated to reach a goal created by the state. Based on a various policies and state strategic goal plans the public health planners used the workshop as a tool, which reflects Foucault's (2000) idea of modern power. The goal of the state's approach is to optimize the use of the state healthcare services, through a scientific holistic approach to delivering maternal and child health services. Therefore, Foucault's (2000) analysis on the art of government, i.e governmentality is not simply about governing. It is about the process of public planners, making sufficient and efficient effective ways to improve state services. I draw attention to the strategies, tactics and authorities of the state that simultaneously mould and conduct individual behaviour. This moulding been with the ambition to "create welfare for all, better together", or: this city works for you", as the logo of the City of Cape Town (CCT) states.

However, after spending time in the workshops and in various clinics, it became clear that public health planning was far removed from the everyday experiences of health workers. Implementing a campaign based on the science of the FTDLC , is very difficult and cannot happen through the simplicity of a workshop. The workshop insinuates that services should improve through healthcare staffs personal capacities, and that each workshop participant should take the message learnt home, and try to implement it in order to improve healthcare services within their individual capacities. However, this is not possible without adequate resources from the state.

Foucault's (1984) governmentality then allows us to analyse how practises of government become intertwined with specific truths and "vocations of experts and authorities. This is what my fieldwork explored and using governmentality explores this. My role through my fieldwork is to analyse what "counts as truth, which has the power to define truth, the role of different authorities of truth, and the epistemological institutional and technical conditions for the production and circulation of truths" (Rose, 1999:30). Therefore, my fieldwork shows how governing is possible within particular epistemological regimes of intelligibility. This type of analysis therefore reveals the amendable gaps in the art of government. According to Rose and Miller (1992) government administrative authorities are framed in problems of problems that need to be addressed. This is usually in relation to particular events such as epidemics or realms of experience such as poverty, crime and teenage pregnancy (Inda,2005:9). This was evident in the basis of using the workshop as a response to social issues in the WCP.

Therefore, Foucault's (2000) analysis on the art of government is about governing about the methods of public planners, in making state services efficient and sufficient. Therefore, government in this context takes place within and outside the "state" within government public health planning, as well as health interventions to health care service delivery workers .Therefore using Foucault's (1984) approach to governmentality, I draw attention to the strategies, tactics and authorities of the state that simultaneously mould and conduct individual behaviour. This intent to mould behaviour can be read in the motto "create welfare for all, better together", or "the city working for you", as the logo of the CCT states. The technology in biopower was motivated and aided by various policies, logos and bureaucracy.

The second analytical theme of governmentality literature involves the technique of government (Inda,2005:9). This entails the technological domain of practical mechanisms such as procedures and documents which authorities have shaped, "normalize and instrumentalize the conduct, thoughts, decisions and aspirations of others in order to achieve the objectives they consider desirable"(Miller and Rose,1990:8). Scholars concern with technologic domain reveals itself through attention paid to specific technical instruments, such as methods of evaluation. Important technical tools are what Bruno Latour (1986) calls material inscriptions, which are the tools such as surveys, reports, or in the case of my fieldwork; pre and post-tests, evaluation forms and workshop group exercise feedback on how to improve maternal and child healthcare services. Inda (2005) argues that these devices make things calculable and programmable, whereby things can be addressed materially and make it possible to be acted upon in reality. Therefore governmentality' literature concern with technologies of government draws attention to the importance of technical means in manipulating and directing the actions of individuals. Without this process, the conduct of government cannot take place (Inda,2005:9). My fieldwork therefore focuses and analyses this process, through the experience of me using these documents to write a report. It has two sides to the story whereby it focuses on how public health planners deliver this technicality of government, as well as takes into consideration of those who it is aimed for (In this case, state employees).

The third analytical theme of governmentality literature involves the subject of government. Scholars tend to ask, "What forms of person, self and identity are presupposed by different practises of government and what sorts of transformations do these practises seek?"(Dean, 1999:32). By focusing on subjects of governmental practises and programmes, scholars can understand how government seeks to cultivate particular types of collective and individual identities (Dean,1999:32). In this case, governmental practises were trying to cultivate responsible empathetic state workers who deliver maternal and child health services with increased empathy and care. Here, the aim of the workshops were to raise awareness about the campaign, in the hope of service providers been able to provide holistic services within their respective individual contexts. Another approach is whereby the focus on subject of government is to deal with how particular individuals cultivate their own selves and identities. Here, the workshop was doing this cultivation through educational approaches. Therefore, for governmentality, scholars have not only looked at forms of collective and individual identity promoted by practises of government, but also at how particular agents have negotiated these forms. Using governmentality I then approach and analyse the agents who are giving the workshop and receiving it to focus on how these agents have produced, embraced adapted and refused an educational intervention.

Using Gupta and Ferguson's (2002) work on spatializing states as a basis for understanding the workshops, I mapped and planned on how I understood and analysed the workshops. Gupta and Ferguson (2000) argue that an important theme running in new literature is that states are not simply bureaucratic apparatuses, but powerful sites of symbolic and cultural reproduction. Therefore it becomes possible to speak of states as "imagined" (Anderson,2001) through entities that are conceptualized.

Gupta and Ferguson's (2002) work on spatializing states argue that the imagination of the state has not adequately been attended to the way in which states are spatialized. They focus on how it is that people have come to experience the state as an entity with spatial characteristics and properties. This is made socially effective through particular imaginative devices, which is what I have studied in the workshops. The question Gupta and Ferguson (2000) pose is how do people experience the state as an entity with certain spatial characteristics and properties? To answer this, focus was on the "images, metaphors and representation practises whereby the

state becomes understood as an overarching concrete spatially encompassing reality" (Gupta and Ferguson: 2002, 982). Their argument is that through these practises, legitimacy of the state is made as well as the naturalization of authority. I had followed and observed this process happening through my participant observation in the workshops.

Gupta (1995) argues that studying the state ethnographically involves both the analysis of everyday practises of local bureaucracies and the discursive construction of the state in public culture (Gupta, 1995: 375). Such an approach raises substantial and methodological questions. He argues that this approach allows the state to be disaggregated without "prejudging their unity or coherence" (Gupta,1995:375). Methodologically, such work will highlight concerns about how a transnational institution is made local through localized practises. His work uses fieldwork on the topic of corruption to show how a negative discourse is a mechanism by which the state becomes discursively constituted. In addition to fieldwork, his approach to exploring the state was done by focusing on the discursive construction of the state; He does this by looking at how fieldwork is represented to state employees and citizens by focusing on newspaper texts. In my fieldwork, I could do this by focusing on how the state was represented, through feedback from state employees. I also focus on how the state becomes what happens in development, is mediated through multiple relays.

The implementation of development programmes is one of the process through which the state becomes legitimated (Gupta, 1995:379). However, in Gupta's (1995) ethnographic work in India on a programme to build houses, he found complex layers of corruption. The programme which was supposed to legitimate the states existence becoming alienated and regretted ever accepting the states help (Gupta, 19993:383). His work also found a contrasting instance, whereby the local officials were not satisfied with receiving the states work. His work found that at a local level is difficult to experience the state as a coherent unity, and what one confronts is a fragmented entity. In the case of Gupta's work, it is the fragmentation of land records, village works, and electricity boards. In the case of my work, the fragmentation of the state is found within the various documents of the workshop as an intervention. These dynamics will include workshop feedback papers, interviews with healthcare staff, and ethnographic work with public health staff.

Gupta (1995) argues that is through the practises of local offices that the state becomes imagined through. Although Gupta's (1995) work is on the discourse of corruption, which is different to mine, his work provides an anthropological lens to understand the discourse of the state with. Through this analysis, he draws attention to which the cultural practises through which the state becomes represented. These cultural practises in my work are embedded within the everyday lives of the healthcare staff. This can be seen and understood through the educational workshop.

He argues that representations of the state are formed, constituted, contested and transformed in public culture. Public culture "is a zone of cultural debate conducted through mass media, other mechanical modes of reproduction, and the visible practises of institutions such as the state"(Appadurai, 1990).Following the approach of Gupta(1995),his analysis of newspapers provided a idea of state imagination, Therefore analysis of state documents, which would be all the workshop feedback provides one with an idea of how the state comes to be imagined. The narratives studied in newspapers by Gupta (1995) were filtered by what he calls institutional filters" (Gupta, 1995:389). The documents I would be analysing were not filtered, and were verbatim, a true and narrative sense of current healthcare system for mothers and children in the Western Cape. For Gupta (1995) corruption was the means by which a complex picture of the state was symbolically constructed in public culture (1995). The multi-layered

diversity of classes was found in the construction of different newspapers for different locality. For my work, the multi-layered complexity of the state was found in workshop bureaucratic tools, such as group work feedback and registers.

Majombozi's (2013) masters dissertation on the work on the experiences of breastfeeding of four mothers who stay in Khayelistha. This was close to my fieldwork as the public health interventions I worked as interventions were targeted for the Khayelitsha Eastern Subdistrict as declared by the DOH. Her work was helpful as it laid out the platform of the current state of some mothers within the KESS region. With DOH prioritizing the FTD initiative, it was interesting to keep her work in mind, whereby I was sitting in the meetings of the very planning of services Majombozi (2013) critiqued. The research explored infants are not breastfed, despite the child health programmes, interventions, current policies and recommendations(Majombozi,2013:4).The study amongst six isiXhosa women in Khayelitsha looked at what were the breastfeeding experiences of women as well as what influenced womens infant feeding choices. In her conclusions, the women expressed that they did not trust the nurses and used different networks such as family relatives to get advice about her children. These findings were relative to my research, as most workshop participants were nurses. The experiences of the nurses shed a light on the everyday experiences of the nurses, and why they could be considered untrustworthy. The nurses in the workshop were mostly from the KESS area, and therefore could add to Majombozi's(2013) research findings.

The recommendations from the study were interesting, one been that she suggested that nurses have a more empathetic attitude and not impose harsh questions like if mothers are feeding their children as recommended by DOH. This work provided an interesting dynamic on what I was seeing, as it was the government side, suggesting to government staff how service delivery can be improved. So, Majombozi's (2013) work gave me insight on how mothers experiences receiving state healthcare. Mothers do not like been accused of not been able to care for their children, to the best of their ability. Therefore, using the FTDLC could once again lead to these accusations, by recommendations from DOH.

From state spatiality I move from meetings to the body, and how personhood creates the capacity for the states interests to play out. De Grazia (1997) argues that personhood is to examine critically the motivations and desires that move one to act and either identify with these desires or reject and work to change them" (De Grazia, 1997: 303). Participants and public health planner's roles and actions presented a lense to understand the gap between the voice of the state and what was happening on the ground." The person becomes progressively reified as a self-contained, self-shaping, independent agent—at least in ideology, though in practice there are new constraints and power-relationship" (Rasmussen,2008:32). The progressive construction of a person was something I could analyse in my fieldwork. By coming to the workshops, participants were adding a dimension to their personhood which was entangled in all other social dynamics of the workshop. Rasmussen (2008) inference of personhood was based on social capital, however could be used as a lens to understand the construction of staff in public health arenas. This was the goal of the workshops was been inferred by the state. The goal was to raise awareness about the FTDLC. Through the influence of the state the personhood of vulnerable families were constructed. In previous anthropology personhood has been used as an analytical term to define a someone as been fully functional in a society (Warren, 2016). This is defined by a person's respective roles in society which include aspects of their "physiological, psychological and social competence as it is defined by a given culture" (Warren, 2016). Participants were defined by their respective job roles, in the workshop. In their respective job roles, many of them complained about having double roles, whereby they were more. This highlights the complexity of social structures within

personhood. Rasmussen (2008) argues that regimes of symbolic classification are powerful and add to the construct of personhood.

"The life cycle is typically accompanied by differing roles, responsibilities, and duties, all of which contribute to the achievement of personhood. Included in the attainment of differing levels of status is the notion of jural entitlement and jural responsibility. To achieve full personhood within a given culture, one often must follow social norms of conception, birth, marriage, death, and ancestor hood. Included in personhood in many societies are cultural models that allow non-human entities or spirits to achieve personhood" (Warren, 2016). Therefore ideas of personhood could be compared and analysed in the respective roles of healthcare workers, and their interaction with workshop material. Culture, experience, and sociality are at the basis of ideas which once a person, and therefore tis requires a holistic perspective (Rasmussen,2008:45) My research therefore give me grounds to challenge and understand how ideas of personhood become constituted within the health system in the Western Cape. Ramussen (2008) asks the following questions when examine personhood: argues that when looking into personhood, one need to ask the following questions :How does personhood/self-serve to symbolize other constructs and roles, such as gender, body, age, connection and disconnection, dependence and independence, individuality and individuality, hierarchy and autonomy? What, if any, are the limits of socialization in these tasks? Using these questions to understand personhood and analyse how personhood constructs the state healthcare system. "Issues of belonging, exclusion, equality, hierarchy, difference, and their interconnections are crucial to the topic of personhood/self and its dialogical positioning to others; understanding these topics requires a wider lens which incorporates problems of cultural scale. The goal should be to uncover conditions in which dividable and individual" (Rasmussen , 2008:54) argues that anthropologists should use these factors to understand how personhood can become constructed. In my fieldwork, I use these ideas and questions to uncover the personhood of staff in the healthcare system in the Western Cape.

"Anthropological research is capable of providing new and important insights on the diverse meanings of patient decision-making, informed consent, non-compliance, public health reporting, the building of political coalitions for health and many other issues " (Das,,Farmer, Kleinman & Stewart,. 2009: 2). From my scholarly contribution, I would hope to produce an insight on public health system in the Western Cape. According to Farmed et al., (2009) anthropologists have the potential to mediate knowledge and translate knowledge into action, whereby they can "elucidate how medical interventions are experienced by those with little power. Farmed et al., 2009 argue that anthropologists no longer believe that culture is a reified object that can be easily described. The analysis is open and goes far beyond cultural competence (Farmed et, al., 2009:4). Two matters go beyond cultural competence. The first is to understand the dilemmas and harsh constraints on decision making faced by people who are powerless and far from decision making centres. The second is that power relations cannot simply be reduced to culture. Both of these dilemmas are in the light of public health. "Within medical hierarchies, power operates not only at obvious moments of command, but also more subtly in the capacity of those with greater power to set priorities and to have their decisions carried out" (Das et al., 2009). They argue that people with less power and important knowledge may have difficulty in getting their voice heard, or translation that knowledge into action (Das et al., 2009: 3). An example of this was found in my fieldwork. The FTDLC raises awareness through the workshop for a nurse to dedicate time to examining the mental health of a patient during their check-ups. However, the nurse might not be in the correct situational context to do so, and this is what I explore through interviews and analysis of workshop feedback. Farmed et al., 2009 argue that such knowledge rarely translates to an upwards level. Therefore "bringing to light the realities within a heterogeneous medical social field: such

analysis can identify fundamental flaws in the basis on which social data are collected for public health purposes "(Farmer et al.,2009 :6).Keeping this in mind, I approached my research with this goal.

Chapter 1- The workshop as a tool of governance

I remember feeling a sense of excitement, as I walked into the Khayelitsha training centre, the venue for the first workshop I attended. Walking into the building, we were late, people were seated listening to a presentation. Janet and I snuck into seats at the back. Janet seemed to know everyone, so I curled up in my seat and started writing notes. Soon there was a break and Janet introduced me to the public health planning team. This included, Dr Malek, Micheal and Dr De Savado. Everyone was friendly, and soon I was involved in helping facilitate the workshop. This was done through handing out workshop documents and helping direct participants where to go. The first thing I notice is a large number of nurses in nursing uniforms, secondly I notice name tags with the City of Cape Town as well as Western Cape Government, logo on name tags, lunch boxes and even clothing. This stands out to me as it represent that this event is run by,or members who work for the city, and government event. Obviously the participants were reached out and invited to the event were people who were part of the government.

The crowd patiently sat and waited. Virginia called me to help hand out pre and post workshop test. I already did it by myself as Janet sent me to have a look at it beforehand. I felt sure that the nurses around me must've understood the terms better than me. I try and do it one more time, and pretty much fill out the right answers. So, this was my workshop of this kind, and I was really interested in what was ahead of me. The content of the workshop was so interesting and I was intensely fascinated by the workshop content. The videos were mostly South African, and therefore felt familiar and relatable. I enjoyed it, and looking around at the faces of participants they were enjoying it too. I found the presentations were really clear and concise, especially for someone who had no background in medicine, especially maternal and child health care. During the break, I walked outside and looked around .The irony of the situation, made me sigh to myself, as here, was health care workers, in the middle of Khayelitsha, a huge informal settlement, surrounded by shacks. The state was here too, trying to improve services in a low income area, in dire need of help.

Therefore, I saw the workshop as a tool of the government reaching down into society from a vertical point. Through images and metaphors the state becomes spatialized (Gupta and Ferguson, 2002:981).The workshop I was analysing was a mechanism through which the state became spatialized through verticality and encompassment. Verticality refers to the state as an institution above civil society whereby state actions and efforts are planned from a top down approach (Gupta and Ferguson, 2002:983). Here, state actions are efforts to plan from above civil society, community and family" (Gupta and Ferguson,2002:983). From the go ahead, this was what I had observed- an effort from heads of departments in maternal and child health, to improve health care service delivery, in the maternal and child health sector through strategic planning meetings. The plans and the need for a student to analyse the process, was part of an effort to manipulate and improve services. Recording the outcome of the workshops were then very important on whether or not these workshops will be used again or not. It was a pilot study in some way.

Therefore, the operation of metaphoric state power was done through public health planners educating staff, on a holistic approach to motherhood. The content of the workshop was the voice of the state gearing towards a goal, by telling healthcare staff about the best and ideal journey of motherhood. The first slide has the logo of the first 1000 Days of life on it and a baby with a rattle and the CCT logo. This was a mechanism of how the state becomes encompassed through symbols. The logo in the rattle, for me at that time provided participants

to trust the work been given to them, as declared by the City. The trust in the workshop content lied in the City administering it with the logo producing this claim.

As I took my seat, the second part of the workshop started, which was the group activity part. This part of the workshop consisted of group members into groups and answering questions on the workshop. These questions asked the participants to suggest how the FTDLC can be incorporated into current service provision. They were given three pages, with posits for everyone in the group to stick their answers on a page. The three pages were divided into the topics-maternal health, child health and intersectoral approaches. I joined one group, and sat and listened. Women, shared their experiences of mother hood and each reflection shed a negative light on the state. Mothers did not have time, and some complained about having to go back to work after birth. Others complained about full hospitals and no time to see to patients and give patients effective and efficient sympathetic care. There were almost little to no men at the workshops, but out of the few, there was one in my group. He was an environmental officer and shared how the environment can really impact a child's upbringing. The rest of the group (mostly nurses) just sat there and listened. Soon, after ten minutes which flew by it was time to collect the pages and each group to present their thoughts. Dr Malek facilitated this process, and each group spoke quickly, as it was the near end of a Friday afternoon, and people were in a rush to get home. After the presentation we handed out badges which says " ask me about the first one thousand days of life". These badges were like a certificate on the campaign, and handed out, because of presence in the workshop. Therefore it was assumed participants were now informed after the workshop and could spread the ideas of the campaign.

The second image was that of encompassment whereby the state plays a vital role in the everyday lives of its people. The state could be found in the local spaces and lived experiences, in this case, of South Africa's mothers and children and to a certain extent, fathers (Gupta and Ferguson, 2002:982). These are that these images are often taken for granted in these spaces, and are not often written about. The second workshop we attended was chaotic, as the caterers were late. After welcoming participants, and making sure they sign the register, I found myself in the kitchen cutting sandwiches and helping out with catering. I stayed in the room, until all the staff came for tea. Majority of the people were dressed in Nurses Uniforms, and seemed to know each other. The room was full and overcrowded, so I went outside. I started chatting to a man, who told me he had no idea what he was doing at the workshop. His field was in medicine, but was not in the public sector and said he would like to leave after the break. I introduced him to Dr Malek, so he could inquire what he was doing there and walked away. As the room was clearing out, I grabbed some tea and took a seat next to a nurse. We started chatting, I explained my role to her and she seemed interesting in the research. I then asked her as a nurse who works in Cape Town, what was her experience of the workshops. She said she was enjoying it, and it is really needed in the communities because the young girls "don't know what they are doing, and too many of them are falling pregnant". She seemed very tired and in some way over her job. We were asked to go back to the second part of the workshop. The group I sat with this time was with all allied health professionals such as occupational therapists and speech therapists. All of them constantly complained about gaps within their service sectors which stopped them from delivering effective service delivery. In that short period of time, answering questions gave these women all time to create a strategic plan to improve maternal and child health services. Each and every time the barriers to doing so lied in the bigger economic structures of South Africa.

In another group activity in the third workshop, one of the participants said "most patients are not in a boat to do the loving and caring thing, and there is a great need for social support". These group discussions therefore showed that healthcare professionals can paint the picture

and suggest the best routes to implement the campaign. Therefore, their feedback really needed to be taken seriously. However, in the workshop, it started later and the time set for feedback was rushed. In some of the feedback forms, participants felt that their feedback was not taken seriously. This was due to logistics. Therefore, if this campaign is to be successful, their feedback and suggestions should be the main factor in turning the current state of maternal and child health around. Interventions such as these need to place more emphasis on feedback from the workshop, as healthcare staff are much closer to vulnerable citizens than public health planners (in most cases).

Hegel (1942) argued that the state was mind objectified whereby the highest ideals and values were played out through the way the state functioned. Therefore the state was thought of as higher than civil society. Although this is an outdated theory, there is the topographic metaphor which allows civil society to appear as a zone of mediation between the state and citizens (Gupta and Ferguson, 2002:984). Therefore in trying to study what was happening, I was taking the infamous "top down" approach whereby the state was using the programme to reach into communities, society, bodies and livelihood of healthcare staff. This was to be carried out from the workshop into the everyday lives of mothers, fathers and children who rely on maternal and healthcare services from the state.

My role in the workshops also added to how I understood the process of the government becoming spatialized. In been part of the team, to analyse the effectiveness of the process. From helping facilitating workshops, to the actual process of writing the report I had learnt how public health comes to be analysed. From the documents I was given I had to write a report. This involved me capturing the feedback from the workshops in an electronic form, marking post and pre test scores, as well as calculating the ranging amounts of participants from different designations and areas in the Western Cape. This work involved me sitting with lots of paperwork, counting, capturing words on paper onto a laptop. It was a time consuming, very boring and monotonous but necessary for monitoring and evaluation requirements.

Marking the pre- and post-workshop tests, revealed the knowledge status of healthcare staff about child and maternal health. The scores were high, but many basic terms about the process of maternal and child health were not know by professionals such as doctors and nurses. For me, this reflected the status of healthcare training. Terms such as the period of the FTDLC were mostly marked as wrong on the pre and post-test. Attitudes from health care staff were revealed in questions such as "the birth of every child is a joyous occasion". Some said yes, but the answer was false, to reveal the importance of mental health of the mother. A documentary was also shown about this to reveal the importance of the mother's mental health, as part of the FTDC. Therefore the voice of the state came through in these techniques of the workshop-the video and the pre and post-tests. This is an example of how the state becomes embodied in the everyday lives of people. This is an example of bureaucratic mechanisms for the state to record and connect as well as capture information from its citizens.

Therefore, for me, the workshop is a mechanical tool, which I had helped administer, and had become various parts of the machine, to make the intervention from the state successful. Gupta and Ferguson (2002) calls this the tool by which the state becomes spatialized vertically and encompassed. The vertical part of it, was the state recording the names, designations and working place, also keeping tabs on the amount of people who attended the workshops. It became encompassed, because participants who attended the workshop needed to have the register signed off. Therefore the imagined and often taken for granted image of the state, becomes evident through the attention on the social and imaginative processes through which state authority is made effective and authorities. Through evaluating the feedback forms as well

as participating in the groups, the current state of the health department was painted. As we sat there, discussing all of this, many people started sharing the challenges the faced. The main theme that came across from the challenges painted the complexity of the maternal and child health care from the state. Largely, people complained about lack of resources, as well as horror stories about how mothers have treated their new born infants. Through stories about lack of resources, staff and equipment in the hospital the picture of the government was painted. As we sat there, through the responses everyone in the group could relate to a bad story, about a mother arriving in the hospital about to give birth in a drugged up state. No story of horror alarmed someone. In all of the feedback, each staff member's story and feedback related to lack of efficient resources to deliver dignified, decent efficient and sufficient service delivery in maternal and child health care.

Chapter 2-The importance and functionality of meetings

The meetings I attended all felt overwhelming. Sitting around a table with public health planners, all much more experience than I was, I felt out of place. However, everyone was welcoming and after a few I soon felt comfortable. Many of the terms I did not understands, and lots of programmes were spoken about. Successful interventions were discussed, always following a plan afterwards. The format of the meetings was each member discussing feedback from current programmes, and then moving onto concerns.

On the day of the third workshop, Janet had a meeting with the WCG staff, on improving maternal, child and women's health and Primary HealthCare levels. This meeting strategically looked at recommendations to strengthen Community Based Workers and non profit organisational support. The building was tall, in the middle of Site B in Khayelitsha, next to the new hospital. The building was one of the tallest building in the area, giving those who worked there a beautiful view of the area. It was a mechanism of how the state became represented through a tall building, almost as if the power of the state was asserted through the length and area where the building was situated. The symbolic representation here, was the state been encompassed vertically, through a building and location. We walked through underground parking lot, with the same white vehicles parked everywhere with the WCG logo on. It's as if the cars were sleeping there, in the work hub. The doors were shut and could only be accessed with a card. Janet opened up for us and we went up three levels of stairs, with each level ben different. The first was education, and the next three were health. All levels were allocated to different government sectors. Off we went into level three.

We were sent into the meeting venue, and I was introduced to all members. There were other people in the meeting, all public health planners. It was interesting to know that they were all previously health state employees, as nurse or allied health professionals. As they discussed strategies to improve maternal and child health, feedback stories were shared about what was happening in the clinics, from governmental tools to measure effective service delivery. Most of these stories were tales of how mothers could not afford to provide holistic care to their child.

These concerns are then jotted down, and to be addressed in the next meeting. Monitoring and evaluation was spoken about in detail and most of the time I had no idea what was happening. I just sat there wondering about the mothers and children who these meetings were planned for. Each solution to all problems in the health sector lied in mapping, and establishing links between all healthcare service providers. Other tools such the catch and match programme or road to health booklet were mentioned in meetings. Problems with them arose, whereby some healthcare staff administered these tools right and others did not. In the groups, the attitudes about the nurses, and low levels of breast feeding mothers were brought into the context. I thought about the findings of Majombozi's (2013) study, and wondered if research is ever effective. Three years after her study, and well, public health planners are fully aware of the results, but things are still the same. I wondered then where the gap lies because I was witnessing sincere efforts to improve maternal and child health, with many well researched programmes already implemented in the health system. Yet, sitting there, it seemed that in each meeting more and more solutions arise on how to improve the situation and, well nothing is really effective. So many things "need to be done", and from those meetings, they do get done, and followed up on a constant basis, so where exactly does the gap lie in planned, strategized services delivery.

Scott (1998) argues that the state invests a great deal of effort into developing procedures and practises to ensure that they are imagined in a specific way. This became evident in the meetings I attended to discuss the workshops, and where to go forward. These meetings were held after hours, of ones average working day, after four. They were held at some the programme directors homes, whereby the planning team would come and discuss how to go forward with them. During these meetings, the workshop was review and plans on what tools to use to go forward came up. The process through these meetings led to how the actions of the state would be played out. I was allowed to observe all these meetings, thanks to the kind Dr Janet Giddy.

Within Medical hierarchies, power does not operate at but rather at subtle capacities, of those with greater power to set priorities and have their decisions played out" (Farmer et al,.2009:2). These power relations were materialized in each meeting set by public health planners, who were carrying out all decisions for the workshop preparation. They were all experienced health service providers, either doctors or nurses, in management positions in the health care government system. They were able to negotiate, through their discussion how medical interventions will be experienced by those with little power. Intensive research at a local level, is often leads to conclusions that are strikingly different from a national level, yet policy is often strongly influenced by national health institutions (Farmer et al., 2009:2). Farmer et al., (2009) work therefore highlights the how public health planning often is done without those who are vulnerable and in need of public health planning from the state. While their personhood is central to the ideals of the campaign, it is largely absent (or heavily mediated) in the workshops themselves.

In each public planning meeting, the best method for an intervention was discussed by a small group of individuals, whereby the best health plan and treatment for the body gets discussed and manipulated, without anyone who actually receives the service. Using the FTDLC campaign in workshops is a clear form of modern power in modern government. The goal of the discipline, results from the WCPSG 3, which focuses on wellness, whereby the state is attempting to produce bodies that are "useful and docile" (Inda,2005:6). Rapps (2011) work found that transformation of child making proceeds involves "entanglements with gender, kinship, religion and government relations" (Rapp,2011: 698). In my work, children were not been made with technology, but the state does become played out in child making and rearing, through the workshops. Rapp (2011) argue that anthropologists have become querying how, why, and with what consequences the reproductive aspirations, practices, and outcomes of one group of people are valorised, while the parenthood of another is despised or unsupported. This became evident in participants attitudes towards the system, and how this was shaped by their everyday life experiences. This point came through in the dialogues in the workshop group feedback sessions.

The programme directors were near the top of the medical hierarchy, and therefore, power held in meetings by a being was then very important. Each meeting I attended held decisions about citizen's healthcare, and how they would receive it. Therefore, meetings are a link between state and citizen, whereby the state is encompassed through conversation and mediation between people, to come to a set decision about the lives of citizens within a KESS region of the Western Cape. Within these meetings, everyone's opinions, stories and experiences were all valid in planning on how to address social issues. Bad and good experiences were shared. I noticed that these meetings held power to the way service delivery from the state would be provided to its citizens. Within these lengthy meetings details of state service delivery,

particularly for child and maternal health were planned. Each factor, from the recording cards and administration to problems faced in the field were brought up. I noticed here, how agency is very important.

Since the Heads of Departments, especially in health were all previously trained health practitioners in the field, their agency and knowledge of the field they previously worked in could add meaningful direction of how to deliver state service delivery. Within the meetings, I saw the passion from all participants. Been government officials they are often imagined as snobbish people, and within the South African spectrum, "people who are lazy and don't work hard". I would go against this stereotype, often picked up in conversations with my fellow South Africans. All members were passionate about collaborative projects to improve service delivery. Each person for me, I felt was trying their best form their positions of authority to improve child and maternal health. Therefore agency and personhood is important in the way the state becomes imagined. Meetings are an important part of the process through which the state creates the platform by which they become encompassed in real life.

The public health planners presented an interesting paradox. They were above civil society by having power to implement provincial public health interventions, yet on the other hand they had worked in public health arenas, and this made it difficult to sustain their image a " above civil society"(Gupta and Ferguson,2002:984). The workshop intervention aimed at manipulating its subjects to think better and create awareness to the importance of the FTD. However, it was not without difficulty as feedback from participants enjoyed the workshop but interpreted it a manner, whereby they felt that it was up to them to make the changes to improve the first one thousand days of life in the maternal and child health care services.

State simplifications can be considered as a project that is never fully realised (Scott,1998). The data from which these simplifications arise are never fully realized. A project of legibility is immanent in any project which aims at manipulating society, but is undermined with state rivalries, technical obstacles and resistance from its subjects. The meetings I attended were all one to two hours long. At each meeting there were only women at the table, and I wondered where the men were. The thousand day of life programme was discussed with reference to many other public health interventional projects. I sat there, sometimes lost; as I was unaware so many projects were happening. Yet, the thousand day programme was a central aspect of "governmentality" in the modern world. The structure of using the campaign was so deeply involved in many other projects. The workshops, it seemed were just a small part of trying to use the content to achieve a provincial goal.

Chapter three- Personhood

By doing fieldwork with the workshop participants, it was possible to see how encompassment came to be actually insinuated in the everyday practises of the programme. The most important mechanism was the educational material to improve healthcare workers service delivery to citizens. In the material, the voice of the state came through, through education content from the FTDLC about the best route to mother hood. However, in reality, the state could not encompass this reality with the participants I spent time with. A clinical facilitator speaks about the workshops having potential to be more compassionate within their respective roles. She expressed worry about it however; as she said not everyone would interpret it in the same way. She broke down the nursing degree for her, and said that in primary healthcare, nurses are forced to do midwifery education. She said that that this is not always good for all nurses as they can develop resentment towards the cause of midwifery and how it relates to one's personhood and being. Here, she is on top the spatial encompassment herself, whereby she provides and facilitates how service delivery is played out. However, she is at the receiving end of the state's voice, with the workshop been an example of how that is done. The workshop in a way was an instrument of state control over the wellbeing of citizens. She spoke of city and provincial need to become what she called "one blood". They create chaos and divisions whereby no one wants to work with no body". She said the city and DOH has issues, and she spoke of the influence of the political parties in South Africa on how it stops service delivery. She spoke of feeling trapped in one part of the city's healthcare and agenda and worried about how it would play out. This notes three different aspects of personhood: namely-one's personal capacity and their agency around them.

Although the workshop is directed at mothers, the aim, was for service delivery workers to step into the world of a mother, where they work, and have a changed attitude more sympathetic approach (Source, 2016). However, after spending time in the workshops, clinics, field the reality of public health planning from what the everyday experiences of life are for health workers are farfetched. Implementing a campaign based on the science of the FTDLC, is very difficult and cannot happen through the simplicity of a workshop. People are often be defined on multiple terms which relate to them as we all as a genealogical frame and social order (Rasmussen, 2008:42). Participants were defined as people with potential to create services that are holistic from the FTDLC. However, from the stories of participants about healthcare, challenges in their job roles prevented them from doing so. Part of these challenges had to do more than their respective jobs requirements. Therefore their personhood capacity in their job roles were different from the FTDLC inference of maternal and child health care from the state. The workshop insinuates that services should improve as soon as possible, and each workshop participant should take the message home learnt, and try to improve healthcare services within their individual capacities. However, this is not possible without adequate resources from the state. Some thought the idea of such services and a wonderful journey for mothers and children in the Western Cape is not possible, on the sole basis of inadequate support from the state.

Through each slide the personhood of the patients were constructed for workshop participants. However, their own agency and personhood was different in their everyday working lives. Each slide in the presentation or video, added to an idea and image of vulnerable citizens, and what was the best approach to use to service them. Through their individual capacities meanings about the imagined state were inscribed in the "uses and trajectories (Appadurai, 1986)" of workshops participants feedback in interviews and workshop documents.

However, when interviewing participants, and speaking to them about their job roles, It seemed to me that they had to play more than one role within their respective job roles. Some had to act in place of job roles whereby there was not enough staff to support the patients. Others had to step in out of their job roles and help patients on a personal level. Therefore the categories presented to understand the participants did not accurately reflect their positions. However, it was the standardized normal tool needed to understand and analyse the participants. Through interviews I developed an understanding how they had to step into roles, mostly social that were not part of their respective job roles assigned to them, on the basis of the socio-economic problems faced in South Africa. The lack of resources within hospital could be accounted to poor leadership at the top of South African government. Yet, from the meetings I attended and meeting many heads of departments, I did not witness poor leadership, but rather a group of people who were experienced and fit to run programmes for state healthcare service provision in the maternal and child health sector .From my workshop, I found that people in public health's characters are organized around ascribed job roles, yet they are also autonomous individuals (Ramussen,2008: 40).Here, a participants identity was asserted through their job title, role, employer and name badge. Yet they were doing much more in their respective job role.

A participant that works at an NGO had similar feedback on the workshops. Through each interview I had done, I found myself in an awkward position whereby I had become someone whereby experiences within the healthcare system were unloaded upon. Each person I spoke to, told me medical stories, whereby they have had to step in, within their own capacity to go the extra mile to help the mothers. The efforts put in went beyond their respective job descriptions and roles. The similarity between the health and the NGO startled me, as those who worked in governmental states spoke to me about terrible stories, alarming stories which were disturbing. Each time, each person having to step in to solve a patient's life crisis, and in each case, possibly saving a young babies life. This was done through either social support or health support. "Personhood therefore cross-cuts many dimensions and social levels (psychological, linguistic, political, juridical, medical)" (Ramussen, 2008:54). My fieldwork showed me that personhood of healthcare staff is constructed through the agency of the state, which is different through the real life construction of their various job roles. Agencies of how the government is played out came through in all interviews. I visualised a map of the state's maternal and child healthcare system in my head. Each time the picture was painted gloomy. It went from meetings, serious meetings to strategically plan a public health intervention to the healthcare staff through education. This then moved from there to the vulnerable people in need of state healthcare services. Here, the plan, from the meeting did not meet up with what was happening in reality. At each public health clinic I walked in and saw rows and rows of ill health, and highly pregnant people waiting tiredly for someone to attend to them. So here, there is a large influx of patients and not enough staff. Of course, this has to do with the larger spectrum of socioeconomic issues faced by South African citizens, as a result of apartheid.

Whilst sitting in the workshops, all I could see around me where the logos of the health departments which run and maintain the workshop all over. The city of Cape Town's logo, on badges and uniforms, the Western Cape Department of Health logo, blue, with the moto which says "better together". The logos, and logos which were neatly placed underneath the logos placed great emphasis on working together.

Underneath the city of Cape Town logo, I noted that it said "this city works for you" – yet, what came to mind was who exactly does the city work for? The WCG DOH and Province are two separate entities that do not work together but provide the same health services. Both these parties compete with each other to produce health state service delivery (Source,2016).

Participants and programme directors have told me on many accounts (through interviews and informal conversation) that there is competition and tension between the CCT and DOH. “The provincial health institution (CCT) pays more so they are in the lead with this competition, this has produced a large duplicate of health service which has led to tax state money been wasted on a duplication of resources (Source,2016).

“ When we were preparing the documents, there was of tension, making it very focused and specific with lots of information, keeping it very focused instead of making it very broad”(Source,2016).” There is clashing like, do they think they can tell u what to do?!” (Source,2016). The tension between DOH and CCT added to what content was brought out and how the states voice was relayed to citizens. The complexity between these relations led to people having to come together and work through this difference. “In the begging there was lots of tension, it was important for the City staff not to perceive this as a provincial thing. They had to perceive this as something we are doing together “(Source, 2016).

Yet, the health operational state institutions which emphasize togetherness. However, the city health service providers have two different state provincial providers which then create difference between people. Therefore there is difference from the top, whereby the institution of the state does not deliver proper and effective service delivery on the basis of tension between two parties. Part of implementing the FTDLC campaign, means that all healthcare sector providers need to come together and create links to provide intersectoral services. Yet, how is it supposed to happen at the face of service delivery if the institutions ‘at the top’ providing services are not intersected.

The Western Cape governments logo says “better together”. Both of these logos emphasize togetherness between people. It reminded me of the backbone of the South African constitution which is “Ubuntu”-which means humanity towards other-a philosophical sense which is a universal bond of sharing which connects all humanity”. I noticed the logos on the workshop slides, on participant’s uniforms, stationery name badges and even lunch boxes. These logos define and present the participants identities within the workshops. Many participants came dressed to the workshops in their work uniforms. These uniforms held power as it showed the rest of their participants their position within their work place. Here the encompassment of the state was evident within these images; to represent the state. There is a stark contradiction which lie within the different logos between health server providers in the Western Cape. Both of them emphasize the state as a body which delivers service by integrating individuals to work together regardless of where they come from. South Africa is a country whereby the citizens were forcedly by law, divided from each other. This was mostly on the basis of race by the apartheid government (Bond,2008:18). Through the liberation of the state the government policies have emphasised the notion of Ubuntu which infers togetherness, to disregard the existing separate social relations, created by apartheid. A province of South Africa, the Western Cape Province, which has been said to be one of the best in the country build from this stance of Ubuntu through provincial logos and mottos. Yet, these mottos, logos and approaches contradict what is happening, through the divide in the WCP health service delivery institutions.

The workshop had all the tools, if is purpose was just to create awareness about the campaign, then I could not find any gaps, and feel that the team did the best that they could. During the workshop, after the presentations there is a group activity whereby members get into groups and answer questions in relation to what they already know, what they learnt which was new, what has already been done, what they are currently doing and what are the barriers they face to what has to be implemented. This activity was very interesting as the state needs to record

this, and try to improve service. However, the field to which the campaign applies is extremely huge. The feedback sessions reminded me of the meetings I have attended and watched on T.V in South Africa's parliament. The participants had to report their feedback to the programme directors about what they witnessed and saw. During each workshop I attended there was a lot of anger, from participants when speaking about they need to do. It was as if they were telling the leaders, you tell us to do x, on the basis of the content from the campaign, but yet, we are still struggling with social problems in our medical centres such as a lack of resources and proper staff to give adequate social support to new families.. Time was limited so there was no time for feedback, except for the feedback 'we will look into it".

.From my research, I found this to be a contradiction within efforts to improve maternal and child healthcare services. From analysis of feedback from the workshops, a huge step in providing holistic maternal and child health care services means having to collaborate. Yet, how is this supposed to happen on the ground level of healthcare services, if it is not happening at "the top" encompassment of the state? (Gupta & Ferguson, 2002:283). This project was a keen approach from both sides of the government to collaborate on a project together to improve services and should be used as an example for both sectors to come together.

Conclusion

My findings show that the workshop was considered informative by participants, but a body of rich information was squeezed into a very short period of time. With regard to service delivery, the ideals from the workshop, concentrated on changing ones behaviour, as well as creating the awareness needed for effective and proper service delivery to maternal and child heath, in a complicated and crucial time in a person's life. However, many participants felt that what the workshop was asking them to do, and trying to implement, the state was very far from doing so. Therefore education, squeezed into a short period of time is not enough for turning the wheels of effective service delivery around. There was high rates of interest, and the workshop did what it was planned to do, as mentioned many times in the meeting with all the programme directors-and this was to improve and turn around the wheel for effective and proper service delivery.

Therefore, medical interventions are complex and those who have power to make these interventions often have never been in need of such an intervention. What was extremely interesting for me was the effort and time put aside by state employees, to plan and liaise a medical intervention, trying to improve and better the lives of vulnerable groups of women in dire need of assistance from the state. South Africa, has had a difficult and long politicized process, whereby the state has not treated its citizens well. Today, South Africa lives in an extremely disentangled political state, with citizens having an extremely negative perception of those inside (Bond,2008:54). The vertical encompassment of the state, has been created negatively, whereby the state as a machine expects but does not provide sufficient means for citizens to deliver expectations from health interventions.

It was a good effort to plan and move forward to avoid the situations that been mentioned, but yet so many stories about obstacles to healthcare service delivery are brushed away quickly onto the next thing. Governance in the healthcare sector is very complicated, and so is time-intensive in terms of gaining the necessary knowledge and rolling out programmes. The people who make the decisions in this sector need to be cognisant of this complexity and what it consists of. It is therefore important to question the nature of expertise, and how the bureaucratic expertise of the planners measures up against the practical, experiential expertise of the health-care workers themselves. I argue that experienced health-care workers are as integral to the planning of health-care services as experienced policy-makers and bureaucrats are, as both groups retain valuable knowledge about how governance functions and what individual recipients of services need.

The workshop was a good attempt from government officials to improve maternal and child health services, however it is not good enough. The workshop squeezes information that is meant to transform maternal and child health services into two hours, and therefore cannot give its intended effects. Although the workshops are just supposed to raise awareness, the time and complex context of the workshops are not accounted for. It was a good effort to plan and move forward to avoid the situations that been mentioned, but yet so many stories about obstacles to healthcare service delivery are brushed away quickly onto the next thing. Governance in the healthcare sector is very complicated, and so is time-intensive in terms of gaining the necessary knowledge and rolling out programmes. The people who make the decisions in this sector need to be cognisant of this complexity and what it consists of. It is therefore important to question the nature of expertise, and how the bureaucratic expertise of the planners measures up against the practical, experiential expertise of the health-care workers

themselves. I argue that experienced health-care workers are as integral to the planning of health-care services as experienced policy-makers and bureaucrats are, as both groups retain valuable knowledge about how governance functions and what individual recipients of services need.

The government in my country has many social dynamic issues, the key example in this research been the two separate entities of City and DOH issues. If the FTLC is suppose to be implemented, many changes needed to be made, starting with the tension between two state bodies who provide maternal and child health services. Having a critical approach is one way of exploring the intervention, and only one dynamic. I felt that I did not have the right to do so, as public health management is an extremely difficult and complex thing to do. My fieldwork showed me that it is one of the most difficult and complex things to do, as humans are so complex and there are many things to consider. With South Africa as a background, the legacy of apartheid filtering into life twenty years later makes the job even harder. The good thing is that people are working very hard to do so, and it is possible. The holistic approach to healthcare insinuated by the FTDLC will require small steps and it can be transformed. My main suggestion from this research is that participant's feedback is carefully taken into consideration as they are the closest to citizens, and therefore could come up with effective solutions to implement the campaign, and hopefully improve lives of mother, fathers and children in the City of Cape Town

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