Is this pregnancy legitimate because it is (un)intended and (un)affordable? An intersectional analysis of pregnancy "supportability"

A thesis submitted in fulfilment of the

requirements for the degree of

Doctor of Philosophy

of

Rhodes University

Makhanda, South Africa

By

Megan Joanne Reuvers

Orcid ID

https://orcid.org/0000-0002-7408-2809

May 2025

Supervisor:

Distinguished Professor Catriona Ida Macleod

Abstract

The provision of social support during pregnancy is considered integral to positive mother and infant health and well-being. Research on the topic has been primarily quantitative and has demonstrated that higher levels of support mediate against poor mental well-being. However, its effects on physiological outcomes and maternal behaviours are less conclusive. Researchers suggest that these mixed findings point to how social support is measured, understood and perceived differently across social groups, socio-cultural settings and global regions. Qualitative studies generally describe the types and sources of social support provision but have not considered how such support is discursively constructed within power relations. Moreover, social support has been conceptualised in relation to *immediate* support networks, leaving *support structures* (socio-economic, -political, and -cultural norms and institutional structures) underexamined.

Macleod's pregnancy supportability framework expands on the notion of social support to include support structures. This framework conceptualises supportability as a "combination of a woman's physiological, emotional and cognitive capacities to carry a pregnancy, which are enabled or constrained through the micro-level and macro-level 'support' that she receives". Micro-level support refers to immediate support networks. Macro-level support relates to support structures; these include socio-cultural norms, discourses and practices and socio-economic and -political institutions and policies.

The supportability framework has not, however, been operationalised methodologically. Using a reproductive justice approach and intersectionality theory, I sought to operationalise this framework qualitatively in this thesis. I argue that a positioning analysis informed by Sue Wilkinson's and Celia Kitzinger's approach to positioning theory and Patricia Hill Collins' domains of power thesis could guide a supportability framework analysis.

To demonstrate this, I conducted a multi-level analysis of the reported support interactions across the personal, micro-level and macro-level social contexts of pregnant women living in two towns in the Eastern Cape province of South Africa. A purposive sampling strategy was employed, recruiting participants over 18 years old, in their second trimester of pregnancy, and attending antenatal care. The rationale for operationalising the framework in this context stems from persistent reproductive disparities that affect the health and well-being of pregnant individuals in post-apartheid South Africa, especially for those who live in rural regions of the country. These inequalities persist despite a progressive rights-based policy

environment and government commitments to addressing the social determinants of reproductive health.

The supportability framework formed the template upon which 15 pregnant women's photo-elicited supportability narratives were analysed. Each pregnancy story was diverse because the support interactions were highly context-specific. However, two interrelated macro injustices – norms surrounding socially (in)appropriate childbearing and structures underpinning socio-economic inequality – shaped participants' discursive constructions of the supportability of their pregnancies. Participants constructed support as *conditional* and subject to *deservingness* based on their social positions in South African society. Participants attempted (and also struggled) to present as legitimate pregnant subjects by justifying their pregnancies given their social locations. The affordability of the pregnancy underpinned participants' ability to present as responsible pregnant subjects and informed their reproductive autonomy in making decisions about their pregnancies.

The findings demonstrate that "exemplary" childbearing is pinned on individual "choices" and behaviours but it is mostly unattainable because it is conditional on the micro and macro support environments that circumscribe it. These environments are imbued with coloniality, apartheid history, capitalism, socio-economic status, race, patriarchy, nationality, maturity and ability, which operate in concert to enable or, in most cases, hinder the supportability of pregnancies. My qualitative operationalisation of the supportability framework demonstrates that, despite a human rights-based policy framework, contextual systemic issues need considered attention in maternal health promotion. A biomedically-based antenatal care model is woefully inadequate in promoting the supportability of pregnancies. Multi-sectoral efforts such as addressing disrespectful maternity care, strengthening maternity social protections and addressing discriminatory labour practices are needed to enhance micro-level and macro-level support.

Table of contents

List of tables and figures

List of acronyms

ANC	African National Congress
ANCWL	African National Congress Women's League
ART	Antiretroviral Therapy
BANC	Basic Antenatal Care
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CI	Contraceptive Interference
CSG	Child Support Grant
CSSR	Critical Studies in Sexualities and Reproduction research programme
DSD	Department of Social Development
FSAW	Federation of South African Women
GBV	Gender Based Violence
HIC	High Income Country
HIV	Human Immunodeficiency Virus
ICT	Information and Communication Technology

ILO	International Labour Organisation
IPV	Intimate Partner Violence
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer or Questioning
LMIC	Low- and Middle-Income Country
MCR	Maternity Case Record
MDG	Millenium Development Goal
MMR	Maternal Mortality Rate
NCCEMD	National Committee on Confidential Enquiries into Maternal Deaths
NDoH	National Department of Health
NHI	National Health Insurance
PMTCT	Prevention of Mother To Child Transmission of HIV
RJ	Reproductive Justice
SDG	Sustainable Development Goal
SDH	Social Determinants of Health
SES	Socio Economic Status

SGA	Small for Gestational Age
SRH	Sexual and Reproductive Health
TB	Tuberculosis
TFR	Total Fertility Rate
UIF	Unemployment Insurance Fund
WHO	World Health Organisation

Explanation of terms used in this thesis

I often refer to or draw upon the social category “woman” in this thesis. This is because all participants in this research project identified as “women”. Where I refer directly to research participants, I use the term “woman”. When discussing pregnancy in general terms, I use “pregnant individuals” or “pregnant people”. This is to acknowledge that the social category “woman” is socially constructed, and that pregnancy can be experienced by people of diverse and variable genders.

This thesis specifically engages with the theory of intersectionality, and I, therefore, make use of racial and ethnic signifiers such as “black”, “white”, “coloured”, “non-nationals”, and “amaXhosa”. South Africa’s apartheid history was instrumental in creating and maintaining rigid racial classifications between different social groupings. These terms are integral to post-apartheid redistribution and transformation initiatives and are key variables used in both qualitative and quantitative research to track persistent social and reproductive inequalities.

Note to reader

This thesis is slightly longer than usual. I apologise upfront for this. The elements of Macleod’s pregnancy supportability framework encompass a broad array of pregnancy issues. For example, where research might only focus on partner support during pregnancy, this dissertation, together with its theoretical underpinnings, required consideration of a wide range of cross-disciplinary literature. I have tried my best to make the reading as easy on the eye as possible. This thesis uses British English grammar conventions.

Acknowledgements

If someone had to ask me what advice I would give someone who is about to embark on a PhD I am not sure I could give them a useful answer. I walked into this journey rather haphazardly, having absolutely no idea how it would pan out because I did not have any academic experience in the field of feminist theory. But here we are after a lot of reading, thinking, repetitive dreaming, agonising, obsessing over detail, doubting, re-orientating, writing and re-writing. Of course, there has been growth, and I dare say a form of thriving through this whole process, making the production of this thesis a highly valuable experience. It takes a village to produce a thesis. There are some key people I need to thank who patiently and stoically endured this journey with me.

Firstly, I thank Catriona Ida Macleod, who guided me patiently through the various literature labyrinths I could not help exploring and who let me work at my own pace in my own way. I knew that a nurturing, collaborative and kind supervisory relationship was required for me to have the confidence to take on this thesis. I enjoyed my supervisor meetings with Catriona and would strategise to extract as much as possible from her while she strategically turned the thinking back on me. I also thoroughly appreciate being supported in presenting my work at some fabulous national and international conferences. Being part of the CSSR research unit has truly been a privilege.

Secondly, to my favourite person in the whole world, Mike Rogan. This endeavour would not have been possible without your calmer-than-you-are-dude, rock-steady and patient support. As a seasoned academic (development economist), it was slightly annoying but also comforting to hear you say, “I don’t understand you qualitative people”, but then still listened to my half-formed thoughts and ideas as I agonised over various aspects of the thesis. More importantly, this thesis was part and parcel of our wonderful, full life together, and you have helped me grow as a person. Thank you.

To Minty, Hud, Jazz and Fishie and the late Titus (my three greythounds and two cats), this thesis would never have gotten off the ground without your distractions (batting typing hands, settling for a nap on top of notebooks, swotting pens off desks, and the reminding me of walks well before walk time). Your couch company and putting up with copious amounts of cuddles during breaks helped produce this thesis.

To my fellow research team members, Esona Bottoman, Yamini Kalayanaraman and Zipho Dolamo, thank you for your kind, generous and collaborative approach to pooling data for this project. Esona, your interviewing and translation skills and sense of humour were integral to completing our fieldwork. I enjoyed our long car journey chats and learning about how your grandmother made you "work" by looking after baby sheep during the holidays in Katkop. Meeting your mom, grandmother and family at our B&B was a highlight, and indeed, to quote your grandmother, "times have changed".

To Tracey Feltham-King, your gentle listening, positive encouragement and reassurance are so highly valued. To the rest of the CSSR team, what a wonderful group to be part of. Thank you.

To my friends Laura Alfers and Lauren Creese who checked in on me. Scratchy thought-provoking love and gentle listening love – a perfect combination.

To all the participants who took part in this research project, I thank you. Your stories will stay with me forever. I hope this thesis does justice to your pregnancy experiences.

CHAPTER 1

Rationale for analysing the "supportability" of a pregnancy

"We all get pregnant under different circumstances."

Nosipho (research participant)

In 2016, Catriona Ida Macleod proposed "a model that places 'supportability' at the center of thinking about pregnancies and that allows for an analysis of the intersection of individual cognitions, emotions and behavior with micro-level interactive spaces and macro-level issues" (2016, p. e384). Guided by the principles of reproductive justice and using intersectionality as a theoretical lens, the objective of this research dissertation is two-fold: (1) to operationalise Macleod's[1] (2016) pregnancy supportability framework[2] through theoretical and methodological explication and extension and through conducting a qualitative analysis of women's narratives of pregnancy support (that they may or may not have received while pregnant); and (2), through these stories, surface how reproductive (in)justices enable or undermine the "supportability" of a pregnancy. Therefore, individual women's experiences of pregnancy support were examined in relation to their social context and location and the power dynamics that operated through the various support interactions that occurred during their pregnancies.

[1] This pregnancy supportability framework was developed by Macleod. It was published in the Journal of Public Health in 2016 and is called *Public reproductive health and 'unintended' pregnancies: Introducing the construct 'supportability'*. I cite this reference only once for the purpose of avoiding unnecessary repetition and to allow for easy reading. Future references to the pregnancy supportability framework in this chapter refer to this citation.

[2] This dissertation forms part of a larger research project which uses the pregnancy supportability framework. There is a qualitative component (with which this dissertation engages) and a quantitative component whereby the framework has been operationalised into a survey. I provide more detail on the research team that was involved in the qualitative component in Chapter 4.

Nosipho's statement at the beginning of this chapter suggests that reproductive behaviours and decision-making go beyond individual thought and control in that there are also extraneous "circumstances" in which pregnancies occur. Nosipho's declaration also implies that these "circumstances" are multiple and variable; no single story can explain the reasons for becoming or being pregnant. In making this statement, Nosipho was attempting to legitimate her pregnancy because the conditions under which she became pregnant were not particularly supportive or fair.

A reproductive justice (RJ) approach pays close attention to the extraneous "circumstances" that inform an individual's ability to make reproductive decisions that are in their best interests, access quality reproductive healthcare, experience pregnancy, and parent in an enabling social environment (Ross & Solinger, 2017). These "circumstances" refer to the social, political, economic, and legal environments that, in the case of pregnancy, underpin how individuals become pregnant, make decisions on whether to keep the pregnancy and manage their pregnancy in ways that ensure their own, their future child's and family's overall well-being. According to Ross and Solinger (2017), an RJ approach aligns with a universal human rights framework. Reproductive justice envisions that all individuals, no matter who they are, should be protected and able to exercise their reproductive rights in a dignified and respected manner. Thus, reproductive rights are considered fundamental human rights, and an RJ approach challenges any social, legal, political, and economic influences that attempt to undermine these rights.

Despite a rights-based policy environment, South Africa has a range of woeful maternal health and well-being indicators such as extremely high levels of gender-based violence (South African Department of Women, Youth and Persons with Disabilities, 2020); associations between Intimate Partner Violence (IPV), alcohol use, food insecurity and depression during pregnancy (Davis et al., 2017; Garman et al., 2019; Redinger et al., 2020); late or inconsistent usage of antenatal care and unmet targets in reducing maternal morbidity and mortality (National Committee for Confidential Enquiries into Maternal Deaths, 2021, 2024); and, a high percentage of unexplained antenatal stillbirths (Hlongwane & Pattinson, 2023). These indicators confirm that pregnant individuals in the South African context experience a range of reproductive injustices.

The pregnancy supportability framework, used as a guide to examine pregnancy support stories, provides the opportunity to present a multi-faceted, holistic portrayal of how pregnant people experience pregnancy within this context. The framework is designed as an

intersectional approach to understanding how the interpersonal, micro and macro social support structures *interact* in ways that enable or undermine pregnancy outcomes or well-being. In other words, the framework shifts the focus from the individual to understanding how the individual and social context are intertwined. In doing so, findings can help identify possible future directions for addressing these poor reproductive indicators, thereby achieving reproductive justice aims.

In this chapter, I build a rationale for operationalising the pregnancy supportability framework qualitatively. First, I outline how, despite a human rights-based policy environment and a supposed commitment to addressing the Social Determinants of Health (SDH), concerns remain around the persistent health inequities of South Africa. I motivate for why the use of the supportability framework might help address these concerns. Secondly, I briefly summarise how the notion of "social support" during pregnancy, included as part of the SDH, has been conceptualised and addressed in the literature. I introduce the pregnancy supportability framework and how it expands on conceptualisations of social support and the intendedness of pregnancies to include support structures. Thirdly, I provide a brief overview of the theoretical approaches I used in conceptualising a qualitative analysis of pregnancy supportability. I explain how adopting a critical realist, social constructionist approach and using the lens of intracategorical intersectionality (upon which the supportability framework is based) helps surface understandings of how reproductive (in)justices operate in participants' talk. Fourthly, I outline how I approached this project from a reflexive standpoint using what Wanda Pillow (2003, p. 187) calls a "reflexivity of discomfort". Fifthly, I present my research questions. I then conclude this chapter by providing a chapter outline summary of this thesis. I now discuss why I have chosen to use the pregnancy supportability framework to guide this research project.

The social determinants of health within South Africa

Ross and Solinger (2017) contend that human rights are unfairly distributed to individuals who occupy certain social positions, and are reflected in the inequities in health and well-being experienced by these individuals. In recognition of this, there has been a shift in the public health arena to adopt a Social Determinants of Health (SDH) approach. An SDH approach understands that disparities in health and well-being are not only health system-related but can also be attributed to multiple influences outside the health system. SDH examples include housing, sanitation, education, work environment, economic stability and social inclusion that may play a role in enabling or exacerbating these health (in)equities. As the

World Health Organisation (WHO) explains, “health inequities arise from the conditions in which people are born, grow, live, work and age and inequities in power, money and resources that give rise to these conditions of daily life” (World Health Organisation, 2014, p. xvi). Thus, it is now understood that health outcomes and well-being are not only the result of individual health behaviours or the services to which people have access but are also influenced by the SDH.

A plethora of South African social policies have been developed as rights-based approaches to state governance to ensure the well-being of individuals living in South Africa. For example, the South African Constitution (Republic of South Africa, 1996) is considered one of the most inclusive and progressive rights-based constitutions globally. It informs all other social policies and state governance. It not only stipulates that people living in South Africa should have equal access to healthcare (including sexual and reproductive health), but its equality clause explicitly protects pregnant individuals against any form of discrimination. In addition, addressing the SDH is incorporated into the South African National Development Plan (South African National Planning Commission, 2012) and maternal health policy (South African National Department of Health, 2021).

With specific reference to reproductive health and rights, South Africa’s transition into democracy in 1996 marked a distinct change in crafting reproductive policies from a rights-based perspective. In their review of the reproductive policy ten years after democracy, Cooper et al. (2004) identified some cornerstone policies that were brought into effect, which included enabling better access to contraception, legalising abortion, making maternal health cost-free, designating maternal death as a notifiable condition by law, addressing gender-based and sexual violence, screening for cervical cancers and the introduction of HIV/AIDs and Prevention of Mother to Child Transmission (PMTCT) policy and programmes. These authors also noted that civil society was instrumental in pushing for policy change, especially when there was a lack of political will. Cooper et al. (2004) concluded, however, that these policies were not implemented effectively due to several shortcomings, including a weak and overwhelmed public health system that lacked strategic planning, human resources capacity, and sufficient funding. In addition, South Africa’s colonialist and apartheid history created huge socio-economic and geographical chasms, which made implementation of these policies difficult.

In a later review of SRH policy implementation twenty-one years after democracy in 1994, Cooper et al. (2016) noted some adaptations to policies. For example, contraception and fertility policy now widened its focus to include people occupying different social positions (as

opposed to heteronormative underpinnings), such as sex workers, non-gender conforming people and people living with HIV. Abortion policy was amended to improve access, and maternal health policies included mHealth or digital technologies to provide extra support to pregnant individuals. Addressing teenage pregnancies was another concern, and a *National Adolescent Sexual And Reproductive Health And Rights Framework Strategy* (South African Department of Social Development, 2015) was introduced in 2015 to develop more youth-friendly approaches to sexual and reproductive health. Concerning HIV, expanded access to antiretroviral therapy (ART), after the era of AIDs denialism by politicians up until 2008, was initiated in 2010. This has had enormous success in reducing mother-to-child transmission of HIV. However, Cooper et al. (2016) asserted that, except for world-class HIV programme implementation and achievements, poor implementation and integration of other SRH policies remained an issue.

South Africa nevertheless continually expands SRH policies, pushed by concerted efforts of civil society activism, and has also used a reproductive justice lens to craft them (see Stevens, 2021). For example, more recent policies have been directed at overlooked and underserved population segments, including school-going youth, sex workers and LGBTQ people. There have also been attempts to integrate these policies more effectively within the *National Integrated Sexual and Reproductive Health and Rights Policy* (South African National Department of Health, 2019). Thus, although the policy environment in South Africa is highly progressive and is actively driven by civil society groups, a lack of implementation because of poor governance, capacity, and political will remains a challenge (Stevens, 2021).

Rights-based policy approaches also call for addressing health inequalities by paying more attention to the SDH through governmental intersectoral collaboration (Mayosi & Benatar, 2014). However, Scott et al. (2017) have argued that, although the SDH are well embedded within the South African primary health care strategy (which is where maternal health services are located), there is no concrete implementation of SDH interventions. There is also no elaboration on exactly how different government spheres should work together in an intersectoral manner. For example, one of the key priority areas in the *Strategic Plan for Maternal, New-born, Child, and Women's Health (MNCWH) and Nutrition in South Africa 2012-2016*. (South African National Department of Health, 2012b) is to address health inequities through the SDH. The strategy only singles out improving water and sanitation as a multi-sectoral priority area and locates it at a community outreach level. However, the strategy does not give specific directions for how this intervention will be accomplished in practice.

Moreover, as Scott et al. (2017) point out, addressing the SDH cannot only be operationalised at a community outreach level but also requires a multi-level, multi-sectoral governmental approach.

Despite adopting human rights-based approaches to framing legal and social and SRH policies and acknowledging the SDH's role in enabling individuals to realise their rights, health inequality in South Africa remains high. It is passed on intergenerationally (Von Fintel & Richter, 2019). I explore some of these reproductive health disparities and indicators pertaining to pregnancy in the South African context more comprehensively in Chapter 2. The lack of engagement on how the SDH may come to bear on reproductive well-being requires closer examination to initiate structural changes across the health system and other social services. Using the supportability framework to surface how health disparities or (in)justices may be embedded in pregnant individuals' discursive framings and embodied lived experiences might help inform concrete, context-specific, and multi-sectoral SDH strategies to mitigate the harms that undermine health and well-being. Health inequalities can be highlighted by examining social support during pregnancy.

Social support as a determinant of health and well-being during pregnancy

It is well documented that social support is a protective factor for overall well-being, such that the World Health Organisation (WHO) initially included social support as one component of the SDH (R. Wilkinson & Marmot, 2003). Social support has been conceptualised as support from a source, such as one's *immediate* social network, including family, partners, friends, and community members (Sarason et al., 1983). In addition to this, different *types* of social support have been identified within these immediate social networks, which broadly encompass emotional (loving family), instrumental or material (financial aid and help with tasks) and informational (health advice) forms of support (Orr, 2004).

Globally, most psychological and social literature studies on social support during pregnancy have been quantitative. These studies have investigated associations between social support and specific pregnancy outcomes (psychological and physiological) or behaviours (smoking or substance use), or cognitions (unintended pregnancies). There is consensus in the literature that there are significant associations between low social support and psychological distress. In contrast, the associations between low social support and physiological pregnancy outcomes (such as low birth weight and preterm birth) and maternal behaviour outcomes are less conclusive. Scholars have highlighted that the limitations of this

research centre on the diverse ways social support is measured and how it may be understood across different cultural and geographical contexts (Bedaso et al., 2021b; Hetherington et al., 2015). This is important for this study because the supportability framework is designed to facilitate an understanding of how the wider support environment and the individual are intertwined; how social support is constructed in talk will give insights into how support is understood in variable ways and provided in different contexts.

In South Africa, a growing body of quantitative literature has investigated associations between social support and maternal health. These researchers have highlighted how low levels of social support, together with other social determinants of health such as HIV status/stigma, food insecurity (Hartley et al., 2011; Tsai et al., 2016a), intimate partner violence (Field et al., 2018; Koen et al., 2014) and poverty, (Heyningen et al., 2016; Onah et al., 2017; van Heyningen et al., 2017) are associated with increased psychosocial risk or poor pregnancy outcomes. Other studies have found that health support interventions such as home-based community healthcare workers have positively affected health-seeking behaviours (Le Roux et al., 2020; Stansert Katzen et al., 2020). These studies have mainly focused on low-income women accessing the public health sector. Despite being quantitative studies, they are helpful for this research because they pay attention to how both the SDH and social support play a part in shaping maternal health outcomes. However, they conceptualised and measured social support within the individual's *immediate* social networks.

Qualitative studies in South Africa have also examined pregnant women's experiences of social support. Like the quantitative studies, these studies have also focused on low-income women who use the public health sector. These studies have paid attention to the social support experiences of specific social groups such as HIV-positive pregnant women (Brittain et al., 2023), HIV teenage women (Hill et al., 2015), university students (Phiri et al., 2023) and immigrant women (Makandwa & Vearey, 2017). Some studies have also considered particular sources of support, such as partners (Lewinsohn et al., 2018) and experiences of health support interventions such as mobile phone information support (Skinner et al., 2018) and social support in general (Mabetha et al., 2024; Mlotshwa et al., 2017). Although these studies have surfaced the sources, types and perceptions of support that pregnant women in South Africa may prefer, together with flagging how the broader social context might play a role in shaping support provision, they are purely descriptive studies. Thus, they do not offer insights into how social support is discursively constructed within power relations. I unpack these studies in greater depth in Chapter 3 to situate my study within this body of research.

A reproductive justice approach to understanding social support during pregnancy

Adopting an RJ approach means understanding that the sources and types of support available to pregnant individuals are shaped by the legal, political, economic, and social contexts in which they live. In addition, an RJ approach views state governance itself as part of the social support system, which should play an enabling role in individuals' access to reproductive rights. In this sense, social support encompasses not only the individual and their immediate support networks but also macro support structures.

It is precisely because of the role that certain "circumstances" (to quote our participant Nosipho) may play in individual pregnancy decision-making and management that Macleod (2016) developed a multi-level pregnancy supportability framework to examine various *support interactions* that may occur during pregnancy. Macleod defines supportability "as the capacity of a woman to carry a pregnancy in such a way that she experiences positive health and welfare" (2016, p. e386). Using the overarching notion of support, this framework facilitates an analysis of supportability on the individual level (cognitive, physiological, emotional, and behavioural), the micro-level (immediate support networks such as partner, family, friends, community, work, education, and healthcare interactions) and the macro environment (such as support structures, systems, policies, and social norms).

The framework was developed to counter public health framings of unintended and unwanted pregnancies, seen to be the result of individualised reproductive missteps. For Macleod, public health constructions of pregnancy intendedness rest on understandings of individual rationality, an autonomous, choosing subject who has, or should have, complete control over their reproductive decisions. In advocating for using this conceptual framework, Macleod argues that public health interventions place too much emphasis on individual behaviour changes or compliance without considering how the social context may enable or undermine an individual's ability to respond to these interventions. Macleod argues that interventions such as these, although aligned with rights-based agendas of bodily autonomy (for example, enabling access to contraception to facilitate better family planning practices), have the effect of reinforcing an individual focus where "the *right* to bodily control is converted to *responsibility* for managing the risk of pregnancy. This responsibility is installed at an *individual level"* (Macleod, 2016, p. e385). In line with Macleod's argument, an RJ approach cautions that only focusing on individual rights or autonomy is insufficient because different people in different social locations have different access to those rights.

Thus, despite searching the literature on social support within the South African context, I found no research specifically focusing on *how* reproductive (in)equities or (in)justices are articulated in pregnant women's talk about pregnancy support. Therefore, operationalising the supportability framework qualitatively offers the possibility to do so. Firstly, introducing the construct of "supportability" is useful because Macleod expands on the notion of social support to include macro levels of support while not losing sight of individual agency and experiences. This facilitates a multi-level examination of the individual in relation to their social environment, thereby incorporating the extraneous "circumstances" (of which Nosipho speaks) into the analysis. Secondly, the supportability framework is aligned with global approaches and concerns to understanding health disparities. This is because the various elements of the framework incorporate aspects of the SDH. Furthermore, by tracking pregnant participants' talk across the framework, one can trace which of the SDH may be more salient for pregnant individuals in particular contexts, together with illuminating how they may have a bearing on the supportability of the pregnancy. I now turn to how the theoretical underpinnings of this study help surface reproductive (in)justices in pregnant individuals' discursive constructions of pregnancy support.

Although SDH approaches do take the broader social environment into account and have incorporated a gender equity lens or social positions to understand the effects that the SDH may have on health and well-being, the WHO has acknowledged that health inequities prevail across and within countries and are specific to particular social groups thereby undermining the achievement of universal health rights (World Health Organisation, 2014). Hankivsky and Christoffersen (2008) argue that SDH approaches do not fully consider that the determinants of health themselves are subsumed into multiple broader structural inequities. These inequities include *mutually reinforcing systems* of racism, classism, sexism, ableism, and nationalism, which operate through the SDH and have the effect of imposing disadvantages on particular social groups. In addition, the authors assert that the power dynamics between SDH relationships are overlooked. They suggest that applying an intersectionality framework can address these shortcomings and, in doing so, can provide a valuable lens for understanding how the SDH can shape health and well-being in inequitable ways. As Ross and Solinger (2017, p. 79) assert, "Reproductive justice is the application of the concept of intersectionality to reproductive politics in order to achieve human rights".

As outlined by McCall (2005), the pregnancy supportability framework is premised on an intracategorical intersectional approach because it focuses on the *event* of the pregnancy.

McCall. (2005, p. 1787) Describes an intracategorical approach as one that "begins with a unified intersectional core—a single social group, event, or concept—and works its way outward to analytically unravel one by one the influences of gender, race, class, and so on". In other words, the single social group is pregnant individuals, the event is pregnancy, and the concept is pregnancy supportability. This approach challenges the homogenising effects of individuals being allocated to "master" social categories. However, it acknowledges that these characteristics (such as race, nationality, and class) are entrenched socially, materially and discursively, thus having consequences for the livelihoods of individuals. Importantly*, no social category is initially foregrounded* because people do not share the same lived experiences by virtue of belonging to a specific "master" category. In this manner, pregnancy supportability is viewed as a complexly intertwined *social issue,* thereby avoiding one-dimensional ways of looking at pregnancy. Pregnancy supportability is the key concept, with support (micro and macro) being embedded therein. Pregnancy supportability is not only understood as a woman's issue, and it is examined in a multi-faceted manner without privileging one form of support (for example, partner support) over another.

By focusing on support interactions that occur within the pregnancy event, the framework allows for a *process-orientated* analysis of how normative or alternative understandings of pregnancy support surface through talk and how they shape the pregnancy experience in the form of possible reproductive (in)justices that an individual may experience within a given social context. In addition, this approach is different to existing SDH models as it provides an intersectional approach to examining support interactions and processes and not upstream or downstream causal effects or outcomes.

However, as will be argued in Chapter 4 of this thesis, the pregnancy supportability framework, as outlined in the original paper, does not give direction on examining power dynamics inherent within pregnancy supportability practices and talk. A key aim of intersectionality is understanding lived experiences in relation to power (P. H. Collins & Bilge, 2020). I incorporate Collins' (2000) concept of power as part of the theoretical approach to this project. In her seminal work on black feminist thought, Collins (2000) outlines four domains of power: interpersonal (socially interactive everyday lived experiences), structural (the organisation and structure of social institutions), cultural (the maintenance of ideologies and stereotypes) and disciplinary (managing dominant social hierarchies through surveillance and bureaucratic means). These forms of power operate by socially organising, generating and maintaining the way certain reproductive (in)justices intersect; understanding how they are

organised to produce these (in)equities is key. One domain of power is not seen as more important than another when examining social issues because they reinforce and operate in relation to one another. This concept of power is suited to the pregnancy supportability framework in that the four forms of power dovetail with the framework's individual, micro and macro elements.

I adopt a critical realist stance within the philosophy of social constructionism for this project. As with intersectionality, this approach takes a political stance in understanding that constructions of the world, through talk and social practice, have real effects on the bodies and material realities of people's lives (Burr, 1995; May, 2015). The structure of the supportability framework (individual supportability /micro/macro support levels) offers the possibility of combining constructionist, materialist and embodied understandings of the pregnancy supportability experience. These understandings can be surfaced by examining women's uptake of subject positions when narrating their experiences of pregnancy support.

Positioning theory, which is premised on social constructionism, has been conceptualised as a discursive practice that takes place within a framework of rights and responsibilities (Harré & Moghaddam, 2003). Social actors are located within various "moral orders, " understood as normative conventions or constraints that guide individuals in adopting socially acceptable behaviour and ways of talking within particular social interactions. Normative constraints make various positions available and provide parameters for what individuals can or cannot do or say in a social interaction. Thus, in taking up or being assigned the subject position of "pregnant woman", there are certain normative context-specific rights and obligations that both the pregnant woman and her support network are expected to fulfil to ensure a successful pregnancy outcome. Positioning theory, conceptualised through the lens of moral orders (or normative constraints) and rights or duties, links agency (for example, bodily autonomy) and structure (the social environment), thereby facilitating multi-level understandings of pregnancy decision-making and management. Challenging certain positions on offer can indicate agency or social change, while normative constraints (social, institutional, and physical structures) can impose positions on individuals.

Feminist scholars Sue Wilkinson and Celia Kitzinger (2003) expand on positioning theory by analysing how individuals use social categories in talk to accomplish discursive goals (such as absolving themselves or others). The authors note that individuals may invoke, index, or specifically name social categories by positioning themselves and others through talk. These interactive positioning strategies are useful from an intersectionality perspective because they

show how social norms or oppressions can be upheld and how individuals may use this form of positioning to demonstrate their relative social advantage or disadvantage in contrast to others. Positioning theory can enable an analysis of the various support dynamics that occur across the elements of the supportability framework and can also surface how social locations play a role in talk. Therefore, I incorporate positioning theory as an analytical tool in my analysis by identifying how participants used self (I-statements), interactive (positioning of others and social entities), and imperative (imposed social characteristics) positioning strategies in their narratives about pregnancy support.

In sum, the pregnancy supportability framework offers the possibility to conduct an open-ended, process-orientated qualitative analysis of pregnancy support. Its use of an intersectionality orientation offers the opportunity to provide a nuanced understanding of how reproductive (in)justices may operate through talk about pregnancy support and how the SDH may inform that support. Therefore, the pregnancy supportability framework guided this research project's conceptualisation, design, and analysis procedures. Using the theory of intersectionality and my theoretical extension of Macleod's pregnancy supportability framework to guide my research, I conducted a qualitative analysis of women's narratives of pregnancy support. I examined the interplay between individual reproductive autonomy or agency and the normative constraints (or "circumstances", as Nosipho asserts) that circumscribed the event of the pregnancy. Women's narratives of pregnancy support were tracked across the elements of the supportability framework and analysed using a positioning analytic and Collins (2000) domains of power. This was done to surface how reproductive (in)justices may play a role in relation to support provision during pregnancy, thereby having a bearing on the supportability of the pregnancy. Adopting an intersectionality approach requires that I am mindful of my positionality concerning each aspect of this research process. I therefore discuss reflexivity upfront, although it is often discussed under the methodology section.

Reflexivity

Qualitative researchers assert that reflexivity is not an afterthought. It involves being cognizant of how the researcher's decisions and assumptions are woven into every aspect of the research process (Chamberlain, 2015). Reflexivity is used to legitimate and validate our (researchers') investigations by making our research process and the power dynamics that shape it transparent (Pillow, 2003). According to Willig (2008), reflexivity can be viewed from two perspectives. Firstly, epistemological reflexivity requires interrogating the

conceptualisation of the research project itself by considering how the knowledge produced is underpinned by a combination of the theoretical framework, methodological tools used, and the assumptions made during the analysis process. The second perspective is personal reflexivity, where the researcher must consider their positionality regarding their political standpoints, world views, social locations, and social identities that become infused with the research process from interacting with, analysing, and making representations of research participants.

A lack of epistemic and personal reflexivity applied in the research process can do harm. Certain social groups can be exploited through research, and social injustices and misrepresentations of individuals are upheld instead of challenged. For example, concerns around epistemic harm have been raised by intersectionality theorists who have argued about who gets to use intersectionality as an epistemological framework and who gets to contribute to the concept's knowledge production (Bilge, 2013). For example, Chiweshe (2018) describes how other feminist scholars challenged him for using African feminist methodologies and researching African women's abortion practices as an African man. The threat of patriarchal power, inherent to Chiweshe's social position as a man, formed the basis of this argument and was seen as infiltrating into what is deemed a woman's issue. Thus, the concern was whether and how patriarchal power may shape Chiweshe's use of African feminist concepts and the introduction of new theoretical concepts into this space. African feminist scholars have also contested how Western-based feminist scholars have represented black women in academic research, often underpinned by colonialist and imperialist assumptions that reinscribe marginalisation and oppression of certain social groups (for example, essentialising pregnant women from the global South as oppressed (Kumar, 2013)).

As with many other scholars who are in social positions of relative privilege to their participants, I had to consider my social position concerning this research topic: What are the implications of researching participants who are primarily poor, black and pregnant within a South African context as a white, middle-aged, middle-classed, child-free, South African woman? Can I use a black/African feminist orientation and construct new knowledge under the rubric of intersectionality given our (still) fractured, segregated, socially unequal, raced and classed context? Given my social position, what are the possibilities or limitations of producing reparative and transformative research?

Pillow (2003) queries whether focusing on self-reflexivity using social positions generates better research in making claims or representing others. She asks whether a

researcher's confession of their social position is necessary for interpreting data to help the reader understand the research. Pillow asserts that transcending problematic social positions by being as transparent as possible does not necessarily overcome these issues. She concludes that unequal power relationships will always exist between researcher and participant, and the researcher's needs will always be privileged.

Instead, Pillow (2003) advocates for a reflexivity of discomfort: "a reflexivity that seeks to know while at the same time situates this knowing as tenuous" (2003, p. 188). Here, written interpretations can remain uncomfortable, unfamiliar, and unresolved. Like Pillow, Chadwick (2021) draws on affective feminist praxis and sees discomfort as a resource for her research. The author argues for adopting a feminist research praxis that is more than empathetic because "our feelings and sensory or gut responses are not extraneous noise or individual matters but need to be recognised as part of feminist methodological and affective praxis " (Chadwick, 2021, p. 15). Researcher emotions such as ambivalence, hope, irritation, shame, dismissiveness or feeling disconnected provide opportunities for encouraging one to analyse and interpret data in different ways without resorting to comfortable or "safer" interpretative practices, which do little to dismantle dominant ways of knowing. This may mean providing examples in our research that are not successful and do not demonstrate seamless and unproblematic connections between our chosen theoretical orientation, methods, researcher subjectivity and interpretations of the research participants' lived experiences.

Employing a reflexive practice of allowing the unfamiliar to remain unfamiliar instead of trying to fashion it to fit or assimilate into dominant knowledge frameworks ties in with how scholars should apply intersectional thought when uncovering knowledge that is unexpected or does not fit with established ways of knowing (May, 2015). Chamberlain (2015) cautions that the reflexive practices that qualitative researchers employ to make their research process transparent and validate their accounts can always be open to contestation. Applying these reflexive practices does not necessarily mean that the researcher's interpretations will be authorised in any way.

By employing a practice of reflexivity of discomfort, I do nevertheless have to confess my subjectivity as a researcher. I am the white product of a colonial system that actively sought to ensure that I was not marginalised in the enduring forms that shape the lives of most of the research participants who took part in this study. Furthermore, I have chosen to use a theoretical orientation crafted by women of colour activists and scholars who have experienced social injustices and marginalisation in vastly different forms compared with my own.

Nevertheless, although apartheid may have structured and shaped my life and other lives, its effects are not monolithic. As the work of the Federation of South African Women (FSAW) in the 1950s has already shown (see more detail on this organisation in Chapter 4), there are spaces for agentic action and meaningful coalitional work in the process of achieving social justice aims.

Chiweshe (2018) echoes FSAW's approach. Although he argues that men have always been very invested and active in women's (only) issues, for example, abortion policy, his social position as a man and as an outsider to women's reproductive experiences remained problematic. He concluded that allyship or collaboration as a black male was a better fit than trying to assume positions of similarity or familiarity to those of his research peers and research participants. My position in this research process will remain uncomfortable, and one of my objectives will be to make the unfamiliar and uncomfortable transparent throughout the research process. In this way, I hope a "reflexivity of discomfort" opens my interpretation of the participants' pregnancy experiences up to scrutiny by other intersectionality-orientated scholars and will contribute to more discussion, more learning, and better mutual understanding between individuals from various social locations. Furthermore, this work might also point to the intricacies of what type of labour still needs to be done in forming social coalitions and collaborations comprising individuals from diverse backgrounds who share similar reproductive justice sentiments. I now turn to the research questions that guide my analysis.

Research questions

The research questions that this dissertation aims to answer are as follows:

How do women's constructions of support speak to pregnancy (un)supportability?

[1] How is this pregnancy defined in personal terms in relation to (un)supportability?

How are self and interactive subject positions taken up or resisted in describing the personal emotional, physiological, cognitive and behavioural aspects of the supportability of the pregnancy?

[2] What and how are (un)supportive micro-level interactions depicted?

How are self, interactive and imperative subject positions taken up, imposed, suggested or resisted in descriptions of micro-level interactions?

[3] What and how are (un)supportive macro-level issues embedded or referred to directly in women's talk?

How are entities positioned in the narratives? What normative constraints are implicitly or explicitly referenced in the talk?

[4] How do power relations operate in women's constructions of support during pregnancy, and how do they shape the uptake and ascription of subject and entity positions?

In answering these research questions, my findings highlight how two overarching reproductive (in)justices were identified by using a positioning analytic and the supportability framework as a guide in analysing talk about pregnancy support. These interrelated reproductive (in)justices were socially appropriate childbearing and socio-economic inequality. They were surfaced by how participants discursively constructed social support as conditional and subject to deservingness. Given the support networks and structures available to them, participants engaged in various positioning strategies to justify their pregnancies and present themselves as exemplary pregnant subjects. In addition, I show how these (in)justices themselves are shaped by relations of power and are embedded in a confluence of historical, capitalist, raced, socio-economic, gendered, nationalist, and ableist assumptions about pregnant individuals, which informed participants' autonomy in relation to making decisions about and managing their pregnancies.

Overview of this dissertation

In this introductory chapter, I have outlined the rationale for researching pregnancy supportability in South Africa using Macleod's pregnancy supportability framework.

In **Chapter 2**, I provide an overview of the macro features of the South African context that shape the supportability of a pregnancy. I provide background on wanted/unwanted fertility, South African family formations (including partner support), maternity protections in employment and state welfare, and an overview of the context of maternity health.

Chapter 3 covers how social support during pregnancy is addressed in the literature. Here, I make an argument for locating this thesis differently from this body of knowledge production because I am more interested in expanding notions of support from immediate social networks to include social structures (such as government support). In addition, I am less interested in investigating descriptions and types of social support and more invested in

investigating how social support is discursively constructed and embedded in power relations. To my knowledge, this approach has not been addressed in this body of literature.

In **Chapters 4 and 5**, I discuss the theoretical underpinnings of this thesis. In **Chapter 4**, I fully explain the pregnancy supportability framework. This framework is premised on McCall's (2005) intra-categorial intersectional approach. I discuss how my thesis uses intersectionality theory as the lens for examining pregnancy supportability. In **Chapter 5**, I argue for drawing together intersectionality theory and critical realist social constructionist approach. I also advocate for why I use Wilkinson and Kitzinger's (2003) approach to positioning theory, which is premised on social constructionism. This approach analyses what social actors *do* with their positioning work by examining how they may use social categories in talk and for what purposes. I argue that using positioning theory in this way also facilitates an analysis of relations of power. In so doing, I advocate for adopting a positioning supportability approach for examining constructions of social support during pregnancy.

Chapter 6 covers the data collection process. Here, I draw connections between intersectionality and narrative methodologies. I use photo-elicitation to collect narratives because the method aids in shifting some of the power relations from the researcher to the participant, which is important from an intersectionality perspective. The participant controls the direction of the initial interview by deciding which photographs to take and discuss with us as researchers. I also reflect on the use of this method and how it can both enable and complicate intersectional aims. I provide details on the research sites, recruitment and description of participants, the interview procedure used to generate data, and the process used to translate and transcribe the data. Finally, I discuss the ethical procedures followed to engage in this research.

In **Chapter 7**, I explain how I translate the theoretical concepts of the supportability framework and positioning theory into an actionable procedure for data analysis culminating in the development of a positioning supportability template. I argue for conducting a template analysis based on the elements of the supportability framework. I explain how I incorporate a positioning analytic within the template. I engage with some of the critiques of analysing data thematically and how I manage them with my analysis. Finally, I outline the four-phased iterative procedure I used for analysing my data.

Chapters 4 through 7 represent the fulfilment of part of the first aim of this thesis outlined at the beginning of this chapter, viz., to operationalise Macleod's (2016) pregnancy

supportability framework through theoretical and methodological explication. I present my findings in the three chapters that follow.

In **Chapter 8,** I outline six case studies of the participants. In doing so, I foreground participants' contextual and situated knowledge, thereby surfacing the similarities, variability and complexity of the pregnancy experience. This is important from an intersectionality perspective because individual narratives can bring subjugated or overlooked knowledge to light. I also draw attention to the normative constraints of reproductive legitimacy, affordability, and responsibility that surface in these case studies.

In **Chapter 9**, I show how the overarching cultural constraint of appropriate childbearing informed participants' talk about coming to accept and justify their pregnancies. Participants constructed social support as conditional, which aided in surfacing the cultural normative constraint of reproductive legitimacy. I show how participants questioned the legitimacy of their pregnancies and used their social positions to justify their pregnancies, given the support networks and structures available to them.

The findings in **Chapter 10** focus on how participants managed their pregnancies in relation to the support networks and structures available to them. The normative constraint that surfaced in these narratives was one of reproductive affordability. The socio-economic implications of the pregnancy shaped how participants discursively constructed social support as subject to deservingness, that is, whether they deserved financial, material or emotional support. Reproductive affordability also shaped their ability to be responsible pregnant subjects, which had a bearing on their reproductive autonomy in making decisions about their pregnancies.

Chapter 11 discusses the implications of the findings in this thesis for examining pregnancy supportability, the limitations of this study, future directions for policy (adopting multi-sectoral approaches to maternal health), and further research opportunities in using the pregnancy supportability framework. An overview of pregnancy supportability in the South African context is discussed in the following chapter.

CHAPTER 2

Pregnancy supportability within the South African context

In Chapter 1, I outlined how the pregnancy supportability framework expands on notions of social support and pregnancy intendedness to include the individual, micro- and macro-level influences that have a bearing on the supportability of the pregnancy. The availability of support for the pregnancy is contingent on a nexus of intertwining macro-influences. These influences are wide ranging and can influence the pregnancy experience in multiple, diverse and inequitable ways, for example, access to infrastructure such as water and sanitation. This chapter provides a broad overview of four key maternity features that shape the supportability of pregnancies within the South African context. I concentrate on these because they surfaced in the participants' narratives of pregnancy support. They take the form of fertility trends (unwanted/wanted pregnancies), family formations (marriage trends and family structures), socio-economic well-being (employment and maternity protections) and the healthcare system.

Wanted and unwanted fertility

According to the 2016 *South African Demographic Health Survey* (SADHS) (South African National Department of Health et al., 2019) , the overall fertility rate in South Africa has been declining for some time. The Total Fertility Rate (TFR) declined from 2.9 children per woman in 2008 to 2.3 children per woman in 2016 (when data were collected for this research project). The fertility rate is skewed across race, socio-economic status, education levels, geographic location, and age. Fertility is higher in population groups who are black African, have lower household wealth and education levels, and live in rural areas. Age-wise, fertility rates are highest amongst individuals aged 25-29 across urban and rural contexts.

The 2016 SADHS also measures fertility preferences and reports that women are having more children than they desire. Of the births recorded in the five years preceding the survey, 34% of pregnancies were reported as mistimed and 20% as unwanted. A Statistics South Africa report (2020b) on unwanted fertility confirms that unwanted fertility is higher in geographical areas where the overall fertility rate is high. Higher fertility rates are prevalent in the Eastern Cape, where this study was conducted. Nine of the fifteen participants in this study confirmed that their pregnancies were unplanned. Of the nine reported unplanned pregnancies, five

participants stated that their pregnancies were initially unwanted. Unwanted fertility thus has implications for the overall supportability of the pregnancy and is explicated in more detail in the findings of this study.

South African family formations

Family support and partner support featured prominently in participants' narratives of pregnancy support. However, family formations are shaped by South Africa's apartheid past and have implications for how support may be provided during pregnancy. I firstly contextualise how the migrant labour system still has a distinctly gendered bearing on household structures. I then move on to how male partner support during pregnancy is shaped by the broader macro-economic and socio-cultural context.

Contextualising family support during pregnancy

How families are organised affects the degree and types of support a pregnant individual may receive. Family formation in South Africa is shaped by mutually reinforcing historical, geographic, socio-economic and -cultural macro influences. Feminist economists Posel and Hall (2021) are particularly interested in how the family unit composition has been re-structured, given South Africa's transition into democracy. Traditional black family structures were ruptured by the colonial and apartheid regimes using several means: the implementation of segregation laws to specifically prevent co-residency of families in urban areas; forced removals from ancestral lands to be repurposed for white settlement; and the construction of the exploitative migrant labour system which separated black males from their families to supply labour to the mining industry. Taking this historical context into account, the authors trace the gendered economic implications of past policies. Using nationally representative household data, Posel and Hall pay particular attention to the following types of households: co-resident heterosexual[3] couple households (either married or in a stable union); mixed households (both male and female resident but not partnered); female-dominant and

[3] Heterosexual unions are used as measurement because the authors are interested in the overall gendered economic well-being of the household and where children are most likely to reside—all participants in my research project identified as being in heterosexual relationships.

male-dominant households; and the prevalence of “stretched” households comprising of non-resident household members who reside in the household for only 15 days of the year (based on statutory leave allowances). The authors tracked the changes in the composition of these households from 1995 (the commencement of democracy) to 2018.

Posel and Hall’s (2021) findings are instructive about the context of this study from a gendered, raced and socio-economic perspective. Firstly, the authors found that heterosexual union households have declined substantially from 51% in 2005 to less than 40% in 2018, and black families mostly feel these effects. Furthermore, the proportion of co-resident heterosexual couple households is lower in rural areas (27%) compared with urban areas (42%). Secondly, the authors report that household formations have become more divided by gender owing to the reduction in the number of co-resident heterosexual households. For example, the number of female-dominated households has increased and is more common in rural areas, where they make up 46.9 % of households in the Eastern Cape. Female-dominant households are more likely to include children and elderly than male-dominant households.

Thirdly, “stretched” households are also more common in rural areas (1 in 5 households), and the authors surmise that traditional migrant labour patterns continue to feature within these family units. Fourthly, South Africa is unique in having the lowest global rates of children who live with their parents. Where and with whom children live is based on income and childcare considerations, and children are often placed in the care of extended families such as grandmothers or aunts. For children who do live with a parent, it is more likely that they will live with their mothers.

Finally, the authors measured the economic precarity of the different types of households. Female-dominant households were more likely to rely on child support social grants and social pensions and are thus likely to be poorer than co-resident couples and male-dominant households that are more likely to rely on salaries. Posel (2020) has, however, cautioned that migrant patterns are complex and has advocated for conducting more qualitative research on the experiences of migrant workers to understand the nuances of migrant labour patterns and household formations better.

The organisation of households and the relationship status to male partners of the fifteen participants in this study are in line with complex, variable and transient family structures. In contrast to Posel and Hall’s (2021) findings, however, over half the participants did live in co-resident heterosexual households – they either lived with both their parents or

cohabited with their male partners or were married. Most males in these households were employed (except for two participants' partners who were unemployed), and some participants reported that their partner or father worked away from home during the week and returned either on weekends or month-ends. Thus, it is worth noting that these families did not necessarily fit the parameters of a "stretched" household but still formed part of the migrant labour system, whereby work commitments limited the permanent physical presence of partners.

The rest of the participants in this study either lived in female-dominated households or rented a room in the town where they worked (thereby becoming migrant workers themselves). As with Posel and Hall's findings, existing children tended to be placed in the care of maternal households where they lived with their mothers and/or grandmothers. Notably, the advent of the pregnancy precipitated a change in living arrangements for some participants, and other participants lamented that their living arrangements at the time of their pregnancy added complications to their lives. There were also debates between family members as to where some participants (and their newborns) would live after giving birth. Thus, the availability of support during pregnancy very much centred on who lived and worked within the current formation of the family unit.

Contextualising male partner support during pregnancy

Normative assumptions construct the (heterosexual) marriage institution as the bedrock upon which childbearing becomes permissible and expected. South Africans' attitudes and aspirations toward marriage are positive (Mohlabane et al., 2019), but materially, the overall marriage and fertility practices present a different picture. Statistics South Africa (2020a) reports that marriages in South Africa have declined continually since 2011. In analysing nationally representative data samples, Posel and Rudwick (2013) show that low marriage rates are racially skewed, where black African women are far more likely than other population groups to have never married nor co-resided with their male partners. The marriage institution is now said to play less of a significant role in determining fertility timing and preferences (Statistics South Africa, 2015a). For example, Biney et al. (2021) found that levels of fertility for never-married women are high and assert that declining marriages are not necessarily contributing to the overall decline in South Africa's fertility rate.

Reasons for the decline in overall marriages and co-resident unions have been attributed to cross-cutting socio-economic constraints such as the high unemployment rate,

the migrant labour system, and the financial limitations of couples in adhering to cultural practices that make marriage possible. This is despite three South African marriage laws that enable different forms of marriage: *The Marriages Act (Act No. 25 of 1961)* (Republic of South Africa, 1961) *,* which covers civil heterosexual marriages*;* the *Recognition of Customary Marriages Act (Act No. 120 of 1998)* (Republic of South Africa, 1998b) , which covers customary or traditional marriages; and, the *Civil Union Act, (Act No. 17 of 2006)* (Republic of South Africa, 2006), which recognises same-sex unions. Declining marriage rates and increases in non-marital fertility also feed into socio-cultural perceptions of male partners, which have implications for pregnancy supportability. These are discussed next.

Social constructions of partner support during pregnancy

Within the South African context, male partners are constructed and positioned negatively as "absent fathers". According to the *State of South Africa's Fathers 2021* report, absent fathers are defined as "fathers (whether biological or social fathers) who are physically *and* economically *and* psychosocially absent from their children" (Van den Berg et al., 2021, p. 14). However, the absence of male partners is attributed to multiple mutually reinforcing historical, economic and social influences. As mentioned in the previous section, families are physically separated through job migration as both men and women travel across the country to find work wherever it may be available. In addition to physical separation, social constructions around fatherhood position male partners squarely as financial providers (Hunter, 2006; Makusha & Richter, 2014; Malinga & Ratele, 2022); male partners are expected to provide economic and instrumental support by ensuring the financial needs regarding pregnancy and child support are met. Support levels falter or become non-existent when men cannot fulfil this provider role owing to unemployment or low-paid precarious work.

The intertwining of unemployment or low-paid unskilled labour or precarious work, migrant work and cultural practices such as *ilobolo* and *intlawulo*[4] also serve to separate

[4] Scholars who have researched this practice in KwaZulu-Natal have used the isiZulu spelling which is *inhlawulo*. *Intlawulo* is the isiXhosa spelling of the word. All participants in this research project who spoke about the practice identified as Xhosa and therefore I use the isiXhosa spelling.

unmarried men physically from their pregnant partners and from opportunities to carry out fatherly duties. The practice of *ilobolo* requires the groom to make a payment (there are variations of the practice) to the bride's family, which is called child price or bride wealth. It is understood to compensate the bride's family because the bride's productive and reproductive labour is transferred to the patrilineal household (Hunter, 2006). The practice also legitimises the couple's union and status in society and symbolises joining families, thereby extending kinship ties (Pakade, 2020; Posel & Rudwick, 2014a).

Intlawulo is when a pregnancy is acknowledged or "legitimised" by both the maternal and paternal family when it occurs outside of marriage. The male partner's family pays "damages" for impregnating a woman as a form of acknowledgement to the maternal family, and this payment facilitates contact between the child and biological father and access to the paternal support network (but not always the paternal name) (Hunter, 2006). Scholars have cautioned that *intlawulo* is not a homogenous custom across communities in South Africa and may be practised in many ways (Malinga & Ratele, 2022).

Because of the economic hardships felt by both families, the practices of *ilobolo* and *intlawulo* impose financial limitations on men and are consequently less attainable for men who are unemployed or who earn very low wages (Malinga & Ratele, 2022). Although many South African couples desire marriage, their financial circumstances do not allow it (Makusha & Richter, 2014; Posel & Rudwick, 2014a). In addition, cohabiting without having commenced some form of the *ilobolo* process (see, for example, Hunter's (2016) study of legitimate cohabitation) is frowned upon socially and is not considered standard practice (Posel & Rudwick, 2014b). Finally, should a male partner be unable to pay *intlawulo,* he may be denied access to his child (Hunter, 2006; Makusha & Richter, 2014). Thus, the confluence of these elements can create the conditions that enable paternity denial and the erosion of support for pregnant women. In my research, paternity denial and concerns around the cultural practice of *intlawulo* featured in some of the unmarried participants' accounts as to how they experienced partner support during their pregnancy and the implications thereof.

Reproductive health and partner support

From a reproductive health policy perspective, improving or increasing male partner participation and support within antenatal care settings has the potential to improve health outcomes for the mother, father and infant (Tokhi et al., 2018). However, male participation is deeply embedded in gendered social practices, and these norms may play a large part in

influencing the types of decisions that women make about their pregnancies and their healthcare-seeking practices (Comrie-Thomson et al., 2015; World Health Organisation (WHO), 2016). The WHO advocates that, although increased partner involvement is important during pregnancy, the participation of partners should only be encouraged based on the needs and wants of the pregnant woman.

In South Africa, partner involvement during pregnancy is not a specific policy area. Health protocols and policies, such as the maternity guidelines, do not specify including male partners within the maternal care setting and instead refer to including birth companions as support for pregnant individuals (South African National Department of Health, 2015). The South African policy environment seeks to increase male partner involvement *after* birth. For example, a Constitutional Court ruling in 2021 changed the *Births and Deaths Registration Act (Act No. 51 of 1992)* (Republic of South Africa, 1992) to allow biological, unmarried fathers the right to register their children's births in their names. In addition, the Constitutional Court in 2024 is deliberating on increasing co-parental leave to four months (the same as maternity leave). Activists have argued that the current law of 10 days of co-parenting leave places disproportionate care duties on mothers, thereby upholding gendered norms of child caregiving. They have also argued that the current laws are unconstitutional because they overlook the rights of other forms of parenting, such as adoptive and surrogate parents and fathers, to be involved in their children's lives (Hawker, 2024).

There have been calls to develop mediation interventions that target *family systems* (mothers, biological fathers, the parents' immediate families and extended kin networks) rather than focusing on individual interventions to encourage male involvement. Activists and scholars argue that mediation interventions could assist in repairing damaged relationships and encourage mutually agreed-upon parenting strategies to foster paternal participation that is both financially and care-orientated (Van den Berg et al., 2021). In this study, partners who were present fulfilled a range of supportive roles regarding pregnancy health, which included financing health care, holding a spot in the queue for antenatal care checkups, helping with household chores, and playing a part in ensuring good nutrition practices.

Intimate partner violence in South Africa

The high levels of gender-based violence (GBV) have been deemed a crisis by activists and politicians, affecting all who live in South Africa. *The National Strategic Plan on Gender-Based Violence & Femicide* (South African Department of Women, Youth and Persons with

Disabilities, 2020) conceptualises GBV as abuse that is physical, psychological, economic, and sexual (including rape and sexual harassment and exploitation). The strategic plan outlines how several macro-level factors enable the conditions for GBV. These include (amongst many others) (1) historical legacies such as that of the apartheid state, which used violence as a form of social control; (2) patriarchal social systems that uphold gendered ideologies and perpetuate unequal power relations, which contribute to the normalisation of violence; and, (3) economic inequality and exclusion which is characterised by precarious work, migrant work, unequal and exploitative pay, unpaid care work and inadequate social protection for those who are the most marginalised and vulnerable, thereby putting these individuals at risk for violence.

A national baseline gender-based violence study, the first of its kind in South Africa, was conducted to investigate the prevalence and patterns of psychological, physical, sexual and economic GBV (Zungu et al., 2024). The authors found that GBV is highly prevalent, starting early and continuing across the life course. For example, 23.9% of ever-partnered women reported experiencing physical violence and or sexual violence from their partners, 25.1% emotional abuse and 13.1% economic abuse. More than half of women reported controlling behaviour from male partners. Notably, over half of women also believed it was a woman's responsibility not to become pregnant. Zungu et al. (2024, p. 19) assert that "the data reveals deeply ingrained gender norms and power dynamics, with strong cultural reinforcement of traditional gender roles and a troubling acceptance of male aggression and dominance". This study investigated GBV in general and did not specifically focus on IPV during pregnancy. I unpack additional indicators for IPV during pregnancy in relation to social support (within the South African context) in my literature review (Chapter 3) of this thesis. In my study, incidents of physical IPV and coercive and controlling behaviours were reported in a few of the participants' narratives.

Gender-based violence and its impact on maternal health and well-being have garnered global attention. The WHO (2016) has based its most recent guidelines on the premise that IPV is associated with poor reproductive health outcomes. The WHO claims that IPV is an issue that needs to be addressed within an antenatal care setting but acknowledges that more empirical evidence is required to understand the prevalence of IPV, how best to screen for it, understand its effects on pregnant women, and examine the effectiveness of various IPV support interventions that could be provided within the antenatal setting. In their recommendations, they have suggested that the antenatal care setting offers a good opportunity for clinical enquiry into IPV, but they advise that this should be done with caution.

Introducing forms of routine enquiry regarding IPV in antenatal contact visits is highly dependent on the context of the antenatal setting, the availability and quality of health service provision, and appropriate referral systems, should IPV be detected.

Partner support during pregnancy within the South African social landscape is complex and intricate. What is deemed a good father, the prevailing hegemonic masculinities to which both men and women aspire, existing laws and customary social practices, precarious socio-economic well-being, and high levels of normalised violence in South Africa all play a part in shaping men's involvement in pregnancy and fatherhood. It is well-known that South Africa suffers from high inequality where socio-economic disadvantages proliferate across raced, gendered and classed lines. In the following section, I present some contextual indicators concerning pregnancy, employment and social welfare.

Employment and maternity social protection

A brief overview of South Africa's employment context and social welfare system in relation to pregnancy is warranted because, as the narratives presented in this thesis will show, the state plays an instrumental role in shaping the supportability of pregnancy through these mechanisms. South Africa has established several labour laws and policies that protect pregnant individuals' employment in the workplace. For example, the *Constitution of the Republic of South Africa* (1996) , the *Basic Conditions of Employment Act* (1997) , the *Labour Relations Act*, (1995) and the *Code of Good Practice on the Protection of Employees During Pregnancy and After the Birth of a Child* (1998) all state that no one may be discriminated against in the workplace because of pregnancy. However, the laws themselves have very limited reach. They only protect pregnant individuals employed in the formal employment sector and do not extend to those who work in the informal sector (such as seasonal farm workers and street traders).

Moreover, according to a policy analysis conducted by Pereira-Kotze and colleagues (2022) , the policy environment is incoherent and does not quite meet international maternity protection standards. The authors identified and analysed 28 policies on maternity protection and interviewed key informants in the national government. They compared these policies with international recommendations from the ILO Maternity Protection Convention 183, the ILO Maternity Protection Recommendation 190 and the *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW). Importantly, they noted that although South Africa has ratified the CEDAW convention, it has not ratified the ILO Maternity Protection Convention.

They found that most policies met international standards concerning health protection, maternity leave, non-discrimination and job security. However, these policies fell short in three key areas. Firstly, some documents were guidelines only and not enforceable by law (such as accommodating pregnant women in shift work schedules), which meant that these practices in the workplace are not monitored and evaluated by government officials. Secondly, various elements making up maternal protections were not integrated but spread across documents and government departments; this made the protections in place challenging to interpret for employees and employers alike. Thirdly, and crucially, South Africa falls short on income protection for pregnant individuals, both from a social insurance and social assistance standpoint. These shortcomings relate to how the South African developmental welfare state is structured.

From a macro-level perspective, South Africa is a developmental social welfare state. Some social policy scholars contend that the African National Congress (ANC) led government engages in "'talking right and acting left" (Seekings & Nattrass, 2015, p. 158) about providing state welfare. In acting "left", the South African government, since democracy, has deracialised social welfare, together with expanding these protections to all citizens substantially and continues to do so. However, in talking "right", the authors describe how ANC leaders have been adamant that state social welfare should not encourage South African citizens to become "dependent" on the state by relying on "handouts". Instead, ANC leaders insist that citizens should empower themselves to become economically independent and self-reliant, with the state playing a supportive role. The ANC has remained consistent in its views on welfare dependency. The current president, Cyril Ramaphosa, has been quoted as saying that South Africa is one of the only countries on the African continent that "takes care" of its people because it *costs* the state billions to provide social grants to over half the population. He called the Social Relief of Distress (SRD) grant, given to unemployed individuals in response to the devastating impacts of the COVID-19 pandemic, a "freebie" (Madisa & Amashabalala, 2023).

The South African welfare state is thus considered unique in that it embraces a combination of mechanisms spanning liberalist, social democratic and conservative approaches to welfare (Button et al., 2018; Seekings & Nattrass, 2015; Seekings & Moore, 2013). According to Seekings and Nattrass (2015), the mechanisms are: [1] **market-based,** whereby pregnant women can purchase private healthcare, and the state subsidises their healthcare costs through tax rebates; [2a] **state social insurance,** which is a state-run

contributory scheme usually financed through deductions from the salaries of those who are formally employed. Employers are not mandated to pay salaries during maternity leave, so the Unemployment Insurance Fund (UIF) enables pregnant women in formal employment to claim financial benefits. However, they only receive a percentage of their earnings; [2b] **state social assistance** in the form of unconditional, non-contributory, means-tested income support funded through taxation. These cash transfers include pensioner, child support, child foster care and disability social grants. These grants are provided to financially "deserving" target population groups deemed unable to be economically active (that is, older adults, children and people with disabilities); and [3] **kin support** whereby the state relies on kin to take on the financial responsibility for those who are not able to nor do not meet the requirements of the above-mentioned state welfare approaches. Structuring the welfare state in this manner means that no state income support or social insurance is provided to unemployed, able-bodied, and working-age adults. As a social category, unemployed pregnant women and pregnant workers who do not work in the formal job sector fall outside of state income protection measures. They must rely on kin for financial support.

Unemployment in South Africa is high. When data were collected for this research project, the expanded unemployment rate was 35,6% (Statistics South Africa, 2016). This rate includes individuals looking for work and those who wanted to work but had stopped looking for employment. In addition, the youth unemployment rate (age 15-34) sat at 37.1%. Although the participation of women in the workforce has increased since democracy, Mosomi (2019), in her analysis of the gendered employment gaps in the South African economy, reports that overall, women are still more likely to be unemployed than men and more likely to leave employment to fulfil motherhood or care duties. Government workfare programmes are in place to provide short-term employment in infrastructure and care work. However, as Seekings and Nattrass (2015) assert, these programmes have not reached the desired employment targets, have not been appropriately implemented, and thus have done little to alleviate the unemployment crisis.

Twelve of the fifteen participants in this study were located within the age cohort characterised by youth unemployment. Only three participants in this study had some form of formal employment. The rest of the participants reported that before their pregnancies, they were either self-employed, did seasonal farm work, internship work or "piece work" (such as short-term employment with the Eastern Cape Public Works Programme (ECPWP) or government internship employment programmes). However, eleven out of the fifteen

participants in this study reported being unemployed or not working during their pregnancies. The advent of the pregnancy resulted in participants either choosing to leave employment or prolonging their unemployment status, and stalled any efforts in seeking new employment opportunities. Health policy in South Africa has been pro-poor, where primary public healthcare does not charge user fees. An overview of the South African healthcare context is provided next.

The South African health system: Maternity care

Maternity care is provided free of charge in the public health sector. However, disparities in access to and quality of maternity services plague the health system. I provide some context by discussing the maternal and perinatal mortality rates, how maternity care is managed in the public health system, the inequitable public/private divide and the medico-legal crisis that is affecting the entire public health system.

Maternal and perinatal mortality

Maternal healthcare in South Africa is a priority focus area because the maternal morbidity and mortality rates are still too high. As a member state of the United Nations, the South African government initially aligned its maternal health policy with Millennium Development Goal 5: improve maternal health. It missed the target of reducing the country's Maternal Mortality Rate (MMR) to 38 per 100,000 live births by 2015 (Statistics South Africa, 2015b). In 2015, South Africa adopted the Agenda for Sustainable Development, comprising 17 Sustainable Development Goals (SDGS). SDG 3 focuses on good health and well-being and includes a revised target of reducing the global MMR to fewer than 70 deaths per 100,000 live births by 2030 (Statistics South Africa, 2019). South Africa managed to reduce *institutional* maternal mortality from a high of over 189 deaths per 100,000 live births in 2009 to slightly under 100 deaths per 100,000 live births in 2019. However, these figures do not include deaths that occur *outside* of facilities (Moodley et al., 2020). In 2016, the time at which this research project was conducted, the institutional maternal mortality ratio (iMMR) was sitting at 83.3 deaths per 100,000 live births (National Committee for Confidential Enquiries into Maternal Deaths, 2018). Maternal mortality and morbidity remain an ongoing national concern. To my knowledge, however, all participants in this study survived childbirth.

Although there is a high survival rate of over 98% for infants born in South Africa (South African National Department of Health, 2021), the health system has work to do in reducing perinatal mortality. The SDG goals are to reduce stillbirths to 12 deaths per 1000 live births by

2030. Stillborn foetuses (occurring at 7 months of gestation) and neonatal deaths (occurring within 7 days of giving birth) are classified as perinatal deaths by the *South African Demographic Health Survey* (SADHS). This survey (2019) recorded a perinatal mortality rate of 29 deaths per 1000 pregnancies over the 5-year period preceding the survey. However, concerns have been raised regarding the high proportion of *antenatal* stillbirths, which accounted for 45% of the overall perinatal deaths from 2015 to 2017 (Pattinson et al., 2019). It was distressing for us as researchers to interview participants only for them to lose their pregnancies or infants during our data collection phase. Two participants experienced pregnancy loss in their third trimester while taking part in this project. One participant spoke of her trauma owing to having had a stillbirth while giving birth during her previous pregnancy, and one participant's infant died within the first four months of life.

Maternal mortality in South Africa is attributed chiefly to non-pregnancy-related complications, that is, HIV and tuberculosis (TB) infections, followed by direct pregnancy-related deaths of hypertensive disorders and obstetric haemorrhage (Moodley et al., 2020). *The 2014-2016 Saving Mothers Report* (National Committee for Confidential Enquiries into Maternal Deaths, 2018), covering the time at which participants gave birth in this research project, acknowledged that the institutional maternal mortality rate did not include deaths that occurred outside of health facilities, which was problematic. The report has highlighted that some maternal deaths were attributed to post-partum complications, where individuals were discharged too early from the hospital after giving birth. In addition, the report acknowledged that there were cases of post-partum deaths by suicide (linked to post-partum depression) that should be monitored more carefully. The four most common reasons for perinatal stillbirths were unexplained stillbirths, spontaneous pre-term birth, hypertensive disorders during pregnancy and intrapartum asphyxia (National Perinatal Morbidity and Mortality Committee, 2016). According to a study across three South African provinces conducted by Lavin, Preen and Pattison (2016), small-for-gestational-age babies (SGAS) comprise one-quarter of unexplained stillbirths, and these deaths peak between 33-37 weeks of gestation.

Although there have been some clear health system improvements in reducing maternal mortality, there are still concerns about the slow decline in reducing perinatal mortality. Both maternal deaths and stillbirths are partly attributed to health system failures. Maternal deaths that stem from substandard clinical and administrative care affect both the private and public health sectors. Examples of clinical sub-optimal care in obstetric settings included poor initial assessments and monitoring of patients, as well as incorrect diagnoses

(South African National Department of Health, 2017b). In the public sector, examples of sub-standard care included not diagnosing poor foetal growth and mismanaging hypertensive disorders in pregnant individuals at the antenatal care level (Lavin et al., 2016; Pattinson et al., 2019). *The Saving Babies Report* (National Perinatal Morbidity and Mortality Committee, 2016) highlighted several health system shortcomings, including failures in governance and leadership, insufficient infrastructure, technology, and human resources, poorly operating referral systems, and a lack of emergency transport. These reports also point to administrative failures, including poor technical, professional and interpersonal communication between health workers (South African National Department of Health, 2017b).

Participants in this study mirror some of these issues. Several participants were diagnosed with hypertensive disorders during pregnancy. Three participants reported being informed that their foetuses were small for their gestational age. However, the manner in which healthcare workers imparted this information caused general panic, stress and consternation for those participants. For those participants who lost their pregnancies, no explanations were given to them as to why they experienced miscarriage, had a stillbirth or why their infant died.

Managing maternity care in the public health sector

As part of the strategy for maternal healthcare, the National Department of Health (NDoH) has developed antenatal care (ANC) health protocols that align with those of the WHO. In 2008, South Africa adopted the WHO's Basic Antenatal Care (BANC) model, recommending four antenatal visits for pregnant women (Pattinson et al., 2019). Despite the implementation of this model of care, certain LMIC countries, including South Africa, did not meet their maternal MMR reduction targets by 2015. In response to these missed targets, the WHO model was critiqued for its over-emphasis on the clinical aspects of care whilst not paying enough attention to psychosocial needs and the general well-being of pregnant individuals (Downe et al., 2016). In addition, the model overlooked the socio-economic and cultural contexts that may influence the usage of antenatal care (Downe et al., 2009; Finlayson & Downe, 2013).

The limitations of the original BANC model are reflected in the South African healthcare nexus. Firstly, healthcare policies and the healthcare interaction privilege biomedical interventions: the clinical management of pregnant individuals as high-risk subjects who should be closely screened and monitored throughout their pregnancy. For example, this is evidenced through the maternity case record (MCR). Pregnant individuals are issued this document on their first antenatal care visit and must present it each time they attend an

antenatal check-up throughout their pregnancy. At each visit, healthcare workers are expected to fill in the MCR with all the required information about the current pregnancy status (Sibiya et al., 2015). This document will also be required once the individual is referred to a birth facility when it is time to give birth. Some participants in my research took photographs of the maternity case record to emphasise how important this document was as part of their pregnancy healthcare regime.

Secondly, although South Africa has ensured that maternal and child health care is free of charge, other socio-economic constraints, such as distance to clinics and transport costs, hinder pregnant individuals' access to health facilities. Most pregnant individuals in South Africa do attend antenatal care. However, socio-economic limitations, such as transport costs, have a bearing on late and inconsistent antenatal care attendance, which have been flagged as an ongoing concern (Moodley et al., 2018). Although some of my study participants could access the clinic easily because it was within walking distance of their homes, others reported that they had to carefully plan their antenatal checkups because of the types of services that were available at these clinics and the distance and cost constraints in getting to the clinic.

The WHO (2016) has subsequently revised its recommendations for ANC. These guidelines now advocate for an increase to eight ANC visits during the pregnancy. Moreover, one of their recommendations is to provide care that enhances a positive pregnancy experience, that is, the provision of respectful care and involvement of women in making decisions about their care. South Africa has followed the revised WHO guidelines for antenatal care by adopting the Basic Antenatal Care Plus (BANC-Plus) approach. On 01 April 2017, the National Department of Health (NDoH) increased the number of ANC contact sessions from four to eight, with the frequency of visits increasing during the third trimester of pregnancy (Pattinson et al., 2019). Again, improved clinical care was the key focus area for effecting this change. An increase in the chances of a stillbirth and/or the onset of hypertension is more likely to occur later in pregnancy. Additional frequent check-ups at this stage enable the healthcare system to address these conditions should they arise (Hlongwane & Pattinson, 2023; Moodley et al., 2018). The older WHO model was still operating when this research project was conducted. However, some participants reported being told to come monthly for an antenatal check-up at one research site.

Despite improvements in clinical care, the NDoH has only recently released the fifth edition of the *National Integrated Maternal And Perinatal Care Guidelines For South Africa* (South African National Department of Health, 2024), which now attends to ensuring women

have a positive pregnancy experience. These guidelines include providing psychosocial support and respectful care per the WHO guidelines. Respectful care has been flagged as a key intervention area in obstetric units (Honikman et al., 2015; Pattinson et al., 2019; South African National Department of Health, 2017b). Indeed, pilot interventions have been implemented to improve respectful care in maternity labour wards, and there have been calls to scale up these interventions across the entire health system (Oosthuizen et al., 2018, 2020). This amendment was not yet implemented at the time of data collection for this study, and respectful care or psychosocial support to pregnant women was not yet a key intervention area. Participants in this study reported that they saw the clinic as a service and not as a form of support where you could "talk" with the nurses. Participants reported variable experiences regarding respectful forms of care where nurses were positioned as "very kind" or "very rude". Participants talk about their healthcare interaction mainly reflected a lack of patient-centred care (whereby patients are included in decision-making about their health), and they simply complied with what they were told to do.

Nevertheless, in acknowledging some of the health system's constraints, the NDoH developed other interventions that provide additional informational and social support to pregnant individuals. Firstly, in 2011, the NDoH implemented the primary healthcare ward-based outreach programme where community healthcare workers (CHWs) provide support services for maternal health through home visits. CHW maternity health tasks include identifying pregnant individuals within the local community, administering pregnancy tests, promoting safe and healthy pregnancies, and assisting with safe post-partum recovery (Schneider et al., 2018; South African National Department of Health, 2012a). In addition, the government uses information communication technology (ICT) or mHealth platforms to provide informational support to pregnant individuals (Moodley & Pattinson, 2011). When pregnant individuals first register for antenatal care, they are signed up to MomConnect. This simple, cost-free text messaging program sends reminders to the individual's mobile phone when their next antenatal visit is due. It also provides information about the gestational age of the pregnancy, danger signs to look for in pregnancy and nutrition advice. Finally, to encourage additional support for pregnant individuals, the NDoH specified that they can choose a birth companion to accompany them to antenatal check-ups and be present with them during birth (South African National Department of Health, 2017a). Participants in this study did not mention that CHWs had attended to them but did acknowledge that MomConnect was helpful to them in a general way. However, it did not address specific issues concerning their own

pregnancies. During our data collection phase, three participants gave birth, and all reported that they delivered without having a birth companion by their side.

The private healthcare sector and maternity care

The South African healthcare system is stratified in that it comprises both private and public healthcare. Maternity care is provided not only by the South African government but also by the private health sector. It is here where the most significant disparity is concerning access to quality healthcare. According to the 2016 *South Africa Demographic Health Survey* (2019), 87.4% of pregnant individuals gave birth in a public health facility, whilst only 8.5% gave birth in the private sector.

According to the ANC-led government, this configuration is considered inhumane as market-based healthcare exacerbates health inequities by socially separating South Africans from each other across race, socio-economic and urban/rural divisions (Paremoer, 2022). The tensions between the capitalist stance of allowing healthcare to be regulated by the free market and adopting a universal healthcare approach have existed for just over 100 years (Whyle & Olivier, 2023). Nevertheless, as democracy dawned in the late 1990s, the state adopted a distinctly pro-poor stance by not charging pregnant women and children under 6 years user fees to use the public health system. On 15 May 2024, the government made a bold bid to regulate the commercialisation of health care and signed into law the highly contested National Health Insurance (NHI) bill. This bill aims to reform and transform the two healthcare systems by making them more accessible to all South Africans.

Despite the ANC-led government citing principles of social solidarity, equity, sanctity of life and positioning healthcare as a public good in its motivation for introducing the NHI (Paremoer, 2022), the state has nevertheless undermined its redistributive efforts due to its track record of poor quality healthcare provision and corruption (Seekings & Nattrass, 2015; Whyle & Olivier, 2023) which itself could be described as *dehumanising*. For example, there is a growing body of research in South Africa with a focus on disrespectful maternity care experienced by pregnant individuals using South Africa's public health system (Bradley et al., 2016; Chadwick, 2017; Honikman et al., 2015; Jewkes et al., 1998; Kruger & Schoombee, 2010) . These scholars have specifically drawn attention to how this type of treatment proliferates because it is upheld by structural inequities that are informed by race, class, gender, age, ability, nationality and colonialist histories. This aspect of maternal healthcare will be dealt with in more depth in the literature review of this thesis.

Nevertheless, this bifurcated system affected participants' access to and perceptions of maternity care during this research. For example, four participants accessed some form of private healthcare or a combination of public/private healthcare (either during their current or previous pregnancy). Private health care in South Africa is considered more resourced and of better quality than the public health sector (Seekings & Nattrass, 2015). However, this form of care is the preserve of population segments who have a high socio-economic status. An online newspaper article reported that in 2018, it cost approximately R25 000 to have a natural birth and approximately R43 276 to have a caesarean section in a private hospital (BusinessTech, 2019).

Individuals who use private healthcare join a medical aid scheme and pay monthly premiums, giving them access to certain health benefits. The higher the premium, the more comprehensive the care. For instance, some individuals may pay for a hospital plan that only covers the delivery of the pregnancy in a private hospital. In contrast, others pay for a more comprehensive care package that includes antenatal care. Pregnant individuals accessing private care generally select one healthcare practitioner (for example, a gynaecologist) who cares for them during the entire pregnancy. These specialists are not employed by hospitals directly but are contracted by specific hospitals. Pregnant individuals themselves need to get authorisation from their insurance provider to give birth at the selected private hospital where their specialist practices. They also need to "book" a bed for the impending birth. Otherwise, they may be turned away if arriving unexpectedly while in labour. Co-payments are a feature of private healthcare services should the specialist or hospital charge rates higher than those of the medical scheme.

The *Medical Schemes Act 131 of 1998 (Republic of South Africa, 1998a)* regulates the private health sector. This Act decrees that no medical scheme may discriminate against pregnancy. However, the Act also allows for condition-specific waiting periods. These waiting periods impose either a three-month or twelve-month waiting condition whereby individuals who join a scheme cannot make any medical claims within this time. This, the medical insurers explain, ensures the protection of all the members of the scheme by preventing instances where individuals only sign up for a medical event (for example, pregnancy) and then leave the scheme directly after the medical procedure has been completed, thus depleting the pool of funds for all members whilst not having sufficiently contributed to the scheme. Therefore, all medical insurance schemes include pregnancy as an existing condition and will not cover pregnancy should a new member join the scheme when already pregnant or become pregnant

within 12 months of joining the scheme. In my study, one participant, Kerry, carefully planned the timing of her pregnancy around this waiting period.

Although it is perceived that one may receive a much higher standard of pregnancy care in the private health sector compared with that of the public sector, there are nevertheless particular systematic issues that hinder access to private maternity care for individuals living in small towns (which included the research sites selected for this project). Firstly, the availability of specialists such as gynaecologists and obstetricians are limited to major metropolitan areas with time, cost, and emergency care implications. Secondly, indemnity insurance premiums have increased exponentially for healthcare practitioners who provide maternity care, and it is currently estimated at over R 1 million per year for obstetricians (Snyman, 2019).

The high indemnity insurance premiums to provide maternity care have had a knock-on effect on General Practitioners (GPs) who practice in small towns. These healthcare providers have now ceased delivering babies, nor do they provide comprehensive antenatal care. For example, a local doctor in one of the towns explained that they would have to deliver 30 babies per month per doctor to cover the costs of their indemnity, thus making the service simply unsustainable from an operational and cost perspective (Dr F. Zietsman, personal communication, May 08, 2023). This situation is owing to a climate of medico-legal claims where maternity care (mostly obstetric care) is now considered high risk for indemnity insurers of healthcare practitioners.

Medico-legal crisis in South Africa

Medico-legal claims in South Africa have been described as a crisis. Although these claims have increased globally, the South African Law Reform Commission (SALRC) (2021), in a discussion paper on medico-legal claims, reported a substantial increase in the number and size of claims in South Africa over the past 12 years between 2009 and 2021. According to the discussion paper, medical negligence claims have been spawned by State medical negligence but have also spilt over into the private sector. In 2018/19, over 2 billion Rand was paid out in claims made against the state nationally. Over the past three years, the Eastern Cape Province has paid out the most significant proportion of all state claims and, in 2020/21, paid out over R920 981 000. The largest proportion of medical negligence claims against the state are related to obstetrics.

The consequences of medico-legal claims are dire in that it is dissuading healthcare professionals from choosing to practice obstetric care, creating a skills unavailability and

deficit in maternity care across both the private and public sectors (Howarth, 2013; South African Law Reform Commission, 2021). In addition, these medico-legal claims are not budgeted for as separate line items in the overall public health sector budget, thereby depriving the health sector of funds meant to provide health services to the general population. The SALRC has put together recommendations to deal with medico-legal claims from legal, political, health, civil society, and academic perspectives to manage the crisis. The medico-legal crisis is a consequence of a failing and unsustainable healthcare ecosystem cutting across both the public and private health sectors. It is undoubtedly fuelling inequitable access to quality maternity care for individuals who become pregnant. This crisis had a direct impact on participants in this study who used private medical care; they were unable to access the full bouquet of maternal care in their hometown, such as getting an ultrasound or giving birth.

Conclusion

In this chapter, I provided an overview of how the South African context, from a macro perspective, provides a supportive environment in some instances to carry a pregnancy, but in general, I have outlined how the macro-environment is mostly unsupportive. I first provided an overview of wanted/unwanted fertility. Although the total fertility rate is decreasing, women are still having more children than they desire.

Secondly, I presented an overview of family formations in the post-apartheid era, outlining how the migrant labour system still shapes how families are organised and how they are gendered. Female-dominant families are more likely to look after children and older adults and are, therefore, more economically vulnerable than other household configurations. I then provided some context into how the socio-economic conditions (unemployment and migrant labour system), social constructions of men as fathers (absent fathers and financial providers) and cultural practices underpin male partner support during pregnancy.

Thirdly, I explained how maternity protections are organised in South Africa. These include laws and policies around employment during pregnancy and how the structuring of the social welfare state negatively impacts pregnant women who are pregnant and are unemployed or are non-standard workers.

Finally, I provided an overview of the health system, outlining how maternal health inequities persist through the country's maternal and perinatal mortality rates. I also explain how the government has made continual improvements to maternal health clinical protocols in line with global policy but that these are undermined by sub-standard care. I also present an

overview of the private health sector and how a medico-legal crisis affects both health sectors with a specific impact on maternity care. In providing this contextual backdrop, I have outlined some key macro aspects that shape the supportability of a pregnancy. The following chapter provides an overview of knowledge production concerning social support during pregnancy.

CHAPTER 3

Knowledge production on social support during pregnancy

In this chapter, I present a snapshot of the literature that has examined pregnancy utilising the construct of "social support". I use the supportability framework as a guide to shape the structure of the chapter. Given that the supportability framework is multifaceted, space does not allow for a full explication of the vast amount of literature on social support that speaks to all the framework's elements. Instead, I will provide a broad overview of this literature from a global perspective, mainly utilising systematic reviews. I will then delve more comprehensively into the growing cross-disciplinary literature on social support during pregnancy in South Africa.

First, I will focus on the literature examining the effects of social support on the individual pregnant woman in terms of her physiological or psychological outcomes and maternal behaviour. I then turn to the micro-level influences and explore the literature in more depth concerning social support provision from partners, family members, healthcare practitioners and the workplace. The macro-interactive space is then explored in terms of how the literature has addressed the socio-cultural practices (cultural, religious and gendered contexts) in which a woman's pregnancy may be supported or unsupported. Literature that analyses policy as a structural form of support and its potential to enable or constrain the supportability of a pregnancy is also discussed.

Finally, I present the limited literature that considers how social support is discursively constructed in relation to reproductive decision-making across the life course. I locate my study within this literature, but with a specific focus on experiences of social support during pregnancy. Most literature covered in this review (especially within the South African context) focuses on presenting surface-level meanings or descriptions of social support during pregnancy. An examination of how the meanings of social support during pregnancy are produced in talk, given the social positions that pregnant women may occupy, has not been addressed. Moreover, the body of literature analysed in this review has not particularly addressed how social support itself is embedded in multiple power relations operating across social divisions (which include gender, age, location, race and nationality) and the broader social context; it is these power relations and their implications for the supportability of the

pregnancy that this thesis seeks to address using a multi-level intersectional approach. The literature on social support and pregnancy outcomes is presented next.

Social support and individual pregnancy outcomes

A substantial global body of psychological and public health literature examines social support in relation to pregnancy outcomes. These outcomes encompass the pregnancy's physiological, psychological, behavioural and cognitive elements (located on the individual level of the supportability framework). Of particular interest is whether the (non) provision of social support influences physiological birth outcomes, for example, pre-term births or low birth weight (Hetherington et al., 2015; Schetter, 2011), and on mental well-being (including subjective well-being, stress, self-harm, anxiety and depression) of pregnant individuals during and post-pregnancy (Battulga et al., 2021; Bedaso et al., 2021b; Biaggi et al., 2016; Modde Epstein et al., 2024; Sufredini et al., 2022; Yim et al., 2015). Poor maternal mental health during pregnancy and its effects on adverse physiological birth outcomes also feature in this literature, whereby it is posited that social support may play a mediating role between the two (Accortt et al., 2015; Appleton et al., 2019; Schetter, 2011). In general, the findings of these systematic reviews show significant associations between low social support and mental distress. In contrast, the associations between low social support and pregnancy outcomes (LBW and PTB) are less conclusive.

Social support provision is also examined in relation to pregnancy health behaviours, for example, whether it influences illicit substance use (Chou et al., 2018; Gruß et al., 2021) , tobacco use or alcohol consumption (Bitew et al., 2020; Elsenbruch et al., 2007; Hanson & Jensen, 2015; Jonsdottir et al., 2017; Masho et al., 2014). The influence of social support networks and healthcare provider support on healthcare-seeking practices, such as attending antenatal care, has also garnered scholarly interest, which is presented in more detail later in this chapter. From a cognitive perspective, pregnancy intention has been examined in relation to social support and mental well-being; pregnancies considered undesired or unwanted are associated with psychological stress, low social support and poor relationship quality (Barton et al., 2017; Biaggi et al., 2016; Feld et al., 2021; Lundsberg et al., 2020; Orr & Arden Miller, 1997).

This body of literature is quantitative and attempts to hypothesise about associations between social support and specific pregnancy outcomes, behaviours, or cognitions. However, in conducting systematic reviews on social support and pregnancy outcomes (Bedaso et al.,

2021b; Hetherington et al., 2015; Schetter, 2011), researchers have drawn attention to how social support is measured in many different ways. For example, Bedaso et al. (2021b) identified 22 different social support instruments that measure social support during pregnancy. These authors suggest that the various instruments used indicate how social support might be understood and perceived differently across social groups, socio-cultural settings and global regions. These findings are important concerning the conceptualisation of this study in that the notion of social support cannot be essentialised or categorised neatly. Moreover, the instruments are conceptualised in relation to immediate support networks and do not consider how support structures such as socio-economic policies, socio-cultural norms or institutional structures may inform the availability and perceptions of social support.

Turning to South Africa, scholars have examined how the (non)provision of social support may influence anxiety and depression during pregnancy (Hartley et al., 2011; Heyningen et al., 2016; van Heyningen et al., 2017) and the prevalence of suicidal ideation behaviours in pregnant women (Onah et al., 2017). Social support has also been examined in relation to how it may play a mediating role in the association between depression and stigma during pregnancy amongst HIV-positive women (Brittain et al., 2017a) and food insufficiency and depression (Tsai et al., 2016a). These studies were all quantitative and focused on pregnant individuals who were economically disadvantaged. A high prevalence of mental distress was found in all these studies. In addition, these scholars found strong associations between increased levels of mental distress and low perceived social support, which aligns with the existing global literature.

In a study conducted by Brittain et al. (2017b) on pregnant women with HIV, however, social support mediated against depression but not against the effects of stigma. This suggests that socio-cultural norms may shape perceived social support. Both this study and a study by Tsai et al. (2016a) on the associations between food insecurity and depression found that high levels of instrumental support over emotional support were a mediating variable in reducing pregnant women's vulnerability to depressive symptoms. The reasons for this, the authors surmise, are that adverse socio-economic conditions will inform the types of support networks available and how those support networks, living in similar circumstances, can provide social support. Recommendations from these South African studies point to implementing tangible structural-level support approaches that reduce poverty, such as nutritional interventions or extending social protections to pregnant individuals (Tsai et al., 2016a; van Heyningen et al., 2017).

There seems to be consensus within most of the literature that low social support during pregnancy is considered a risk factor for depressive disorders during and after pregnancy, and to some extent, poor physiological outcomes and adverse maternal health behaviour. Social support from immediate social networks thus mediates or acts as a protective mechanism against adverse life events and contexts during the individual's pregnancy. However, the context in which social support is provided points to its more complex interaction with pregnancy outcomes. I now turn to how the literature addresses micro-level support during pregnancy.

Social support on a micro-level

In this section, I focus on how the literature on social support during pregnancy has addressed partner, family, workplace and healthcare interactions in relation to providing social support to individuals while pregnant.

Partner support

Research has shown that pregnant women rank their partners as the primary and most important source of social support (Battulga et al., 2021; Bedaso et al., 2021b; Dunkel-Schetter et al., 1996). Thus, the partner has been a key consideration in some of the literature that has examined the effects of social support on pregnancy experiences and outcomes. The literature on partner involvement or support during pregnancy tends to focus on heterosexual relationships and is examined within four main themes: Partner support and psychological outcomes; experiences of partner support during pregnancy; partner participation and support within an antenatal care setting; and intimate partner violence (IPV) during pregnancy.

Partner support and psychological well-being

There is consensus in the quantitative literature that a lack of social support provision from a partner is a risk factor for the mental well-being of a pregnant woman. Low levels of partner support have been associated with perinatal depression and anxiety (Biaggi et al., 2016; Sufredini et al., 2022) , and low levels of subjective well-being (Battulga et al., 2021). Relationship status, such as marital status, whether pregnant women cohabitate with their partners, the length of the relationship and whether they are partnered or not, has been a feature of this research (Biaggi et al., 2016). For example, Bedaso et al. (2021a) investigated the social determinants of social support in Australian women during pregnancy. They found that unpartnered women were more likely to report low levels of social support (both emotionally

and financially). The authors asserted that partners were the most important sources of emotional and affectionate support for pregnant women in their study. Two South African studies that examined predictors of anxiety disorders in low-income pregnant women (van Heyningen et al., 2017) and perinatal suicide ideation behaviours (SIB) (Onah et al., 2017) found significant associations between not living with a partner and experiencing adverse psychological outcomes. Onah et al. (2017) found that pregnant women who were in casual relationships were more at risk for SIB.

In contrast, however, scholars have argued that it is not so much the relationship status that is a factor for maternal psychological outcomes, but rather the relationship quality (Biaggi et al., 2016). In a systematic review on predictors of post-partum depression in pregnant women, Yim et al. (2015) reported that women who were cohabiting with their partner demonstrated fewer post-partum depression symptoms compared with those who were non-cohabiting. However, these effects were diminished when accounting for relationship quality. Kruse et al. (2013) have critiqued how social support from a partner or partner status is conflated with the quality of the relationship. The authors argued that just having a partnered status or social support from a partner may not always be that positive or beneficial for maternal psychological outcomes. They advocated for an expanded range of indicators to measure partner support, including an Intimate Partner Violence (IPV) variable and a subjective measurement of how satisfied the pregnant woman is with her romantic relationship. The authors applied these variables to an existing research database of 567 perinatal US women, which sought to measure the effects of prenatal post-traumatic stress disorder (PTSD) on childbearing outcomes. The authors concluded that including these two variables better explained variance in maternal health and behavioural outcomes compared with just using relationship status as a variable for partner social support and as an indicator of maternal health outcomes.

Other studies have focused on relationship quality in relation to maternal outcomes. For example, in an Iranian study, increased levels of marriage satisfaction, specifically the quality of communication between the couple, reduced mental stress (Alipour et al., 2019). An Icelandic study conducted by Jonsdottir et al. (2017) focused on relationship quality in relation to pregnancy mental well-being. They found that increased perinatal depression was significantly associated with partner dissatisfaction. This dissatisfaction stemmed from the inequitable division of childcare and household labour. In a nationally representative UK study of partnered mothers (Barton et al., 2017), the authors found that an unplanned pregnancy was

a significant risk factor for post-partum psychological distress, especially for those who were ambivalent or unhappy about their pregnancies. Moreover, the authors found that poor relationship quality was a significant driver of this relationship. Women in their study who had unplanned pregnancies were more likely to report lower relationship quality and social support in general compared with those who had planned pregnancies.

Notably, these quantitative studies show that perceived social support in intimate relationships can be constructed differently in different contexts. Although there are strong associations between having a partnered status and improved psychological well-being in pregnant women, the quantitative studies that focused on the relationship quality suggest that beneficial social support provided by a partner is contingent upon the manner in which it is given. Qualitative analyses can provide researchers with a richer understanding of how perceived social support is constructed through interpersonal interactions between the pregnant woman and her partner. I now turn to how partner social support is addressed in the qualitative literature during pregnancy.

Experiences of partner support during pregnancy

In conducting a qualitative systematic review of pregnant women's experiences of social support during pregnancy, Al-Mutawtah et al. (2023) found three main themes across the studies they analysed concerning how pregnant women described their partner's support. These themes included pregnant women's: (1) (dis)satisfaction with their romantic relationship: pregnant women voiced dissatisfaction when partners did not provide enough emotional support or displayed a lack of understanding about their pregnancy experiences; (2) emotional support in the form of care and affection: being attentive, listening and being encouraging was seen as a form of emotional support while paying attention to the nutritional requirements of the pregnancy was seen as a form of care; and (3), instrumental support such as financially providing for the pregnancy. This review did not include any studies from South Africa.

South African studies have reported similar findings regarding the importance of emotional and financial support provision. The most important source of social support was the partner's, and emotional support was valued over and above instrumental support (Mabetha et al., 2024; Mlotshwa et al., 2017; Phiri et al., 2023). Emotional support was described as partners being available, attentive, and initiating daily contact. Instrumental support in helping with small tasks, household chores, and attending antenatal care appointments with pregnant women was also valued (Phiri et al., 2023). Financial support was

constructed as a partner's responsibility, including covering healthcare and transport expenses, purchasing groceries, and baby and maternity items (Lewinsohn et al., 2018; Mabetha et al., 2024; Phiri et al., 2023). However, two studies reported that having an employed partner was not enough to cover the costs of the pregnancy; the pregnancy imposed financial strain and distress on both the partner and the pregnant woman (Lewinsohn et al., 2018; Scorgie et al., 2015). In addition, low social support from male partners took the form of financial provision that was inconsistent (Scorgie et al., 2015) , and it was also reported that pregnancy was a catalyst for an increase in relationship disputes about finances (Lewinsohn et al., 2018; Scorgie et al., 2015). Unintended pregnancy could destabilise the relationship, thereby undermining support provision (Lewinsohn et al., 2018; Phiri et al., 2023). Partner reactions to an unintended pregnancy could take the form of partner displeasure, violence, detachment and paternity denial (Lewinsohn et al., 2018; Mlotshwa et al., 2017).

Other notable findings within the South African context were that pregnant women reported being highly stressed because of partner infidelity. The advent of the pregnancy was either said to be a catalyst for infidelity, or it contributed to increased conflict between the couple, where there were pre-existing concurrent relationships (Lewinsohn et al., 2018). A lack of emotional commitment by their male partners and the fear of contracting HIV (because of multiple sexual partners) were cited by pregnant women as the main concerns within these types of relationships (Lewinsohn et al., 2018; Mlotshwa et al., 2017). Mlotshwa et al. (2017) also reported that concurrent partnerships were tolerated so as not to jeopardise support for pregnant women and future children. The above studies provide some descriptive insights into the types, sources, and perceptions of male partner support pregnant women in South Africa receive. They have also flagged that gendered norms underpin support provision. These studies have focused on pregnant populations living in low-resourced urban areas. Less attention has been paid to partner support experiences of women living in the country's rural regions.

Increasing male partner involvement by encouraging them to attend antenatal care with their pregnant partners is also seen as an important form of support in the literature. I now turn to how this aspect of social support has been addressed.

Partner participation and support within an antenatal care setting

Male partner participation and support within an antenatal care setting are said to improve maternal and infant health outcomes (Tokhi et al., 2018). This research has mainly been conducted in LMICS and has focused on whether male involvement improves pregnant

women's health-seeking practices. For example, Ladur et al., (2015) in their scoping review on male participation in maternal healthcare for promoting safe motherhood, reported that socio-patriarchal hierarchies underpin healthcare-seeking practices by pregnant women. Male partners are usually the key decision makers and control access to resources such as nutrition and finances, thus influencing pregnant women's health care practices and utilisation. In another systematic review conducted by Suandi et al. (2020) that sought to examine whether involving men in antenatal care improves pregnant women's healthcare utilisation, the authors found that men's involvement was associated with giving birth in a health facility, using a skilled birth attendant and continuing with post-partum care. However, they found no evidence that men's involvement improved the number of antenatal care visits by pregnant women.

Research has also investigated barriers to the involvement of men in pregnancy and childbirth within the antenatal healthcare setting. For example, a scoping review by Moyo et al. (2024), which looked at a broad range of qualitative, quantitative and mixed-method studies in sub-Saharan Africa, found that men who were married, living with their partners, who were educated and earned higher incomes were more likely to participate in antenatal care services. In contrast, men who were older, unmarried, who were unknowledgeable about maternal health and who feared testing for HIV were less likely to participate in antenatal care services. The studies that they examined also reported that low involvement of men stemmed from other social, economic and health system factors such as gendered social norms where pregnancy is considered the woman's responsibility; the financial costs in attending antenatal care, which included transport to the clinic and time away from work; and, an unconducive healthcare environment consisting of unfriendly healthcare worker attitudes, long waiting times, long distances to health facilities, physical spaces that could not accommodate men and maternal health check-up procedures that excluded the participation of men.

Several recommendations have been made to improve the participation of men in antenatal care. Some of these include developing community-based interventions that encourage men's involvement through endorsements of respected community members (Ganle & Dery, 2015; Singh et al., 2014; van den Berg et al., 2015), making clinics more accessible to men in terms of suitable opening hours and the proper training of staff in male-specific health needs (Ditekemena et al., 2012; Falnes et al., 2011; van den Berg et al., 2015), and developing interventions that challenge gendered notions around pregnancy through enhancing joint decision making between the pregnant woman and her partner (World Health Organisation (WHO), 2015).

According to the WHO (2015), various interventions to improve men's participation in maternal healthcare have included media campaigns, community outreach programmes, couples counselling at health facilities and home visits. However, the evidence for the impact of these interventions has been low—a systematic review conducted by Tokhi et al. (2018) on interventions directed at men concluded that, although there is evidence that interventions to improve men's involvement in maternal care can have positive effects on pregnant women's healthcare practices and behaviours as well as the couple's relationship dynamics, they can also have detrimental effects on pregnant women's autonomy owing to existing gendered hierarchies. For example, a Zambian study (Hampanda et al., 2020) found that involving men in the prevention of mother-to-child transmission (PMTCT) interventions during antenatal care amplified unequal gendered power relations. They found that men's behaviour was ultimately controlling concerning finances, HIV disclosure and the trajectory of the relationship. In some cases, men undermined pregnant women's choices in how they were able to manage their well-being during pregnancy, such as adhering to HIV treatment regimes. Supportive men were described through the lens of what *men* deem as supportive (such as deciding to stay in the relationship despite an HIV diagnosis). The authors concluded that the risks of involving men must be carefully considered and that future interventions should be designed with a gender transformative lens.

Comrie-Thomson et al.(2015) critiqued how interventions are developed using an instrumentalist and not a gender-transformative lens in their review of the evidence for including men in maternal health interventions. For instance, interventions did not target gender relations, address gendered roles, nor did they challenge patriarchal structures. Instead, the interventions focused on men's behaviour and instances of support rather than examining the interpersonal interactions between the couple and how this may affect decision-making around pregnancy. Secondly, the studies did not report men's subjective experiences or attitudes toward the interventions. Lastly, the studies were based on assumptions of what men's involvement means. These interventions positioned men as gatekeepers and decision-makers who controlled resources and who influenced women's access to healthcare and nutrition. Thus, changing the viewpoint of the main household decision-maker to allow healthcare access was a focus of these interventions over promoting shared decision-making.

Very little literature exists on men's involvement in antenatal care within South Africa. Scholars have reported that in some cases, men might hold a spot in the clinic queue for their pregnant partner. However, it is not common practice for men to attend public antenatal care

appointments, although pregnant women desire this form of support (Audet et al., 2023; M. G. Matseke et al., 2017; Mlotshwa et al., 2017; Phiri et al., 2023). The reasons why men might not participate in maternal healthcare are similar to the findings of the existing literature in LMIC countries, whereby socio-cultural, socio-economic and healthcare system structures, protocols, and practices exclude them. For example, socio-cultural norms position pregnancy as the domain of women. The clinic is also seen as a highly gendered space, mainly comprising women, which prompts disinterest from men (Mlotshwa et al., 2017) and ridicule and stigmatisation by community members should a male partner be seen in those spaces (Nesane & Mulaudzi, 2024). Cultural notions of being bewitched by women have also been touted should men attend antenatal care with their partners (M. G. Matseke et al., 2017). Socio-economic barriers included loss of income for taking time off work, being a migrant worker precluded men from attending antenatal care appointments, and transport costs to the clinic were considered prohibitive if male partners were unemployed (Audet et al., 2023; Maman et al., 2011; M. G. Matseke et al., 2017; Nesane & Mulaudzi, 2024). Finally, researchers have reported that the health system is not set up to accommodate men and that they find it challenging to navigate the rules, schedules and spaces in which they were allowed to participate (M. G. Matseke et al., 2017).

Interventions to improve male participation in antenatal care have not received much attention in South Africa. However, a qualitative study by Audet et al. (2023) explored how pregnant women would like men to be involved in antenatal care services. The authors proposed three ways men could be invited to attend antenatal care appointments and asked the pregnant women in their study which option they preferred. This included an invitation by the pregnant woman herself, an official letter from the clinic, and encouragement from a community healthcare worker. Notably, almost half of their sample opted for an official letter from a clinic. The reasons cited for this choice were twofold. An official letter was said not to be easily ignored, which had a responsibilising effect on male partner behaviours. The letter could also be presented to their partner's employer to allow him to take time off work to attend antenatal care appointments. It is worth noting that using an "official" clinic letter speaks to drawing on social hierarchies and structures to enforce compliance by different stakeholders. All these studies focused on a specific population segment in South Africa, mainly comprising black, low-income individuals who use the public health sector. I found no studies focusing on male involvement in antenatal care services from a middle-class/private healthcare perspective.

As with the Zambian study cited above, male participation in attending antenatal care services is not always desired by women within the South African context, given that many women receive a positive pregnancy result and a HIV-positive diagnosis simultaneously during their first antenatal care appointment. Some women specifically choose not to involve men during their pregnancy, and this has been related to perceived violence should they disclose their HIV-positive status (Maman et al., 2011). The social support literature has surfaced how intimate partner violence can be embedded in social networks. I will explore this literature in more detail next.

Intimate Partner Violence (IPV) and pregnancy

Gender-based violence is a worldwide concern, and this has implications for the supportability of a pregnant woman's pregnancy. There has been a deluge in scholarly knowledge production on IPV during pregnancy concerning its prevalence (Román-Gálvez et al., 2021), physiological pregnancy outcomes (Da Thi Tran et al., 2022; Donovan et al., 2016; Pastor-Moreno et al., 2020) , psychological distress (Halim et al., 2018) and the impacts of IPV health interventions within health settings (Van Parys et al., 2014). The quantitative literature on social support (see first section on social support and pregnancy outcomes) has also flagged IPV as a risk factor for poor psychological outcomes in pregnancy (Alipour et al., 2019; Biaggi et al., 2016; Kruse et al., 2013; Yim et al., 2015).

Turning to the African continent, an earlier literature review, which specifically focused on IPV amongst pregnant women in African countries, evaluated the prevalence and risk factors for IPV (Shamu et al., 2011). There was a wide range in the prevalence of IPV across countries, but the authors concluded that most of the studies had a 27% prevalence or more, which is considered very high by global standards. Thus, it is assumed that there are high rates of IPV during pregnancy in African countries. It is worth noting that the authors found that some studies measured IPV before and during pregnancy and that IPV decreased during pregnancy. This has been attributed to pregnancy acting as a protective factor against IPV, but the authors caution that this requires more research. The main IPV risk factors identified in these studies were a positive HIV status, alcohol and drug use, multiple sex partners and a history of abuse.

There is some South African quantitative research on the association between IPV and birth outcomes (low birth weight babies), which did not produce significant findings (Koen et al., 2014). On the other hand, research has shown significant associations between IPV and poor psychological outcomes in South African pregnant women (Brittain et al., 2017b; Gebrekristos

et al., 2023; Heyningen et al., 2016; McNaughton Reyes et al., 2021; Tsai et al., 2016b; van Heyningen et al., 2017). Emotional, physical and sexual forms of IPV, as well as male controlling behaviour, have been reported in these studies. Most studies have reported a high prevalence of IPV within their population samples, ranging from 15%-48% (Bernstein et al., 2016; Field et al., 2018; Gebrekristos et al., 2023; Groves et al., 2014; McNaughton Reyes et al., 2021). Risk factors for IPV were a history of violence and poor mental health, a younger age, low relationship power, low partner social support, food insecurity, unemployment and being unmarried (but in a relationship) (Bernstein et al., 2016; Field et al., 2018; Groves et al., 2014; McNaughton Reyes et al., 2021). Thus, these risk factors for IPV reveal how the macro-influences pertaining to socio-economic and socio-cultural gendered practices interact and influence the nature of a pregnant woman's most intimate part of her support network.

Qualitative experiences of IPV during pregnancy are less explored. One study in South Africa examined pregnant women's experiences of IPV during pregnancy. These women were HIV positive and had experienced IPV within the past 12 months (Marais et al., 2019). The authors of this study were particularly interested in the intersection of IPV and HIV during pregnancy. Their findings revealed that male partners displayed a range of emotional, physical, sexual and controlling behaviours. These behaviours compromised pregnant women's physical and mental health by undermining how they were able to manage their pregnancies and included interfering with nutrition and sleep practices, isolating women from their support networks, preventing women from attending antenatal care and accessing ARV timeously, and humiliating women because of their HIV status. Notably, the authors found that pregnant women's suffering was compounded by stigma associated with both IPV and HIV, which blocked access to support structures through the fear of disclosure. This is suggestive that social support provision is contingent on socio-cultural perceptions of pregnancy (and HIV), where stigma plays a key role.

Whilst the above study selected a particular population segment for their analysis, Field et al. (2018) collected some qualitative data on a more generalised pregnancy population (18 years older, accessing antenatal care in the public sector and who had not already tested for HIV). They reported that domestic violence was not limited to partners but could also occur within the wider family. The types of violence included emotional, physical and sexual violence, including the withholding of food. They also reported that violence occurring within these support networks was shaped by substance and alcohol misuse. Moreover, they noted that violence within these settings was normalised.

Thus, IPV adds another dimension to constraining the supportability of a pregnancy. For instance, there are implications for placing too much focus on improving partner involvement as part of an antenatal healthcare strategy in contexts where there are high levels of gender-based violence. Including other individuals integral to the pregnant woman's support network may be more beneficial. However, this approach also needs to consider that violence can be widespread across support networks in general. I now turn to how the literature has addressed how families provide social support during pregnancy.

Family/kin support

The role of family support has received some attention in the literature concerning pregnancy. This literature has focused on two main themes: The role of family support and pregnant women's psychological well-being and perceptions and experiences of family support.

Family support and psychological well-being during pregnancy

Studies have investigated whether social support from family and friends mediates or acts as a protective mechanism for psychological stress during pregnancy. Yim et al. (2015) , in their systematic review on predictors of post-partum depression, found that after the partner, a pregnant woman's mother was the most important source of support. However, the effects of support from family and friends on reducing the risk for post-partum depression were less conclusive.

In their mixed methods review on social support and pregnant women's mental well-being, Sufredini et al.(2022) found that low family support was predictive of depression but not anxiety. In South Africa, lower scores on family support predicted depression and, in general, perceptions of low support from families prevailed (Heyningen et al., 2016). Authors attributed a lack of family support to living in low-resource environments, which made it a struggle for families to provide practical support. Low social support was experienced by pregnant women living far away from their extended family (which contributed to feelings of isolation), and social environments characterised by violence also undermined support provision. With regards to the effects of family support on anxiety, van Heyningen et al. (2017) found that perceived support from friends seemed to reduce the potential for anxiety, but not from family. The authors hypothesised that if the quality of the relationships with pregnant women's partner and family is poor, support from friends might be perceived to be more significant.

Although these studies are quantitative, scholars have concluded that families have the potential to both negatively and positively influence pregnancy well-being in more complex ways and have called for more research to understand how family dynamics influence social support in pregnancy. I now consider how the qualitative literature has addressed family support during pregnancy.

Experiences and perceptions of family support

Most qualitative studies that examine experiences and perceptions of family support during pregnancy have been conducted in LMIC countries. These studies have drawn attention to the gendered and hierarchical nature of family support provision and the instability in family relationships that can ensue from pregnancy disclosure.

Studies have reported that family support is highly gendered and usually provided by mothers, grandmothers, aunts, sisters, and other female kin, where support from mothers is considered the most important source of support (Al-Mutawtah et al., 2023). In their systematic qualitative review of social support during pregnancy, Al-Mutawtah et al. (2023) reported that support from female kinship networks ranged from emotional, practical, financial and informational to spiritual support. From a cultural practice perspective, these authors have found that in some countries (India, Pakistan and Bangladesh), the maternal home itself is integral to social support provision; it is common practice for pregnant women to return to their family home to have their pregnancy needs taken care of by maternal kin. A study conducted in northern Tanzania reported that women might also seek out support and take refuge with the maternal family should they experience serious forms of violence from their husbands; these pregnant women were nevertheless still encouraged by their families to safeguard and work on their marriages despite the violence (Sigalla et al., 2018).

The operation of social hierarchies in families has been reported to exacerbate stress during pregnancy and undermine safe pregnancy practices. For example, in a qualitative study on pregnant women's experiences of maternal social support in urban India, Raman et al. (2014) outlined how paternal families were less accommodating to pregnant women, whereby they were still expected to carry out onerous domestic duties despite their pregnancies. Abuse from mothers-in-law was also reported, such as denying pregnant women food and preventing them from accessing antenatal care.

Scholars have also explored the role of family support in pregnant women's health-seeking behaviour regarding the uptake of and compliance with antenatal care. For example, a

qualitative study conducted in Mali paid attention to the influence or role of the mother-in-law in the uptake of ANC by the daughter-in-law (White et al., 2013). These communities are said to comprise traditional and hierarchical family structures that have a bearing on the expected roles of the pregnant woman. Furthermore, women in these communities also reside in the homestead of their husbands' families, where the mother-in-law is the matriarch, has the most power and controls the family's household resources. In their qualitative study, using in-depth interviews with both pregnant women and mothers-in-law, White et al. (2013) described how mothers-in-law had a somewhat negative influence on the uptake of antenatal care. If the mother-in-law had not received ANC herself, if resources were scarce and if household duties were affected, the pregnant woman was unlikely to seek out ANC. Furthermore, the findings revealed that the pregnant women would defer to the mother-in-law's authority due to the power differential in hierarchical family households. Mothers-in-law were said to have less influence if they did not reside in the same household. The researchers recommended that interventions that seek to improve access to antenatal care should not only consider social determinants or the partner's role but also the influence of other family members.

South African studies have reported various findings concerning family support during pregnancy. As with other studies in LMIC countries, female family members are relied on the most for support, especially when a partner is absent (Crankshaw et al., 2016; Lewinsohn et al., 2018; Mlotshwa et al., 2017; Phiri et al., 2023). Pregnant women might live with family in the last trimester and for a few weeks post-pregnancy (M. G. Matseke et al., 2017). South African studies have reported that both positive and negative forms of support are received from the partner or husband's family, where the paternal family has provided emotional and material support (such as food) or they have been unaccepting of the pregnancy are disengaged, which was cited as stressful and hurtful (Mlotshwa et al., 2017).

Social hierarchies in families have been reported to constrain making financial provisions for the pregnancy. In a qualitative study conducted by Scorgie et al. (2015) on pregnant women's experiences of living in poverty, the authors found that pregnant women who relied on financial assistance from parents or family had very little choice in how to provide for their pregnancies financially. Moreover, pregnant women who earned an income reported that they themselves were responsible for providing for the rest of their family and that keeping enough money aside for their pregnancy needs was difficult. In addition, some pregnant women described how they had no decision-making power regarding how they spent their own wages,

as the distribution of finances amongst family members was decided upon by more senior family members.

Various reasons for low levels of family support have been covered in the South African literature. Due to the high mortality and morbidity of parents, this avenue of support has been rendered unavailable for some pregnant women (Crankshaw et al., 2016). Early childbearing, having too many children, being partnerless or having an unintended pregnancy have increased tensions within family relationships where becoming pregnant was met with judgement and disapproval from families; thus, the fear of being shamed and being thrown out of the maternal home has been reported as some of the reasons for late pregnancy disclosure to family members (Crankshaw et al., 2016; Lewinsohn et al., 2018; Mabetha et al., 2024; Phiri et al., 2023). Furthermore, as mentioned in the previous section on IPV during pregnancy, violence has not only been perpetrated by intimate partners but also by family members (Field et al., 2018).

Thus, the type of social support from families varies depending on what social locations pregnant women occupy and the social contexts in which they live (Mabetha et al., 2024). In their study on young Sowetan women's experiences of social support during pregnancy, Mabetha et al. (2024) recommend that support interventions consider this diversity when identifying social support needs for pregnant women within the South African context. Moreover, fearing to disclose a pregnancy to family members implies that social support might be perceived as conditional and subject to certain social norms. However, these dynamics are not explored in depth in this literature. The literature on pregnancy has also addressed how the workplace does or does not support pregnant workers and is explored next.

Social support in the workplace

According to the International Labour Organisation (ILO) (2016) (when data were collected for this study), women's labour force participation rate worldwide was 49.6 %. This means that pregnancy in the workplace should be a common and supported occurrence. The literature on social support during pregnancy in the workplace has drawn attention to various tensions or conflicts that exist between the pregnant worker and their place of work. This literature is split into two main trajectories: (1) Workplace conditions and pregnancy outcomes (pre-term birth, low birth weight and psychological well-being) and (2) how pregnancy is socially perceived within the workplace. This second body of literature mainly focuses on how maternal

discrimination, mistreatment and stereotyping play out across the policy and socio-cultural structures of workplaces, thereby having implications for the supportability of the pregnancy.

Workplace conditions and pregnancy outcomes

Gross and Pattison (2007), in their review of the literature on pregnancy in the workplace, have highlighted how the construction of pregnancy as a "sick role", as well as notions of "risk" assigned to pregnancy status, have shaped how pregnancy is researched within the work environment. These authors found that most studies were quantitative and mainly examined the associations between the type of job performed and its effects on pregnancy outcomes (pre-term birth, low birth weight and psychological stress). Examples of these studies include measuring the teratogenic effects of the work environment; the ergonomic set-up of workspaces; the physical work required, such as lifting objects or standing for long periods; and whether a pregnant woman works in a high-stress job. Furthermore, these studies were more focused on whether performing the task or the job itself negatively influenced the pregnancy outcome rather than considering the role of social dynamics that might operate within the pregnant employee's work environment. Finally, these authors reported that the findings of these studies are varied. This is because different methodologies and sample sizes were used, and different types of work environments, jobs and tasks were measured. Variable outcomes were also reported in terms of low birthweight, preterm births, stillbirths, and pregnancy complications.

More recent systematic reviews on workplace risk factors and pregnancy outcomes (see Cai et al., 2019; Corchero-Falcón et al., 2023) have shown how this body of literature has adopted similar research approaches as analysed by Gross and Pattison back in 2007. Moreover, in line with Gross and Pattison's critique of this literature, these systematic reviews have not reported any studies considering how the socio-cultural work environment might shape pregnancy outcomes. Importantly, Gross and Pattison (2007) drew attention to how the findings of these studies have been used as the empirical evidence base on which to provide safer working environments and have also influenced the type of advice that is provided to pregnant women in terms of how to individually manage risk factors in the workplace that may affect their pregnancy negatively.

Pregnancy is not only treated by employers and government policymakers as a potential legal risk, but it is also constructed as a "risk" to the smooth everyday operations of the workplace, threatening productivity and profits. Scholarly attention has thus been paid to how

pregnant individuals are socially perceived in the workplace and how this translates into a non-supportive work environment.

Social constructions of pregnancy in the workplace

Arena et al. (2023) report that the academic literature on maternity within the workplace has focused chiefly on the conflict between socio-cultural understandings of motherhood and employee identities. These tensions surface how workspaces are unsupportive of pregnant workers because of maternity bias, which results in mistreatment, stigma and discrimination. In their literature analysis, the authors show how maternity bias occurs in structural, interpersonal and internalised forms, thus affecting how pregnant individuals navigate their work environments. Structural forms of bias included wage penalties (such as unpaid maternity leave and earning inequitable wages post birth) and inadequate Human Resources (HR) policies (such as rejected job applications, overlooked promotions or training, unfair dismissals, missed pay rises, exclusion from specific tasks or meetings, lack of flexi-time and inflexibility in reorganising workloads). Interpersonal forms of bias were negative reactions to the pregnancy by colleagues and superiors, such as: perceiving pregnancy embodiment as an offensive and disruptive feature of the workplace environment (for example, vomiting because of morning sickness, having to use the toilet often, and breastfeeding practices); incivility toward pregnant women through teasing and joking about their pregnancy and changing body sizes; devaluation as a worker by being positioned as uncommitted to the organisation because of motherhood duties; being positioned as both physically and cognitively incapacitated to perform the job properly (examples include being too sick, “disabled” and too emotional and irrational because of uncontrollable hormones); and, providing unsolicited pregnancy advice. Internalised bias took the form of pregnant women individually managing stigma and discrimination in the workplace through pregnancy concealment, selective pregnancy disclosure, overperforming within the current job to demonstrate a business-as-usual approach, individually resolving pregnancy/work conflicts (such as taking on the responsibility for organising staff shifts to accommodate the pregnancy, going to antenatal care outside of work hours); and, in some cases, opting out of the workforce.

In addition, these authors found that a wide range of theoretical orientations underpinned this literature (including role, identity and stigma theories), while a small body of this literature drew from feminist theory and feminist standpoint theory as a lens upon which to examine social constructions of pregnancy in the workplace. However, in pointing out the limitations of this body of research, Ares et al. (2023) conclude that this literature has been

chiefly located in high-income countries and has generally focused on white, middle-class and educated pregnant populations working within the formal employment sector. Thus, this research only provides a partial view of pregnancy in the workplace by overlooking other pregnant population segments who are from different social locations (but see Mehra et al., 2023 on black pregnant women's experiences of workplace discrimination in the USA), geographical regions and who are engaged in various types of work besides the traditional formal sector employment (for example, precarious workers, informal workers, those in the gig economy and entrepreneurs). However, in a study conducted by Verhoff and Buzzanell (2022) in the USA, disclosing a pregnancy in the workplace was not perceived as the only risk for those individuals who occupied "non-normative" social positions. This disclosure was also linked to additional risky identity disclosures where being pregnant served to highlight other aspects of the pregnant person's identity, such as non-marital status, religion, sexuality, ability, race and age. As such, these authors recommend that organisations should adopt an intersectionality orientation to understand better the risks of pregnancy disclosure within the workplace environment.

Turning to South Africa, there is very little research on pregnant workers' experiences of support in the workplace. Law reviews have mainly analysed pregnancy discrimination cases brought before the law courts in the formal work sector (Behari, 2021; Cohen & Dancaster, 2009; Mubangizi, 2000; Wyllie, 2000). I have not found any studies that have examined pregnant women's experiences of work discrimination in the South African workplace. One study reported that pregnant women left employment because of the pregnancy. However, they did not provide details on the type of work environment or why pregnant women exited the workforce (Lewinsohn et al., 2018).

One qualitative study, however, conducted by Makola and colleagues (2020), used focus group interviews to explore first-time mothers' perceptions of support within their workplace post-pregnancy (that is, participants were not pregnant at the time of the interview but were interviewed about their pregnancy experiences in the workplace). Their sample was a racially heterogeneous group that worked in small, medium, and large enterprises within the formal employment sector in the province of Gauteng. In conducting a descriptive thematic analysis of their data, the authors' findings were similar to those reported in high-income countries regarding how pregnancy affected the quality of the interpersonal relationships between the women and their supervisors and colleagues. Where supervisors were perceived as unsupportive during their pregnancy, participants reported that they displayed a lack of

concern for their well-being, denigrated motherhood identities in relation to career ambitions, and were circumspect of the participant's commitment to new business projects, thereby actively sidelining them from specific work tasks. Notably, from an organisational structure perspective, participants drew attention to how human resource departments were unhelpful and obstructive and asked invasive questions when participants asked for assistance in applying for maternity UIF benefits. Where supervisory support was perceived as positive, flexibility in allowing participants time off to attend antenatal care appointments was cited (which is, in fact, a legal requirement), as well as being accommodating of working hours and workloads. Support from work peers ranged from excitement at the pregnancy announcement, organising surprise baby showers, and asking about participants' well-being. At the same time, unsupportive behaviours were reported as distinct negative changes in attitudes toward pregnant women, such as non-collegial behaviour in finishing job tasks.

The above literature shows that there is much necessity and scope for engaging in more research to understand how the economic activities in which pregnant individuals engage, together with being socially positioned in different ways, have a distinctive bearing on the supportability of their pregnancies. Given the paucity of knowledge of how pregnant workers fare within the South African context, the supportability framework provides an opportunity to explore how workplaces form part of the pregnancy support experience. I now consider how social support is understood within the antenatal healthcare interaction.

Healthcare service provider support

Experiences and perceptions of the healthcare interactions between pregnant individuals and their healthcare providers have been examined within the social support literature on pregnancy. Social support interventions complementary to maternity care and issues around respectful maternity care are two main themes I identified within this literature. These are addressed next.

Social support interventions as complementary to maternity care

Providing additional social support for pregnant individuals within the healthcare setting to improve maternal and infant outcomes has been recommended by scholars researching social support in pregnancy. Where social support in other areas (for example, partner and family support) and structural support (socio-economic constraints) are lacking, some scholars have recommended incorporating social support interventions that are complementary or integrated with standard maternity care programmes. Examples of such interventions have

been directed at improving birth outcomes (premature birth and low birth weight babies), which had minimal effects (East et al., 2019); addressing mental health, which showed mild benefits (Gajaria & Ravindran, 2018; Le Roux et al., 2020; Sufredini et al., 2022); reducing substance use, which reduced stigma and enabled a positive shift in self-perceptions from being an addict to that of being a mother (Gruß et al., 2021); improving antenatal care attendance and engagement (Coleman et al., 2020; Le Roux et al., 2020); and providing additional informational and emotional support during pregnancy (Gale et al., 2018; Renbarger et al., 2021).

These interventions were delivered through peer or community support groups, lay healthcare workers, and telephone, internet or mobile health (mHealth) platforms. MHealth platforms and home visits by community healthcare workers (CHWs) are popular avenues for providing additional informational social support and influencing health behaviours within low-resourced LIMIC contexts (Skinner et al., 2018). MHealth platforms use mobile text-based messages to impart health-related pregnancy information and psychosocial support to pregnant women. For example, findings from a Ugandan study (Atukunda et al., 2023) reported that participants found the phone app helpful because it helped address questions during pregnancy, provided additional and tailored information about the pregnancy and encouraged conversations and support from the pregnant women's immediate support networks. Similar to this study, Skinner et al. (2018), in evaluating the South African MomConnect mobile programme, reported that pregnant women found the messaging helpful because it provided information on foetal development, common pregnancy ailments, and advice on preparing for birth. Participants also reported saving text messages and sharing them with social networks (where partners also engaged with them). A disadvantage reported in this study was poor network connection, which interrupted messaging from time to time. In another study that compared two samples, one control group that did not receive the messaging and an intervention arm that did receive MomConnect, researchers reported that antenatal care usage was better and more consistent for the group receiving the intervention (Coleman et al., 2020).

South Africa has also used community health workers (CHWs) to provide extra support by conducting home visits. Evaluations of the effects of CHWs in delivering maternity-related care have reported improved health behaviours during pregnancy, such as attending antenatal check-ups (Stansert Katzen et al., 2020). Another study (Le Roux et al., 2020) that sought to evaluate the impact of CHWs in rural areas (Eastern Cape Province of South Africa) also found better usage of antenatal care. However, researchers reported that the intervention was less impactful than in urban areas. The authors surmised that CHWs need to be more supported

transport-wise to improve their accessibility to communities. In general, these interventions encourage individuals to improve pregnancy and postpartum health practices for themselves and their newborns.

Within the South African context, scholars have also suggested improving social support for pregnant women by integrating additional screening tools and services into the current antenatal care model. For example, recommendations for mental health screening, screening for IPV and mental health support services for low-income women have been made. However, these recommendations have also called for interventions to address the broader determinants of health, such as providing practical support through assistance in accessing social grants and improving maternity social protections. As both East et al. (2019) and Gale et al. (2018) have pointed out in their reviews on maternal support interventions, placing the onus on healthcare workers to provide additional support to pregnant individuals who experience maternal health inequities will not suffice. These authors assert that systemic changes are required to mitigate adverse pregnancy outcomes and inequitable access and receipt of care.

In their review of maternity interventions designed to improve maternal equity in healthcare, Bohren et al. (2024) proposed that interventions should be designed using an intersectionality lens. The authors argue that an intersectionality orientation will enable stakeholders to understand how power relations shape the structuring of maternal healthcare systems and their clinical practices, which serve to uphold maternal inequities. However, they found no interventions designed or evaluated using an intersectionality orientation in the studies they reviewed. Where interventions did address social dimensions of inequality, they mainly focused on socio-economically marginalised and rurally located population segments. The authors also found an overemphasis on access to care compared to addressing inequities in providing quality and respectful care. Since respectful maternity care has been flagged as a priority within the literature and is a key element of the healthcare interaction, I now turn to how it is addressed.

Respectful maternity care

The global literature has highlighted how disrespectful forms of care feature prominently in experiences of maternity health care and health-seeking practices. For example, verbal and physical abuse, abandonment, neglect, long waiting times, loss of dignity, lack of privacy, lack of communication, stigma and discrimination were common forms of mistreatment that have been identified across high, middle and low-income countries (Bohren

et al., 2015; Mannava et al., 2015; Rosen et al., 2015). Moreover, these experiences are reported for those who occupy marginalised social positions. For example, this literature has included the maternity care experiences of women who are young mothers (Crooks et al., 2022; Duggan & Adejumo, 2012; Redshaw et al., 2014), immigrants (Balaam et al., 2013; Fair et al., 2020; Higginbottom et al., 2015; Small et al., 2014), disabled (Blair et al., 2022; Heideveld-Gerritsen et al., 2021; Matin et al., 2021; Redshaw et al., 2013), have existing health conditions such as HIV (Brittain et al., 2021; Greene et al., 2016, 2017; Groves et al., 2010), as well as women of colour, indigenous populations and those who are of a lower socio-economic status (Chan, 2022; Downe et al., 2009; LeMasters et al., 2019; Mehra et al., 2020; Shaw et al., 2016). In general, this literature has highlighted how experiences of and access to quality maternity care are inequitable based on the different social positions that pregnant individuals occupy.

In order to understand what drives the inequitable quality of maternity healthcare provision, scholars have used socio-ecological conceptual models to gain a better understanding of the mistreatment of pregnant individuals. For example, Bradley et al. (2016) found that the quality of maternal care was underpinned by macro influences such as institutional structures that are technocratic and highly medicalised. These structures, in turn, shaped how midwives exerted authority and control over their patients by focusing on the clinical and technical aspects of care over patient-centred care. In another systematic review that used a socio-ecological model to analyse how studies addressed factors contributing to disrespectful care, Mannava et al. (2015) found that a combination of individual, organisational and societal factors played a role. Individual factors showed how healthcare providers positioned themselves in relation to their patients regarding their competency, authority, and personal beliefs. Organisational factors included aspects around poor working conditions and high workloads that also impacted these behaviours. The authors considered cultural contexts as the societal factors influencing healthcare workers' attitudes, such as negative attitudes toward traditional antenatal care and birth methods.

For Schaaf et al. (2023), the mistreatment of pregnant individuals within health facilities denotes that power relations are inherent within maternal care provision. Using a socio-ecological model, these authors investigated whether and how studies on disrespectful maternity care have addressed power relations. As with the other reviews outlined above, most studies addressed disrespectful care across more than one level of the socio-ecological framework, especially regarding how social, political and organisational structures underpinned the existing interpersonal relations and healthcare practices of healthcare

workers and patients. As with previous reviews, this body of research has examined how disrespect was normalised within health settings and directed at individuals occupying social positions that do not conform to normative constructions of ideal motherhood (such as race, class, marital status, caste, and nationality social dimensions). However, to address these power imbalances, the authors found that most interventions only addressed the quality of care on individual or interpersonal levels and did not advocate for system changes considered fundamental in changing the unequal power dynamics that undermine the provision of respectful care. I now turn to how disrespectful care within the healthcare interaction is addressed in the literature, specifically in South Africa.

Much research on pregnant women's experiences of maternity care living in South Africa has been conducted within the public health care setting. Moreover, the provision of respectful maternity care has been an ongoing concern in the public health sector. It has garnered scholarly attention, especially concerning the abuse of pregnant women in birthing facilities. In general, research findings have identified that the healthcare interaction between nurses and pregnant individuals has been shaped by power relations that operate through historical, social and institutional hierarchies of order and that the resultant violence has been normalised and "ritualised" within the healthcare setting (Chadwick, 2017; Jewkes et al., 1998; Kruger & Schoombee, 2010).

In the late 1990s, this dynamic was first highlighted in a study by Jewkes et al. (1998), who drew attention to the abuse of pregnant women by nurses. In their findings, women were scolded, shouted at and judged during antenatal care. Pregnant women were told that they were stupid and ignorant and were laughed at. The pregnant woman was coerced into becoming compliant and punished if she displayed resistance. The authors drew attention to the complex reasons for this behaviour, citing how it was shaped by history, the structuring of the health institutions, and how nurses were positioned in society. For example, nurses were socially constructed as professional, middle-class and authoritative, while patients were positioned as inferior. They recommended that the social constructions of what constitutes a nurse must be challenged; the pregnant woman's autonomy should be valued; patient and healthcare provider communication should be improved; and the perceived hierarchy of authority nurses presume to have over patients should be addressed.

Issues around the mistreatment of pregnant women in health facilities have continued, however. Using an intersectional lens to understand how obstetric violence operates in birthing facilities, Chadwick (2017) analysed the intersections between the nurse and pregnant woman,

the birthing body and the relational power dynamics that interact during the birthing process. She describes how nurses, through their moralising lens of care, use obstetric violence as a disciplinary tool to assert their medical power. The pregnant woman, in response, positions herself as the compliant subject to obtain the care she requires and to avoid punishment. However, the powerful birthing body disrupts and resists both the compliance strategy of the patient and the authority of medical power. Importantly, Chadwick (2017) argues that resultant obstetric violence is not isolated within the individual who carries it out. Aspects such as history, race, class, age and gendered norms shape the interaction between nurse and pregnant woman. For instance, the patient is unable to achieve a compliant status not only because her birthing body resists the medical power imposed on it but also because her race, age and socio-economic status might already position her as a "bad patient".

Those automatically perceived and treated as "bad patients'' are not only poor but are also young and positioned as an "inferior" nationality. Phiri et al. (2023) , in their study on pregnancy support experiences of university students, found that early reproduction is stigmatised within health settings, and negative health interactions such as unfriendliness, judgement and remonstrations for becoming pregnant at an inappropriate life stage were reported as common responses from healthcare practitioners. In contrast, however, Mabasa et al. (2024) found that HIV-positive pregnant adolescents reported receiving good emotional support from the clinic nurses, whereby nurses were friendly, provided them with advice and encouraged them to continue taking their medication.

Two participants in my study were non-nationals (one was Zimbabwean, and the other was Brazilian). According to the latest Statistics South Africa migration report (2024), the largest source of migratory populations to South Africa is Zimbabweans and Mozambicans, comprising 48.5% and 20% of the total migrant population, respectively. Non-national women can access the public healthcare system without paying user fees. Qualitative studies by Makandwa and Vearey (2017) and Tebid et al. (2011) have explored immigrant women's experiences of maternity care provided in the public health sector. Their findings were similar to those of other worldwide studies (see for example, Fair et al., 2020) in that immigrant women experienced language barriers, cultural insensitivity, and stigma and discrimination from healthcare workers. Overt discrimination and stigma in the form of xenophobic attitudes were reported in the South African context. For example, both studies reported how nurses sought to highlight a pregnant woman's foreign status to communicate that immigrant women did not belong in the South African public health system. Makandwa and Vearey's (2017) participants described how

nurses would verbally abuse pregnant women, delay or deny care, or pretend not to understand them because migrant women spoke to the nurses in English. By not being able to speak any of the other native South African languages (such as isiXhosa or isiZulu), they were effectively positioned as foreign nationals, which provided the impetus for nurses to offer sub-standard care compared to the care South African nationals received. This treatment, these authors report, resulted in pregnant women delaying or missing antenatal care appointments.

The research on respectful maternity care has drawn attention to the complex nature of the healthcare provider and pregnant woman interaction in the South African context, which has severe implications for the supportability of a pregnancy. This body of literature is helpful for this study because descriptive studies have provided insights into the relationships between healthcare workers and pregnant individuals occupying certain social positions. In addition, some of this literature has also used an intersectionality orientation to examine the nurse-patient relationship, surfacing how pregnant individuals' health experiences are embedded in power relations shaped by historical, political, economic, and cultural systems and structures. However, this literature has only focused on the healthcare interaction and not on the full spectrum of social support that pregnant women may receive. Scholars have flagged that structural influences underpin support provision during pregnancy. This literature is explored next.

Macro-level support structures

Socio-cultural practices (which include cultural, religious and gendered practices) have also been addressed in the social support literature. Although they are interrelated and overlap in many ways, I discuss them separately. The literature on the maternal policy environment (including social and health policy) will be covered in this section.

Socio-cultural practices and social support

Research worldwide has acknowledged that cultural practices play a key role in shaping a pregnant woman's social support networks, health-seeking experiences and behaviour (Schetter, 2011). Health environments that conflict with cultural practices can be deemed unsupportive by pregnant individuals, and this has been brought to the fore in studies of experiences of migrant women (Fair et al., 2020) as well as women in LMIC contexts (Dahab & Sakellariou, 2020; Finlayson & Downe, 2013). The WHO (2015) has recommended providing culturally appropriate maternity care as a key intervention for improving maternity experiences and outcomes. In reviews (Downe et al., 2009; Finlayson & Downe, 2013) on barriers to

maternity care in both high-income countries (HIC) and low- and middle-income countries (LMIC), certain cultural beliefs and approaches to pregnancy that inhibited access to care were identified. These included perceiving pregnancy as a regular event which did not necessitate medical care unless complications arose; considering early confirmation of a pregnancy as socially risky such that disclosure of the pregnancy happens in later trimesters; preference for home births because women remained closer to their support systems; and oftentimes birth is combined with religious practices that cannot be carried out in a hospital environment. Moreover, within healthcare settings, Fair et al. (2020) reported that immigrant women not only felt that their cultures were often stereotyped by healthcare staff but also felt conflicted when the advice and medical options they were given differed from culturally informed advice and procedures.

Coast et al. (2016) reviewed the literature that examined the effectiveness of interventions implemented to provide culturally appropriate maternity care. They found that these interventions included using translators or mediators in the healthcare setting, training healthcare staff in cultural competencies, and changing the antenatal care setting to be more culturally receptive to patients. Although the studies reported some positive effects of these interventions, for example, accessing antenatal care services more timeously, the authors concluded that the evidence for the overall impact of interventions was low. Notably, the authors caution against singling out cultural factors that may influence health-seeking behaviour as cultural influences interact with a range of other aspects of the pregnant woman's environment (SES, location, policy, politics), which also influence access to care. Finally, the authors reported that few studies focused on interventions within LMIC contexts.

Turning to South Africa, the tension between the use of "Western" versus "traditional" health practices has been examined within a South African pregnancy context. The use of traditional healers has generally been framed as a public health concern. It is not encouraged because the type of services traditional healers provide is deemed a risk to pregnancy well-being and outcomes (see for example, Le Roux et al., 2020; Stansert Katzen et al., 2020 who report that NOT using traditional healers is a positive outcome for a health intervention). However, qualitative studies have sought to explore how and why pregnant women may use traditional healers during pregnancy. In general, pregnant women seek the services of traditional healers to prepare for conception, to mitigate against social risk to the pregnancy (witchcraft, ill wishes of others and evil spirits), to relieve common pregnancy ailments

(diarrhoea or heartburn), and to promote easier labour (Mogawane et al., 2015; Thipanyane et al., 2022).

Earlier studies have analysed how pregnant women use a combination of traditional healing services and public health facilities. For example, one qualitative study in the Limpopo province (Ngomane & Mulaudzi, 2012) examined cultural practices that delayed pregnant women's attendance at antenatal clinics. The researchers reported that their participants viewed their pregnancy as confidential. Culturally, the pregnancy is concealed from the general community until the immediate family is informed, and necessary rituals for the ancestors are performed to ensure the protection of the pregnancy. Furthermore, it is believed that contact with other women at clinics could cause harm through the passing on of evil spirits. The authors surmised that these cultural aspects inform women's decisions to stay away from the clinic during the first trimester of their pregnancy. Finally, the women also trusted the knowledge and expertise of traditional healers. However, they were wary of the disapproval of the clinic sisters should the sisters find out that they delayed antenatal care visits because they used indigenous healing methods instead. The authors recommended that knowledge of traditional practices around pregnancy should be included in the curriculum for midwives so that a better understanding and improved communication can be fostered between the healthcare provider and patient.

Similarly, an earlier qualitative study conducted by Abrahams et al. (2002) that explored the use of indigenous medicine during pregnancy found traditional healers were used when the women were not satisfied with the service provision at the clinic, if the clinic was unable to provide relief for a particular ailment, or if the ailment is considered minor. The authors caution that by not acknowledging how cultural values might inform the dual use of health-seeking behaviours, health practitioners miss out on opportunities to gain a deeper understanding of their patients' needs and provide a more culturally informed service.

Religious practices and pregnancy support

Studies have explored the value and relevance of faith while pregnant (Al-Mutawtah et al., 2023; Aziato et al., 2016; Callister & Khalaf, 2010; Jesse et al., 2007; Redelinghuys et al., 2014), the association between religiosity/spirituality and psychological well-being (Mann et al., 2007a; Piccinini et al., 2021; Redelinghuys et al., 2014), and the associations between religiosity/spirituality and various health-seeking behaviours or outcomes (Ha et al., 2014; Mann et al., 2007b). Most of these studies assert that religious practices may be a positive

influence on the pregnancy experience, and they advocate for spirituality/ religiosity to be included in medical practitioner training so that a more holistic package of care can be provided to pregnant women.

Understanding how pregnant women individually draw on their faith as a form of support during pregnancy has been investigated in two studies (Callister & Khalaf, 2010; Jesse et al., 2007). These studies reported that engaging in religious interactions provided emotional support, helped in seeking guidance and protection, was used as a coping mechanism, and made pregnant women feel blessed and hopeful for a good pregnancy outcome. However, the studies did not explore or reveal whether a woman's faith or religious practices could be a source of stress during pregnancy.

Religiosity has also been examined in terms of improved mental health during pregnancy. A quantitative study by Mann et al. (2007a), which sought to investigate how a woman's faith could serve as a protective factor against depressive symptoms during pregnancy, found that the association between religiosity/spirituality and psychological well-being diminished as other forms of social support increased. They concluded that social support, spirituality and personal well-being are intermeshed and that practising one's faith, if there are low levels of social support, may improve depressive symptoms.

Studies have also examined whether religious practices and institutions influence health-seeking behaviours. A Zimbabwean quantitative survey (Ha et al., 2014) found that religious affiliations or structures may impede the health-seeking behaviour of pregnant women. This study focused on the Apostolic church, of which almost a third of Zimbabweans are members, and where faith-based healing forms part of the church's practices and doctrines. Pastors heal their congregants through prayer, blessing artefacts, anointing women and laying hands on their abdomens. The authors found that a significant number of women who were members of ultra-conservative apostolic congregations were less likely to access antenatal care and child immunisation services than those who were not members. However, the authors acknowledged that the sample they studied was poorer, had more socio-economic disadvantages, had lower education levels and lived in more rural areas than other Zimbabwean citizens. When considering these factors, they found that the negative effect of the apostolic faith on health-seeking behaviour was smaller.

In their South African study on social support during pregnancy, Mlotshwa et al. (2017) explored whether the church itself was a site of social support for pregnant women.

Participants reported that the church disapproved of being unmarried and pregnant. This resulted in participants being dissuaded from wearing their church uniforms and attending church. Participants did report, however, that older women who were church members were assigned to provide pregnancy advice and spiritual guidance. One participant framed the pregnancy as “this process of sin I am in”, (Mlotshwa et al., 2017, p. 5) according to which a church elder would mentor her before being allowed to resume church attendance once having given birth. The authors also reported that church attendance ceased through participants’ volition because they lacked the energy and motivation to travel long distances to church services.

Gendered practices and social support

Researchers have shown how aspects of gendered social practices have surfaced in their findings on pregnancy and social support. Much of the literature on the micro-level of support interactions during pregnancy has already been covered in this review, but some pertinent aspects will be briefly summarised here. With regards to partner support, studies in LMIC countries have shown how this support is overwhelmingly shaped by heterosexist hegemonic frameworks that fuel unequal power dynamics within couple relationships; male partners are positioned as financial providers, decision-makers and violent, thereby playing a key role in shaping pregnant women’s reproductive decisions and management of their pregnancies (Lewinsohn et al., 2018; Maman et al., 2011; Mlotshwa et al., 2017). Studies that have focused on gaining a better understanding of pregnant women’s health-seeking behaviour and compliance have drawn attention to how gendered practices can constrain the timing and access to antenatal care (Dudgeon & Inhorn, 2004; Hampanda et al., 2020; Ladur et al., 2015; Tokhi et al., 2018). Furthermore, the studies have drawn attention to how gendered roles constrain male partner participation or involvement in antenatal care programmes because pregnancy is constructed as a feminine practice (Falnes et al., 2011; M. G. Matseke et al., 2017; Mlotshwa et al., 2017; Singh et al., 2014). Moreover, the maternity healthcare space and interaction itself are gendered in that it is not designed to include men (M. G. Matseke et al., 2017; Moyo et al., 2024). Lastly, critiques on interventions to improve partner participation in maternity care outline how they are not designed with a gender transformative lens and can exacerbate unequal gender relations (Comrie-Thomson et al., 2015; Hampanda et al., 2020).

Findings from studies concerning social support provision from family have shown that female relatives play a prominent role in pregnancy-related support functions over that of male relatives (Al-Mutawtah et al., 2023). Thus, support from family is also highly gendered. Notably,

it has been found that families themselves will uphold gender norms, such as expecting pregnant women to remain in violent marriages (Sigalla et al., 2018) or stigmatising family members who are unmarried and have an unintended pregnancy (Crankshaw et al., 2016; Lewinsohn et al., 2018).

Scholars have drawn attention to the conflict between motherhood and worker identities (Arena et al., 2023)in the workplace. Organisational structures are constructed around the ideal male worker, where efficiency and productivity clash with the positioning of pregnant female workers as "sick", uncommitted and unreliable (Arena et al., 2023; Gatrell et al., 2023; Gross & Pattison, 2007). Although legislation serves as a support structure upon which women are supposedly protected from pregnancy discrimination, findings show that how women manage their pregnancies in the workplace reinforces not only masculinist notions of what constitutes a high-performing worker and business-as-usual approach (Billotte Verhoff & Buzzanell, 2022; Gatrell, 2014) but also how women are individually expected to negotiate their work task requirements as well as care for, nurture and manage their pregnancy; reciprocal supportive social relations in the workplace are largely ignored (Gatrell, 2011b; Makola et al., 2020). Gendered practices are also intertwined with cultural and religious macro domains, where unmarried pregnant women are stigmatised by being ostracised by the church.

The policy environment and social support

A fair proportion of studies covered in this review have drawn attention to how structural forms of support, such as access to social services, the structuring of health systems and interventions, and addressing cultural perceptions or stereotypes of specific pregnant population segments, are required to improve maternal health outcomes. These studies have highlighted how social determinants (for example, living in deprived contexts) and occupying certain social positions (such as socio-economic status, race, age, relationship status, ethnicity, nationality and employment status) have a bearing on the type and quality of social support received from support networks which in turn have a bearing on pregnancy well-being.

However, very few studies have explicitly engaged with how the policy environment may play a (un)supportive role for pregnant individuals. In critiquing how global health policy can have negative consequences for ethnic, rurally-based pregnant populations in Peru, Chan (2022) highlights how, in attempting to achieve biomedical global maternal health targets (that is, attending the required number of antenatal care visits and giving birth in a health facility), the Peruvian government has introduced additional maternal support packages. These packages

have included maternal and child nutrition programmes and conditional cash transfers, but are only accessible through participating in state-mandated care. In Chan's findings, pregnant women were subjected to both official and unofficial coercion to comply with health directives. They were threatened with fines, loss of state support benefits and denial of birth certificates for their infants if they did not adhere to state-sanctioned antenatal care and birth protocols. The author asserts that an overemphasis on achieving policy goals has instead undermined pregnant women's reproductive autonomy in carrying out cultural traditions and practices. For example, the Peruvian government has banned the use of midwives who traditionally were companions and birth assistants to pregnant women in far-flung rural areas. Although global policy aims to address maternal and infant mortality and morbidity rates are valid, Chan contends that *how* these targets are achieved by government health policy structures and the implementation thereof deserves careful consideration.

Given that South Africa is known to be a highly inequitable country, research has flagged how the structural environment plays an integral role in shaping pregnant individuals' support systems and health practices. Despite state healthcare being free, it is not enough to alleviate the vulnerabilities experienced by many low-income pregnant women; social inequalities in maternal health and well-being remain a concern (Wabiri et al., 2016). Scholars have called for additional state structural support interventions in the South African literature on social support during pregnancy. For example, some scholars have recommended developing social protection schemes, providing access to improving employment skills and giving food vouchers to pregnant women (Field et al., 2018; Heyningen et al., 2016; Tsai et al., 2016a). Extending social welfare by providing the child support grant (CSG) to pregnant women has also been suggested (Chersich et al., 2016; Scorgie et al., 2015).

For example, Chersich et al. (2016) reviewed pregnancy support programmes in LMIC countries to identify best practice examples that might suit the South African context. The authors envisage that extending the child support grant (CSG) to pregnant women may decrease maternal mortality and improve health outcomes; the support intervention could be designed to encourage pregnant women to access ANC sooner and more regularly, as well as prepare for the birth by being able to afford better nutrition. The authors argue for incorporating pregnancy support interventions into existing social grant packages and that the conditionalities for accessing the grant should be kept to a minimum to reduce administrative complexity and costs.

However, it is worth noting that the authors suggest advocating for the policy by focusing on the needs of the newborn rather than on the needs of the pregnant woman in order to convince policymakers that extending the grant to pregnant women would be beneficial. By adopting this approach, there also remains a danger that the needs of the foetus may eclipse the reproductive rights of the pregnant woman. In South Africa, *The Choice on Termination of Pregnancy Act* (Act No.92 of 1996) states that the foetus is only granted personhood status after a live birth. Therefore, should the grant be framed in this manner, there would instead be a lack of policy coherence between women's reproductive rights (abortion rights) and maternal social protection policy. Moreover, Chan's (2022) critique of how the Peruvian government implements additional state support to the detriment of pregnant women through state-mandated participation in maternal healthcare foregrounds how interventions such as these can have unintended consequences for pregnant women's reproductive autonomy and lived experiences.

Discursive constructions of social support

The literature on social support during pregnancy has generally focused on describing the types and sources of support provided to pregnant women. For example, social support has been conceptualised in several ways: emotional, informational, appraisal, practical, and instrumental support. Social support has also been examined in relation to perceived support when a pregnant individual evaluates the type, quality, and quantity of support they may or may not receive from their support networks. However, little literature has considered how social support is discursively constructed in talk. In conducting a discourse analysis, two qualitative studies conducted by Clarke et al. (2021) and Smissen et al. (2020) in Australia examined how women constructed social support concerning a broad range of reproductive decisions (such as those on contraception, abortion, unplanned pregnancy, not having or having children). These authors found that overall, women sought to maintain a balance between the influence of their support networks and their autonomy in making reproductive decisions.

In the Clarke et al. (2021) study, the desired forms of social support were affirmational and non-judgmental. Social support was also constructed as conditional. For example, being unsupportive was understood as justified either by lacking similar life experiences or because support networks were considered incapable of providing certain kinds of support because they did not have enough resources, skills or similar experiences. Constructing social support in this manner, the authors assert, revealed that participants were aware of the socio-cultural

influences (such as reproductive norms) that had a bearing on the type of support their networks could provide.

Smissen et al. (2020) elaborated in more detail on how notions of affirmational or non-judgmental support were constructed in complex ways around existing social discourses. They identified a social discourse of "my choice, my decision" that participants strategically drew upon to demonstrate whether the support they received validated or undermined their reproductive decision-making. At the same time, the authors showed how this discourse was utilised in gendered ways, creating ideological dilemmas that constrained how support should be provided. For example, participants saw themselves as active decision-makers, while their male partners were represented as passive and peripheral to the decision-making process. Here, affirmational support from partners was constructed as respectful of their decision, as the aim was to de-emphasise men as controlling reproductive decisions. However, at the same time, social norms of men being incompetent or incapable of participating in reproductive decision-making were upheld, thus placing the responsibility for these decisions firmly with women. Notably, the authors demonstrate that prevailing social norms, together with claims to agency, circumscribe how social support is constructed.

These studies benefit this research study because they provide insights into how social support is perceived, subject to the constraints of the broader social environment. These studies also shift the focus to how social support is produced in different ways through talk. This differs from the other studies on social support covered in this review, which provide more surface descriptions of the types and sources of social support. It is possible to glean a more nuanced understanding of the power dynamics embedded in support provision during pregnancy by focusing on how social support is discursively constructed.

Conclusion

There is a large body of reproductive health research that has examined the role of social support on individual pregnant women within a healthcare setting. Much of the psychological literature is quantitative and aims to understand the effects of social support on physiological and psychological pregnancy outcomes. Support was defined and measured in many ways, and different sources of support were measured to understand the associations or effects of support networks on pregnancy outcomes. There is a consensus in this body of literature that providing social support is conducive to a better pregnancy outcome, especially mental well-being. However, where findings are inconclusive, scholars have surmised that this

is because social support is understood, conceptualised and measured in variable ways across different contexts.

Regarding micro-level support networks, the partner, family, healthcare interactions, and the workplace environment have all been examined to understand pregnancy outcomes, health-seeking behaviour and pregnant women's experiences of support provision. There is consensus in the literature that poor support from partners can have adverse effects on the psychological well-being of the pregnant woman. Descriptions of the types of support male partners provide have been a feature of qualitative research, where emotional support is preferred over any other form of support. Understanding barriers and assessing interventions to improve partner involvement in antenatal care has received a fair amount of interest within the healthcare setting, as partners, if present, have a significant bearing on healthcare-seeking practices and decisions. While some research has advocated for including men in antenatal care and pointed to how gendered norms undermine men's participation in this regard, other research has flagged how interventions to involve men in maternity care do not address unequal gendered power relations, which can have negative consequences for pregnant women's health and well-being. Furthermore, because of high levels of gender-based violence worldwide, IPV during pregnancy has also received attention in the literature with regards to identifying risk factors for IPV, examining IPV's adverse effect on birth outcomes, its influence in delaying health-seeking behaviour during pregnancy as well as women's desire to include their partner in antenatal healthcare programmes.

There is consensus in most of the literature that family is an important source of social support for pregnant women. This literature has also noted that family support is highly gendered, where primarily female kin provide support. These studies have reported that families and family members can influence the uptake of maternity care and pregnancy management positively and negatively, depending on the hierarchical composition of family structures and contexts. Research in South Africa has drawn attention to how violence also occurs within families and how families may be unable to provide certain forms of support owing to economic deprivation. Although these studies found that pregnancy can cause strain and conflict within families, they have not considered how pregnant individuals discursively construct the support they may or may not receive from their families, given the social norms and power dynamics inherent in family formations.

In the workplace, a large body of literature has examined the effects of the workplace environment on pregnancy outcomes with mixed findings. These findings have nevertheless

informed pregnancy legislation in providing safer work environments for pregnant women. Social constructions of pregnancy in the workplace have also been examined in understanding how pregnancy stigma and discrimination operate in the workplace and how women, in the light of these constraints, manage their jobs and interpersonal social work relations. Notably, some scholars have used feminist theory and intersectionality to analyse these relations, which is useful in highlighting how stigma and discrimination may be differently experienced based on one's social position in society. However, these scholars have explicitly focused on the workplace, not the whole gamut of social support in pregnancy.

In the healthcare setting, a large body of literature worldwide has examined women's experiences and perceived satisfaction with antenatal care. This literature has analysed whether complementary social support programmes packaged with antenatal care positively affect pregnancy outcomes. The literature has increasingly focused on disrespectful maternity care. Findings from this literature have highlighted that maternal inequities will persist if structural or social changes are not addressed. Moving towards a better understanding of the power dynamics that undermine healthcare experiences using an intersectionality orientation has been suggested, but not implemented. Some qualitative studies have examined healthcare interactions using intersectionality theory to understand the power dynamics inherent in the interaction between healthcare workers and pregnant persons. However, these studies have focused on birthing experiences and less on antenatal care experiences. These studies have focused only on healthcare interaction.

Turning to the macro environment, researchers across the board have highlighted how social support during pregnancy is highly gendered, and researchers draw attention to these gendered aspects across the partner, family, workplace, and healthcare support interactions. Some attention has been given by researchers to cultural practices that may shape the pregnancy experience. Cultural practices in the form of using traditional health healers and practices have also been studied to understand health-seeking behaviour during pregnancy. In South Africa, researchers have described how pregnant women may make dual use of traditional and medicalised forms of care, but this has generally been framed as a public health concern. Religious practices have been studied to understand whether faith serves as a coping mechanism and protective factor for psychological well-being or whether it influences health-seeking behaviour during pregnancy. Scholars have found that faith-based practices alone cannot account for the positive effects on pregnancy well-being or health-seeking behaviour. These practices are intertwined with the woman's support network and other socio-economic

and socio-cultural influences. Moreover, some scholars within sub-Saharan Africa have revealed that church structures themselves can constrain the supportability of the pregnancy through social exclusion or possibly prevent appropriate health-seeking practices. Studies focusing on cultural or faith-based practices have been either quantitative or qualitative studies that are descriptive.

The structural policy environment has also been shown to play a part in constraining or enhancing a pregnant woman's pregnancy experience. Scholars who have conducted policy reviews have mainly focused on health policy shortcomings that hamper the achievement of maternal outcomes. Suggestions to address the social determinants of health and provide additional structural social support in the form of social protection or social income during pregnancy have been recommended. However, other scholars who have conducted qualitative studies with a specific focus on the effects that policies have on certain population segments have critiqued how the formulation and implementation of policy (through conditionalities and a lack of intersectoral engagement) can have unintended consequences for the lived realities of those who are marginalised and to whom the policies are directed. These studies have focused on healthcare only.

Finally, I presented a tiny body of literature (two Australian studies) considering how social support might be discursively constructed when making reproductive decisions. These studies have shown how more nuanced understandings of social support can be generated by examining how social support is perceived, subject to the constraints of the broader social environment. These studies shift the focus from descriptive analyses to interrogating how notions of social support are produced in different ways through talk, which is key to providing an intersectional understanding of pregnancy supportability. However, these studies considered reproductive decision-making, where the pregnancy experience was not the prime focus.

The literature on social support covered in this review is helpful for this study because it covers a range of support contexts that can inform the supportability of the pregnancy and may be relevant to the experiences of the participants who took part in this study. However, this body of literature mainly focuses on single support dimensions (i.e. workplace interactions, healthcare interactions, health policy or social support from immediate support networks). In using the supportability framework as a guide, this thesis will engage with the full spectrum of support across the individual, micro and macro support structures. In addition, this research project will engage with how social support is discursively constructed during pregnancy by

considering the power relations that may inform these constructions. In this way, the findings will address some of the limitations identified in this research by providing more nuanced understandings of how social support during pregnancy may be perceived, understood and provided in variable ways given the social, political, and economic contexts that circumscribe the provision of this support.

The pregnancy supportability framework was conceptualised as an intracategorical intersectional approach to understanding support interactions during pregnancy. In the following chapter, I discuss the theoretical framework used for this study.

CHAPTER 4

An intracategorical intersectionality approach for understanding supportability during pregnancy

This chapter is divided into two main sections: (1) a full explanation of Macleod's supportability framework and (2) a discussion of intersectionality and the intracategorical intersectional approach used for this research project.

In the first section of this chapter, I explain how Macleod has conceptualised the supportability framework (2016). This framework allows for examining the pregnancy event by focusing on the construct of "supportability". I elaborate on how "supportability" includes *both* the individual woman *and* her social context regarding the support she may or may not receive during pregnancy. I outline how the supportability framework is structured to incorporate personal, micro and macro support elements. The supportability framework has been designed with an intracategorical intersectional analysis in mind. This approach is process-oriented in that it aims to illuminate *how* normative (or alternative) constructions of pregnancy support are achieved through talk.

Therefore, in the second section of the chapter, I introduce the theory of intersectionality. I first provide a background on intersectionality in that it has been applied both as a social praxis within activist spaces and as a theoretical tool within academia. I then present some key intersectionality theoretical tenets and explain how these concepts apply to aspects of the supportability framework. Finally, I also engage with some of the critiques levelled at intersectionality and how they have been addressed through the structuring of this research project.

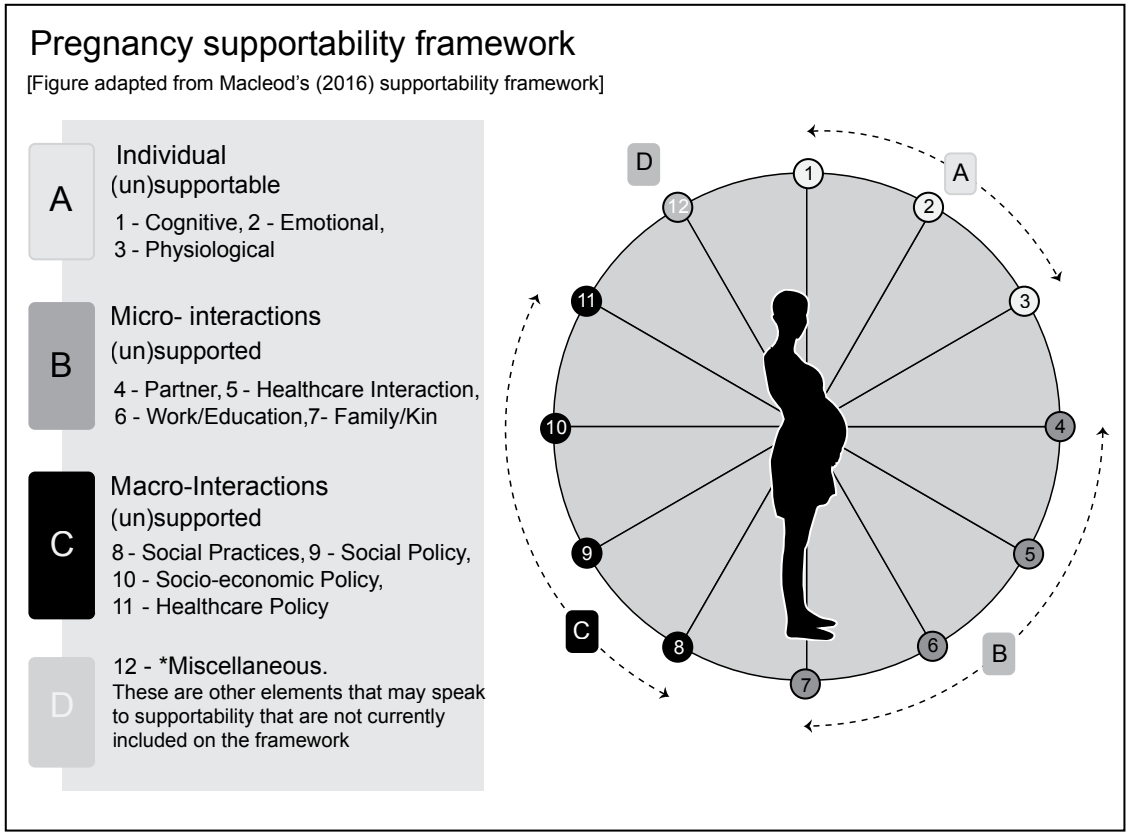
The pregnancy supportability framework

Macleod developed the supportability framework (2016) to examine the complexity of a pregnancy experience. Macleod contends that too much emphasis is placed on measuring and managing unintended pregnancies in public reproductive health research and policy. Unintended pregnancies are viewed within public health as a key underlying cause for concern in relation to poor pregnancy healthcare outcomes. She maintains that the framing of unintended pregnancies in a negative manner tends to translate into holding the pregnant

woman individually responsible for making appropriate pregnancy decisions and adopting good health behaviour. Harnessing unintended pregnancies to individual cognitions and behaviour, Macleod claims, does not sufficiently consider how the social environment may impede or contribute to a woman's ability to plan and manage a pregnancy effectively.

Macleod, therefore, advocates for an analysis of pregnancy supportability, shifting attention from the pregnant individual's cognitions and behaviour to focusing on the interconnectedness of the pregnant individual and their wider social environment. This, she argues, can provide a more holistic understanding of pregnancy experiences within a particular context. In addition, the structure of the supportability framework, through its inclusion of macro elements of support, enables insights into the types of social inequities that may shape the reproductive health and well-being of the pregnant person. In Figure 1, which is adapted from Macleod's conceptualisation of the supportability framework, I place the pregnant woman in the centre of the diagram so that an overall picture of the pregnancy event may be visualised.

Figure 1: **Adaptation of Macleod's (2016) supportability framework**



In reference to Figure 1, Macleod's supportability framework is structured in such a way that the pregnancy event/experience is examined by taking into account the following dimensions: (A) the **individual** pregnant woman's physiological, emotional, cognitive and behavioural ability to carry the pregnancy successfully; (B) **micro-level interactions** which include the woman's immediate support network, for example, her partner, family, friends, workplace and healthcare interactions; and (C) **macro-level interactions** which include social practices and discourses (which encompass gendered, religious and cultural power relations) and those of governmental socio-economic policies and structures.

Introducing the construct of "supportability" aims to shift the focus from the individual woman to a holistic understanding of pregnancy as a multifaceted event. Within this overarching construct, "(un)supportable" encompasses the individual's ability to carry the pregnancy successfully. For example, a pregnant person might have wanted the pregnancy (emotionally and cognitively supportable) but have a late miscarriage (physiologically unsupportable). The construct "(un)supported" encompasses the micro and macro levels of support that the person may or may not receive when pregnant. For example, the same pregnant person may have a partner who welcomes the pregnancy (supported) but has a family who disapproves of the pregnancy (unsupported) and may receive poor quality healthcare (unsupported). The two constructs, (un)supportable [individual] and (un)supported [micro and macro], cannot be examined separately from each other, nor can one be focused on at the expense of the other, as they are interconnected. Thus, the interactions and combinations between the individual, micro and macro support levels a pregnant person receives are multifaceted. This framework, therefore, allows for a multi-level, contextual and nuanced analysis of the pregnancy in that an overall picture of the supportability of the pregnancy is provided from both an individual and socio-structural perspective. Part (D) of the framework speaks to aspects of support that may not have been incorporated within the supportability framework's original formulation. These aspects are discussed in more detail in the methodology chapter, explaining the analytical procedure for this research project.

Macleod (2016) suggests that the supportability framework is intersectional (intracategorical intersectionality – see later discussion). By focusing on the construct of "supportability" (rather than on the individual woman), the framework facilitates a multi-level examination of the intersections of the various support elements. These intersections can surface how certain health (in)equalities may operate in the background, thereby affecting the reproductive welfare of the pregnant woman. For example, gendered practices in the form of

household social hierarchies (macro-element) intersecting with partner support practices (micro-element) can shape the type of healthcare choices that pregnant women make and their ability to respond to healthcare interventions. The supportability framework is therefore used as the backdrop upon which to examine the pregnancy event.

The supportability framework has been utilised in studies on reproductive decision-making (see for example, Strong et al., 2022). Mavuso, Chiweshe and Macleod (2020) conducted a thematic analysis of women's narratives of abortion decision-making. They found that the supportability framework enabled them to surface how the decision to abort the pregnancy did not stem from notions or practices of an autonomous, choosing, independent subject but was very much shaped by the woman's social context; the women in their study reported that there were no options open to them but to terminate the pregnancy. As such, the authors demonstrated how reproductive agency was highly constrained by the social contexts in which the women lived. For example, the supportability framework helped surface how gendered norms (whereby men had the power to deny paternity) contributed to how the pregnancy was constructed as individually unsupportable both emotionally and cognitively. In addition, these gendered norms (partner desertion) interacted with poor socio-economic prospects (unemployment) and generational social hierarchies (becoming more dependent on families), which also imposed constraints on the choices that pregnant women were able to make about their pregnancies. The authors conclude that the supportability framework provides an opportunity to expand our understanding of how different social aspects can come to bear on reproductive decision-making, thereby shaping the supportability of the pregnancy.

The above-mentioned study illustrates how the supportability framework can be used to conduct a multi-level analysis and helped inform the approach to this research project. However, it focused only on reproductive decision-making. The experiences of those who have decided to go ahead with their pregnancies and their experiences of support in relation to their support networks and social context while pregnant have not yet been studied using this model. Furthermore, fleshing out McCall's (2005) intracategorical intersectional approach, which forms the foundation of the supportability framework, is another avenue that can be explored in more depth. Therefore, a discussion of some key concepts pertaining to intersectionality and an explanation of the intracategorical intersectional approach is necessary. In the next section, I provide background on intersectionality as both a form of praxis and scholarly work and its usefulness for understanding pregnancy supportability.

Intersectionality praxis and theory

The concept of intersectionality evades a precise definition (P. H. Collins, 2015). Nevertheless, Patricia Hill Collins and Sirma Bilge (2020, p. 2) offer the following description:

> Intersectionality investigates how intersecting power relations influence social relations across diverse societies as well as individual experiences in everyday life. As an analytic tool, intersectionality views categories of race, class, gender, sexuality, class, nation, ability, ethnicity, and age – among others – as interrelated and mutually shaping one another. Intersectionality is a way of understanding and explaining complexity in the world, in people, and in human experiences.

May (2015) further describes how intersectionality is not neutral because of its application in the quest for social justice. One of its key aims is that it can be used as a tool to analyse the role that social inequality plays in social spaces.

In this chapter section, I provide some background on how intersectionality was initially rooted in social activism and was deployed as a form of praxis in activist spaces before being introduced into academia. I draw specific attention to how an intersectionality orientation was adopted within activist spaces during the 1950s apartheid era in South Africa by the Federation of South African Women (FSAW). I then move on to how intersectionality has been conceptualised within academia. I outline some key tenets of Kimberlé Crenshaw's seminal work on intersectionality (1989, 1991) in challenging single-axis thinking. I discuss five theoretical aspects of intersectionality that guide scholars in challenging single-axis frameworks and explain why these are important in the conceptualisation of this pregnancy supportability research project. In addition, I include a discussion of how power is understood from an intersectionality stance. I introduce Collins' (2000)[5] conceptualisation of the domains of power thesis and how this approach aligns with the supportability framework.

---

[5] I use Patricia Hill Collins' seminal work, *Black Feminist Thought*, to explain the domains of power thesis compared with her and Sirma Bilge's most recent edition of *Intersectionality's Key Concepts Ed 2*.

Scholars have adopted two broad approaches to applying intersectional insights in the maternal health arena to examine social issues concerning reproductive justice and maternal well-being. I provide some examples and discussion of this research. In selecting an intersectional approach to guide this research project, I explain and motivate for using McCall's (2005) intracategorical intersectional approach upon which the supportability framework is premised. I also provide two limitations in using the intracategorical approach as a lens to examine pregnancy supportability and explain how they have been addressed for this research project. Finally, I outline some of the critiques and debates aimed at intersectionality and how I address these in relation to structuring this research project.

Intersectionality and social activism

The interconnectedness of multiple social divisions or categories and their implications for social inequality, disadvantage or oppression of specific social groups has been a key focal area in the development of intersectionality theory. Intersectionality, although it may not have borne the same name, originated in grassroots social activism. Marginalised communities in many regions of the world, including Asia, Africa, South America and the United States of America, have used what Hancock (2016, p. 43) terms "intersectionality-like thought". This involved the formation of broad-based social coalitions that attempted to overcome various inequities or oppressions to which these social groups had been subjected. Hancock (2016) draws attention to how these particular coalitions were unique in their understanding of and ability to engage with differences *within* and *between* their groups. This understanding shaped their various strategies in advocating for more inclusive social justice.

Furthermore, these groups held a unique understanding of the interactive marginalising effects of social divisions. For example, Collins and Bilge (2016) describe how, in the 1800s in India, activist Savitribai Phule dealt with inequities in her community across multiple social divisions. These included those of caste, religious intolerance, gender and economic disadvantage, where, as part of their activist projects, she and her husband set up shelters for pregnant widows and championed their rights to remarry.

One of the most widely referred to coalitional movements that embraced intersectional thought and practice is the Combahee River Collective (1978). This was a U.S. black feminist lesbian organisation that, amongst other issues, challenged Marxist notions of examining oppression from a class-only perspective; the feminist movement for their underlying racism in focusing mainly on white middle-class women's issues; and anti-racist or black nationalist

movements for ignoring their own sexist politics in terms of how these affect black women. They saw the social divisions of race, (hetero)sex and class as interlocking forms of oppression that required an integrated approach to organising to mitigate the effects of the various disadvantages that were imposed on black women.

Intersectional orientations, therefore, underpinned social activist strategies in four key ways: (1) forming broad-based social coalitions to challenge social inequities; (2) understanding that, although social activists organised around a common social issue (for example, reproductive health), the group's needs and experiences were heterogeneous; (3) drawing attention to how socio-structural aspects are intertwined with an individual's lived experience and therefore have a distinctive bearing on an individual's social location within society; and (4) rejecting one-dimensional thinking about a social issue (for example, focusing on gender only) by foregrounding how social divisions are interconnected and mutually operate with each other to create social inequities.

These foundations of intersectionality-like thinking have also been applied within the South African context, where this research project is located. Therefore, it is fitting to discuss how specific features of intersectional praxis shaped the activities of a 1950s women's political activist organisation, the Federation of South African Women (FSAW).

Intersectional thinking and political activism in the South African context

Embracing an intersectional approach requires examining history and acknowledging its influence on the present (May, 2015). As Sylvia Tamale (2020, p. 1) points out, "no situation, concept or person can ever be fully understood without probing their histories". In the late 1940s, the apartheid government purposely fractured South Africa along social divisions of race, gender, class, ethnicity and religion, the effects of which persist today, such as ongoing maternal health disparities (Bloom & Mcintyre, 1998; Wabiri et al., 2016). Despite these challenges, women's political activism has played a crucial role in South Africa's liberation and advancing gender equality.

FSAW, established in the early 1950s, was a women's political organisation that mobilised women across race, class, gender, and religion. Cherryl Walker (1982) highlights FSAW's pioneering nature as an independent (not a subsidiary of a male-dominant political organisation) multi-racial movement operating within an inordinately challenging context in which the nationalist government began to hone their vision of an apartheid state by rolling out its segregationist policies. The organisation aimed to unite and improve the status of all South

African women by advocating for eliminating discriminatory practices and promoting justice, equality, and fair wealth distribution. While multi-racial, FSAW primarily focused on the majority of marginalised black women.

To fully grasp FSAW's efforts, it is crucial to consider the social position of black women in 1950s South Africa, particularly in relation to their labour roles in both the workforce and the home, as well as their legal entitlements.

Women's positions in South Africa in the 1950s

In the 1950s, women's labour in South Africa was heavily influenced by gender, class, and race stereotypes (Walker, 1982). Poinsette (1985) describes how the majority of black women worked as domestic workers in white households or as farmworkers, facing low wages, poor working conditions and a lack of social protections. A smaller proportion found employment in the textile and food canning industries, with limited opportunities for union representation and consistently lower wages than their white counterparts. Only a tiny percentage of black women held positions as teachers or nurses.

The nationalist government perceived black women as having little economic value and implemented influx control measures to restrict their movement to urban areas (Poinsette, 1985). These marginalising policies confined black women to rural areas known as "reserves", "homelands", or "Bantustans"[6], where they faced isolation and increased burdens related to subsistence farming and childcare. The splitting of families due to the migrant labour system exacerbated poverty, starvation, and health issues in these areas.

While white women achieved legal advancements such as voting rights and political participation, black women were excluded from such progress (Walker, 1982). Under customary laws, black women were considered minors, unable to own property, inherit wealth,

[6] The reserves, homelands or Bantustans were rural land that was set aside by the apartheid government for black ownership with the aim of encouraging separate development. On an administrative level, black communities were allowed to govern themselves on local matters, but these areas ultimately fell under the power and control of the nationalist government (Poinsette, 1985).

or have legal autonomy. They were also subjected to restrictive racial laws imposed by the apartheid government, including the *Group Areas Act of 1950*[7] and the *Bantu Education Act of 1953*[8], which significantly worsened their living conditions and access to education (Poinsette, 1985). A significant point of contention was the extension of the *Bantu Abolition of Passes and Co-ordination of Documents Act of 1952*[9] to black women, which required them to carry passbooks to access urban areas, severely limiting their employment opportunities, freedom of movement, access to their families in urban areas and the education of their children (Walker, 1982). The mandate to carry reference books or passes to gain access to urban areas inspired intense resistance from various communities of black women.

In response to these oppressive conditions, the FSAW sought to challenge discriminatory structures through political activism (Walker, 1982). FSAW was instrumental in organising a multi-racial anti-pass protest march with the African National Congress Women's League (ANCWL), culminating in the historic 9 August 1956 march, where 20,000 women of diverse backgrounds protested against pass laws in Pretoria. This event remains a significant milestone and is commemorated annually as Women's Day in South Africa.

---

[7] The *Group Areas Act* (Union of South Africa, 1950) enforced separate geographic residential areas for black and white communities. This meant that black people could not live in white areas, and white people were not allowed to live in black areas. It also meant that with the advent of these laws, people of colour were forcibly removed from their homes if the government deemed a particular location an exclusively white area. Under this Act, only certain black people qualified to live in white areas based on their type of employment, for example, domestic workers.

[8] The *Bantu Education Act* (Union of South Africa, 1953) enforced separate education for black and white communities in terms of the educational facilities provided and the type and quality of learning curriculums that were deemed appropriate for racial groups. Control of education was moved from the provincial level and private entities (for example, missionary schools) to that of the central government.

[9] *The Bantu Abolition of Passes and Co-ordination of Documents Act of 1952* required black people to carry identification containing their picture, fingerprints and employment details. The pass had to be taken at all times and produced on demand. Failure to produce the document would result in arrest. This Act was also designed to control the influx of workers into the cities; that is, only black people considered suitable for employment were permitted into urban spaces. Otherwise, they were forced to reside in the homelands (Poinsette, 1985). The apartheid government intended to extend this law to all black women, and it is this act that galvanised mass anti-pass demonstrations (Walker, 1982).

FSAW also conceptualised and drafted *The Women's Charter* called *"What Women Demand"* (Federation of South African Women, 1955), which underpins some of the constitutional rights afforded to pregnant individuals today. This document is instructive from an intersectional standpoint because of how its members paid attention to the interconnectedness of gendered and national liberation ideologies. FSAW understood that focusing on women's issues alone would not suffice; the charter needed to address the gendered, class and race disparities which particularly shaped black women's experiences at that time. Some key features of intersectional praxis are evident in FSAW's approach to organising and crafting *The Women's Charter* document. These include organising around a common social issue, forming broad-based social coalitions, acknowledging the heterogeneity of women in South Africa, valuing situated knowledge and experience, and addressing the multiple structural constraints that affected women's lives. These intersectionality-like features will be discussed next.

FSAW's political organising, *The Women's Charter* and intersectional praxis

FSAW's organising strategies and drafting of the 1950s *Women's Charter* were revolutionary in linking race, class and gender to the struggle for national liberation. However, I address three caveats upfront: FSAW demonstrated certain intersectional features but not others. Firstly, concerning the *Women's Charter*, Hassim (2014) rightly notes that the document was crafted around heteronormative notions of male and female participation in the liberation of South Africa. Secondly, the 1954 Charter is silent on other intersectional concerns such as immigration status, age, and disability. Thirdly, the activities of this organisation were firmly located within the nationalist discourses of that time. Intersectionality theorists critique constructions of nationhood because of who is included or excluded and how these conceptualisations contribute to social hierarchies and social differences (McClintock, 1991; Yuval-Davis, 1993). However, regarding the first two points, the initial *Women's Charter* was developed in the 1950s, not in contemporary times. Concerning nationalist discourse, it must be remembered that black women in South Africa were homeless and stateless by apartheid design. Hassim (2014) asserts that what was transgressive about FSAW as a women's political organisation is how it organised across social divisions to resist a deeply segregationist and oppressive regime.

In line with an intersectionality standpoint, which rejects single-dimensional thinking about a problem (that is, framing an issue around race only), FSAW committed to organising across social divisions around a **common social issue**: the liberation of *all* people living in

South Africa. There have been feminist scholarly debates on whether the national liberation struggle took precedence over gendered claims (Hassim & Gouws, 1998; Walker, 1982). Hassim (2006) argues that national liberation was not seen as separate from women's liberation, but there were tensions about incorporating both. Gasa (2007a) rejects claims that place gender and liberation politics in a dichotomous relationship. The author argues that doing so does not fully appreciate the complexity of black women's experiences at that point in time. black women's struggles against the pass laws were not only connected to protecting their gendered roles in society but also to their freedom of movement and economic well-being.

Helen Joseph, who was a national executive committee member of FSAW and who put together the first draft of *The Women's Charter* for discussion, deals with this tension in her memoir thusly:

> Our demands reflected very clearly the direction and thinking of the women of the Federation. The stress was on the struggle for liberation of men and women together. Separationist feminist liberation did not feature strongly beyond the call for the vote for women, election to state bodies, equal rights in marriage and guardianship and equal work for equal pay. (Joseph, 1986, p. 47)

I argue that FSAW clearly understood the interrelatedness of liberatory and gendered claims because of how *The Women's Charter* is worded. The two claims are consistently linked together throughout the charter. I explicate this by examining some of the extracts of the charter that follow.

To achieve its aims, FSAW, by adopting an intersectionality orientation, strategised around building **broad-based political and civil society coalitions** to build a multi-racial women's movement. This is evident from their slogan, "Side by Side", which encompassed the vision of mobilising across race, class, gender and religion in a bid to remove multiple oppressions in the fight for liberation (Gasa, 2007a). The federation was willing to cooperate with political parties, women's organisations and trade unions as part of the liberatory

movement. FSAW fully aligned itself with the national liberation movement[10], and it had close and overlapping ties to the African National Congress Women's League (ANCWL)[11]. The extract below sums up how *The Women's Charter* sought to make both liberatory and gendered claims by working within social coalitions; it notably framed its aims around working *with* men to improve conditions for women:

> As members of the National Liberatory movements and Trade Unions, in and through our various organisations, we march forward with our men in the struggle for liberation and the defence of the working people. We pledge ourselves to keep high the banner of equality, fraternity and liberty. As women there rests upon us also the burden of removing from our society all the social differences developed in past times between men and women, which have the effect of keeping our sex in a position of inferiority and subordination. (Federation of South African Women, 1954, para. 6)

Although this organisation was open to all women, FSAW acknowledged and understood that women within South Africa were a **heterogeneous group** in that they did not share common experiences, identities or viewpoints. This is important from an intersectional stance, which resists homogenising a social group's experiences (McCall, 2005). Walker (1982) describes how the leaders and members came from a mix of poor, working-class and middle-class backgrounds. Some leaders had university degrees, and some had not completed their foundation schooling. FSAW also recognised that it was not representative of all South African Women (Walker, 1982). The organisation was well aware that structural oppressions exacerbated differences between women; the segregationist policies of the apartheid government restricted contact between the various racially defined social groupings as well as between rural- and urban-based women. *The Women's Charter,* therefore, embraced the

[10] The national liberation movement consisted of a congress alliance which included the African National Congress (ANC), South African Indian Congress (SAIC), Coloured People's Congress, Congress of Democrats (COD), and SA Congress of Trade Unions (Gasa, 2007b).

[11] The ANC Women's League (ANCWL) and FSAW shared presidents during the 1950s, for example, Ida Mtwana and Lillian Ngoyi.

heterogeneous nature of the social category "woman", where different needs and viewpoints were included.

This is evidenced by the preamble below. Here, the charter attempted to appeal to a range of individuals who were socially positioned within the category of "woman":

> We, the women of South Africa, wives and mothers, working women and housewives, African, Indian, European and Coloured, hereby declare our aim of striving for the removal of all laws, regulations, conventions and customs that discriminate against us as women, and that deprive us in any way of our inherent right to the advantages, responsibilities and opportunities that society offers to any one section of the population (Federation of South African Women, 1954, para 1).

There is debate among feminist historians about whether the FSAW could appeal to a broad range of women and whether its members embraced feminist ideals. Some scholars argue that FSAW members were sceptical of Western feminism, as it did not align with the social realities of black women (Hassim, 2006). There were also assertions that FSAW's membership was conservative, focusing primarily on protecting their gendered roles as mothers and that the organisation relied on motherhood and nationalist discourses to make political claims (Gasa, 2007b; Hassim, 2006; Healy-Clancy, 2017). The use of motherhood discourses is seen as problematic from a feminist standpoint, not only because it supposedly locates women firmly within gendered roles but also because it defines women in relation to others (men and children) and not as independent, autonomous beings (Hassim, 2006). Aspects relating to motherhood are, of course, quite clearly and often articulated in *The Women's Charter* (see the following extract below).

However, some scholars contend that the use of motherhood in political discourse was common in feminist movements globally in the 1950s, strategically deployed to make demands for social services[12] from the state (Healy-Clancy, 2017). Another argument is that motherist

[12] In July 1955, Federation members Helen Joseph, Lilian Ngoyi and Dora Tamana attended The World Congress of Mothers in Lausanne, Switzerland, organised by the Women's International Democratic Federation (Healy-Clancy, 2017; Joseph, 1986)

politics simply reflected the lived realities of women at the time (Hassim, 2014). Gasa (2007b) argues that the focus on motherhood reflected the harsh realities of black women's lives under apartheid, which severely limited their ability to mother. Defending families during this time, especially when children were subject to police brutality, was critical. McClintock (1991) highlights that black motherhood politics in South Africa did not align with typical nationalist gender discourses, which often positioned women as reproductive bearers of the future nation[13]. Instead, motherhood in the women's movement was constructed as more than biological; the idea of an agentic, militant, political or "revolutionary mother" who mobilised to protect both the community and their children was embedded within South African nationalist discourses of liberation. Another argument is that motherisms were mainly deployed in South Africa to find common ground across a vastly divergent social group (Healy-Clancy, 2017).

Nevertheless, in reading the charter extract above, what is notable from an intersectionality standpoint is how the FSAW's coalitional politics attempted to accommodate the divergency of this social group of women. FSAW positioned women as equal to men from a feminist perspective but took into account that there were different perceptions around what that might mean for different women. For example, Helen Joseph (1986) reflects on one of the demands that she suggested, but that was dropped from the draft of the charter. This was a demand for better birth control clinics. The suggestion was rejected outright from the floor as the consensus was that everyone should have the right to have a child. The delegates viewed the birth control clinics as part and parcel of the apartheid system, which sought to reduce the birth rate of black children but increase the birth rate of whites.

The crafting of *The Women's Charter* drew from the narratives, conversations and discussions initiated from the floor at FSAW's inaugural conference in 1953. Making the social realities of marginalised groups visible is a key intersectionality tenet (Hancock, 2016). Joseph (1986) describes how each and every demand was carefully discussed by the delegates and

[13] This conception of black motherhood politics was quite different from the strategies deployed by white Afrikaner women who deployed the "Volksmoeder" (mother of the nation) ideology in the 1920s to secure their vote in South Africa. See Louise Vincent's (1999). argument on how white Afrikaner women were more involved in mobilising around suffrage than initially perceived

detailed the struggles and hardships that women faced. Thus, the charter reflects women's **social conditions and situated experiences** and the particular needs that affected various groups of women in South Africa at that time. These realities are expressed under the section of the charter called “Women’s Lot”:

> We women share with our menfolk the cares and anxieties imposed by poverty and its evils. As wives and mothers it falls upon us to make small wages stretch a long way. It is we who feel the cries of our children when they are hungry and sick. It is our lot to keep and care for homes that are too small, broken and dirty. (Federation of South African Women, 1954, para 4)

Drawing from situated experiences, *The Women’s Charter* highlighted the **multiple structural constraints** that shaped women’s positions in South African society and demonstrated an understanding of the interconnection of oppressions. It, therefore, specified removing legal, economic and social inequities that shaped women’s lived realities:

> The law has lagged behind the development of society; it no longer corresponds to the actual social and economic position of women. The law has become an obstacle to progress of women, and therefore a brake on the whole of society.
>
> This intolerable condition would not be allowed to continue were it not for the refusal of a large section of our menfolk to concede to us women the rights and privileges which they demand for themselves.
>
> We shall teach the men that they cannot hope to liberate themselves from the evils of discrimination and prejudice as long as they fail to extend to women complete and unqualified equality in law and in practice. (Federation of South African Women, 1954, para 17-19)

The last paragraph of the above extract above is particularly instructive. FSAW clearly saw that liberation for South Africans was not one-dimensional; it had to include removing oppressions for **all** South Africans. According to Hassim (2014), the strength of the 1950s charter (and later 1990s women’s charter) is that women were explicitly envisioned as equal, active, and participating citizens within South African society. FSAW, thus, was ahead of its time in incorporating some key intersectional features that shaped its ethos, activist stance and campaign activities. Although FSAW lasted only eight years (because the federation’s leaders were persistently targeted and consequently banned or incarcerated by the apartheid government (Joseph, 1986)), the organisation’s enduring legacy of intersectionality-like thinking can be found within the South African Freedom Charter and the South African Constitution today.

In the 1950s, the Congress Alliance expressed the idea of drawing together all South Africans to develop and adopt a Freedom Charter, which stood for a non-racial, united and democratic South Africa. Helen Joseph (1986) describes how FSAW worked closely with the alliance by campaigning amongst communities of women in talking about the Freedom Charter, distributing information pamphlets and collecting signatures, and organising accommodation for the upcoming conference to be held in June 1955, where the Freedom Charter would be adopted. It was in preparation for this conference that FSAW regional committees formulated *The Women's Charter*, "*What Women Demand",* to be included in the Freedom Charter. According to Joseph (1986), the final version of the Freedom Charter very much resembled the list of demands that FSAW submitted. Features of the Freedom Charter, together with the Universal Declaration of Human Rights, were then infused into The Bill of Rights, which is today considered the cornerstone of South African democracy and is enshrined in the South African Constitution. The Bill of Rights contains an equality clause that reads as follows:

> The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth. (South African Government, 1996, p. 6)

During the dismantling of the apartheid state, critical race theorist and intersectionality law scholar Kimberlé Crenshaw facilitated workshops for the South African constitutional court judges on constitutional law and helped draft the above-mentioned equality clause for the new South African Constitution (The African American Policy Forum, 2019). Thus, the edifice upon which the South African Constitution stands today contains the strands of grassroots intersectionality-like contributions from women in the 1950s and the scholastic input of the person who introduced the concept of intersectionality into academia. Notably, unfair discrimination against pregnancy is explicitly stated within the above-mentioned clause.

In the next section, I explain how, in academia, intersectionality has been conceptualised as a theoretical lens to interrogate how normative political, economic and social structures operate in marginalising and oppressive ways on the social conditions of specific social groups. Critically questioning single-dimensional thinking about social issues is a fundamental premise of intersectionality theory, and this will be expanded on in more detail next.

The introduction of intersectionality into academia

Kimberlé Crenshaw (1989, 1991) introduced the term intersectionality into academia in the late 1980s to trouble the understanding and workings of social divisions or categories within a legal context. According to Crenshaw (1989), intersectionality challenges single-axis frameworks. As with activism that uses intersectionality as praxis, single-axis thinking means examining social issues by treating one social dimension or factor as primary, for example, examining an issue through a gender-only lens. Thus, in challenging single-axis thinking about black African American women's experiences of discrimination in the workplace and of domestic violence, the author analysed the *relationship* between the social categories of race and gender and their uniquely marginalising effects on these women. By examining various court rulings, Crenshaw showed how the effects of the relationship between race and gender were unacknowledged by law doctrine. Black women were only protected by law if they experienced discrimination similar to that of black men (racial discrimination) or that of white women (gendered discrimination). However, these laws did not protect black women if they claimed that they suffered from both forms of discrimination. Thus, Crenshaw posited that these social categories should not be understood as entirely separate dimensions but as intersecting ones and that laws should acknowledge this.

As part of her analysis, Crenshaw (1991) also highlighted how social categories are connected to systems of subordination. Crenshaw presented three systemic forms of intersectionality: structural, political and representational. Firstly, structural intersectionality refers to how social institutions or policies shape the everyday experiences of individuals who occupy multiple social positions in particularly marginalising ways. For example, access to and experiences of education institutions, housing, healthcare and legal protection have different implications for people located in different social locations.

Secondly, Crenshaw (1991) describes political intersectionality as contexts where individuals who occupy multiple social locations find themselves and their interests caught between incongruous political agendas. Dean Spade (2013) provides a good analysis that speaks to political intersectionality, whereby he shows how reproductive rights agendas intersect with population control policy, thereby having inequitable effects on women of colour. I discuss this work in more detail further along in this chapter.

Thirdly, Crenshaw (1991) describes representational intersectionality as multiple cultural narratives that replicate and reinforce negative stereotypes of individuals who occupy

particular social locations. The author maintains that an intersectional analysis examines how racism and sexism are embedded within cultural narratives and operate together to the detriment of black women. An example of representational intersectionality is the stereotyping of black pregnant women as the "welfare mother". Other scholars have drawn attention to how the "welfare mother" is constructed in both racist and sexist ways (Alexander-Floyd, 2007). The sexist welfare mother imagery has been used in black nationalist narratives to defend the actions of black men (absent fathers and the breakdown of the African American family) and in white nationalist racist narratives to justify more punitive welfare reforms. The deployment of various cultural narratives containing this imagery mutually reinforce one another to uphold the stereotypical notions of the "welfare mother".

Crenshaw's approach to examining how structural, political and representational systems of subordination operate to create various social inequities for individuals within specific social locations can be considered a structural analysis in that it is conducted from a macro perspective. These forms of intersectionality speak to the macro elements of the supportability framework. The framework itself provides a backdrop upon which social practices (representations), socio-economic policies (shaped by political agendas) and institutional structures (structural systems) can be examined in terms of how they enable or constrain the overall supportability of the pregnancy.

In order to challenge or disrupt single-axis knowledge frameworks, intersectionality scholars have outlined some key theoretical concepts that should be considered when examining social issues with an intersectionality lens. These concepts are similar to those of intersectionality praxis (as explained in the previous section), and they inform the conceptualisation of this research project. These theoretical concepts are discussed next.

Challenging single-axis frameworks with intersectionality's theoretical insights

The theoretical insights of intersectionality that are discussed in relation to challenging single-axis thinking and the conceptualisation of this research project include the following : (1) rejecting universalist assumptions by acknowledging intra-group heterogeneity; (2) viewing situated individual knowledge in relation to the structural systems that shape lived experience (using a "both-and" lens); (3) understanding social categories and systems as contingent; (4) rejecting additive notions of disadvantage or marginalisation; and (5) examining social issues in relation to power.

May (2015) discusses how single-axis thinking obscures *intra-group differences* or creates false universals. As mentioned previously, black feminist thought has challenged how the category "woman" is often homogenised to reflect white women's middle-class experiences, thereby ignoring the heterogeneity amongst women. Thus, the author argues that single-axis thinking serves to essentialise or reify a given group's experiences, whereby a specific group is treated as uniform in terms of their needs or actions (e.g., assuming all pregnant women will be able to comply with the required number of scheduled antenatal care visits). This way of socially categorising or describing individuals along single social dimensions, May argues, can obscure various social inequities that may affect individual members who have been assigned to a particular social group. An intersectionality orientation is critical of describing individual social characteristics in relation to a social issue. Instead, it interrogates the *process* by which these normative representations or practices come into being. Macleod (2016) asserts that a strength of the supportability framework is that it moves the focus away from essentialising or describing individuals and focuses on the **event** of the pregnancy to surface the complexity and variability of support practices and systems that contribute to the pregnancy's overall supportability. The individual, micro and macro elements that comprise the structure of the supportability framework do not foreground any social characteristics of a pregnant individual. Thus, the framework allows an open-ended investigation to understand the process by which individuals construct support during pregnancy.

Intersectionality rejects an *either/or (or binary) approach and adopts a relational "both-and" approach* to analysing the interconnections between social justice issues. For example, May (2015, p. 102) used the notion of "individualising logics", whereby certain types of bodies are considered problematic. The solution to their shortcomings is instigating interventions aimed at individual behaviour change rather than considering how structural or political transformations may serve to overcome these issues. An intersectional approach does not lose sight of the individual but insists on analyses that examine both the individual and the social context in which they are socially located. Hancock (2007) suggests that intersectionality theory offers the opportunity to mediate between individual-level research (which risks pathologising the individual) and structural-level research. She argues that persistent inequalities, such as poverty and lack of education access and quality, will not be solved if micro-level research is isolated from macro-level research. These arguments link with the aims of the supportability framework (2016) , which is not only to examine the pregnant woman's individual ability to carry the pregnancy to a successful outcome but also to examine this

capacity in relation to the women's social context of support networks and structures. The framework offers an approach to examine both the individual and social context to view the pregnancy in a range of spaces because the individual is intermeshed with her context. Therefore, this approach opens possibilities to understand pregnancy issues that might be obscured should the focus only be centred on the individual or social/structural issues.

Although intersectionality views social categories and social systems in terms of how they are related or connected, it also acknowledges that these *categories and systems are contingent*. The meanings, saliency and relationships between social categories and systems are variable across time, places and contexts (P. H. Collins, 2015). Thus, the organisation of these systems or relationships between social categories and divisions cannot be described in fixed or static ways. As Marecek (2015) argues, it is the shifting *meanings* associated with social categories that are of interest to intersectionality scholars because the dynamism of these meanings may have implications socially, culturally and politically. May (2015) maintains that intersectional research is invested in prioritising situated knowledge and experience. Thus, attention to an individual's articulation of their social location in relation to their wider sociocultural environment can provide insights into the contingent nature of social categories and their relationship to social systems and structures. Moreover, the contingent nature of various social dimensions can illuminate unique living conditions or experiences and, at the same time, can provide insights as to how normative knowledge frameworks are upheld or challenged.

By acknowledging the contingency of social categories and systems, intersectionality also rejects *additive notions of disadvantage or marginalisation* in that it seeks to examine how people might be uniquely disadvantaged. For example, an intersectional orientation will reject a view whereby people located within given social groups are rated as the *most* disadvantaged or oppressed because they are classified within multiple "unfavourable" social categories, for instance, female + poor + rural + black + immigrant + pregnant. Hancock (2007) argues that additive notions of disadvantage assume that categories are static, homogenous, and independent. Thus, viewing social groups in this light assumes uniform experiences and needs, which mask the variability and diversity within these groups. Moreover, additive notions suggest that these elements can be separated when they are interconnected on both individual and structural levels.

An intersectional point of view acknowledges that the social constructs of race, class, gender, and nation can operate simultaneously as characteristics of a person and as social,

political, and economic systems of power (Dhamoon, 2011). The interactive effects between these constructs and their relation to power are key to an intersectional analysis. In the next section, I discuss how intersectionality has been conceptualised in relation to power.

Intersectionality and its engagement with power

Using intersectionality as a theoretical lens can assist scholars in understanding how power operates in social spaces and how certain groups experience the effects of these power manifestations. In her work on intersectionality, Crenshaw (1991) draws specific attention to how social categories are constructed through the workings of social power; this form of power operates through the attachment of particular values to social categories through social categorisation. These values are entrenched into social hierarchies or systems of domination that have material or social consequences for certain persons occupying specific social categories. Crenshaw acknowledges that power is relational and that the process of social categorisation is not unidirectional; subordinated persons have the agency to subvert and challenge being categorised in certain ways and challenge the structures that uphold the values attached to these social categories to regain power for themselves.

In a similar vein, Collins (2000) has developed, within an intersectionality approach, what she calls a matrix of domination. This matrix has four domains of power: Interpersonal, structural, disciplinary and hegemonic/cultural. These four overarching domains of power operate by socially organising, generating and maintaining how certain oppressions intersect, for example, those of race and gender. According to Collins, these domains of power can appear across various oppressions, but what is key is understanding how they are organised. Collins (2000) posits that these four domains are not mutually exclusive but are interconnected and reinforce one another or overlap. Furthermore, one domain of power is not seen as more important than another when examining specific social phenomena because they operate in relation to one another. I discuss each domain of power in turn.

Interpersonal power operates on a micro-level and involves the power relations that occur in an individual's everyday lived experiences through social interaction. This type of power operates in how individuals relate to one another in a given interaction. Individual attributes (race, gender, nation), together with how individuals actively and discursively uphold or subvert social norms, provide insights as to who may be more privileged or disadvantaged within the interaction. For example, the social interactions between a pregnant woman and her immediate support network are where the effects of interpersonal power relations may be felt

regarding how supported or unsupported a woman may feel during her pregnancy. Interpersonal power dovetails with the micro-level of the supportability framework.

Collins (2000) conceptualises *structural power* as the organisation and structure of social institutions. This type of power operates through social, health, economic, and legal policies and the way institutions are structured. For example, a WHO bulletin (Bhan et al., 2020) focusing on informal work and maternal and child health has drawn attention to how the public health literature and outdated social protection policies overlook the informal work sector in terms of facilitating access to healthcare, income security and labour protection for pregnant women and new mothers. In low to middle-income countries, the informal sector comprises a substantial portion of the working population, primarily women. Thus, informal work, without the necessary social protection measures put in place specifically for pregnancy and childcare (where, for example, pregnant informal traders fear losing their vending spots due to childbirth or medical needs), is considered integral to the feminisation of poverty. The authors have called for new models of social protection where benefits are not solely directed through employers or formal work sectors. As discussed in Chapter 2 of this thesis, similar socio-structural issues exist in South Africa. Seemingly fair labour laws that protect women from pregnancy discrimination in the workplace mask issues around who gets to access those rights. These rights mainly protect persons either permanently employed or in stable contractual employment. In contrast, a fair proportion of South African pregnant women are informal workers or are unemployed and do not get access to those rights. Regarding the supportability framework, structural power operates at the macro level of support; policies are implemented in specific ways that constrain the supportability of the pregnancy for those who are not workers in the formal employment sector.

Collins (2000) describes how the domain of *disciplinary power* operates by managing dominant social hierarchies through surveillance and bureaucratic means. Collins draws particular attention to how organisations manage and deploy this power by how individuals within these spaces may be organised (included or excluded), categorised, policed and disciplined to ensure that they behave in acceptable ways. Although laws, policies and social norms may appear fair and natural, disciplinary power operates through these mechanisms unevenly for different people depending on their social position (P. H. Collins & Bilge, 2016). In addition, disciplinary power can also operate by people freely subjecting themselves or policing their behaviour in relation to these perceived norms so as to become model citizens (Burr, 1995).

For example, Macleod and Howell (2015) illustrate how the media exerts disciplinary power by shaping pregnant women's behaviour according to normalised ideals of a "good" pregnancy. Their study of South African pregnancy websites reveals how foetal imagery, such as ultrasonography, functions as both medical and cultural surveillance, reinforcing gendered, racial, class-based, and heterosexual norms. These websites place responsibility for pregnancy outcomes on individual women by labelling the foetus as "your baby" together with providing directives to pregnant women to nurture their physical well-being in specific ways at various stages of the pregnancy. Despite South Africa's predominantly black population, the imagery mainly features white bodies and foetuses, subtly reinforcing whiteness as the ideal. Additionally, the sites link a "good" pregnancy to financial privilege through advertisements for premium baby products. They also reinforce traditional gendered norms, portraying male partners as busy, sporty, rational breadwinners and as extraneous to the pregnancy while positioning women as primary caregivers. Ultimately, the study highlights how online foetal imagery disciplines women by promoting an ideal pregnancy as white, heterosexual, and financially secure. This example demonstrates how the domain of disciplinary power operates across individual, micro, and macro-level interactions of support and is, therefore, useful in providing insights into how discursive and social norms shape support interactions during pregnancy.

Whereas structural and disciplinary domains of power are bureaucratically managed through organisational practices, the *Cultural or Hegemonic*[14] domain of power is linked to these forms of power by justifying these practices through the maintenance of ideologies, stereotypes and taken-for-granted knowledge in everyday social and discursive practices. According to Collins (2000, p. 285), "The significance of the hegemonic domain of power lies in its ability to shape consciousness via the manipulation of ideas, images, symbols, and ideologies." For instance, particular discursive framings in the health research literature universalise pregnancy experiences in the global South by constructing pregnant women as

[14] In Collins 'initial work in *Black Feminist Thought* (2000), where she introduces her domains of power thesis, she refers to this form of power as hegemonic power. Collins and Bilge (2016, 2020), in their latest work, have renamed this domain of power as cultural power. I use the latest term in this dissertation.

"others": powerless victims, poor, diseased and susceptible to maternal mortality. These framings and subject positionings of global South women, in turn, have implications for the development of health policies (Kumar, 2013). Similarly, as mentioned previously, U.S. scholars have drawn attention to how young, black, low-income women are constructed as irresponsible welfare mothers and that these cultural representations are reinforced through punitive welfare reform policies (Alexander-Floyd, 2007). Furthermore, these cultural representations are bound up with ideologies around uncontrollable fertility, hypersexuality and bad mothers (P. H. Collins, 2000). In the South African public healthcare context, healthcare workers' discursive framings of young, black pregnant women as inferior or ignorant have implications for the nature and quality of healthcare they may receive (Chadwick, 2017; Jewkes et al., 1998). Concerning the supportability framework, macro-discursive constructions of pregnant women and the consequent subject positioning of these women by these constructions will have implications for how support is enabled or constrained during pregnancy across both micro- and macro-level support depending on their social location.

In outlining the various power domains, Collins (2000) reiterates that there is always a dialectical relationship between these four domains of power and empowerment. Power is relational in that it can be both oppressive and empowering. An individual, based on their unique social location, will experience the effects of the domains of power differently according to their relative penalty and privilege. Viewing power as relational means that it not only shapes the individual's social conditions but can also be resisted or even re-shaped by individual agency or social coalitions. On the one hand, one can gain an understanding of the effects of the various domains of power on a pregnant woman's material and social conditions using a multi-level analysis of the individual, micro and macro influences of her support network. On the other hand, this understanding of power also offers the opportunity to gain insights as to how that power may be taken up, subverted and resisted. In relation to the supportability framework, the relations of power can surface within the individual, micro, and macro levels and across them.

The expansion of intersectionality from its origins in black feminist thought into the health arena has helped contribute to understanding the complexities around reproductive and maternal health. This literature has been increasing (see for example, reviews conducted by Brünig et al., 2024; Hoang & Wong, 2022), and there have been arguments for the necessity of using intersectionality frameworks to analyse and address persistent maternal health inequities, which are fundamental to achieving the SDGs (Bohren et al., 2024). In this growing

body of work, intersectionality has, however, been used in a multitude of different ways and across different disciplines (P. H. Collins & Bilge, 2020). I therefore discuss two broad approaches (and provide examples) to applying an intersectionality analysis. These approaches are instructive in relation to how the supportability framework is operationalised.

The application of intersectional insights in reproductive and maternal health

Intersectionality has been conceptualised as a theoretical lens from both a macro and micro perspective. Using a macro perspective, scholars have examined and critiqued how powerful structural systems, developed around single-axis thinking, impose various forms of marginalisation or social inequities for particular social groups. Intersectionality has also been conceptualised from a micro-perspective, that is, understanding people's day-to-day lived experiences, identities and subjectivities in relation to the social systems that shape their lives. These two broad approaches to intersectionality have incorporated some of the theory's insights discussed in the previous section to challenge normative, single-axis frameworks that impinge on maternal and reproductive health.

Intersectionality applications from a macro-perspective

Yamin and Boulanger (2013) provide an in-depth intersectional critique of global maternal health policy. These authors drew attention to the universalising or homogenising effects of the Millennium Development Goal 5 (MDG5) – which was to improve maternal health – and its unintended consequences for sexual reproductive health. Universalising tendencies were reflected in how the MDG5 was conceptualised, measured and translated into policy planning at the country level in three ways. Firstly, the MDG5 initially only focused on reducing maternal mortality, thereby excluding other aspects of sexual and reproductive health needs (such as access to contraception and abortion, information on family planning and sexually transmitted diseases and HIV), which also play a part in shaping maternal health and mortality indicators. In this way, the MDG5 discursively positioned all women as mothers or potential child-bearers instead of seeing women as independent social citizens with sexual and reproductive rights that may need to be accessed in different ways. Secondly, these authors draw attention to the limitations in how maternal mortality targets were measured. The one-size-fits-all measurement approach focused on quantifiable, aggregate maternal mortality outcomes only; the failure to disaggregate maternal mortality data obscured inequities and disparities that may have occurred within and across population groups within a given country and failed to provide insights as to maternal health inequities that existed between countries.

Thirdly, Yamin and Boulanger (2013) report how these target-driven measures (tied to accessing finance) undermined human rights-based and multisectoral approaches to dealing with systemic inequalities in maternal health. Instead, this approach resulted in countries adopting short-term, quick-fix policy approaches and programmes to achieve acceptable targets (for example, directing maternal health programmes at urban populations to the exclusion of far-flung rural populations). Thus, these authors contend that the imposition of normative or universalising frameworks can exacerbate rather than reduce social inequities.

Law scholar Dean Spade (2013) bases his interest on how state violence plays out through population control. He tackles the shortcomings of reproductive rights-based agendas, arguing that these agendas use single-axis frameworks by foregrounding gender to the exclusion of other social influences. In addition, these agendas emphasise individual rights without considering how socio-structures affect how those rights are realised. Furthermore, Spade argues that rights-based agendas use additive strategies to ensure an individual's inclusion into existing state administration systems to meet their needs. This focus on inclusion upholds dominant state systems instead of changing them. In raising these issues, Spade (2013) contends that rights-based agendas privilege the reproductive concerns of white women (for example, challenging pronatalist policies that restrict women's access to contraception and abortion) and fail to address a host of other interrelated issues that also contribute to reproductive social injustices for individuals who are not white. For instance, U.S. state-sanctioned anti-natalist agendas have been known to be implemented in the form of forced sterilisations and forced forms of contraception that target particular social groups of colour.

In contrast, Spade (2013) maintains that a reproductive justice approach is intersectional; it moves away from an individual focus and single-axis gender logic to framing reproductive issues around a specific *social issue*, such as population control. Intersectional reproductive justice movements not only focus on the individual but also pay attention to other interacting elements that have reproductive implications for individuals. These include a lack of healthcare access, violence, poverty, wage gaps, environmental hazards and immigration policies that determine who can reproduce. "Reproductive justice politics rejects the narrow reproductive rights framing both because of who it leaves out and because it participates in reproducing logics and narratives that are harmful to the well-being of those left out" (Spade, 2013, p. 1040). Thus, one can argue that the single axis thinking model that places "women" at the centre of maternal health (and seems like a perfectly natural thing to do) can hide the

workings of other inequalities that contribute to unfavourable maternal health outcomes (such as the experiences of trans men).

The examples above have conceptualised or addressed reproductive health inequities from a macro-perspective, that is, by paying close attention to how overarching structural systems, in the form of world health policy, national policy and rights-based agendas can be imposed on individuals that they are meant to benefit with undesirable consequences. These policies or agendas may seem inclusive, but using single-axis approaches, universalising logic, and additive approaches in their implementation reinforces social exclusion and health inequities because of their normative underpinnings.

The supportability framework is a reproductive justice approach in that it considers how multiple, broadly defined macro-structural elements may shape the pregnancy event. The framework is, however, structured in a way that includes an analysis of the individual from a micro-perspective (thereby not losing sight of agency) and a macro-social systems perspective. Other intersectionality scholars have applied intersectionality as a theoretical lens from a micro perspective by examining individual subjectivity and agency in relation to the socio-structural aspects that have a bearing on those subjectivities. I turn to examples in literature that use this perspective next.

Intersectionality applications from a micro-perspective

Candace Johnson (2014) has used intersectionality as a framework to explore the political dimensions of how inequality shapes preferences for maternal healthcare by examining the narratives of individual women in different contexts. Johnson (2014) argues that global recommendations for maternal health care affect women in a wide variety of ways depending on the contexts in which they access this care. The author advocates for an intersectional analysis that incorporates *both* identity *and* socio-structural elements as it is their interrelatedness that shapes how pregnant women make decisions about their health care; an analysis that privileges identity risks overlooks the effects of social inequality or possibilities for social justice. According to Johnson (2014), intersecting dimensions of sex, gender, socio-economic status, race, ethnicity and immigrant status influence the types of maternal health care that pregnant women prefer, resist, accept and receive. In examining and comparing narratives from pregnant (and recently pregnant) women from the USA, Canada, Cuba and Honduras, she demonstrates how there is much discursive variation in preferences for care not only across countries but also within countries across population segments. For

example, some global North women use their socially privileged positions to resist medicalised care and opt for "natural" childbirth.

In contrast, some women in "developing" or global South contexts, with limited resources and decision-making power, prefer medicalised care; these women perceive this care as symbolic of improved social status. Johnson's (2014) main argument is that her findings show how structural elements shape the agentive dimensions of maternal healthcare decisions, and an analysis of agentic action can reveal how structural inequities constrain healthcare preferences. Thus, Johnson concludes that global health policies that universalise women's pregnancy health needs, desires and decisions will fail to address social inequities that shape preferences for maternal healthcare within specific social settings and contexts.

In South Africa, Chadwick (2017) uses intersectional insights to examine the effects of obstetric violence[15] on pregnant women's subjectivities and agency in childbirth. The author argues that women who experience violence in the maternal healthcare setting are mostly constructed in the public health literature as passive victims of violence. Obstetric violence in this (public health) literature is framed from a perpetrator/victim perspective, and agentive elements or acts of resistance that women may deploy during the birth process are overlooked. Furthermore, Chadwick (2017) claims that obstetric violence cannot only be characterised as gender-based violence; it is also infused with other elements of social domination. Therefore, Chadwick (2017) considers how obstetric violence operates in relation to the intersectional subjectivities (class, race, age) that women may occupy. In examining the women's narratives, the author traces how power plays out within the micro-interactions of healthcare practitioners and birthing women. In her study, the author found that women used patient compliance or

[15] According to Chadwick (2017), the notion of obstetric violence originated in Venezuela, where it was legally categorised as gender-based violence. This form of violence has a broad definition and occurs during the birthing process. Elements that make up obstetric violence include structural violence (failures of health systems, stigma and discrimination), direct violence (physical) and emotional violence (disrespectful care). Chadwick (2017) also sees this violence as a form of objective violence: subtle forms of violence which are obscured by normative taken-for-granted maternal health practices, discursive frameworks and institutional arrangements.

docility as a strategy in order to secure good care during the birthing process. However, their social location, that is, being poor, black and young, together with their physically birthing bodies (over which the women had very little control), shaped how this compliance was achieved or not achieved. For example, in trying to adhere to the nurse's instructions on not to push during labour, some women were severely admonished or verbally humiliated if their bodies involuntarily took over through the natural physiological process of giving birth. Furthermore, the ways in which the admonishments and humiliations were meted out revealed how the nurses socially positioned their patients despite whether they were compliant. Thus, Chadwick (2017) proposes that closer attention needs to be paid to how the conditions for obstetric violence are made possible by examining the relationships that exist between race, class, gender, historical colonial legacies and normative frameworks of medical power.

Both examples demonstrate the value of surfacing the complexity of lived experiences in relation to the social structures that shape those experiences. The value of applying intersectional insights from a micro-perspective is that the situated knowledge of those who are marginalised can be illuminated in relation to their social location and the systems that shape their lives. Furthermore, these approaches demonstrate the contingent nature of social categories and systems and their interconnectedness. These aspects of intersectionality are fundamental to the aim of the supportability framework, which examines the interconnections of support during pregnancy from both a personal and social standpoint.

From the examples above, it is clear that there are several ways in which intersectionality can be used as a theoretical lens to examine social issues. This is because intersectionality considers multiple and diverse aspects of social life. Decisions need to be made by the researcher as to what theoretical aspects should be included or excluded in the analysis, as this has a bearing on the knowledge that is produced. McCall (2005) has provided three possible intersectional approaches to manage the theoretical complexity of the analysis. One of the approaches is the intracategorical intersectional approach. Macleod asserts that the foundation of the supportability framework is the intracategorical intersectional approach. In the next section, I describe this approach, which theoretically informs this research project.

Intracategorial intersectional approach

According to McCall (2005), one of the most challenging aspects of using intersectionality, reflected in the approach's many debates, is how social categories are managed. The author asserts that single-axis thinking informs how "master" social categories

are understood and represented in social spaces. These understandings of "master" categories do not consider the range of experiences, identities, social locations and power dynamics of persons allocated to those categories. The construction of these categories homogenises certain social groups, which goes hand in hand with normative assumptions about these groups.

For McCall (2005), an intracategorical intersectional approach seeks to disrupt these normative assumptions by interrogating the circumscriptions of a particular social category while at the same time acknowledging that the stability of this social category may be entrenched by social structures that create a specific social reality for particular social groups. In other words, the intracategorical approach does not give any social category primacy because people do not share the same lived experiences by belonging to a specific "master" category. At the same time, however, the approach acknowledges that "master" social characteristics cannot be entirely ignored in that they play a significant part in structurally, materially and discursively shaping an individual's lived experience. This approach allows a qualitative investigation of an individual's lived experience of a specific social group, site or event. The lived experience is mostly articulated from a socially disadvantaged standpoint or "at neglected points of intersection" (McCall, 2005, p. 1780), thereby acknowledging that certain master characteristics have some significance in shaping that experience. Therefore, the examination aims to illuminate the complexity and variability of lived experience in relation to a specific social location, which may be overlooked or ignored owing to the normative understandings or frameworks that obscure the group's, site's or event's diversity and complexity. In addition, the approach is not centred on describing this complexity; scholars using this approach are interested in the *process-orientated* nature of how these normative understandings come about and how they play a part in shaping the lived experience of the individual.

Thus, in using this approach, a single event (e.g. pregnancy), social group (e.g., pregnant women) and social issue (e.g., pregnancy supportability) is selected, and the complexity of experience is examined (experience of social support during pregnancy). The social category "pregnant person" is explicitly used to define the subject of analysis as this is the one similar characteristic that the group shares. For this project, the intracategorical intersectional approach is applied by examining the pregnancy experience of support articulated through talk: narratives provided by pregnant women. Differences, commonalities and complexity are thus revealed within the group experiencing pregnancy. The individual stories are then used to

examine the broader social, economic and political structures that shape the pregnant person's social and material reality. The complexity of the intersectional analysis is managed by the group sharing one common characteristic or social location, which in this case is pregnancy.

McCall's (2005) intracategorical intersectional approach is useful for this research project because it facilitates several possibilities for examining social support during pregnancy using an intersectional perspective. Firstly, Macleod (2016) describes the supportability framework as an intracategorical approach in that the event of the pregnancy is examined by incorporating both the individual person and their social context by exploring the interactions of her support network on an individual, micro- and macro-level basis. Thus, the complexity of the pregnancy experience is revealed by conducting a multi-level analysis that explores individual, interpersonal and macro discursive constructions and practices that shape the supportability of the pregnancy.

Secondly, because the framework begins with the analysis of the event of the pregnancy in relation to the overarching construct of "supportability", there is no initial foregrounding of any particular social categories. In this way, the analysis is not centred around identity, nor does it privilege any social category except that the social group under study shares pregnancy as a characteristic.

Thirdly, in conducting an open-ended qualitative analysis guided by the supportability framework and intracategorical approach, one can show the *process* of how the pregnant subject discursively invokes, reproduces, experiences or resists these categories in relation to their social context by narrating their experiences of pregnancy support. Thus, one does not focus on who the pregnant people are but rather on what their stories do. Therefore, this approach can give insights into how pregnant individuals' agency and subjectivities are made possible regarding support practices during pregnancy.

Fourthly, by allowing the pregnant individuals' narratives to reveal the uniqueness and commonalities of their social locations in relation to social support, one can avoid making universalist or essentialist assumptions about the social group under study or reifying their experiences.

Fifthly, additive notions of disadvantage are also avoided as the approach instead seeks to outline the complexity of the pregnancy experience in relation to the range of both positive and negative aspects of support that the pregnant individuals may or may not receive.

Finally, the supportability framework, through its consideration of the individual, micro and macro aspects of support during pregnancy, satisfies intersectionality's stance towards how the meanings of social categories are contingent, that is, they are dynamic, fluid and uniquely shape (and are shaped by) changing social contexts. Pregnancy itself is a fluid social category contingent on time (9 months), and pregnant individuals' stories can reveal how category meanings associated with pregnancy and motherhood can vary from context to context. A pregnant individual's social location, for example, being pregnant in a rural area with poor employment prospects, will experience macro-level forms of support that are contingently varied compared with an individual who has permanent employment in an urban area.

There are, however, two limitations regarding the use of the intracategorical approach and supportability framework in applying an intersectional perspective. Firstly, they do not elaborate on how to analyse relations of power, which is fundamental to intersectionality's aim of understanding the role that inequality plays in a given social group's livelihoods. Incorporating Patricia Hill Collins' (2000) domains of power (interpersonal, disciplinary, structural and cultural) when analysing pregnant women's stories of support should overcome this limitation as the domains of power dovetail with the multi-level analysis of the individual, micro and macro levels of support facilitated by the supportability framework.

Secondly, as Macleod (2018) points out, the supportability framework is helpful for illuminating inequities that might constrain the supportability of pregnancy, but it does not give direction for action. This is also a strong critique of intersectional theorists who firmly believe that academic enquiry should go hand in hand with social praxis. For example, May (2015) argues that intersectional analyses that only provide descriptions of a particular social group offer little in the way of mobilising. Hancock (2016) argues that descriptions of marginalised groups might talk to the visibility project of intersectionality but do little to re-organise or reconstitute categories of difference. However, one must consider that the first step is to bring knowledge that has been subjugated or overlooked to light. Moreover, as this project's literature review has found, there is scant knowledge about women's experiences of support during pregnancy within the South African context from an intersectional and multi-level perspective. Therefore, by using the above approaches, the knowledge surfaced from women's stories of support can add to a reproductive justice agenda of paying more attention not only to the support needs of pregnant women in South Africa but also to the structures that may enable or constrain that support.

Intersectionality itself, of course, is not without its critics. In the next section, I discuss some of the critiques and debates regarding the theory of intersectionality and how they are addressed in relation to the conceptualisation of this research project.

Critiques and debates on intersectionality

Intersectionality has been applied as an analytical tool, methodology, theoretical approach, and paradigm (Hancock, 2016). It is much debated and contested because of its cross-disciplinary nature, the multiple ways in which it is understood and the variety of ways in which it has been put to work in practice. Intersectional scholars have addressed several critiques made against intersectionality. These critiques and debates have primarily centred on the use or theorising of social categories (how, why, when and what categories are used) and the methodologies used to carry out intersectional analyses. I focus on three debates that pertain to the conceptualisation of this particular research project and explicate how one may respond to these critiques concerning the use of the supportability framework as an intracategorical intersectional approach.

Firstly, intersectionality has been understood and criticised as a theory of identity where too much credence is given to using individual identity to explain the social and political issues that particular social groups experience (P. H. Collins & Bilge, 2016, 2020). Crenshaw (1989, 1991), when first introducing intersectionality, explicitly focused on the identity categories of race and gender. However, she argued that socially constructed categories have significance because the values attached to them have varied powerful effects that can contribute to exclusion, subordination or disadvantage. Furthermore, Crenshaw (1989, 1991) examined *how* identities are constructed, not only on an individual level but also in relation to how structures (both social institutions and political movements) construct these categories and consider or ignore their interconnections. Thus, through the *process* of identity construction from both an individual and structural level, she showed how people *within* structurally defined social groupings experienced social and material disadvantages differently. Crenshaw viewed identity not as an inherent individual essence but as multiple interconnected social dimensions enmeshed in structural, political and social locations mediated by social power. Therefore, she maintained that intersectionality is not just about describing or illuminating unique identities and their relevant disadvantages; social constructions of identities are always examined in relation to social and political power, systems and structures that shape the unique experiences of a group under study. Furthermore, she suggested that knowledge gained from

examining these relationships can be used to reconstruct categories and structures, thereby achieving social justice aims.

In adopting a social constructionist position (see discussion in the next chapter), this research project does not foreground any particular social categories in examining support during pregnancy. For instance, it does not aim to examine pregnancy supportability from a raced and classed lens. Instead, it examines how discursive constructions of support speak to supportability during pregnancy and how these constructions may draw on normative or use alternative knowledge frameworks around pregnancy. This is achieved by examining various subject positionings (discussed in the next chapter) articulated within the women's narratives, which makes it possible to analyse the process-orientated nature of talk. Using insights from intersectionality, this approach acknowledges that the social construction of categories through talk about pregnancy support has real effects.

The second critique is that, in challenging universalism, intersectionality may become separatist, fragmentary and exclusionary as scholars become too concerned with differences within social categories. For example, the category "woman" may be splintered into a myriad of sub-categorizations (Cho et al., 2013; Hancock, 2016). In addition, this critique contends that the continual splintering of categories can be made to such an extent that they lose their coherence, which undermines the common good of social groupings when fighting for social justice issues or reduces the ability to explain discrimination or disadvantage coherently (Cho et al., 2013; P. H. Collins & Bilge, 2016; May, 2015). Mohanty (2003), who envisions a transnational feminist approach to social justice and equality, argues for her "belief in the importance of the particular in relation to the universal" (2003, p. 505). Awareness of power differentials between social groups is fostered by paying attention to differences within social groupings. Moreover, Mohanty moves her analytic framework beyond the dynamics of social identity categories to examine how local contextual particularities (everyday micro-politics) are intermeshed with economic, global and universal politics (macro-politics). She posits that understanding differences using this analytic framework encourages a process of seeking connections and commonalities. Thus, political strategies built around understanding the dynamics of sameness and difference will be far more inclusive in fostering social solidarity than strategies that become exclusionary because they overlook differences.

Based on Mohanty's (2003) argument, the supportability framework solves this dilemma because of its emphasis on the event of the pregnancy and not on social identity characteristics. Pregnancy is the universal identifier in that it is the one descriptor the social

group shares. The "particular" refers to the distinct support experiences and power dynamics the social group may articulate in their narratives. Commonalities may be identified through the effects of the macro-elements that form part of the supportability framework, such as health policies or gender norms that are common to the social group experiencing pregnancy. Interconnections can be identified by the interactions of support across the individual, micro and macro elements of the supportability framework.

Thirdly, there have been many debates around who or what social groups should be studied using intersectional frameworks in that the focus is mainly directed at marginalised, minority or oppressed subjects (Cho et al., 2013; P. H. Collins & Bilge, 2016; May, 2015). However, some intersectionality scholars are of the view that a variety of social groups can be studied using intersectional frameworks because the aim is to understand how taken-for-granted knowledge systems, together with their distribution of power, shape how relative privilege and disadvantage operate for specific social groupings in different social spaces (Cole, 2009; Dhamoon, 2011). Furthermore, limiting which social groups should be studied using an intersectional framework risks reifying and essentialising social boundaries where men can be overlooked when talking about gender, and whiteness can operate unseen when talking about race (Yuval-Davis, 2015). In readings of intersectionality based in the global North, people who are marginalised or disadvantaged are considered to be located on the margins of dominant groups, i.e. minority groups that may include black women, disabled persons or immigrants (Staunæs, 2003). Yuval-Davis (2011) argues that social constructions of black women tend to be based on minority groups who live in predominantly white societies when, globally, the vast majority of black women live in black societies. She contends this has important implications for how intersectional analyses are conceptualised within an international perspective[16].

[16] Yuval-Davis advocates for an intersectional analysis that is transnational. Her specific approach is to use intersectionality in a social stratification analysis which analyses people's situated positions on hierarchal social grids of power.

In South Africa, the normative demographic structures that are assumed in the global North (advocating for minorities against the backdrop of the majority) are inverted. Historically, because of colonial apartheid practices (as discussed in detail in the section on intersectional praxis in South Africa), the minority (white population) dominated and oppressed the majority (black population). The effects of these practices are still felt today in the form of health inequities, experienced mainly by black African women, especially concerning poorer maternal health outcomes (Wabiri et al., 2016). Thus, the signifier "marginalised", when used as a descriptor for a social group, cannot be used as a homogenous term in assuming that the specific group in question is in the minority from a numerical perspective. Considering that the majority of the population suffers from health inequities, the South African context demands that we pay attention to a majority group that experiences marginalisation and disadvantage.

Conclusion

In this chapter, I explained Macleod's (2016) supportability framework and how it offers the opportunity to view support during pregnancy holistically. The individual pregnant person is considered in relation to their social context (that is, their support networks and structures) to gain insights into the kinds of inequalities or reproductive injustices they may face during their pregnancy. The supportability framework is conceptualised as an intracategorical intersectional approach. I provided a background on the intersectionality theory, outlining how it has been practised in activist spaces in South Africa, how it was initially conceptualised when entering academia, and how it has been used in reproductive justice research. I then introduced McCall's (2005) intracategorical intersectional approach, which involves conceptualising an analysis based on a specific event (pregnancy) to examine the complexity, variability and similarities in constructions of support during pregnancy. I explain how the supportability framework facilitates a multilevel analysis. It does not initially foreground social categories and allows for a process-orientated understanding of what participants do with their narratives of support during pregnancy.

I also draw attention to the limitations of the intracategorical approach and supportability framework concerning how relations of power are conceptualised or managed, which is a critical component in adopting an intersectionality approach. I discuss how Collins' (2000) domains of power thesis can aid in understanding how structural, disciplinary, interpersonal and cultural forms of power may shape or be shaped by constructions of support during pregnancy. This conceptualisation of power complements the supportability framework

because it offers the opportunity to consider both micro and macro operations of power in relation to support during pregnancy in an interactive way.

The structuring of the framework in relation to the individual, micro and macro aspects of support during pregnancy offers the possibility of combining constructionist, materialist and embodied understandings of the pregnancy support experience. In the next chapter, I explain why I located this research project within the philosophy of social constructionism and the reasons for adopting a critical realist stance. I also motivate for incorporating positioning theory, which is premised on social constructionism, as a lens and analytical tool to examine support during pregnancy. In drawing the complementary features of the supportability framework, intersectionality and positioning theory together, I propose adopting a Positioning Supportability Approach to examining women's narrative constructions of pregnancy support. How this approach is conceptualised is presented in the chapter that follows.

CHAPTER 5

A positioning supportability approach to understanding constructions of support during pregnancy

In this chapter, I discuss how the broad philosophy of social constructionism underpins this research project. In drawing connections between intersectionality theory and social constructionist approaches, I explain why I adopt a critical realist stance within the various social constructionist approaches and debates. The debates include combining the discursive and extra-discursive, bridging the individual versus social context divide, and how power is conceptualised within various social constructionist approaches. I discuss these debates in relation to how the structure of the supportability framework informs my critical realist stance; the elements that make up the supportability framework include not only the discursive environment but also those of embodiment and the material world.

In the next section of this chapter, I argue for incorporating positioning theory to enable an intersectional analysis of the multiple interacting support practices during pregnancy. Positioning theory is a social constructionist approach developed by Rom Harré and colleagues (Davies & Harré, 1990; Harré & Moghaddam, 2003; Harré & Van Langenhove, 1999). It examines how social actors locate themselves discursively in relation to one another during a social interaction by taking up various subject positions. Two advantages of using positioning theory are that it addresses scholarly concerns about the separation of agency and structure (Van Langenhove, 2017) and enables scholars to pay close attention to the social context in which social interaction occurs (Harré & Van Langenhove, 1999). These are essential aspects concerning operationalising the supportability framework across its various support elements and adopting an intersectional stance of paying close attention to situated experiences.

In laying out my argument for using positioning theory, I first introduce the concept of "positions" outlined by Harré and van Langenhove (1999). I then discuss three approaches to positioning theory, which include: (1) how Harré and van Langenhove (1999) use a framework of rights and responsibilities in which various moral orders or normative constraints circumscribe what individuals can say or do in a given social interaction, thereby creating certain positions for social actors. I also explain how these theorists address the micro and macro divide whereby both individuals and social entities can deploy positioning tactics to accomplish

discursive goals thereby offering possibilities to surface macro-level constraints and agency or social change; (2) how these positioning theorists have engaged with the operation of power by using a rights and obligations framework and how this aligns with Collins' (2000) concept of power as relational; and (3) how positioning theory has been extended by feminist theorists (S. Wilkinson & Kitzinger, 2003) in enabling a process-orientated way to analyse social interactions, that is, identifying what social actors *do* with positioning work by examining how they may use social categories in talk and for what purposes. Throughout this section, I discuss how each of the above approaches aligns with the theoretical stances of intersectionality, how they need to be tailored to achieve intersectionality aims and how they theoretically inform the supportability framework. I conclude this chapter by drawing together the complementary features of intersectionality and positioning theory to operationalise the supportability framework qualitatively.

A critical realist approach to social constructionism

In this section, I discuss how the broad philosophy of social constructionism underpins this research project. Drawing extensively from Vivien Burr's (2015a, 2015b) work on social constructionism, I outline some key features of this paradigm that are integral to the conceptualisation of this project. Scholars have adopted various social constructionist approaches, and they are not without debate or disputes. Some of these differing perspectives are important concerning the theoretical standpoints of intersectionality. I draw attention to these aspects in my discussion and locate my particular approach, a critical realist stance, within these debates.

The discursive and extra-discursive in relation to intersectionality

Social constructionist scholars posit that it is through language and social practices, not through objective observations, that individuals come to understand the reality of their world (Burr, 1995). As such, the ways in which individuals know and experience their "real" world is constructed through social interaction and processes, mediated by talk, where social actors reproduce and modify certain commonly understood conceptual frameworks that are socially embedded within their every-day lived experience. Thus, social categories such as "race" and "gender" are not considered inherent essences of people; instead, they are deemed to be social constructs. Social categories are reproduced through discursive constructions (for example, narratives), social interactions and practices and are shaped by history and different contexts (Burr, 2015a). In pregnancy, discursive constructions of pregnancy and pregnancy

support (together with support practices) can reinforce common knowledge frameworks concerning the types of support required and how support should be provided.

Some approaches to social constructionism argue that it is not only the discursive but also the extra-discursive that is integral to the *process* of how people interactively construct their world. The extra-discursive is understood as being located outside of talk or language frameworks and incorporates embodiment and materiality (Nightingale & Cromby, 1999). For instance, a pregnant woman not only experiences support through talk or support practices. The type of support provided is also shaped by the embodied physiological changes during pregnancy. For example, normative support practices within specific contexts may dissuade women from lifting heavy objects in the late stages of pregnancy because of the risk to the foetus. Intersectionality theorists have also argued that embodiment encompasses race and gender (May, 2015). Thus, one can argue that support can also be shaped by the visible raced and gendered embodiment of the pregnant body.

In contrast, materiality is understood as the physical environment (Edley, 2001b). The physical world has tangible effects that shape support provision and the survival and well-being of the pregnant woman and foetus. Two examples are structural aspects that affect access to safe water and sanitation or physical distances that affect access to healthcare provision. As Edley (2001b, p. 439) points out, "the realms of the material and the symbolic are inextricably bound up with one another and it is a pretty futile task to try to tease them apart". As with this approach to social constructionism, intersectionality's "both-and" lens sees the discursive and extra-discursive as intertwined. The supportability framework incorporates the extra-discursive because it includes the physiological aspects of pregnancy and macro support elements as key influences of the supportability of the pregnancy. A critical realist stance is required to incorporate both the discursive and extra-discursive. Critical realism versus relativism is discussed next.

Relativism and critical realism in relation to intersectionality

Burr (1995) describes social constructionism as a critical approach to understanding the "reality" of social life. Thus, the knowledge we assume to be true, natural and based on objective observations can be interrogated. Some social constructionists argue that there can be no single universal truth (Burr, 2015a). What is considered factual, untrue, right or wrong in the world is entirely up for debate and interrogation. Therefore, "facts" relating to social categories are rendered suspect because they are socially produced. This particular approach

to social constructionism adopts a strong relativist approach. Burr (2015a, p. 93) describes the position of relativism thusly, “Different constructions of the world can be judged only in relation to each other and not by comparison with some ultimate standard or truth”.

Intersectionality scholars likewise reject the idea of a single universal truth because this is akin to single-axis thinking, which overlooks the diversity of certain social groups’ experiences (May, 2015). Intersectionality theorists adopt positions of disrupting taken-for-granted knowledge, which universalises a given social group’s experiences based on their social characteristics (Cho et al., 2013). This position, therefore, acknowledges that there are multiple perspectives and variations in how social actors experience social phenomena. Concerning the conceptualisation of this research project, a relativist-lite approach offers the opportunity to surface alternative knowledge, viewpoints and ways of constructing lived experiences. This aligns with McCall’s (2005) intracategorical intersectional approach, which seeks to demonstrate variability and complexity within a given social group’s lived experience. Surfacing the complexity of support provision during pregnancy as women narrate their experiences of support they may or may not receive is a key aim of this project.

However, arguments that an extreme relativist position, by privileging all perspectives as equally valid in understanding the world, is limited in that one cannot take a political or moral stand concerning social practices that are considered oppressive (Burr, 2015a). A strong relativist position suggests that one cannot prove factually whether certain practices are unjust or not. Intersectionality is not neutral because it is committed to social justice and disrupting multiple intersecting oppressive practices that affect certain social groups (May, 2015). Thus, adopting a strong relativist position would be rejected from an intersectionality standpoint. Indeed, Crenshaw (1991) warns against what she calls a form of vulgar social constructionism. By only viewing social categories, for example, “woman”, as nothing more than social constructions, one can overlook the material and embodied effects that these constructs may have on the lives of individuals who may be ascribed this master social characteristic and who may be located within specific social spaces. Crenshaw (1991) points out that, although socially constructed, these constructs still have political import in that the various forms of power, discrimination and oppression linked to social categories continue to operate in a socially hierarchal manner.

On the other hand, a critical realist stance takes a political stance in understanding that constructions of the world, through talk and social practice, have real effects on the bodies and material realities of people’s lives (Burr, 2015a). In this vein, theorists have contended that an

almost exclusive focus on language negates the material and structural effects on lived experience (Edley, 2001b). In addition, critical realists critique relativist positions in that they do not address how emotions, although not seen as natural inner states, are experienced as real and do not explain why people behave in certain ways (Burr, 2015a).

However, more extreme forms of critical realism posit that certain aspects of the world, for example, biological differences, exist independently of human thought and talk (Burr, 2015a). An intersectionality viewpoint will reject such an approach as studies of biological differences have served to uphold repressive and oppressive regimes of knowledge, for example, the eugenics movement and the re-inscription of binary, normative notions of male/female sex characteristics (May, 2015). Although the supportability framework includes physiological aspects concerning pregnancy support, its focus is not to ascribe, describe or categorise the physical characteristics of individuals and thus extreme forms of critical realism are avoided. Overall, critical realists, as with intersectionality theorists, put forward an anti-essentialist and anti-reductionist argument in that social categories are not "essences" of people and cannot be narrowed down to one simple explanation; they are created through powerful social processes and interactions (Burr, 2015a; Crenshaw, 1991; May, 2015; Nightingale & Cromby, 1999).

In sum, the supportability framework incorporates aspects that speak to the emotional, behavioural, physiological and macro supportability elements, which form part of the extra-discursive and, as such, include embodiment and the material world. This is done to gain a holistic view of how and what is accomplished when pregnancy support is spoken about and practised in certain ways. Thus, the structure of the supportability framework aligns with a critical realist approach to understanding supportability during pregnancy. Another aspect that should be considered when adopting a critical realist stance within social constructionism is how the individual is understood in relation to their social context. This will be discussed in more detail next.

Social constructionist positions on the individual and social context

An intersectionality orientation posits that the individual is embedded within social, political and economic influences that shape their social interactions and life experiences. However, there is some concern within the social constructionist literature that scholars either focus on the individual or the broader social environment. This is seen as problematic because it creates a dualism between the individual/social to the detriment of understanding a

dialectical relationship between the two (Burr, 2015a). Burr (2015a) describes these approaches as macro social constructionism and micro social constructionism and provides an outline of these approaches as follows.

Macro social constructionism focuses on the operation of the overarching social discourses[17] that are used in talk. This view sees individuals as constructed by existing discourses. In other words, an individual's sense of self and experiences are brought into existence by drawing on the broader social discourses commonly available within a specific community. This is a top-down approach in that these social discourses determine an individual's social position by placing boundaries and possibilities on what an individual can say or do in a given social interaction and context. Furthermore, these discourses are examined in terms of their powerful effects in upholding dominant and normative knowledge frameworks of social life, which can be oppressive and marginalising for particular social groups. For example, a pregnant woman's emotional attachment to her pregnancy is not understood to be an existing inner state; her emotions about her pregnancy may be brought into existence by normative good motherhood discourses or family planning discourses that she might draw upon in explaining how she feels about her pregnancy. A variety of discourses may be available concerning a specific event or social practice. A macro social constructionist approach acknowledges that an individual has some agency in that there are possibilities to accept and reject the premises of particular discourses available within a particular social interaction. However, Burr (2015b) maintains that this approach tends to privilege the workings of wider social influences over individual agency. This has raised concerns that a macro social constructionist approach, although surfacing potential oppressive norms and practices, does not fully consider the possibilities of social transformation and change. This is problematic for intersectionality as it is committed to social transformation (Hancock, 2016).

[17] According to Burr (2015a, p. 74) "A discourse refers to a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce particular version of events. [A discourse] refers to a particular picture that is painted of an event, person, class of persons, a particular way of representing it in a certain light". Burr further explains that discourses are not only seen as verbal exchanges between people but are also seen as forms of social practice.

Micro social constructionism, according to Burr (2015a), places a focus on the social interaction at person-to-person level of talk. In adopting this approach, scholars are interested in what people accomplish with their talk. The individual is not merely produced by social discourses but is viewed as an active and agentive participant in a social interaction and as strategically constructing accounts for specific purposes in the interaction. For example, social constructionists using this approach are interested in how a declaration of certain emotions related to pregnancy is *used* in talk and *what is accomplished* in talking about these emotions. Thus, a pregnant woman might describe her positive feelings about the pregnancy in relation to her marriage status, thereby upholding normative notions of the ideal nuclear family; that is, it is acceptable and appropriate to be happy with the pregnancy because one is married. Burr (2015a) maintains that this approach takes a more relativist position because it centres on micro-levels of talk which bring different lived realities into focus, and because this approach places value on an individual's agency. However, Burr (2015a) argues that social constructionists taking this position tend to privilege individual agency over the constraints of the wider social environment.

In a similar vein to the micro versus macro social constructionist debates, there are also contestations as to how various social constructionist approaches engage with or theorise power (Burr, 2015a). In the next section, I explain how power has been conceptualised within social constructionist approaches and how this relates to intersectionality theory and its engagement with power.

A social constructionist understanding of power

Burkitt (1999) contends that social constructionists conceptualise power from either a macro or micro social constructionist perspective. A macro-social constructionist position seeks to understand the effects of the power dynamics that shape the various inequalities experienced by a given social group (Burr, 2015a). This approach sees power as operating through social discourses, social practices and institutional structures. These multiple forms of power operate together by regulating and placing limitations on what social actors can do or say (Burkitt, 1999). This understanding of power draws from Foucauldian notions of power. Two aspects of Foucauldian power will be briefly touched on in this discussion because scholars using social constructionism and intersectionality as theoretical lenses have extensively used this approach to power (Burr, 2015a; Hancock, 2016).

According to Foucault (1978), power is not seen as a possession (located in a person, institution or structure) nor a monolithic, oppressive force but actively operates through discourse and discursive practices. This means that this power is available to everyone and can be used to produce and uphold dominant knowledge or create alternate and resistant knowledge in their talk. Thus, knowledge and power always work in tandem and have a range of effects for various types of people. This is an important link to intersectionality in that power cannot be universalised and is understood to operate in multiple and varying ways (May, 2015). Viewing power in this way means that differences (or commonalities) between and within social groups, their social locations and the many different power relations they may experience within social, economic and political spaces are not overlooked. Foucauldian approaches to power have been associated with macro-social constructionist positions because of their interest in understanding how power operates through overarching social discourses in inequitable ways for particular social groups (Burr, 2015a).

Another important aspect pertaining to a Foucauldian (1978) analytics of power is that power and resistance always work together. They are not seen as binary systems, and resistance is not seen as simply reactionary. Instead, power and resistance are seen to work in relation to one another and resistance can, therefore, also operate in multiple and varied ways; “But more often one is dealing with mobile and transitory points of resistance, producing cleavages in a society that shift about, fracturing unities and effecting regroupings” (Foucault, 1978, p. 94). An intersectionality viewpoint acknowledges that everyone has some power in that they can take up or reject certain discourses and produce resistant forms of knowledge in multiple and contradictory ways. This view also considers that intra-group variability will occur regarding the types of resistance deployed within power relations. Examining how individuals negotiate these power relations through various strategies of resistance can aid in the contesting, reconceptualising, reconstituting or upholding knowledge associated with social categories or experiences.

Within micro-social constructionist approaches, less attention has been paid to overarching structural and social power operations. Instead, the focus is more on how power is understood as a discursive product (Burkitt, 1999). That is, theorists examine how power operates on an interpersonal level, enabling or limiting what individuals can accomplish in talk. However, Burkitt (1999) argues that understanding power from only a discursive perspective is limited as power is also embedded in material and socio-structural contexts and thus plays a part in shaping social activities and talk. Furthermore, Burr (2015a) points out that talk or social

interactions on an individual level can legitimate dominant social norms and knowledge frameworks, thereby upholding power relationships that marginalise certain social groups. Burkitt (1999) argues for analysing power *relations* or connections *across* the micro and macro social realms. As mentioned previously, understanding lived experience in relation to power is a fundamental premise of intersectionality. In line with Burkitt's argument for analysing relations of power, applying Collins'(2000) concept of power offers possibilities to draw the discursive, extra-discursive, individual and social together. For example, interpersonal power is located within the micro-context of everyday social practices and processes. However, it is also related to the cultural, disciplinary, and structural forms of power operating in the macro-social context. Furthermore, as already explained, these forms of power are all understood to be dialectical; one form of power is not more important than the other as they operate simultaneously and in concert with one another. This conceptualisation of power, therefore, aids in adopting a social constructionist position that does not privilege either agency or social constraints but instead sees them as interconnected.

Bridging the individual and social context divide is a key component in operationalising the supportability framework. Positioning theory, premised on social constructionism, has been used to bridge the divide between agency and structure and engage with power relations. As such, utilising positioning theory for this research project helps to understand how the dynamics of support during pregnancy are discursively and extra-discursively constructed. I turn to a discussion of positioning theory and its usefulness for this research project next.

Positioning theory: Introducing a positioning supportability approach

In this section, I argue for using a positioning supportability approach as a theoretical stance to examine women's narratives of pregnancy support. I explain how various conceptualisations of positioning theory are aligned with an intersectionality orientation and, aid in operationalising the supportability framework qualitatively.

Conceptualising positions

Within social constructionism, a "position" is a concept that expands on the notion of a "role" (Harré & Van Langenhove, 1999). For example, a woman with children is accorded the role of a "mother" by society. For van Langenhove and Harré (1999), however, positions are viewed as more dynamic than roles because a myriad of different positions become available during a social interaction, or what these authors call a social episode. "Positions" encompass a whole range of attributes and beliefs that may be taken up without question, rejected,

explicitly or implicitly assigned or may not even be on offer for an individual who engages in a specific social interaction (Harré & Moghaddam, 2003; Harré & Van Langenhove, 1999). For example, positions are not only made available by virtue of an individual's enduring social characteristics (a mother or woman) but also an individual's behavioural actions (organised, skilled or incompetent), embodied physical attributes (race and age), cognitive attributes (anxious or kind) and according to the social context (work, home or social environment). Thus, van Langenhove and Harré (1999) see positions as collections of attributes and beliefs that constantly shift and change for social actors as they engage with others in various social interactions within specific contexts. Positions are seen as relational in that individuals are always positioned in relation to others (Harré & Moghaddam, 2003). As Edley (2001a) explains, subject positions locate individuals within a social interaction.

In conceptualising positions as dynamic, positioning theory has been used to analyse the dynamics of social interactions to understand how social actors make meaning or come to perceive their world through talk (Davies & Harré, 1990; Harré & Moghaddam, 2003; Harré & Van Langenhove, 1999). Positioning analyses have examined how individuals construct social phenomena, their personhood and the identities of others on an interpersonal level. Recent advances in positioning theory have theorised that social entities, such as government institutions or nations, can position other social entities and individuals (Harré et al., 2009). Thus, positioning theory can be theoretically applied both on a micro (personal) and macro level (social). This is an important aspect in relation to operationalising the supportability framework's features, which include the individual, micro, and macro elements of support.

Positioning and the normative constraints of moral orders

Positioning has been conceptualised as a discursive practice within a rights and responsibilities framework (Harré et al., 2009; Harré & Moghaddam, 2003; Harré & Van Langenhove, 1999). According to these scholars, social actors are located within various "moral orders" when speaking. Moral orders are conceptualised as commonly understood normative conventions or rules that guide individuals in adopting socially acceptable behaviour and ways of speaking within a particular social interaction. These moral orders are characterised by rights and duties, which are both contextually created by and imposed on members of society (Van Langenhove, 2017). Harré et al. (2009) see the rights and duties located within various moral orders as constituted by socio-cultural "normative constraints". Stemming from these normative constraints, multiple positions are made available within social interactions that circumscribe what individuals can or cannot do or say in a social

episode. For example, a woman, in discovering she is pregnant, will take up or even be assigned the subject position of “pregnant woman”. Positioned as “pregnant" within her specific social context, there are certain rights and obligations that the pregnant woman and her support network are expected to fulfil to ensure a successful pregnancy outcome. The positions that are made available in relation to pregnancy support are shaped by various moral orders or normative constraints that limit and endorse the types of conversations, personal accounts and social practices that may take place during the woman’s pregnancy.

Van Langenhove (2017) claims that the conceptualisation of moral orders in positioning theory is key to bridging the individual and broader social environment. Positioning theory thus facilitates an understanding of the dialectical relationship between agency and structure instead of viewing these as separate entities (Van Langenhove, 2017) , which is an important consideration when adopting an intersectionality stance. The author has proposed five varieties of moral orders that guide social interactions. At a micro-level, there are personal (private dialogue) and conversational (interpersonal) moral orders. Cultural, legal and institutional moral orders are located on the macro level. The author points out that these moral landscapes do not operate independently of one another; they are intermeshed and encompass individuals at all times. Furthermore, there are a myriad of different moral orders (with their attendant rights and duties) that may be located within these varieties. The saliency and variability of these moral orders depend on the type of social interaction and context, which aligns with an intersectional orientation of paying attention to situated knowledge. Positioning theory was initially conceptualised to examine the dynamics of social episodes by examining person-to-person talk on a local level. These concepts are discussed next.

Positioning theory and micro-level interactions

Harrè and Moghaddam (2003) posited that, in using positioning theory, the dynamics of a social interaction can be examined in relation to different moral orders and multiple storylines and positioning acts that individuals bring to a social episode. For example, a social episode could take the form of an antenatal care check-up where the social interaction occurs on an interpersonal level between nurse and patient. A moral order to which the nurse may align is that of a medical authority: the right to inform or tell the pregnant patient what they can or cannot do health-wise during their pregnancy. The social episode unfolds through the storylines adopted by the nurse, who draws from various medically authoritative social narratives to instruct her patient about health practices during pregnancy. In doing so, her speech acts create positions. The nurse may implicitly position the pregnant woman as ignorant or

unknowledgeable by drawing from a medical authority cultural narrative. Within this medical moral order, the nurse assumes the right to instruct the patient, and the patient has the duty to comply with the healthcare instructions. In contesting the storyline introduced by the nurse, the pregnant woman may bring a different moral order to the social episode in that she perceives the antenatal care interaction as a space for her to exercise patient autonomy. Her storylines may draw from a moral order of person-centred care where the healthcare practitioner has the duty and the patient has the right to engage in mutual discussions and decision-making concerning pregnancy healthcare. Different relational positions between the nurse and patient are created; the patient may position the nurse as rude and incompetent, and the nurse, in turn, re-positions the pregnant woman as difficult and uncompliant.

The initial act of positioning the patient by the nurse is what Harrè et al. (2009) call prepositioning or first-order positioning; at the outset of the antenatal social episode, the nurse may position the pregnant woman based on the normative assumptions she has of her patient's attributes. For these scholars, this initial positioning sets the scene for analysing contested storylines and positions that may occur during the social interaction. It illuminates how people may view a social episode from very different perspectives. From an intersectionality standpoint, however, prepositioning acts do more than show how people can view a conversation differently. Prepositioning can signal normative assumptions about an individual's more enduring social characteristics, that is, their embodied characteristics, such as age and other more stable attributes, such as low socio-economic status. These initial positioning acts can also surface how the rights and duties within moral orders may vary for different individuals based on their race, gender, age, and socio-economic status. Therefore, the prepositioning of an individual sets a precedent for how rights and duties within particular moral orders may be differently distributed amongst social actors and whether storylines can be contested within the social episode.

In examining the positioning work done from different moral orders, the social episode can, therefore, be examined not only in relation to how positions may be claimed and contested within dominant storylines but also how the storylines themselves may be enforced by normative constraints or contested or altered by social actors who bring alternative storylines to the social interaction. Thus, viewing positioning acts through a rights and responsibilities framework can reveal the uneven social, political and economic normative constraints imposed on individuals in a given social interaction. It also allows one to see how these

normative constraints may be challenged. Positions can, therefore, be understood as conduits that connect individual agency and the socio-structural context (Van Langenhove, 2017).

In the antenatal social interaction example provided, the contested storylines and positioning tactics deployed by the nurse and pregnant woman on a micro-level can illuminate certain normative constraints that operate on the macro level. Thus, the application of positioning theory on a local level of talk can provide insights as to whether healthcare policy may be aligned with the right to impose a framework of medical authority on patients instead of a duty to provide person-centred care on a macro level. Support during pregnancy, viewed through a rights and responsibility conceptualisation of positioning theory, can surface how normative constraints shape support practices and experiences and how these may be accepted or contested through the uptake of various positions. Positions that pregnant women take up in relation to others in talking about the support they receive are the linkages between the individual, micro and macro elements of the framework and can, therefore, provide insights as to whether the supportability of the pregnancy may be enabled or constrained.

Positioning from a macro-structural level

Whereas Harré and van Langenhove (1999) initially focused on how various moral orders shape person-to-person interactions on a local level of talk. These authors also assert that positioning theory can be applied on a macro-level because social entities (nations or institutions) not only position each other but can also position individuals. Social entities can impose moral orders on individuals (Harré et al., 2009). Harré calls this “forced self-positioning” and “forced positioning of others”. For the former, individuals within an institution must account for positions assigned to them, such as the forced positioning of a person as a patient when entering a health clinic. For the latter, “forced positioning of others” refers to the deliberate positioning of citizens through government policy. This type of positioning is important concerning the macro elements of the supportability framework because they incorporate government institutions or policies.

Van Langenhove’s (2017) more recent work introduces the notion of institutional moral orders. This particular variety of moral order includes the physical and institutional configurations of social structures and how these may shape discursive and social practice. Institutional moral orders refer to how social entities, such as healthcare clinics, are organised in relation to rules, protocols, conventions and material configurations (such as clinic buildings and waiting rooms). Therefore, once a pregnant woman enters a healthcare clinic, institutional

moral orders in relation to the healthcare interaction are activated. The very physical organisation of these entities create positions for individuals. For van Langenhove, the material reality of the physical world and discursive practice are, therefore, part of each other. Structures may impose various moral orders and positions, but van Langenhove argues that these structures may also be created, challenged or accepted through the positioning work done by the individual. Although not elaborated on by the author, this suggests that social actors can also agentively position institutions and social entities in certain ways, which offers key insights into how social change can be realised. van Langenhove's (2017) expansion of positioning theory in this manner incorporates both the material and discursive and therefore aligns with a critical realist stance in understanding social phenomena. Intersectionality perspectives align with this view because structural influences have real and material effects on individual's lives (May, 2015).

Intersectional theorists have, however, argued that institutional structures do not position individuals in neutral and uniform ways (P. H. Collins & Bilge, 2016). Thus, I argue that institutional moral orders will be infused with the processes of racialisation, colonialism, capitalism and sexism, which will surface in the available rights and duties that are afforded to individuals who are positioned by these structures. An intersectional stance maintains that the positions imposed by these structures and institutions will also be informed by an individual's more enduring characteristics, such as age and socio-economic status. These uneven positions will influence an individual's access to competing moral orders and the distribution of who has access to what rights or obligations. For example, the competing moral orders of person-centred care versus medical authority may be available to some individuals but not others and can be gleaned through the various positioning acts adopted within a social interaction. Thus, examining the positioning dynamics in pregnancy stories can provide an understanding of how both individuals and structures can generate, maintain and reject variations of moral orders or normative constraints.

Therefore, the notion of moral orders or normative constraints allows scholars to understand the various positioning interfaces made possible from both micro and macro perspectives. This aligns with the conceptualisation of the elements of the supportability framework. In addition, I argue that the modes of pre-positioning in social interactions (Harré & Moghaddam, 2003) and forced-positioning by social entities (Harré et al., 2009) are fundamental to intersectional understandings of how normative constraints can impose rights and responsibilities on individuals in inequitable ways based on an individual's social location.

These positionings not only refer to dynamic instances of positioning within a social episode (as initially envisaged by positioning theorists) but may also include the embodied social characteristics of individuals, which can be somewhat stable across different types of social interactions. Although this research project does not place any initial emphasis on any specific social category, the modes of pre-positioning and forced positioning form an essential part of the theoretical conceptualisation of this project because they are infused with normative understandings of individual attributes, for example, “black” “pregnant” “woman”. These positioning modes also align with the intracategorical intersectional approach, which acknowledges that, although master characteristics should be challenged, they have significance concerning lived experience. In the future, I will refer to these modes of forced positionings as imperative positions.

Conceptualising rights and responsibilities circumscribed by various moral orders is also helpful for this research endeavour. This is because one can identify how social, structural, political and economic normative constraints impose different rights and responsibilities on different social groups in material and discursive ways. This offers possibilities to surface single-axis ways of thinking about support during pregnancy. This approach is also important for understanding interactions of support across the levels of the supportability framework. From now on, I refer to moral orders as normative constraints to align with intersectional understandings of dominant logics (or dominant knowledge frameworks) (May, 2015). Positioning theory not only considers how people may be limited by normative constraints; it also offers the possibility to examine agency and the potential for social change.

Positioning theory, agency and social change

Harré (2009) likens positioning theory to narrative approaches (see next chapter) because the positions individuals may take up when narrating their experience can reveal normative constraints. Self-positioning is where an individual may express their identity and perceptions of their world, explain their behaviour or describe their experiences through discursive practice (Harré & Moghaddam, 2003). According to these authors, these positions are usually indicated through the word “I” and are always relational, requiring the authorisation of others. When individuals engage in acts of self-positioning, they will also be cognisant of how they position themselves in relation to others (thereby also positioning others). These authors see self-positioning as shaped by the rights and duties associated with the various normative constraints that may be at play when narrating an experience. From an intersectionality stance, self-positioning acts will also be influenced by how the individual may already be prepositioned

(that is, according to more enduring attributes such as age) and will also play a fundamental role in the uptake of self-positions when providing narrative accounts.

Individuals can, however, strategically self-position themselves when providing individual accounts. Burr (1995) has discussed how, through the use of positioning analysis, one can gain insights into how various positioning tactics can be employed for personal and social change. Because multiple social narratives may explicitly and implicitly accompany a specific subject position in a particular context, Burr (1995) argues that some of the positions on offer may not be accessible or acceptable on an individual, social or economic level. Thus, she contends that the individual has the agency and potential to recognise the multiple social narratives on offer and then take up various positions that may be most suitable to their context, thereby offering an opportunity for change. This complements intersectionality's stance on how categories are contingent and how categories can be re-conceptualised. For example, a woman may be experiencing some form of anxiety as certain normative practices are demanded of her now that she is pregnant. However, compliance with these practices has proven problematic because of her economic status (imperative positioning). In narrating her story about trying to adhere to pregnancy healthcare guidelines, she may self-position as individually responsible for her failure to comply with these practices. However, there are possibilities to draw from other social narratives that offer alternative positions. Thus, she may be able to change her viewpoint on being an uncompliant pregnant subject by changing the meaning of her subject position. Recognising that her environment is not conducive to being compliant and that she lacks appropriate social support, she can re-interpret the meaning of what a compliant pregnant subject might mean. The various acts of self-positioning, positioning her environment (entity positioning), and social support networks may help the woman change her initial position of being individually irresponsible for non-compliant health behaviour. Thus, she may position herself as compliant in relation to her context.

This approach to analysing subject self-positioning shows how positions are nuanced, dynamic and context-specific. The self-positioning performed in narrative accounts may provide insights into the variable ways in which a person may strategically take up intersectional subject positions depending on the social context in which they find themselves. Scholars have emphasised that, in using positioning theory, the social context is understood to play a fundamental role in shaping the moral landscape (Harré & Moghaddam, 2003; Warren & Moghaddam, 2018). Thus, these authors argue that universal positions may be hard to find in a specific social practice, given the variability of social contexts. This is similar to

intersectionality's stance in rejecting universal truths and single-axis thinking. An intracategorical intersectional approach is invested in understanding the variability and complexity of lived experience. Concerning the supportability framework, self-positioning can provide nuanced insights into the cognitive, behavioural, and emotional aspects of the pregnancy experience and how pregnant women position themselves in relation to their support networks and structures.

The positioning dynamics that occur in the context of normative constraints and their consequent rights and duties not only show the interconnections between the individual and social context but can also illuminate how power operates within these interactions.

Positioning theory and conceptualisations of power

Positioning theory also allows an examination of power dynamics by analysing the positioning tactics employed in a social interaction. Warren and Moghaddam (2018) argue that positioning theory can be used to show how individual or group rights and duties can be enabled or constrained, thereby affecting the individual's or group's capacity to experience well-being or social justice. The authors describe how power dynamics are revealed when storylines (shaped by various moral orders/normative constraints) are contested, thereby exposing the tensions within the framework of rights and duties between individuals or groups. Contestation of a storyline through various positioning tactics thus "maps multidimensional perspectives in a moral space that can explain for example why 'justice' to one group's position may be 'injustice' to another" (Warren & Moghaddam, 2018, p. 323) or how one group can hold power over another.

In addition, these authors contend that the value people assign to rights and duties is determined by their social context and the power dynamics within these contexts. Thus, those with less power in the interaction argue or position themselves to gain more rights (the pregnant woman), and those with more power argue or position themselves to impose more duties on others (the nurse). The relational positionings in a given person-to-person interaction or between groups are where power dynamics are revealed (Warren & Moghaddam, 2018). Thus, power is not seen as possessive in that interactive positioning tactics can illuminate relations of power within a social interaction. From an intersectionality stance, this aligns with Collins' (2000) conception of power as dialectical. The relationships between interpersonal, structural, cultural and disciplinary forms of power will shape how rights and duties in social interactions are distributed between social actors. Positioning tactics adopted by social actors will reveal

how these forms of power operate on both micro and macro levels of the social interaction. Positioning theory and its conceptualisation of power in this way is helpful because it can illuminate how interconnected power relations shape the supportability of a pregnancy. Another way in which power relations can be identified is through examining positioning in action.

Positioning in action

Applying positioning theory through the lens of rights and responsibilities helps understand how various normative constraints may shape a social interaction. Furthermore, the different modes of positioning that scholars have conceptualised, such as prepositioning individuals, person-to-person positioning, forced positionings by social entities and self-positionings, can provide insights into the dynamics of the social interaction. In addition, these notions of positioning can demonstrate how agency and structure are interconnected, how the material and discursive are part of one another, and how normative constraints shape these interactions. However, an intersectionality standpoint values a *process-orientated* approach to understanding how normative constraints may operate in marginalising and unequal ways. Therefore, I draw on feminist theorists Wilkinson and Kitzinger's (2003) work to align the positioning concept with an intersectionality orientation.

Feminist theorists have used an alternative approach to using positioning theory to examine social episodes. Wilkinson and Kitzinger (2003), who specialise in conversation analysis (CA), have emphasised how people are not passive reflections of existing life conditions; they also actively construct their world through talk in everyday conversations. Thus, their approach is different to simply providing descriptions of the various positions that social actors may take up or reject in a social episode; they do not aim to describe a social actor's attitudes and beliefs based on their positionalities, nor do they merely wish to report back on the dynamism of social episodes. Instead, the authors are more concerned with how social actors accomplish (strategically or unwittingly) and deploy various positionings in their talk, that is, what they *do* through positioning work. Thus, they see a positioning act as executed with a goal in mind, for example, deflecting, persuading, justifying and excusing oneself through talk.

This approach to positioning provides possibilities for revealing how social categories are produced, reproduced, reinforced, resisted and masked through the utilisation of positioning tactics in talk. The authors suggest that positioning tactics can be accomplished in

the following ways: (1) naming a category, whereby a social actor may explicitly use an enduring categorical reference, for example, “pregnant woman”, “black”, or “poor”. The person is then explicitly positioned and thus becomes representative of a specific social group; (2) indexing, whereby a category is not explicitly named, but the context of the storyline provides enough grounding for the listener to identify to which category a social actor may belong, for example “she accessed antenatal care in the public sector” that is, the pregnant woman is of a lower income bracket within a South African context; (3) invoking attributes, where a social actor may describe the type of person they are, for example, “us people use the clinic in the township”; and (4) invoking categorical membership through assumptions that are made within talk. In relation to the last point, the authors argue that “normative” categories are not usually named in talk, for example, “white” or “heterosexual”, but “non-normative” categories generally are explicitly named, for example, “black pregnant woman”. They see this approach to positioning as an opportunity to understand how the social divisions of race, age and gender (amongst others) are maintained through talk. Furthermore, the inequalities and the effects of power dynamics revealed through the positioning process are seen as accomplishments of talk.

Wilkinson and Kitzinger’s (2003) approach to positioning is helpful for this research project for several reasons. Firstly, although this approach has been used to examine every-day interactive conversations between people, it is flexible enough to be applied in analysing individual stories or accounts. Secondly, this conceptualisation of positioning does not focus on *a priori* definitions or descriptions of social categories. It enables the researcher to examine, in a more open-ended manner, *how* the generation of categories or representations within narratives of pregnancy support is accomplished. This reduces the risk of homogenising or essentialising social categories. At the same time, however, social positions that may be stable or enduring over time and across various social interactions can be illuminated. Thirdly, in being more concerned with how social categories might be deployed through the uptake of subject positions, this approach to positioning can provide insights into individuals’ social and material realities. Fourthly, a multi-level analysis is made possible by examining the positioning work conducted on a micro-level, which draws on aspects of macro-level influences. Individuals will still use categories in talk to argue for more rights and impose more duties on one another within the realm of normative constraints. Fifthly, a variety of positioning tactics can be included in this approach, including imperative positionings (pre-positioning and forced positionings), self-positioning, positioning of others, and positioning of social entities.

Finally, this approach to positioning facilitates an examination of the relational nature of power and can, therefore, incorporate Collins' (2000) domains of power. The interactive positioning tactics deployed at the micro-level in talk can reveal not only shifting interpersonal power dynamics within a pregnancy support network but also how subject positions are shaped by disciplinary mechanisms (taking up subject positions that reflect being a "good" mother) and cultural representations (deploying social categories like appropriate age or economic status when explaining an unplanned pregnancy) and the negotiation of structural forms of power that impose constraints on the range of subject positions that can be taken up (for example, women accessing antenatal care in the South African public health sector may have trouble in drawing from women-centred care social narratives). These are the hallmarks of an intracategorical intersectional approach.

Positioning theory, therefore, provides a way to draw together particular macro and micro social constructionist approaches, thus negating some of the debates of the individual/social and discursive/material divide (Burr, 2015b, 2015a). This is because positioning theory considers that individuals are not only determined by the normative constraints implicit social interactions but can also strategically take up or reject the subject positions on offer which can provide insights into social change. Examining how pregnant women position themselves, others and entities in their support network, together with how they may already be positioned by sociocultural and institutional normative constraints, will facilitate a multi-level analysis that foregrounds the interrelated workings of the elements of the supportability framework. This conceptualisation of positioning theory will ensure that pregnancy supportability cannot only be examined by focusing on the individual to the exclusion of their macro-social context.

Conclusion

In this theory chapter, I have argued for using a positioning supportability approach as a theoretical lens to understand supportability during pregnancy. I explained how these approaches are underpinned by social constructionism, which considers how women socially construct their support networks and experiences during pregnancy through talk. I locate my research project within a critical realist, social constructionist stance incorporating both the discursive and the extra discursive. This is because the supportability framework is structured to include aspects relating to the material world and embodiment during pregnancy.

In adopting a critical realist stance, I advocate for using a positioning theory as a lens to understand constructions of support during pregnancy. Positioning theory offers the possibility to bridge the divide between macro and micro forms of social constructionism. I explain how positions form a conduit for examining the support interactions across the different levels of the supportability framework. I outline three approaches to positioning theory that are useful for this project, namely: (1) considering how normative constraints (moral orders) that operate through a framework of rights and responsibilities create possibilities and limitations in relation to the subject positions that individuals may take up in talking about support during pregnancy; (2) examining individual accounts by identifying self-positioning practices (i-statements) to surface agentive practice, alternative knowledge and social change in relation to pregnancy support practices; and (3), positioning in action, a feminist approach to positioning theory, which enables a process-orientated way to examine what women do with positioning work, that is, how they use social categories in talk when talking about pregnancy support subject to the normative constraints that circumscribe them.

Narratives have traditionally been closely associated with intersectional approaches and praxis in that much value is placed on telling stories that reflect social conditions (McCall, 2005). Narrative research methods were used in this research project to collect women's stories about their experiences of support during pregnancy. I now turn to a discussion of how data were collected for this project.

CHAPTER 6

Using an intersectional orientation to collect qualitative data

This chapter explains the rationale and procedures for collecting and generating data for this research project. Firstly, I discuss why narratives are highly valued within intersectionality traditions. They provide insights into people's unique lived experiences and can surface how the broader social environment informs these experiences (Alexander-Floyd, 2007; P. H. Collins & Bilge, 2016; Ross & Solinger, 2017). Narrative methodologies, therefore, informed the data collection process for this project. In this section, I provide some background on how scholars have applied narratives methodologically with intersectionality theory. Both dominant cultural narratives and individual narratives have been used for analysis purposes, but have different implications for the type of knowledge produced. I outline how individual narratives can be used with Macleod's supportability framework (2016) to facilitate a multi-level qualitative analysis that incorporates both micro (unique individual knowledge) and macro aspects (social norms and structures) of lived experience that may occur within the support nexus of pregnancy. I explain how this choice is integral to conducting an intersectional analysis.

Next, I discuss how and why I incorporated the method of photo-elicitation into the methodological procedures for conducting narrative interviews. I explain how the technique aligns with narrative approaches in obtaining rich, detailed and complex accounts. I elaborate on how this method aligns with intersectional stances in that unequal power relations between the researcher and participant are considered when collecting data. In reviewing studies that have examined pregnancy using participant-generated visual methodologies, I highlight how this methodology has surfaced (intentionally or not) how the wider socio-cultural and socio-structural environment plays a part in shaping the multi-faceted and complex nature of the pregnancy experience. The operationalisation of the supportability framework qualitatively aims to give insights regarding the interface between the pregnant individual and her social environment. Therefore, photo-elicitation was considered a particularly suitable method for collecting data for this project.

Moving on to the data collection process, I discuss the rationale for selecting the research sites, the sampling criteria for participants, and the process of recruiting participants. I provide demographic details of the participants who agreed to take part in the study. I reiterate

that, in line with an intersectionality orientation, this description should not serve to essentialise these participants' experiences of pregnancy or categorise them in any specific way. In the data generation section of this chapter, I explain how I incorporated the photo-elicitation method into the narrative interview structure. I provide detailed information about each contact session with the participants. I then move on to discuss the translation and transcription procedures as well as the ethical procedures followed for this research project.

Throughout the chapter, I reflect on various aspects of my research journey and how they may have helped or hindered the adoption of an intersectionality orientation to understanding supportability during pregnancy. These reflections included some ethical concerns raised at various stages during the data collection process. I provide explanations as to how these complexities were managed. I now turn to a discussion on how narrative research and intersectionality have been used together.

Intersectionality and narrative methodologies

According to Riessman (2008), narratives are understood as a form of oral storytelling within a specific context; they provide an opportunity to examine how people construct themselves, others and their social realities within a given interaction. Narrative accounts can also provide insights into the structural aspects (historical, political, and cultural) that are embedded in people's lives. When constructing a narrative account, social actors draw from dominant cultural storylines (Riessman, 2008) to make meaning for themselves and achieve coherence and acceptance of their account by their audience. Thus, the cultural narratives drawn upon when narrating a story circumscribe what is possible or not for individuals to say in a given social interaction. Therefore, individual narratives can be used as tools to solve the individual/social and relativist/realist dualisms in that narratives enable a dialectical view of the micro and macro aspects of lived experience. This is important from an intersectionality "both-and" standpoint (May, 2015) in understanding the individual as intermeshed with their social context.

Narrative research has traditionally been associated with the social justice aims of intersectionality (Alexander-Floyd, 2013; Chadwick, 2018; P. H. Collins & Bilge, 2016; Hancock, 2016; Ross & Solinger, 2017). Activists and scholars, in adopting intersectionality orientations, have used the power of narratives to challenge and examine social injustices in two main ways: through challenging powerful, dominant cultural narratives that impose disadvantages on particular population segments and through the deployment of individual narratives to raise

consciousness about social issues that affect individuals in uneven ways. In drawing attention to social inequities, intersectionality scholars have interrogated how master narratives or dominant cultural narratives shape people's subjectivities and lives in deleterious and unjust ways. These dominant storylines comprise common social and ideological knowledge frameworks from which individuals and social groups draw when making meaning for themselves and trying to understand and communicate with others. Master narratives operate by "normalising" or universalising knowledge and experiences, which may be imposed on particular individuals (Andrews, 2004). The normalising or hegemonic power of these narratives not only aids in constructing enduring cultural representations of specific individuals but also becomes intermeshed in institutional structures and government policies.

For example, political scientist Alexander-Floyd (2013) argues that using a black feminist framework to examine master narratives is key to understanding hegemonic power. Her work explores the harmful effects of the black cultural pathology paradigm (BCPP) metanarrative on black women in the USA (Alexander-Floyd, 2007). The author highlights its effects on gender, race, black nationalism, and white nationalism. She contends that the BCPP narrative gained traction by framing black family poverty as an individual moral failing. This narrative positioned the black female-headed household as the emblem of dysfunction, fostering stereotypes such as "the welfare queen" (portraying black women as lazy, having uncontrolled fertility and exploiting welfare) and "the endangered black male" (depicted as unemployed, violent men raised by single mothers). Alexander-Floyd traces how these representations influenced religious and political discourses, leading to U.S. welfare reforms and fatherhood initiatives in the 1980s-1990s. Despite their ideological opposition, both black and white nationalisms drew from the BCPP narrative to advance their political agendas, thereby mutually reinforcing each other by stigmatising black single mothers. White nationalism used the "welfare queen" stereotype to justify welfare cuts, while black nationalism promoted patriarchal fatherhood breadwinner models based on the "endangered male" stereotype. Alexander-Floyd highlights the broad structural, political, and material impacts of the BCPP narrative on underemployed black U.S. women. She also suggests that its influence extends transnationally, as seen in South Africa, where popular culture and media accuse poor black women of having children to exploit social grants (Ferreira, 2017; Patel, 2015; Richter, 2009). This analysis exemplifies a structural intersectional approach to analysing how dominant cultural narratives thread their way through policy, institutional structures, political organising and individual lived experiences.

Intersectionality scholars have also examined narratives on an individual level. An individual narrative has been described as a form of oral storytelling whereby individuals make sense of a life experience or event within a specific context (Riessman, 2008). On a micro-level, individual narrative accounts have rendered obscured knowledge and experiences visible by foregrounding the stories of those particularly affected by various social inequities within specific contexts, for example, U.S. enslaved narratives (P. H. Collins & Bilge, 2016; Hancock, 2016; McCall, 2005). Thus, these narrative accounts have been viewed as important mechanisms for facilitating claim-making, publicising social issues, encouraging solidarity, and promoting resistance to marginalisation (Hancock, 2016; Ross & Solinger, 2017).

In addition, individual narrative accounts have been used to challenge how the imposition of social categories homogenises an individual's experience or identity by drawing attention to the complexity of the lived experiences of a specific social group (McCall, 2005). However, analysing individual accounts can also include a structural analysis (Chadwick, 2018). As mentioned previously, individual accounts not only provide insights into people's constructions of their lived experience given their social identities and social locations but can also illuminate how the broader structural influences (historical, political, economic and cultural) have a bearing on the construction of these accounts (Parker, 2005). For example, as discussed in the theory chapter on approaches to using intersectionality as a theory, both Johnson (2014) and Chadwick (2017; 2014) analysed individual pregnant women's narratives to surface how social inequalities and injustices shaped maternal healthcare practices, preferences, and experiences.

Understanding relations of power is critical to an intersectional orientation (P. H. Collins, 2000). Narratives offer opportunities to gain insights into relations of power by examining the interplay between personal narratives and overarching dominant narratives. Top-down power can be said to reside in the collective voices or ideologies that are embedded in the macro-narratives upon which individuals draw to make themselves understood by their audience (Buitelaar, 2006). However, bottom-up power can be demonstrated by how individuals may use counter-narratives to challenge dominant cultural narratives (Bamberg & Andrews, 2004). An individual narrative thus provides the opportunity to illuminate how a person agentively negotiates their way through various power dynamics by examining how they deploy narratives (for example, to argue, justify, persuade, entertain and deflect) as well as how they draw on macro-narratives in the process of claim making (Riessman, 2008).

In light of the above discussion, I have incorporated narratives within the methodological framework of this project for the following reasons. Firstly, narratives generate rich accounts of experiences, which, according to Hancock (2016), contribute to intersectionality's visibility project. Thus, the telling of an experience can reveal knowledge that has been overlooked or different from assumed knowledge about pregnancy or can provide insights as to how normative assumptions about pregnancy may be upheld. Secondly, an individual narrative provides the platform upon which to examine the complexity and heterogeneous nature of the pregnancy support experience, which can challenge essentialist notions that may be associated with pregnant individuals. Thirdly, narratives provide opportunities to understand how social positions or representations are constructed and how they may operate within a pregnancy context. Fourthly, narratives can surface how agency might be enabled or constrained when negotiating the power dynamics that shape pregnancy support experiences. Finally, narratives facilitate an examination of both the individual and their social location within context, thereby offering the possibility of incorporating structural influences that may have a bearing on the pregnancy experience; an analysis of individual narratives guided by the supportability framework will satisfy this objective. In the next section, I discuss how narratives are elicited within the research interaction.

Narrative elicitation

Chadwick (2018) claims that when integrating narrative methodologies with intersectional approaches, researchers do not always provide specific details on how they approach the task of inducing narratives in the interview process. Firstly, the author maintains that narrative methodologies traditionally embrace specific criteria which guide how interviews should be structured and conducted. These criteria have implications for how an intersectional orientation is incorporated within the research interview format. Secondly, an intersectionality orientation demands ethical research practice. This means being mindful of how power is shared during research interactions between the researcher and participants who may be socially disadvantaged. Narrative methodologies that are appropriately implemented actively aim to shift some power to the participant so that they may also shape the research interaction compared with interviews that are entirely researcher-controlled. I will discuss these two concerns about how narratives should be elicited for this project next.

Narrative methodologies and the qualitative interview

Qualitative interviews are a method researchers use to understand people's life experiences and perceptions (Kvale, 2007; Polkinghorne, 2005). The unit of analysis is not necessarily a person or social group but the experience (Polkinghorne, 2005); individual interviews conducted with multiple participants can provide different perspectives of an experience, and these alternative viewpoints offer evidence for the complexity of the experience. Thus, the qualitative individual interview method fits with an intracategorical intersectional approach in that the event or experience is investigated in the analysis (McCall, 2005). In addition to this, the data generated from multiple individual interviews can show how individuals and their experiences cannot be essentialised or homogenised. This satisfies another epistemological position of the intracategorical intersectional approach.

According to Kvale (2007), a qualitative interview can aid in the social construction of knowledge depending on the types of questions asked in the interview. The production of knowledge during the interview is facilitated in two main ways. Firstly, the interaction between the participant and researcher during the interview means that knowledge is co-produced (Mishler, 1991). Secondly, the interview's structure, format, and types of questions asked shape how the knowledge is constructed. In-depth and unstructured questions emphasise surfacing the participant's contribution to knowledge, whilst semi-structured questions allow for the researcher's agenda to be incorporated in producing this knowledge (Kvale, 2007). A narrative-inducing interview is a useful qualitative method that facilitates the examination of experience, emphasises the participant's contribution, includes the researcher's agenda, and can be used within a social constructionist paradigm.

A narrative-inducing interview format is based on three key premises which informed the design of this research project. These included a semi-structured interview format, multiple contact sessions with participants, and, to a certain extent, limited researcher control during the interviews. Firstly, a narrative-inducing interview format moves away from stimulus-response or highly structured interview questions because the aim is to generate rich or detailed information about life experiences from the individual's perspective and context (Mishler, 1991). These types of interviews encourage storytelling by making use of questions that are predominantly open-ended, unstructured and/or semi-structured in nature. Kvale (2007) explains the kinds of questions used in the interview thusly: open-ended questions are designed to induce the narrative; unstructured and semi-structured questions ask for more elaboration of a participant's story to learn more about their experience; and semi-structured

questions are also designed to align with the researcher's epistemological and theoretical orientation in answering their research questions (thereby providing some form of structure to the overall interview). The use of open-ended and unstructured questions in the interview process for this project provided an opportunity to hear the voices of pregnant participants in constructing their pregnancy support experiences within the South African context. The semi-structured questions were based on this project's theoretical orientation, which was to illuminate aspects of the supportability framework that may not have been mentioned in the women's initial narratives.

Secondly, narrative interviews were initially conceptualised as a once-off interview by Schütze (1977, as cited in Jovchelovitch & Bauer, 2000). According to Polkinghorne (2005), however, conducting more than one interview is preferable because multiple interviews provide the opportunity to build a trusting relationship between the interviewer and participant. Multiple interviews also allow opportunities for reflection on the researcher's part, which aids in developing additional questions around the initial data generated. Likewise, participants get to reflect upon and add to their stories, which can provide further insights into their experiences. Wengraf (2001) suggests that the researcher can impose their agenda in the final interview. In his view, the second interview should be conducted after a period from the first interview because data from the initial interviews need to be analysed to facilitate the development of the researcher's semi-structured questions. For these reasons, my co-researchers and I designed three separate contact sessions with our participants over the data-gathering period. These sessions are explained in more detail in the data generation section of this chapter.

Thirdly, narrative-inducing interviews allow the researcher to control the overall topic for discussion but limit their control or influence during the interview process; this is done to maintain the emphasis on obtaining participant-generated data (Jovchelovitch & Bauer, 2000). Wengraf's (2001) approach advocates for minimal interventions on the researcher's part during the interview and for handing over as much control to the participant as possible. In these types of interviews, the researcher is instructed to be attentive but to hold back, allow for silences or pauses and provide mostly non-verbal forms of support to encourage narrative. Questions remain open-ended and are limited to asking participants to elaborate on the topics they raise themselves. The researcher's agenda may shape the overall subject of the interview, but can only be introduced in the form of semi-structured questions in the final part of the interview, once a participant has finished giving their whole account. Wengraf (2001) does concede that

this interviewing technique requires much skill, experience, and training on the part of the investigator.

In contrast to Wengraf's (2001) structured approach to the narrative interview, where researcher intervention is minimal, other scholars conceptualise the narrative interview as more of a conversation between the researcher and participant (Mishler, 1991; Riessman, 2008; Taylor & Littleton, 2006). These interview formats also aim to generate detailed accounts by giving the participant control over providing the narrative. However, Taylor and Littleton (2006), who use narrative methodologies to examine identity work, maintain they are less interested in the "naturally occurring data" embedded in a person's life story and are more interested in the research interview becoming a space in which a participant may continue with their project of identity work. Thus, these authors maintain that adopting a slightly more conversational approach to the research interview facilitates this process. Although researchers are still encouraged to listen mostly, dialogue between the researcher and participant is seen as acceptable. Mishler (1991) considers the result of this type of narrative interview to be a discursive accomplishment between the participant and researcher. He maintains that this interaction should not be overlooked when analysing the data. This approach to the narrative interview, where conversation between the researcher and participant is encouraged, aligns with intersectionality's stance in facilitating opportunities for claim-making by individuals whose voices are not often heard. It also makes the researcher's role (in shaping the knowledge produced through the interview interaction) transparent, which aligns with intersectionality's commitment to self-reflexivity during the research process.

My approach to the narrative interview was similar to that of Taylor and Littleton (2006). I was interested in conversing with my study participants as my focus was on their making meaning of the support they may or may not have received during pregnancy. Nevertheless, I still wanted to limit some of the control I, as a researcher, had over how participants wanted to share their stories on pregnancy. Therefore, I borrowed from Wengraf (2001) by developing a SQUIN (Single Question question-inducing narrative). The exact procedure used is explicated in the data generation section of this chapter. In addition, I used photo-elicitation as a method to induce narratives around pregnancy support. My aim in using this method was to place the initial data generation directly and wholly into the hands of the participants, which meant that the data were initially participant-controlled and generated. Incorporating this method into my study design meant that the interview style was active and conversational; the photographs

taken by participants encouraged discussion and reflection by both parties. I now turn to an in-depth discussion of the usefulness of photo-elicitation.

Generating narratives through participant-generated photo production

Several scholars have turned to visual methodologies to aid in eliciting narratives. Riessman (2008) maintains that visual methodologies have expanded and reshaped narrative traditions; stories can be told and collected differently based on how the images are used, received by their audience and interpreted. Photo-elicitation is a method that can be used to induce narratives. Harper (2002, p. 13) describes photo-elicitation as "based on the simple idea of inserting a photograph into a research interview". This method allows participants to become actively part of the research process by taking pictures on instructions from the researcher in relation to the research topic. The photographs are then discussed during interviews to generate narratives for data analysis.

The benefits of using photo-elicitation

Participant-driven visual methodologies embrace some key feminist epistemological tenets that are centred on respecting lived experience, empowering individuals in the research process and being oriented toward social justice aims (Wang, 1999; Wang & Burris, 1994). Photo-elicitation was thus considered a suitable method for this project because it offered some distinct benefits regarding the data-gathering process. These are outlined below.

Firstly, Reavey (2011) argues that a social constructionist approach should use multi-modal ways of obtaining accounts as people engage with the world through language and visual means to express themselves. Through photographs, the participants not only narrate their experiences but also "show" how they experience their lives, thereby producing detailed and complex accounts. In this project, the participants constructed rich accounts of their pregnancy experience through the generation of photographs. For example, one of the participants "showed" us how isolated and abandoned she felt by taking a picture of an empty bed and pillow, which represented her partner leaving her because of the pregnancy.

Secondly, Harper (2002) explains how photo-elicitation enables collaboration between the researcher and participant as they co-construct the account. Through sharing photographs, cultural boundaries potentially become permeable: the image itself may depict commonalities to which both parties may relate, and in discussing the image, taken-for-granted knowledge can be challenged as the participant and researcher learn from each other. In addition, I found that

this method changed the tone and formal nature of the interview process. The photographs acted as “icebreakers” between me, my co-researcher and the participant, creating an informal conversational space. The physical space was informal as the participant and I sat side by side rather than opposite each other (as would generally occur in a formal interview). There were no awkward silences, as studying the image allowed us time to reflect on what had been said. Furthermore, the image broke additional boundaries by enabling us to ask questions about sensitive issues, which would have been considered far more intrusive in formal interviews.

Thirdly, although the researcher may control the overall direction of the research, participant/researcher roles are re-negotiated as the participant is empowered to shape the accounts produced through their choice of photographs taken and then selected for discussion (Rose, 2012). By giving open-ended instructions to our participants on taking pictures for this project (see later discussion under the data generation section), they were free to choose what they wanted to discuss about their pregnancy. Another way in which our participants controlled the process was by enlisting others to help them construct their accounts. For example, participants who had supportive partners co-constructed their narratives with their partners by deciding together on what pictures to take. This introduced a unique view of how partners were involved in the pregnancy. Therefore, this approach satisfies intersectionality’s stance on giving participants agency to articulate their situated experiences in relation to their social locations and to reveal meanings about pregnancy that may be hidden from view. In addition, when asking participants why they decided to take part in the project, a few felt that they were given the freedom to “just talk”, an opportunity they told us was not possible during clinic visits or with their support networks. Thus, they felt that participating in the project benefited them.

Fourthly, by discussing their photographs, participants actively constructed their social realities, identities, and those of others as they made meaning of their experiences (Reavey, 2011). As Reissman (2008) points out, participants will compose images to accomplish specific goals. This was useful for understanding how the participants took up subject positions and positioned others in their support networks when narrating their stories. For example, in taking a photograph of the empty bed and pillow, one participant accomplished the task of communicating to us how difficult her pregnancy was for her. In explaining the image, she positioned her partner as unsupportive by his absence. Simultaneously, she took up the subject positions of a vulnerable, ill and distressed person by describing how her partner’s absence had exacerbated her chronic health conditions of blood pressure and diabetes.

Finally, Rose (2012, p. 313) describes “the photograph as trace of the real, and the photograph as a culturally encoded image”. The production of images provides a window into the broader social contexts and structural aspects that shape people’s lives, and this is shown not only by what is depicted in the image but also through the detailed stories that are told in explaining why the image was taken. Furthermore, using images facilitated the process of conducting a multi-level analysis. When discussing their pictures, our participants expressly and implicitly drew attention to structural aspects that shaped their pregnancy experiences. This was captured both in the photographs and in their narratives. For example, pictures showing our participants’ washing regimes revealed the limited access to basic services. In narrating her story, one of our participants drew attention to the increased need for water to drink and to be able to wash during her pregnancy. Because the family’s dwelling had no piped water, water had to be fetched from a communal water point, making our participant feel like a nuisance to her family.

Other scholars have found that social issues, memories and experiences not directly related to the contents of the photograph enter the discussion when participants reflect on the image (Hodgetts et al., 2007). This was true in our experience, as evidenced by some of my fieldwork notes: “I really had no idea that a ‘selfie’ could elicit a story of such hardship”. This relates to one of the participants who started her interview by showing us a “selfie” of herself. She told us she took the picture when she first found out she was pregnant to remind herself of that time in her life. The pregnancy was unplanned, and finding out about the pregnancy was difficult for her. Foremost in her mind when taking the picture were concerns about her unemployment status and her ability to secure the economic means to provide for and protect her child when it was born.

The discussion above shows how photo-elicitation is a suitable method in that it can aid in constructing narratives from discussions of an image between the participant and researcher. I now turn to a discussion of the literature in which visual methodologies using photographs have been utilised in relation to researching pregnancy.

Photo-generation research in relation to pregnancy

A small body of social science literature conducted over the last 25 years has used participant-driven visual methodologies to examine pregnancy. I draw specific attention to how findings generated by using these methodologies have provided intersectional insights concerning pregnancy issues. The visual methods applied in this literature have included

photovoice and photo-elicitation. Photovoice is a participatory action research strategy developed by Wang and Burris (1999; 1994, 1997) , who used the technique to examine issues around women's healthcare needs in China. This method differs slightly from photo-elicitation because it involves community participation, whereby multiple stakeholders photograph a particular issue affecting their local community. These photographs are then discussed and presented within the community through dialogues and exhibitions to encourage social action and engage policymakers. Although my research project used photo-elicitation as a methodology, I included photovoice studies in my discussion. Both approaches have illuminated various issues that enable and constrain the supportability of a pregnancy. In addition, these methodologies have mainly been used with social groups that are considered marginalised in some way.

Participant-generated photographs have demonstrated the **heterogeneity of a group** under study when examining pregnancy health behaviours. A Canadian photovoice study sought to investigate Chinese immigrant women's food choices while pregnant (Higginbottom et al., 2018). The authors found that cultural practices and beliefs firmly underpinned the food choices that the women made. However, these practices were mediated by the Canadian context in which the women now lived: the women's social support networks, the high cost of living in Canada, and the time required to prepare home-cooked meals significantly influenced their food choices. Notably, discussions of the photographs revealed that the participants were not a homogeneous group. Different beliefs and practices were described based on the region of China from which the women came.

A photo-elicitation study has surfaced the **interaction of socio-structural issues** (including gendered and socio-economic challenges) that have affected pregnant and post-partum women's health in western Kenya (S. M. Collins et al., 2019). The participants' pictures revealed the far-reaching effects of water insecurity on their well-being. Regarding gendered dimensions, women showed that fetching water remained women's work even if they were pregnant. In rare instances, men may help out in the last month of pregnancy or for a short time after birth; however, women mostly had to rely on other family or kin networks to help them fetch water if they could not. Furthermore, women reported that they were likely to experience violence from their partners should they fail to bring back water to the household. Pregnant women often neglected their hygiene practices and prioritised men's needs and those of their families. In terms of the economic dimensions, many women reported that they could not work because fetching water for the household was prioritised. Moreover, during the dry season,

water had to be purchased, which meant that expenditure on nutrition was curtailed. The authors reflected that this methodology enabled both the participants' and researchers' perspectives to be included in the study design. The participants were considered "cultural insiders" and provided rich details important for understanding the issues associated with water insecurity. On the other hand, the researchers could probe for additional information based on a set of a priori themes that aligned with their research interests (which included water acquisition, prioritisation and use) that may not have necessarily been discussed in the participants' accounts.

Participant-generated (photovoice) images have also surfaced the **enduring effects of overarching systems of oppression**. A Canadian study by Oster et al. (2018) asked fathers of a local Nehiyaw community to take pictures detailing their perceptions of being a supportive partner during pregnancy. In discussing their photographs, all participants drew attention to how the impact of colonisation has undermined men's roles and identities as fathers, thereby affecting the support provided during pregnancy. They specifically drew attention to the enduring intergenerational effects of residential or boarding schools[18], which destroyed the community's language, knowledge systems and traditional family support structures (resulting in making the roles of fathers unclear). Discussions of the pictures illuminated how supportive fathers were seen chiefly as financial providers (this was difficult for unemployed participants). Men also experienced fear and anxiety during pregnancy and needed the assistance of familial support networks. Men reported that antenatal classes were not structured in ways that included them in preparing for parenthood. The participants considered themselves involved fathers and elaborated on their support to their pregnant partners, for example, being physically present, providing emotional support, and helping with running the household.

A photo-elicitation study surfaced how **one's social position shapes behavioural motivations** concerning pregnancy (Ponsford, 2014). This study examined young, British, low-income women's consumption patterns for pregnancy-related products. Although the author

[18] In this system, children were taken from their families and "assimilated" into Canadian colonialist culture by being placed in boarding schools.

did not discuss photo-elicitation in detail, the generated data revealed that the women's buying patterns were shaped by "good motherhood" discourses. A prerequisite of being a 'good mother' was perceived as the ability to provide materially for a child, and participants took pains to achieve this status to overcome the stigma associated with being a young mother. The pregnant women described how they strategically purchased items through careful product research, capitalising on sales, buying over time, and buying acceptable brands for the unborn infant rather than purchasing items for themselves. They often required additional family support to cover some more significant costs. Furthermore, women also bartered or exchanged baby goods within their social networks in preparation for the impending birth; purchasing second-hand baby items was viewed in an unfavourable light.

The above literature discussion demonstrates how participant-generated photos can reveal the multi-faceted and complex nature of the pregnancy experience. The discussion of photographs by participants reveals how social support does not happen in isolation from a pregnant woman's context. Participants have drawn attention to specific macro issues (for example, water insecurity), which are often overlooked in the support literature and can potentially undermine the supportability of a pregnancy. Furthermore, all these studies demonstrate how participant-generated photographs are valuable in surfacing local knowledge. This ties in firmly with intersectionality's objectives of making this knowledge visible, refraining from essentialising a social group's experiences, and understanding the socio-cultural, political and economic structures shaping the pregnancy experience. Thus, in light of the findings of the above-mentioned studies, using a participant-driven photo-elicitation method is particularly suited to this research project, which aims to examine the supportability of pregnancy in a South African context.

Photo-elicitation and its limitations

There are some debates about the limitations of using participant-produced photographs as a methodology. These primarily relate to ethical issues, such as the implications of photographing third parties and who owns the copyright of images (Rose, 2012). Other scholars have drawn attention to the complexities of balancing institutional ethical constraints with ethical research practice (Allen, 2015; Langmann & Pick, 2014; Nutbrown, 2011). For example, ethical research practice involves respecting participants' wants and desires in the research process, which may conflict with institutional ethics proscriptions. Moreover, the researcher must consider how visual methodologies are used in analyses and disseminated to wider audiences. Some of these limitations are pertinent to this project and

are discussed in more detail in the ethics section of this chapter. We also experienced some other challenges not covered in the literature. These are explained in more detail under the data generation section of this chapter, where I reflect on the unexpected complexities of using photo-elicitation for my research project.

Data collection process

The pregnancy supportability research project comprises a team of researchers. Four researchers collected data for the qualitative component of this project; two honours students (both isiXhosa speaking), one master's student, and myself. The two honours students fulfilled the role of research assistants by conducting interviews in isiXhosa and helped translate and transcribe the data of the isiXhosa interviews. The data generated was used in all four respective research projects. Data collection took place in 2015 in the Makana municipality and 2016 in the Elundini municipality.

In this section, I provide an outline of the data collection process. I first describe the research sites and our reasons for selecting them for our study. I then explain the sampling criteria applied in selecting participants for the study. Finally, I explain how we recruited the participants and briefly describe the research participants who agreed to participate in this study.

Research sites

According to *The Saving Mothers Report* (National Committee for Confidential Enquiries into Maternal Deaths, 2018) and the *South African Demographic Health Survey Report* (2019), which cover the time the fieldwork was conducted for this project, the availability and quality of health care provision in rural[19] regions of South Africa are reported as more limited than in

[19] According to Statistics South Africa, a rural area in South Africa is defined as "farms and traditional areas characterised by low population densities, low levels of economic activity and low levels of infrastructure" (Statistics South Africa, 2010, p. 113). The Rural Health Advocacy Project (a civil society group) puts forward the view that what is considered "rural" in South Africa can be defined in terms of access to healthcare. They campaign and lobby for government policy change addressing rural health needs' complexities. The group contends that what is considered "rural" should be based on several contextual factors, including population size; demographics, economic opportunities or wealth; how the

urban areas. Inequitable distribution of healthcare facilities, health services, skilled personnel, and technological resources negatively affects people living in these areas. This affects healthcare interaction, a fundamental element of the supportability framework. We, therefore, selected two local municipalities in the province of the Eastern Cape as our research sites for this study. This was Elundini Municipality, located in the Northeastern part of the province, and Makana Municipality, located in the southern part. Both are classified as Category B (rural) municipalities. High levels of unemployment and basic service delivery challenges affect both areas (Elundini Municipality, 2016; Makana Municipality, 2023).

Regarding healthcare facilities, Elundini municipality has two district hospitals, 21 primary healthcare clinics and four mobile clinics. The municipality acknowledges that these facilities are inadequate to provide equitable healthcare services to its local population (Elundini Municipality, 2017). Makana municipality has one district hospital, one community healthcare centre, and eight primary healthcare clinics. Women with low-risk pregnancies who access public healthcare services typically attend primary healthcare clinics for antenatal check-ups. We recruited participants from public primary healthcare clinics at both sites. These were either located in the centre of the respective municipalities' main towns or in townships[20], which are adjacent to the main towns.

Pregnant individuals in these municipalities are referred to district hospitals for specialised maternity services or to give birth. District hospitals are supposed to conduct, among other procedures, ultrasounds and caesarean sections (South African National Department of Health, 2015). However, reports from our participants indicated that the district hospital in Elundini was able to perform ultrasounds but unable to conduct caesarean sections. Instead, the participants were referred to another district hospital in a town called

---

land is utilised; access to services (which includes health, education, water, and sanitation); and migration patterns (see Rural Health Advocacy Project, 2015).

[20] Townships are planned yet underdeveloped settlements predominantly populated by black communities usually situated on the outskirts of the main town. These settlements are the legacies of the apartheid spatial segregation policies (see Union of South Africa, 1950).

Tsolo, located 60km away. In Makana, the local district hospital could provide obstetric functions such as caesarean sections, but was unable to provide abortion services after 9 weeks of gestation.

Participant sampling criteria

A purposive sampling strategy was used to select participants for this study. Polkinghorne (2005) describes this method of participant selection as a way in which a researcher strategically selects subjects best suited to provide detailed information and insights from different perspectives about their experience concerning the phenomenon under study.

The criteria for participant selection included 12-15 participants in their second trimester of pregnancy, accessing antenatal care (in either the private or public health sector) and aged 18 years and above. The sampling criteria for participants were selected on the following basis. Firstly, regarding the age criteria, women aged 18 and above can legally sign documents for consent purposes. We also surmised that young mothers may form a distinct group regarding the social support they may experience compared with women who are socially considered adults. Secondly, we chose women in their second trimester of pregnancy as they would have been pregnant long enough to be able to provide detailed information about their pregnancy experience. Thirdly, we were interested in participants' healthcare experiences as the healthcare interaction is a facet of the pregnancy supportability framework. This sampling approach meant that we fulfilled the aims of an intracategorical intersectionality whereby the sample shared a similar characteristic of interest, that is, being pregnant, but at the same time allowed for diversity across the sample as the South African context itself is characterised by diverse and variable population characteristics and practices (McCall, 2005).

Recruiting participants

We recruited twelve of the participants from primary healthcare clinics. All participants in Elundini were recruited through the clinics. In Makana, five participants were recruited from primary healthcare clinics, one through an advertisement in a school parent community newsletter and two using snowball sampling techniques. Snowball sampling is when a research participant uses their social network to help researchers recruit additional people to participate (Braun & Clarke, 2013).

We contacted all the clinics before conducting the research. We submitted the relevant permissions from the university and the provincial Department of Health, as well as a letter requesting the head nurse's permission to conduct research at each clinic (see Appendix 4). Recruiting of participants at the clinics mostly took place in the mornings when the clinics were busy. The healthcare workers and clinic nurses assisted the recruitment process by providing us with a room to meet potential participants, and, depending on how busy the clinic was, they directed pregnant individuals to us before or after they went in for their antenatal care consultation. This was very useful as this process was relatively discrete, and we did not have to seek out potential pregnant participants in the clinic waiting room. It also meant that we were given the opportunity to meet most pregnant individuals accessing the clinic for antenatal care on that specific day, thereby enhancing the chance of getting enough participants. If there was no clinic room available for us to use, we invited potential participants to our car (parked on the clinic grounds) to introduce ourselves and explain the project to them. On reflection, this may have been problematic, as potential participants might not have perceived the initial meeting as particularly befitting of "professional" researchers or practices. However, rural clinics have minimal resources, and in some cases, there were no other private spaces available in the clinic to discuss the research project with potential recruits.

In one of the clinics, healthcare workers addressed everyone in the waiting room. They handed out our information flyers (available in English and isiXhosa – see Appendix 5) outlining the research project. Although the help provided by the healthcare workers, by recruiting participants in this manner, was valuable, sometimes a misunderstanding of the project criteria resulted in some recruitment complications. For example, in two instances, young pregnant women under the stipulated age of 18 came to see us and displayed an interest in participating in the project. This had ethical implications in managing this dilemma in that we had to inform the young women that they could not participate in the project because of their age. This created an uncomfortable situation whereby we were aware that we could be contributing to the stigma associated with young pregnant women by marking them as "other" in not letting them take part in the project. We tried to resolve this by assuring the young women that we would value hearing their stories, but we could not include them in the study due to constraints in terms of the legal age for giving informed consent. To ensure they had some support, we asked the young women if they had a trusted adult with whom they could confide. Both confirmed they had enough support, but we provided them with toll-free psychosocial support numbers (Lifeline) per our ethics protocol.

Another issue arose where some potential recruits were only in their first trimester. Finally, we were not entirely sure if potential recruits were told to come and see us or whether they were invited or encouraged to find out about the research project; we suspected the former. Because of this, we emphasised the voluntary nature of participation in the project. Despite these slight difficulties, and because we were recruiting in the healthcare practitioners' working spaces, we had to respect their modus operandi. We had to follow their lead on how they best saw fit to assist us with the recruitment process.

The recruitment of participants took place during the first meeting. When meeting potential participants for the first time, we introduced ourselves as researchers from Rhodes University. Then, we asked them if they would like to hear about the research project. Once we confirmed their interest, we then checked that they fit the participant criteria as indicated on the flyer that was given to them (see Appendix 5). We explained the project in more detail if they met the sample criteria. Once we were sure that the participant understood the project's aims, we moved on to obtaining the participant's consent to participate. We assured them that their participation was voluntary, and we explained, completed, and obtained signatures for the various consent forms (see additional details in the ethics section). We then gave them the SQUIN question and provided instructions on what they were required to do (The instructions we gave our participants are discussed in more detail in the data generation section of this chapter). After providing them with their instructions, we checked in with the participant to see if they had any additional questions or needed further clarification regarding their participation in the project. Finally, we recorded the participant's contact number and arranged a date and time later that week to conduct the first interview. That evening, we sent the participants text messages thanking them for participating in the project and confirming the date and time of their upcoming interviews.

Description of participants

Seven women in the Elundini region and eight in the Makana region consented to participate in the research project. The reader will recall that McCall's (2005) intracategorical intersectional approach acknowledges that a social group may share some common master category identity characteristics, as these characteristics have material or social effects. Demographic details are outlined in the following table, keeping in mind that these characteristics should not serve to homogenise this group's pregnancy experience. One Zimbabwean participant, Kudzai, interviewed with her male partner Simbarashe. This was because she could not speak much English and isiXhosa, and her partner helped with the

translations. We were cognizant that he would substantially shape the interview process based on his own experience and viewpoints and possibly speak for her, but we nevertheless decided to include the couple because they contributed to the diversity of the sample.

Table 1: Participant demographics

Elundini and Makana participants									
	Participant pseudonym	**Parity**	**Month of gestation**	**Race**	**Age**	**Healthcare type**	**Employment status**	**Partner status**	**Geographic location**
1	**Ayabonga**	3	8	Black	27	Public	Unemployed	Absent	Elundini
2	**Sandra**	3	9	Hispanic	34	Public & Private	Unemployed	Cohabiting	Makana
3	**Kwanele**	1	5	Black	19	Public & Private	Student	Non-cohabiting	Makana
4	**Tayla**	1	5	Coloured	25	Public	Unemployed	Married	Makana
5	**Nosipho**	1	7	Black	27	Public	Unemployed	Absent	Elundini
6	**Siphe**	2	5	Black	24	Public	Unpaid leave	Cohabiting	Elundini
7	**Ntombi**	1	6	Black	24	Public	Unemployed	Cohabiting	Makana
8	**Zenande**	2	5	Black	28	Public	Employed	Married	Elundini
9	**Thandeka**	1	8	Black	27	Public	Unemployed	Absent	Elundini
10	**Xoliswa**	2	4	Black	27	Public	Unemployed	Cohabiting	Elundini
11	**Linda**	1	6	Coloured	27	Public & Private	Employed	Single	Makana
12	**Thando**	2	8	Black	21	Public	Unemployed	Non-cohabiting	Makana
13	**Kerry**	1	4	White	33	Private	Self employed	Cohabiting	Makana
14	**Anelisa**	2	6	Black	34	Private	Employed	Married	Makana
15	**Kudzai and Simbarashe**	1	5	Black	20	Public	Unemployed	Cohabiting	Elundini

Data generation: Interview method and process

To generate data for this project, my co-researchers and I had to decide how the interview method and procedure would be structured. As mentioned in the previous section, narrative traditions mainly use highly structured interview procedures (Jovchelovitch & Bauer, 2000; Wengraf, 2001). For example, Wengraf's (2001) Biographical Narrative Interpretative Method (BNIM) is structured in the following way. In the first interview, the investigator asks a single narrative-inducing question (SQUIN). The participant tells their story, whilst the researcher plays a minimalist (yet attentive) role and takes notes until the participant indicates they have finished. Thereafter, a 15-minute break ensues, and the participant leaves the room. The researcher consults their notes and develops additional open-ended questions based on topics raised by the participant. These questions aim to induce additional narratives from the participant once they return from the interview break. The first interview ends once the participant indicates they are finished telling their story. The second interview is based on the researcher's interests and takes place after some time from the first interview. Semi-structured questions are developed by analysing the data generated in the initial interview and to align with the researchers' epistemological or theoretical orientation.

My co-researcher and I had to consider two additional aspects that had to be incorporated into the interview procedure: the photo-elicitation method, which not only changes the nature of the interview between the participant and researcher but also requires additional time for participants to take photographs. Therefore, the recruitment of participants and the provision of the SQUIN question took place in the first contact session. Secondly, because many interviews were conducted in isiXhosa, the additional time between interviews was required to translate the initial interview into English so that I could prepare my next set of questions based on the information provided by the participants in the first interview. This meant we collected data over three contact sessions compared with Wengraf's (2001) two contact sessions. I will discuss the interview process in conjunction with the methods next.

Contact session 1: Recruitment and SQUIN question

After the participants agreed to participate in the project and signed all consent forms (see Appendices 6,7,8, and 9), we provided instructions on taking photographs of their pregnancy journey. We incorporated Wengraf's (2001) SQUIN approach, a single-question-inducing narrative. This open-ended question is developed around the overarching aim and topic of the research investigation. We, therefore, instructed pregnant participants to take

between 5 and 10 pictures with their mobile phones to capture their pregnancy support experience. The images needed to answer the following narrative-inducing question: What makes your pregnancy easy or difficult regarding the support you may or may not receive? We also asked them to take pictures of their daily routine while pregnant, encouraging them to reflect on how their lives may have changed because of their pregnancy.

We envisioned that using mobile phones instead of digital or disposable cameras was the best way to induce visual narratives. This is because they are readily available and accessible (usually carried permanently on one's person). Furthermore, we felt that mobile phones allow a more spontaneous way of capturing emotions or events regarding the pregnancy than a standard camera. The participants were also free to discuss pictures they may have already taken on their mobile phones that spoke to their pregnancy experience, thereby providing an opportunity to connect with their memories of initial thoughts and emotions about becoming pregnant. If the participant did not have a mobile phone to take pictures, we provided one on a loan basis.

We did not focus on training participants to take photos because photographic composition and function were not considered necessary for our project. The images were used as a tool to elicit narratives. Drawing from narrative traditions and adopting an intersectional orientation, we also wanted to limit the researcher's control and let women choose how they wanted to tell their stories. This means we did not want to impose guidelines for taking photos that could restrict how the women chose to tell their pregnancy stories. Put differently, we did not want the women to focus on trying to take "good" photographs for us at the expense of being able to tell their stories.

However, we did explain the ethical considerations should participants include third parties (see Appendix 7). We explained to our participants that they should obtain another person's consent before taking and sharing the photographs of that person. We suggested that if a third party did not want to be included in the photograph, the participant could instead take a picture of something symbolic that might be linked to that person (for example, a possession of theirs). Finally, we explained to our participants how we would ensure their confidentiality by not revealing their identities in the research report. We explained that both their names and pictures would be anonymised. Interestingly, a few participants did not mind being identified; ethical questions about anonymising pictures are discussed in this chapter's ethics section.

Contact session 2: Photo-elicitation interview

The second meeting took place wherever participants felt most comfortable, often in our car at a convenient location. We also offered transportation to and from the interview, which helped them with errands and reduced their transport costs. Interviews lasted 20 minutes to an hour, were audio-recorded, and were primarily conducted in isiXhosa by my co-researcher because participants preferred to be interviewed in their mother tongue.

In line with Wengraf's (2001) approach to interviewing, we tried to encourage the participant to direct the interview. They could do this initially because they decided what pictures to take and what they wanted to discuss with us. We attempted to use non-verbal encouragement for the most part when participants described the images they had taken; we clarified certain aspects of our participants' stories when necessary (sometimes paraphrasing) and probed for additional narrative on topics that the participants had touched on in their stories. We found that the interview was conversational because the images themselves prompted discussion. As mentioned, this more active role of the researcher follows Taylor and Littleton's (2006) approach to the narrative-discursive interview. Using this approach to the interview, the authors view the research interview as another interactive opportunity for participants to continue with their identity project or make meaning of their experience. The researcher's active role in encouraging this process is not seen to detract from the interview.

Once the participant had finished discussing her photographs with us, we thanked her for her time and gifted her some baby items, including newborn clothes, nappies, wipes, and cream. The strategy was to build a "baby shower" hamper over successive interviews, and our participants greatly appreciated this. Finally, we confirmed with our participants that we would meet for another interview with some follow-up questions after transcribing their first interview.

The transcription process at this stage was informal. The quick transcription process allowed me a basic understanding of what was discussed in the isiXhosa interviews so that I could formulate follow-up questions for our next interview session, which took place 2-3 days later. It also allowed me to note aspects of the supportability framework not mentioned in the participants' talk so that I could develop some semi-structured questions that probed these absences. This process involved my co-researcher listening to the initial interview, translating and dictating the meaning to me. At the same time, I roughly transcribed the data in preparation for our third session with our participants.

Contact session 3: Follow-up interview with semi-structured questions

The third contact session took place 2-3 days after the second interview and focused on follow-up questions based on the initial photo-elicitation interview transcriptions. Participants were not required to provide additional photographs, but could if desired. This session aimed to clarify any ambiguities and explore any significant issues from the previous interviews in more depth. We also incorporated our research agenda by asking semi-structured questions about the elements of the supportability framework that were not covered in the earlier interviews (antenatal care, church support, and the workplace). Participants were given the opportunity to retract any photographs or interview content, with only one requesting that part of their interview be redacted.

Interview preparation

To prepare for data collection, the supportability research team conducted two role-play interviews with a fellow research student acting as the stooge interviewee. The first interview focused on explaining the project details and consent procedures, during which the interviewee was instructed, just as actual participants would be, to take photos with her mobile phone of aspects that made her “pregnancy” easier or more difficult. In the second session, we reviewed the photographs and practised our interview techniques.

The role-play interviews proved invaluable in several ways. It provided an opportunity to refine the clarity of instructions given to participants. Feedback from the interviewee highlighted the need for more detailed guidance on the SQUIN question, leading the team to suggest that participants reflect on how their daily routine had changed because of the pregnancy and to recommend taking 5-10 photographs.

The exercise also offered insights into the interview process itself. It became clear that the recruitment interview might take longer than anticipated, as thorough explanations regarding consent, especially concerning third-party appearances in photos, were essential. Additionally, the second interview was expected to be time-consuming, given that discussing photographs could elicit more in-depth responses than standard question-and-answer formats.

Practising interview techniques was another key benefit. Asking open-ended and semi-structured questions that encouraged detailed narratives was a key aim. For instance, instead

of asking closed questions like “Is work affecting your pregnancy?” we learned to frame them in a way that invited richer responses, such as “How is work affecting your pregnancy?”

Furthermore, the role-play interviews led to valuable discussions about best practices. It was agreed that participants should have the flexibility to choose interview locations where they felt most comfortable. Ultimately, the exercise helped refine our research approach and gave us confidence as we prepared to enter the data collection phase.

Reflections on the use of the photo-elicitation method

We experienced two main challenges to using photo-elicitation for this research project that have not been covered in the literature. Firstly, we experienced high attrition rates when recruiting participants, which was noticeably missing from the literature I read, and we encountered technological issues that may be specific to low-resourced geographic locations.

Although Murray and Nash (2017) have drawn attention to the burden and time considerations that can be placed on participants when taking part in this form of research, the high attrition rate for our study was perplexing as all participants agreed to take part and signed all the consent forms knowing that their participation was voluntary and that we only required them to take a limited number of photographs. However, when we followed up with them to arrange a time to meet to discuss their pictures, they either did not arrive for the interview (even though we offered to pay for their transport), put their phones on voicemail or ignored our follow-up calls. One participant, to whom we lent a mobile phone so that she could take pictures, changed her mind and returned the phone to the clinic. The reasons for these withdrawals were not clear. We surmised that the time and effort of taking photos and participating in interviews may have contributed to the attrition of participants.

Secondly, social and gendered dimensions also affected participation. One recruit who wanted to participate informed us that she could not participate because her boyfriend would not allow her to. When we followed up with another participant, my co-researcher could hear a male voice in the background arguing with the woman about participating in the project. At the same time, she tried to defend her decision and convince him otherwise. Her phone went to voicemail, and we could not reach her again. This unnerved us somewhat, as we had no wish for anyone to experience any negative repercussions for wanting to take part in our research project. We surmised that one of the main reasons the women might have opted out is that they discussed the project with their support networks, who may not have fully understood what the project entailed and thus dissuaded them from participating. This particular issue may have

also shaped the sample recruited. For instance, we did not interview any women who had partners who were unsupportive and present in their lives.

Thirdly, how healthcare workers helped us recruit participants may have played a role. As explained in the recruitment section, nurses would see the pregnant person first and then instruct them to see us afterwards. Participants were not exactly encouraged, nor were they asked if they would be interested in participating in our research project. We had very little power to shape this recruitment interaction because we were on healthcare workers' turf and were inserting ourselves into jam-packed spaces where healthcare workers had high workloads. Although we got permission from the head managers of each clinic to recruit participants, they were issued with top/down instructions from higher provincial management levels, from whom we had to obtain ethics clearance. It is worth noting, however, that there was no further attrition from the sample once the women had taken photographs and discussed them with us.

Conducting research in remote, low-resourced areas presented significant technological challenges. Transferring images from participants' mobile phones to our devices proved more complicated than anticipated. While WhatsApp was our primary transfer method, unreliable 3G connectivity often hindered the process. Attempts to use my device as a hotspot were similarly ineffective due to slow speeds. We sometimes paid for additional data to facilitate transfers where possible.When WhatsApp failed, we resorted to direct USB transfers, but compatibility issues arose between participants' devices and our laptops. Some participants lacked USB cables, and our backups were not always compatible with those of the participants. In one instance, a participant without a cable or WhatsApp access required an improvised solution— with my mobile, I photographed the images directly from her phone screen!

Providing participants with handsets could have resolved many of these issues, but budget constraints and bureaucratic hurdles, such as government-mandated SIM card registration using identity documents, made this impractical. Despite these challenges, the methodology remained invaluable for data collection, as demonstrated in subsequent analysis chapters.

Translation and transcription

The researcher's theoretical and analytical aims (Braun & Clarke, 2013) guide how interviews are transcribed. This means that decisions must be made on how the interview data

are transcribed and what transcription conventions best represent participants' spoken words. Braun and Clarke (2013) argue that transcribing ad verbatim in detail can capture how and what is said in the interview. Because I am interested in how women discursively construct support during pregnancy, the transcriptions needed to capture enough detail to demonstrate what participants accomplished with their talk. This included recording silences, emphasis in speech, other emotive sounds (sighs, giggles or crying), clarification notes (especially regarding translating isiXhosa words into English) and recording the overall interactions between the participant and researcher. In addition, the possibilities around the types of transcription conventions that could be used were influenced by having to both translate and transcribe the data.

Therefore, all audio-taped interviews were transcribed using Parker's (1992) transcription conventions (see table in Appendix 10), which enabled capturing sufficient detail in the analytic process. I transcribed English interviews for the Elundini region. English interviews for the Makana region were transcribed by my co-researcher, who was also English-speaking and used those interviews for her master's research project. All isiXhosa interviews were transcribed and translated by our isiXhosa co-researchers, who were completing their honours degrees, and who used the same data for their respective research projects. IsiXhosa interviews were interpretatively translated into English. Our co-researchers took care in capturing the participants' intended meaning and ensured that cultural meanings were interpreted appropriately.

Translation and interpretation between languages and across contexts are not a simple process (Temple & Young, 2004). Swartz (2015) argues that because we construct our lives and who we are through language, these language terms shape our interpretations and how we make meanings of ourselves and our experiences. These language resources (although dynamic) are culturally and contextually specific. Thus, people who belong to different cultures and speak different languages construct and understand their lived realities in various ways, which has implications for how the meanings of words are translated (Temple & Young, 2004). A social constructionist position acknowledges that language is saturated with context. Thus, there is no "correct" or "accurate" translation version, meaning conceptual equivalence may be challenging to achieve.

The second issue, Temple and Young (2004) argue, is the position of the researcher in the translation process. The translation process is not neutral because the translator brings their value systems, understandings and contexts into the translation process, influencing how

they represent research subjects. Researchers can manage validity concerns when translating and transcribing between languages by using insider expertise and knowledge (keeping in mind that there are still power issues around researcher authority and "expert" status) (L. Swartz, 2015). One of my co-researchers spent her childhood in the Elundini area, so she was familiar with the region and cultural context. Although she was not always sure of the exact meaning of some specific isiXhosa terms, she was familiar with the local colloquial terms and dialect, which enhanced the translation and transcription of the data for this area. Validity was further enhanced by having the translations checked by another isiXhosa speaker who grew up in the Eastern Cape. They listened to the interviews in isiXhosa and checked the English translations for accuracy and meaning. Any discrepancies were discussed and clarified with the research team at this stage of the translation and transcription process.

The third issue to which Temple and Young (2004) draw attention is the power hierarchies that exist across languages. Converting a source language (isiXhosa) into English has structural and political consequences. The source language is often subsumed into a dominant colonial language and rendered invisible to fit dominant ways of producing knowledge. As May (2015) contends from an intersectional perspective, significant differences in world views are silenced when fashioned in ways that align with established assumptions and norms. We encountered an example of such a translation dilemma during the translation process. Two of our participants, when describing how their partners had abandoned them because of the pregnancy, used the isiXhosa terms *ukubukulwa* (direct translation is "rejection") or *ukwaliswa* (direct translation is "allergy"). When we asked our participants what they meant by these terms concerning their pregnancy, we were told it is when the foetus hates the father (or the father hates the foetus), and this drives the father away or makes him reject his partner for the duration of her pregnancy. The father's absence is understood as temporary because it is said the father may return after the child's birth.

The question, therefore, was how to deal with this translation dilemma in representing the meaning-making of our research participants. Lincoln and Guba (1986) suggest that a researcher can use informal member checking to ascertain the credibility or trustworthiness of data. Member checking involves testing the meaning with other participants and other community members or through peer debriefing (checking meaning with other professional peers, for example, working in a similar reproductive health context). We checked meaning with our participants by paraphrasing what they meant by these terms and noting any affirmations or corrections. Initially transcribing the data at our accommodation in Elundini (for interview

question purposes), we asked a local isiXhosa woman from the area, who was mature in years and worked for the establishment, what the term meant. She confirmed that this state during pregnancy exists and that it had happened to her when she was pregnant. Notably, there was no singular explanation of this pregnancy term. When we asked isiXhosa-speaking peers about the term, one of them suggested it might be the woman's change in hormones that drives the partner away. The second issue we confronted was how to translate these terms. Considering the power hierarchies between languages and being mindful of how we as researchers represent others, we decided to leave the isiXhosa words as is rather than provide an English translation.

Ethics and ethical research praxis

In this section, I provide details on the various permissions and consent procedures that the research team sought to conduct this research. I then offer some reflections on photo-elicitation in relation to the selected theoretical orientation of intersectionality and some ethical implications for this method's use in the research setting.

Permission and informed consent

A full ethics protocol was submitted to conduct this research project. The ethics protocol included two honours research projects, one master's project and this study. This was approved by Rhodes University's Research Projects and Ethics Review Committee (RPERC) on 25 March 2015 (Appendix 1). Following this approval, permission was sought by the Eastern Cape Provincial Department of Health (ECDoH) to recruit participants at specific clinics and approval was given by letter on 01 June 2015 (Appendix 2 and 3). We also sought permission from clinic supervisors to recruit participants from specific clinics (Appendix 4).

We explained the informed consent process during the first meeting, and once participants agreed to participate in the study. We explained that participation was voluntary and that participants could withdraw from the study at any time should they wish to do so. We also informed participants that they could withdraw any photos if they changed their minds about wanting to include them. We reiterated that their participation or non-participation in the project would not affect the services they receive from the clinic in any way, as we were only using the clinic for recruitment purposes. We then explained the various consent forms. These included the formal consent form to take part in the project (Appendix 6), image consent forms (Appendix 7), image release forms (Appendix 8), and consent for audio-recording of interviews (Appendix 9).

Ethical practice and photo-elicitation

Some ethical concerns are particular to using visual methodologies in research. As suggested by Rose (2012), we followed ethical guidelines regarding issues of informed consent (discussed above), confidentiality and copyright. In addition, we also had to satisfy institutional ethics guidelines in protecting our participants. For example, much emphasis was placed on guiding participants to be mindful of ethical practices when taking photographs of third parties (discussed previously under the data generation section of this chapter). Participants' identity and anonymity are protected because we use pseudonyms in the analysis, and photographs are altered to ensure that facial features or identifiable places are not recognisable. We also explained to the participants that, in terms of copyright (see Appendix 8), their photographs would only be used for research purposes within the ambit of the Critical Studies in Sexualities and Reproduction research programme (CSSR).

However, researchers have raised concerns about how institutional ethics bodies, in enforcing the protection of a participant's identity and confidentiality, can undermine the potential of visual methodologies to generate new knowledge and meaning and adversely affect how participants are represented (Allen, 2015; Langmann & Pick, 2014; Nutbrown, 2011). This is of particular concern when researching vulnerable groups and sensitive topics. Allen (2015) , who researches school-based youth and sexualities, draws attention to how enforcing anonymisation from an ethics perspective constrains participant agency regarding how participants would like to represent themselves. Anonymising images can undermine a participant's dignity and "can be seen as a form of objectification in that a participant's identity is being somehow distorted or even erased" (Langmann & Pick, 2014, p. 712). Secondly, Allen (2015) argues that meanings meant to be conveyed through the image can be lost, primarily through the blurring of facial expressions; images can be reduced to body parts, thereby losing context.

Thus, it could be argued that anonymising or altering images directly contradicts intersectionality's stance on enhancing the visibility of marginalised groups. Although this project used photographs more as a tool to elicit rich narratives, many of the images produced by the participants captured their facial expressions as they reflexively made sense of their pregnancy experience. In hindsight, anonymising the photographs may detract from the depth of the analysis, even though the images themselves will not be analysed. However, the ethical dilemma here is balancing the participants' agency without undermining their dignity. As Langmann and Pick (2014) point out, participants may consent without realising the full

implications of that consent. For example, participants who have never engaged in university spaces will not have any actual conception of how research data are collected, analysed and disseminated. In addition, these authors argue that neither the researcher nor the participant can control precisely how their images will be interpreted once disseminated to a broader audience.

Another ethical concern for researchers using visual methodologies is deciding what images are deemed “appropriate” or “suitable” for selection in the analysis and the dissemination of the final report (Allen, 2015). The image itself may be contentious because of what it depicts. This raises questions about balancing the ethical imperative of protecting a participant from undue harm while respecting the participant's autonomy to take, discuss, and consent to use the picture. Secondly, systems of beliefs held by the target audience and researcher (both personal and political) may have a bearing on how problematically the image may be perceived. Thirdly, similar to particular discourses, the photograph's contents can have broader political implications. For example, a picture may have specific representational effects in perpetuating stereotypical notions of individuals.

This issue was revealed when I presented some initial data analysis and ideas in a work-in-progress colloquium held by my research unit. The Critical Studies in Sexualities and Reproduction (CSSR) research programme holds colloquia for all students registered within the unit. Its purpose is for students to present wherever they are in their research to bounce ideas, seek advice on research difficulties and get feedback from their peers. This is a nurturing and informal environment, but also rigorous and constructive in its feedback. The photograph used as part of my presentation is intimate. It depicted the isiXhosa-speaking participant sitting sideways on her bed in her bedroom, clad in plain underwear, with one hand supporting her and the other hand placed on her pregnant belly. She is looking down at her belly while smiling. This picture, the last one composed together with her partner, sums up her entire happy pregnancy experience:

> Participant: Well, here, after I took all these photos, photos that make my pregnancy easy, I feel free, at ease with my pregnancy. I don’t have any problems. I am holding my pregnant belly because I cannot smile, otherwise I would have smiled.
>
> Researcher: But your smile is beautiful.

Participant: [giggles] See after I told (1) my family and his family, there were no problems or difficulties. So, even when I am sitting alone (1), I don't regret or feel bad about being pregnant with his child. All the photos that I have shown you don't show difficulty in my pregnancy.

Researcher: So, do you feel content?

Participant: Yes, I feel content and enjoying my pregnancy, you can even see in my pose. I am talking to myself, wishing that s/he can grow.

During the question-and-answer session after my presentation, I was asked by some of my research colleagues why I had used that particular picture in the presentation. It had clearly created some discomfort for some in the room. I explained that this was the picture that the participant had taken to sum up a pregnancy that is special to her and, in terms of the methodology, the narrative and picture go together as a unit. Furthermore, unlike other participants, this participant made a particularly noticeable effort to demonstrate how easy her pregnancy was in how she took, curated, and shared her pictures. This spoke closely to the agency she adopted in sharing her pregnancy experience with us, which is why this picture and narrative were included together in the presentation.

Some colleagues argued for being "true" to the data and felt that the participant's choice in taking, selecting and discussing the picture should be respected. However, this did not alleviate other colleagues' concerns regarding what the image depicted. The intimacy of the photograph may have bothered some colleagues in that it may have troubled personally held beliefs around privacy (and from my standpoint, I know that I would be highly unlikely to share a similar picture of myself with a researcher). However, another colleague brought up the political implications of the image in terms of how black women's bodies are all too easily displayed for public consumption. In examining how the oppressions of race, class and gender intersect, Collins (2000) explains how the cultural representations or stereotypes that have been used to label black women (for example, welfare mother, matriarch and hoochie mama) have served to control black women's sexuality by devaluing them to maintain a dominant status quo of white supremacy. Thus, black women are seen as objects and commodities for easy consumption. Both Collins (2000) and hooks (1984) have discussed how the devaluation of black women is also demonstrated by the ease with which black women's bodies are exhibited or put on show, both in popular culture and in academic scholarship. Thus, some audience members questioned the representational effects of this image used in the presentation.

Findlay (2002) explains that employing a reflexive lens involves understanding the unequal power between the researcher and participant in that how the researcher presents participants' accounts has representational effects. Thus, reflexivity can also influence what data the researcher chooses to include in their analysis, creating what she calls "selective silences" (Findlay, 2002, p. 220). This dilemma also demonstrates how researchers must make political choices around the complexities of being committed to intersectionality's visibility project (Hancock, 2016). Enter the reflexivity of *extreme* discomfort (Pillow, 2003). The incident made me question whether I should have presented this picture. Did I too easily display a black woman's body in a thoughtless manner, even though the space within which I presented the image and its accompanying narrative allows for initial conceptualisations, questions and debates in the research process?

The tensions were made apparent between being "true" to the data, in that a participant was demonstrating her happy and easy pregnancy by using a powerful image, but at the same time being mindful of how an image may be viewed by an audience and the potential collective harm[21] (cultural representations and readings of black women's bodies) that may be caused through the use of the picture. The argument that the integrity of the methodology is undermined when images are altered or left out of the analysis is certainly worth consideration in terms of ethical research practice. However, perhaps the question that should also be asked is whether the image and its political and representational entanglements can overpower, undermine, and obscure the meanings of the accompanying narrative to which it is attached.

I am not sure that there is a straightforward answer to this dilemma. However, this example demonstrates some of the complexities of using photo-elicitation. This method facilitates more participant inclusion, power, and voice, yet can simultaneously trouble fulfilling intersectionality aims. I decided this picture would not be used in the analysis due to its uniquely intimate nature. This also meant that all other photographs needed to be carefully considered as to whether they should be included as part of the analysis or not. Pictures were only included if they and their paired narrative fitted within the overarching analysis of the

[21] Individual harm would not be experienced by the participant as the data are anonymised.

findings chapters. These included pictures that showed objects, symbolism or everyday activities. Pictures that depicted pregnancy embodiment were carefully considered in light of the above discussion. Fortunately, the photos included in the analysis chapters depicted mostly objects and everyday activities.

Conclusion

In this chapter, I discussed how narratives have traditionally been closely attuned to intersectionality orientations and praxis in that much value is placed on telling stories that reflect social conditions (McCall, 2005). Narrative research was used in this research project to collect women's stories about their experiences of support during pregnancy. This method helps elicit rich accounts of an event or lived experience and surfaces the socio-cultural, economic and political aspects that may shape that experience (Riessman, 2008).

I then provided a rationale for the usefulness of using photo-elicitation to induce the narratives, as it is a method located within feminist approaches oriented toward shifting power between the researcher and participant. I provided details on incorporating the photo-elicitation method into the narrative interview format.

This chapter also covered the procedures for collecting data for this research project, including sampling criteria, participant recruitment and description, and how the research team prepared for data collection. Throughout the chapter, I reflected on the research experience collecting data for this project. I discussed some of the complexities encountered during the research process regarding how ethical practice might be challenged concerning the selected theoretical framework. These complexities involved being cognizant of how photo-elicitation, the recruitment process and the translation and transcription of the interviews can trouble intersectionality aims. I also provided some details on how these complexities were managed.

One of the many critiques directed at intersectionality is that it is seen as methodologically deficient because it does not offer a step-by-step guide on applying an intersectional approach or analysis (Cho et al., 2013). In the next chapter, I discuss how I developed the analytic procedure for examining narratives of pregnancy supportability.

CHAPTER 7

Building a pregnancy supportability analysis informed by intersectionality and positioning theory

This chapter outlines how the analytical procedure and the interpretation of the data for this research project were conceptualised and implemented. Although there may not be a step-by-step way to conduct an intersectional analysis, there are certain key tenets that are considered critical when conceptualising one, and these include conducting a multi-level or structural analysis, being explicit about managing the complexity of the analysis in terms of its treatment of social dimensions; examining lived experience in relation to power; and adopting a reflexive stance throughout the entire process (Chadwick, 2018; P. H. Collins & Bilge, 2020; May, 2015; McCall, 2005). Therefore, I incorporate these key tenets into this research project's analytical design and procedure.

I make a case for bringing the analytic perspectives of intersectionality, a template analysis and a positioning analysis into conversation with each other. The aim is to allow for an open-ended exploratory analysis of support during pregnancy, simultaneously shaped by intersectionality's empirical aims. In the first phase of approaching this analysis, I explain how I conceptualise narratives. I incorporate overarching social narratives and micro-narratives into my analysis. In addition, I discuss why I have chosen to examine broader features of talk (what participants *do* with their narratives) rather than focusing on the intricacies of talk or how narratives might be structured.

Next, I outline how I applied a deductive template analysis (Brooks et al., 2015; King, 2004; King et al., 2018), which helped me code data according to the elements that make up the supportability framework. I also discuss some limitations of using a template analysis from a social constructionist and discursive psychology perspective, and how I address these limitations by incorporating a positioning analysis within the template analysis.

The template analysis enabled a multilevel analysis, but incorporating a positioning analytic was necessary. A positioning analysis also allows for a multilevel analysis because it is understood to be the conduit between agency and structure (Van Langenhove, 2017). I explain how I conceptualise self/reflexive, interactive (person-to-person, person-to-entity) and imperative positioning (social characteristics) for this study. I outline how I incorporated them

into the template because they align with an intersectional orientation of examining agency in relation to structure. I also explain how I extended the analytic use of positioning by incorporating Wilkinson and Kitzinger's (2003) conceptualisation of positioning to fulfil intersectionality aims.

Although positioning theory enables an analysis of agency and structure, provides glimpses of the power dynamics inherent within a social interaction, and surfaces how social categories may be used in talk, it still falls short in enabling an analyst to trace how social dimensions and relations of power are *mutually co-constitutive* which is considered a hallmark of intersectionality theory (P. H. Collins, 2015). I, therefore, argue for superimposing Collins' (2000) domains of power thesis onto the narrative positioning themes identified in the analysis. This was done to explicitly understand how the intersection of structural power dynamics may shape the discursive positionings deployed by the speaker. Intersectionality and narrative theorists raise criticisms about analysing data thematically, and I address two of these concerns in this chapter.

Moving on to analysis and interpretation, I explain the steps I followed in conducting the analysis to answer my research questions. This included four iterative phases: data familiarisation, applying the supportability positioning template, identifying normative constraints and enablements and superimposing the domains of power analysis over the identified micro-narrative-positioning themes.

Research questions

The research questions that this dissertation aims to answer are as follows:

How do women's constructions of support speak to pregnancy (un)supportability?

[1] How is this pregnancy defined in personal terms in relation to (un)supportability?

How are self and interactive subject positions taken up or resisted in describing the personal emotional, physiological, cognitive and behavioural aspects of the supportability of the pregnancy?

[2] What and how are (un)supportive micro-level interactions depicted?

How are self, interactive and imperative subject positions taken up, imposed, suggested or resisted in descriptions of micro-level interactions?

[3] What and how are (un)supportive macro-level issues embedded or referred to directly in women's talk?

How are entities positioned in the narratives? What normative constraints are implicitly or explicitly referenced in the talk?

[4] How do power relations operate in women's constructions of support during pregnancy, and how do they shape the uptake and ascription of subject and entity positions?

Conceptualisation of narratives

There is considerable debate within the literature about what makes a narrative and what does not (Riessman, 2008). There is not enough space in this thesis to engage with these arguments, so I have instead looked for connections and overlaps between an intersectionality orientation and particular approaches to narratives. Narrative analysis has often been used to understand how identities, experiences and social meanings are constructed within a given social interaction. Chadwick (2018) contends that the analytic approach to examining narratives is not always clearly articulated when combining intersectionality theory and narrative theory. The author argues that the narrative analytic approach should "enable the exploration of structural dynamics as well as multiple articulations of power/resistance" (Chadwick, 2018, p. 2).

Scholars who conduct their research in discursive psychology have developed narrative analysis methods that examine the interrelationships between micro (agency) and macro (structural) contexts. For example, in Mavuso's (2017) research on narrated experiences of the pre-termination of pregnancy counselling within the South African public healthcare system, the author distinguishes between identifying two narrative modes across the data set: canonical narratives and micro-narratives. Canonical narratives are dominant social narratives and are conceptually located on the macro level of talk, such as the "dominant coupledom narrative" (Reynolds & Taylor, 2005; Taylor & Littleton, 2006). This social narrative suggests an ordered heterosexual life stage progression of dating, getting married and then having children. These narratives act as common knowledge frameworks that guide or dictate how individuals make themselves understood by others within a given social interaction. They indicate how various social practices should unfold. From an intersectionality perspective, dominant social narratives can give insights into how structures impose normative constraints on people's lives.

In contrast, micro-narratives or little narratives ("*petit récits*"), according to post-modernist theorist Lyotard (1986), are diverse and variable because individuals who story their own experiences do not necessarily identify with dominant social narratives; it is through these small narratives that the legitimacy of dominant narratives can be challenged. Small narratives or micro-narratives have thus been conceptualised by scholars as highly personalised (self-narratives), contextually specific to a given social interaction (research interview), an event (pregnancy), community (pregnant women support group) or experience (having an unintended pregnancy) (Blommaert, 2006; J. Mavuso, 2017; O'Donovan, 2006; Payne, 2013). For example, a married woman with an unplanned pregnancy may uphold the "dominant coupledom narrative" by constructing this micro-narrative; "This pregnancy is not a problem for me because we are married". In contrast, a single pregnant woman's micro-narrative may talk against the coupledom narrative by claiming, "The child will still grow without a father" (as some of the participants did in this study; see Chapter 10). These contrasting micro-narratives not only give insights into how individuals are differently socially positioned but also how different acts of agency may be deployed by participants given the normative constraints that govern their lives.

According to Mavuso (2017), the advantage of analysing micro-narrative constructions of individual experiences is that they offer the opportunity to highlight how individuals construct and represent experiences or events in variable or alternative ways in relation to the dominant cultural narratives that shape them; micro-narratives can make individuals visible. Therefore, micro-narratives indicate agency (or lack thereof), adherence or resistance to social narratives and can signal social change. This aligns with intersectionality perspectives on social marginalisation or transformation (May, 2015). As with Mavuso (2017), I distinguish between identifying micro-narratives and dominant social narratives (which can operate as normative constraints) within my dataset as part of my analysis procedure.

In the analytic procedure, I take into account another consideration, which is how the researcher also plays a part in shaping the narrative constructions of pregnancy support. As Riessman (2008) points out, a narrative elicited within an interview interaction is a co-construction between the researcher and the participant. Not incorporating this aspect in my analysis could overlook how we, as researchers, influenced the positioning work done by the participants when narrating their accounts. For Taylor and Littleton (2006), incorporating a positioning analytic within their narrative-discursive method made the researcher's contribution to the interview process more visible. Their approach considers that the

participant engages in positioning work with both the immediate interview context and a wider perceived audience in mind. Paying attention to how participants might be positioning us as researchers and themselves in relation to us while telling their story makes the researcher's role in the interview transparent. This is fundamental to an intersectional orientation, whereby researcher reflexivity is required (May, 2015). I now turn to a discussion on how I incorporated, from a social constructionist standpoint, the various theoretical underpinnings of the supportability framework, positioning theory, and intersectionality into an analytic method.

Developing a template analysis

The supportability framework underpins the design of the entire research project, which means that the analysis needs to be guided by the supportability framework. I decided a template analysis would be a good fit for organising and coding data in the analysis phase. In this section, I draw from Nigel King's (1998) approach to template analysis to examine how narrative constructions of pregnancy support operated and were interconnected across the individual, micro- and macro-levels of support as envisioned by the design of the supportability framework. King (2004) maintains that template analysis is a flexible technique because it is not prescriptive on how to conduct the analysis, and it allows researchers to fashion their own type of analysis based on their theoretical aims.

Brooks et al. (2015) liken a template analysis to a thematic analysis, but a key difference is that this form of analysis lends itself to a structured approach to analysing data. When conducting a template analysis, the researcher approaches the data set with a set of *a priori* themes or topics, and data is coded around these pre-selected themes. King (2012) suggests two possible ways to develop a template using *a priori* themes. Firstly, using an interview schedule as a guideline to develop a priori themes is considered useful. I could not apply the template analysis in this manner because I did not collect data using an interview schedule. I collected narrative data using a SQUIN question or instruction. Secondly, King suggests that an analyst can start inductively with the data and develop *a priori* themes from a few initial interviews to develop a template. This template is then applied to the rest of the dataset. The author cautions that the analyst should be flexible enough to amend the template if an interesting feature of the data needs to be incorporated into the analysis. This approach to developing *a priori* themes was not quite suitable for my purposes either, because I wanted to use the supportability framework elements as the *a priori* template. However, I was open to amending the supportability framework should there be data items in the interview that are not

covered by the supportability framework elements. Therefore, the elements of the supportability framework became the *a priori* "topics" upon which I analysed my data.

A template analysis also offers flexibility in the coding process; one can code according to a hierarchy and conduct parallel coding (King, 2004). The structure of the supportability framework lends itself to both of these forms of coding. For example, extracts of interviews can be coded across multiple *a priori* themes. An extract that speaks to a health interaction on the micro-level of the supportability framework can also be coded on the macro-level under health policy and possibly social practices. Parallel and hierarchical coding allows an analyst to see the connections, interactions and relations between different aspects of pregnancy support. In addition, King (2012) suggests that this form of coding facilitates the identification of integrative themes. These are themes that become salient across the entire dataset and are related to and interwoven with other themes. A template analysis applied in this manner thus facilitates a multi-level analysis that provides a platform for the analyst to trace connections and relationships within and across the dataset. The strength of the supportability framework is that it offers the opportunity to conduct a multi-level analysis to gain insights into the overall supportability of the pregnancy; that is, its conceptualisation insists on an examination of both the individual pregnant woman and her social context. Therefore, I argue that using a template analysis developed from the supportability framework can facilitate an intersectional multi-level analysis because it incorporates both agency and social context. Therefore, the entire data set for this project was allocated to *a priori* themes based on the personal, micro and macro elements of support.

King and Brooks (2017) assert that a template analysis is a tool to help the researcher engage with and interpret their data; the development of the codebook or final template is thus not necessarily the end goal of the analysis. Putting together a final, polished template was not my aim. I wanted the structure of the template to help me focus in a particular manner on my data in relation to the supportability framework (see also positioning analysis section). Thus, my analysis is considered deductive because it seeks to impose my theoretical aims in a particular way over the data (Braun & Clarke, 2021; King & Brooks, 2017). The question arises, then, as to whether using a template analysis can achieve intersectionality aims by imposing *a priori* themes on data; those who adopt intersectionality orientations are wary of excluding knowledge simply because it does not speak to an *a priori* theme.

Therefore, when approaching an analysis from an exploratory and intersectional orientation, the difficulty arises in trying to balance both by allowing for an open-ended way of

analysing data and imposing some form or structure on the data to conduct a coherent analysis. Joffe (2012) maintains that a qualitative analysis that uses both deductive and inductive approaches to analysing a dataset can produce a high-quality analysis. A template analysis is flexible because it allows an analyst to locate their analysis within a continuum of an inductive-deductive analysis (King et al., 2018). The supportability framework does present a somewhat realist and systems-oriented approach to the analysis as it focuses on personal, micro, and macro systems of support, thereby making the analysis deductive. Although the supportability template is structured, I also wanted to allow for an inductive way of analysing the data and my template needed to allow this. The elements that make up the supportability framework are very broadly defined, such as the healthcare interaction, and therefore do not impose too much structure on how the data are allocated to these codes. Thus, by selecting *a priori* themes that were broadly defined and by using a flexible approach of amending codes to the template based on a data-driven analysis, concerns of overlooking important aspects of the data or imposing too much structure on the dataset through the imposition of the *a priori* themes were addressed. Coding the data to the supportability framework elements gave me a contextual overview of how participants spoke to the various facets of support and enabled me to build and write up the individual case studies of the participants (see analysis Chapter 8 on the participants' case studies).

Although Brooks et al. (2015) consider using a template analysis a flexible way to examine various texts, these authors caution that researchers must carefully examine their epistemological position before choosing this analytic form. They claim that researchers utilising template analysis are more orientated to realist or positivistic standpoints. For example, they assert that a template analysis is unsuited to discursive approaches because they require a far more detailed analysis of talk than can be captured by the *a priori* codes of a template analysis. Furthermore, the authors contend that a template analysis cannot capture the multiplicity, contradictions and ambiguities of meanings that may be given in an individual account. These concerns about analysing data thematically are similar to the critiques by narrative and intersectional theorists and are addressed later in this chapter.

Nevertheless, I argue that a supportability positioning template can facilitate the examination of discursive constructions of pregnancy support. This project's approach was to focus on the broader features of talk in narratives (i.e. what people are generally trying to accomplish with their narrative) rather than focusing on the intricacies of structuring or turn-taking in talk (for instance, examining multivocality in individual accounts is not prioritised in

this analysis). I propose incorporating a positioning analysis within the template analysis to address this concern so that discursive constructions of pregnancy support can be analysed. This will allow the analysis to become inductively driven and capture participants' discursive strategies by analysing their positioning work. Building the positioning analytic is explained next.

From positioning theory to a positioning analytic

There are different debates and ways in which a positioning theory can be used in an analysis (see for example, Bamberg, 2020; Deppermann, 2015; Kayi-Aydar, 2021; Taylor & Littleton, 2006), but space constraints in this thesis do not allow for an exploration of these debates and approaches. I, therefore, focus on how I translate positioning theory into a positioning analytic for my project.

In my theory chapter, I explained how different modes of positioning have been conceptualised by scholars, such as imperative or forced positioning, person-to-person positioning, positioning by social entities, and self-positioning, which can provide insights into the dynamics of social interaction (Harré & Moghaddam, 2003; Harré & Van Langenhove, 1999; Van Langenhove, 2017). In addition, I explained how these authors have proposed that these modes of positioning can surface how agency (micro) and structure (normative constraints) are interconnected, how power dynamics might be at play through positioning tactics deployed through talk, and how the material and discursive are part of one another. I argued that these aspects of positioning theory align with an intersectionality perspective.

According to Jeanne Marecek (2015, p. 180), “Discursive psychologists investigate social processes and interactions, largely through the detailed analysis of people’s talk”. She argues that being interested in the action-orientated nature of talk and how talk functions aligns with an intersectional orientation. Therefore, the narrative accounts in this study are analysed not in terms of their content (what people say) but in what people *do* with their talk. Concerning this point, Marecek (2015) maintains that both intersectionality theory and discursive psychology are less interested in capturing descriptions of social categories but are more concerned with what types of meanings are ascribed to these categories. In other words, what do people *do* with social categories when they name, index or invoke them in their talk? From an intracategorical intersectional standpoint, social categories can be used strategically and critically within an analysis, as McCall (2005, p. 1783) states: “The point is not to deny the importance – both material and discursive – of categories but to focus on the process by which

they are produced, experienced, reproduced, and resisted in everyday life". This is important from the social constructionist position adopted in this project. Pre-defined social categories (such as a class and race analysis of pregnancy supportability) were not used as a basis upon which to conduct this analysis. Instead, the project focuses on the event of the pregnancy and, in so doing, allows the labour done in narrative accounts to reveal the process of how social categories may be used in talk. Similar to intersectional stances in which social categories are understood to be contingent upon one another (Hancock, 2016), discursive approaches are concerned with context-specific interactions. They can, therefore, facilitate an understanding of how historical and political contexts and the present interaction shape the meanings of social categories.

Thus, Wilkinson and Kitzinger's (2003) approach to theorising positioning theory was instrumental in applying the intracategorical intersectional approach. Moreover, this positioning analytic also considers how attributes or descriptors are assigned to social categories (for example, single mother). This is important from an intersectionality perspective because social categories are not seen as hegemonic and are informed by social contexts (Yuval-Davis, 2006). By examining how attributes are linked to social categories, we can glean variances in how social categories are constructed similarly or differently in talk. In applying Wilkinson and Kitzinger's (2003) approach to positioning, consider the following extract from one of the participants in giving a narrative account of an unplanned pregnancy:

> Researcher: So, does that mean that this was an unplanned pregnancy?
>
> Participant: The baby was not planned but because of my age:: and considering that at least I have completed school::, I can work for myself::, I'm not like someone or a child in Grade 11 (.) so termination was not an option.

The participant explicitly names the social category "age" (self-positioning) as indicative of when it is acceptable to have a child. The participant indexes "teenage pregnancies" (interactive positioning) as unsupportable and her pregnancy as more supportable by affirming that she has "at least" completed school. At the same time, by positioning herself as independent (self-positioning) because she can earn an income (I can work for myself), being socio-economically secure (imperative positioning) is also indexed as a prerequisite for appropriate childbearing. Dependency on others is a social attribute assigned to the positioning of adolescents, thereby linking being pregnant with requiring independence. Social entity positioning also takes place, whereby the school is indexed as an unsuitable

space in which to have a pregnancy, and the social practice of abortion is positioned as justified only for those who are too young to reproduce. At the same time, abortion is invoked as unjustified for those who are of an appropriate reproductive maturity.

In my theory chapter, I described how Wilkinson and Kitzinger's (2003) approach to positioning facilitates an examination of power. These scholars see power and oppression as accomplishments of talk. That is, by a speaker actively choosing to name, invoke or index a social category in their talk on a micro-level, this act in talk serves a purpose in upholding, resisting or re-configuring major social divisions. Using a positioning analytic in this manner, one can get glimpses of how power operates through the positioning tactics deployed on a micro-level. In the example extract provided, the participant interactively positions her unplanned pregnancy as more legitimate than that of someone who is pregnant and still attends school. Power on the macro-discursive level operates by normalising the stigmatising effects of having a child at a young age, thereby positioning these pregnancies as unsupportable.

Analysing mutually co-constitutive social dimensions

Intersectionality raises the fundamental methodological question of how to analyse mutually constitutive processes (Christensen & Jensen, 2012). Although Wilkinson and Kitzinger's (2003) positioning analytic allows researchers to consider how social categories may be used in narrative accounts, it does not show how various social dimensions, divisions or systems might mutually co-constitute each other within this discursive formation of pregnancy support. For example, an intersectional approach rejects single-axis thinking in that not only the social categories of "age" or "economic ability" are operating in this participant's talk. The question, therefore, remains as to how the operation of mutually constitutive social dimensions, social divisions and systems of oppression or marginalisation should be managed as part of an analysis.

Conducting an intersectional analysis requires interpretative work on the researcher's part because of the implicit workings of social dimensions that contribute to how the account is shaped (Bowleg, 2008). In discussing some of the methodological challenges of intersectionality, Sirma Bilge (2009) draws attention to the difficulty of how to construct an inductive analysis that is compatible with intersectionality's empirical aims of illuminating the interactive and the non-additive (or simultaneous) effects of social dimensions as part of the findings. In an inductive analysis, the author draws attention to how individual accounts may

mention some social dimensions but not others, even though individuals are located in multiple interacting social locations. Thus, specific social dimensions will go unmarked or unacknowledged within an account. This is also evidenced by the example extract provided above.

Bilge (2009) suggests, firstly, conducting an inductive analysis and, secondly, imposing the theoretical aims of intersectionality on the findings by using a more deductive framework. In her work on masculinities (which focuses on the views and aspirations of second-generation Canadian youth born of immigrant parents), she first conducts an inductive thematic analysis of a case study where she looks for patterns or themes in the individual account. In her study, race or racialised practices were salient in the accounts. These practices were, therefore, identified as themes even though race was not *a priori* assigned as a unit of analysis. However, an intersectional orientation acknowledges that race does not operate alone; it is co-constituted or interacts with other social dimensions. Therefore, in the second step of her analysis, Bilge (2009) uses a generic intersectionality template in which she imposes the social dimensions of race, gender, class, ethnicity, sexuality and so forth over the identified themes. For example, she imposes the lens of class on an identified racial theme by asking how class informs the account or which dimensions of the experience are interacting with class in the account. The author does the same for other social dimensions if relevant. Bilge (2009) concludes by asserting that, in adopting this approach, insights were gained from how the social dimension of race works through class, gender, sexuality and so on. The author maintains that analysing data in this manner can provide alternative insights as to how masculinities are constructed compared with the limitations of applying a gendered-only lens to understanding masculinities.

I impose intersectionality's empirical aims over the positioning analysis differently from Bilge's (2009) method of applying other social dimensions over inductively analysed data. Firstly, the supportability framework facilitates examining the interactions of support on an individual, micro- and macro-level through women's discursive constructions of pregnancy support. Interactions of support are, of course, different to the interactions of social dimensions. However, the value of examining the various support interactions provided an understanding of how a pregnant woman is intertwined with her social context, which is fundamental in adopting an intersectional orientation. Therefore, using a nested approach of conducting both a template analysis (guided by the supportability framework) and an inductive analysis (using a positioning analytic) simultaneously aided both the identification of normative

constraints used in constructions of pregnancy support and assisted in revealing the embeddedness of the pregnant individual and her social environment.

Secondly, and referring to the extract example provided above, within the South African socio-cultural context, multiple situated social locations and master characteristics shape the participant's account. Although the participant uses the social category "age" to legitimate her unplanned pregnancy, this participant is black, unmarried and unemployed. Thus, by introducing "assigned" master categories of the participant into the analysis at this stage, one can show how, through her narrative account, the relationship between race, relationship status, age and economic status may play a part in shaping this account. Given her other assigned master social characteristics, this participant has no alternative but to use her age to justify her pregnancy.

What this analysis is not telling us yet is quite how the interactive or mutually co-constitutive effects of these various social dimensions are implicated in this participant's discursive constructions of pregnancy support. Paying attention to how power operates may provide some answers. As mentioned in the theoretical chapter, the supportability framework and the intracategorical intersectional approach do not specifically engage with aspects of power. To overcome this limitation, I incorporated Collins' (2000) domains of power thesis as part of the analysis (discussed in the theoretical chapter). This approach offers the opportunity to highlight how the effects of interpersonal, disciplinary, cultural and structural power may collectively shape women's talk about pregnancy support that is on offer (or that is challenged) and have a bearing on the narrative positionings that are taken up when providing accounts of pregnancy support. The domains of power thesis supplements the supportability framework because it also incorporates micro and macro articulations of power. Thus, a micro and structural analysis of pregnancy supportability in relation to the power dynamics (that enable or constrain it) is facilitated.

For example, in referring to the extract example provided above, research points to how "teenage" pregnancies are both racialised and viewed as a social problem within the South African social landscape (Macleod et al., 2020; Macleod & Durrheim, 2002) . One can identify how systems of power operate through and in relation to one another to uphold these normative constraints of socially inappropriate teenage pregnancies by using the domains of power thesis: interpersonal power operates by the participant positioning herself in relation to young mothers; she uses her advantage of age to adopt a position of relative privilege to that of a young person who is pregnant at school. Disciplinary power is seen to operate through

disciplining women as to when it is (or is not) appropriate to have a baby, whereby early reproduction is socially frowned upon. Cultural or hegemonic power operates through the stigmatising effects of stereotypical notions of teenage pregnancy. Structural power operates by positioning institutions of education as unsuitable social spaces for young pregnant bodies. Thus, one can trace the productive forces of these forms of power as they mutually reinforce one another in positioning the pregnancies of young mothers, who are mostly black in the South African context, as unsupportable.

Based on the rationale for my analysis provided above, I argue that by applying intersectionality's empirical aims through the domains of power thesis on the data, one can capture both the power dynamics related to pregnancy support and show how the mutually constitutive nature of social dimensions may enable or constrain the supportability of the pregnancy.

Critiques and limitations of analysing data thematically

In the previous section, I drew together some of the features that a template analysis, positioning analysis, and intersectionality share in terms of both being open-ended and flexible in producing and examining knowledge around pregnancy support. However, two critiques against analysing data thematically need to be addressed concerning the approaches used in this research project.

Firstly, it is generally understood that the purpose of a template analysis and analysing data thematically is to examine aspects across an entire data set rather than analysing single accounts. Therefore, it is argued that contradictory knowledge, subject positions, and anomalies articulated through single accounts will be overlooked (Braun et al., 2015; Buitelaar, 2006; Chadwick, 2018). This is not ideal for scholars within intersectional narrative traditions as they emphasise multivocality within individual accounts (Buitelaar, 2006; Chadwick, 2018). The question, then, is whether a template analysis conducted across a data set generated through narrative methods is a suitable platform for analysing variability within and across multiple accounts. Braun and Clarke (2006) argue that most qualitative data require some form of thematic coding. Although this approach may not facilitate an examination of the intricacies of talk, thereby illuminating the multiplicity and contradictory nature of an individual account, Joffe (2012) argues that the generation of themes from data does provide the opportunity to understand intra-group variability. The author maintains that the purposive sampling strategy used in relation to the research question aids in this process. For example, for purposively

selected participants sharing the characteristic of pregnancy, one may identify common normative constraints at play concerning partner support. However, pregnant participants speak to these normative constraints in multiple and contradictory ways when constructing their partner's supportiveness (see, for example, how individuals may utilise the dominant coupledom narrative in different ways from the example provided in the first section of this chapter). This is because the positioning analytic shifts from focusing on describing the individual to focusing on discursive manoeuvres used within and across the accounts. The above-mentioned concerns are therefore circumvented.

Secondly, and related to the point above, analysing data thematically has been critiqued in that the researcher risks categorising and essentialising research participants' experiences (Braun et al., 2015). Intersectional approaches reject the reification of experiences outright (May, 2015), and any form of essentialism is entirely at odds with the intracategorical intersectional approach, which, in part, specifically aims to demonstrate the heterogeneity of experiences concerning a specific event (McCall, 2005). Thus, this raises another question of how to avoid the trap of categorising individuals through theme development. The application of the positioning supportability analytic is applicable here. Various positioning tactics will be used within and across these accounts. By focusing on generating themes based on what positioning micro-narratives accomplish when deployed in talk (not whom they describe), the researcher avoids the pitfall of categorising people's lived experiences in personal terms. I now turn to how I conducted my analysis, using the positioning supportability template I developed.

Analysis and interpretation

The analysis procedure is outlined below. Although it is presented in phases, the analysis was an iterative process requiring flexibility and reflexivity as the analytic process unfurled. Thus, certain phases were returned to as and when notable features of data were identified or when certain analytic decisions needed to be reflected upon more closely.

Phase 1: Data familiarisation

In this phase, I familiarised myself with the data. This was an emotionally challenging process because many of the participants' stories were of extreme hardship; the conditions surrounding many of the pregnancies were unfair and unjust. Often, I had to step away from this process and give myself some space. Apart from feeling deeply saddened about what happened to some participants, what concerned me significantly was the sheer depth of anger

that I felt. I was cognizant of how my feelings may inform how I analysed the data and what I wanted to present of the data.

In getting to know the data, I made copious notes and reflections on a Microsoft Word document and mind maps in notebooks about specific features of participants' talk. Chadwick (2021) asserts that engaging with one's emotions while working with the data can provide useful analytical insights. I noticed where I felt anger, sadness, frustration, hope and amusement. I also noted if I felt agreeable or disagreeable, irritated or empathetic with aspects of participants' stories. For example, I felt notably exasperated with some aspects of middle-class participants' narratives (thus indicating that I was comparing oppressions or social advantage from a subjective standpoint). I used Nvivo coding software to allocate chunks of data to "topic talk" to get a sense of what content relating to support was covered across the elements of the supportability framework. I noticed the context surrounding pregnancy stories varied, but similar topic talk was identified. Participants elaborated on pregnancy wantedness and timing; (non)acceptance and (non)judgement of the pregnancy by support networks; various forms of instrumental, emotional and informational support provided from support networks; gendered partner dynamics concerning how partners were present or not during the pregnancies; future plans for when the infant was born; financial concerns about providing for the future child; and, how participants navigated the health system and complied with health directives.

During this process, I sensed that participants were trying to validate their pregnancies or behaviours by explaining or accounting to us, as the researchers, in some way. Braun and Clarke (2021) caution against latching on too closely to an initial idea about the data, and I was mindful of this. I tried to keep open to other aspects of the data by writing down contextual summaries under each element of the supportability framework, noting differences and similarities between the participants and potential absences in their talk. The contextual summaries came to approximately 60 pages, as the supportability framework covers a broad array of pregnancy support issues, which was simply overwhelming! I was deeply concerned about how I would "control" or speak to all this data. A week or two later, I re-read through these summaries and caught myself making "claims" about the data. Where I made "claims", I added review comments in the margins to critique them and cautioned myself that I would need to be sure that I could back these claims up with evidence from the complete analysis and extracts.

Another aspect that became clear during the familiarisation process is that pregnancy is a highly dynamic event. The substantial physiological and psychological changes that occur

over nine months of gestation meant that each pregnancy phase or trimester provided different experiences and meanings for the participants. Participants reflected, questioned, resisted and re-oriented themselves toward their pregnancies and support networks as their pregnancy progressed. Their stories shifted backwards and forwards temporally (especially those with second pregnancies) and were sometimes contradictory. Participants did not necessarily start at the beginning of their pregnancy journey when discussing the pictures they had taken. For example, many started their narratives by showing pictures of daily embodied pregnancy practices.

Given the broad reach of the supportability framework in that it speaks to many facets of support (I felt like I was looking at support through multiple angles of a prism) and the different points in their pregnancy where participants started telling their stories, together with the different subject positions from which participants spoke concerning whether they were talking about the healthcare interaction, their partners or families, it is no wonder that I felt overwhelmed by the variety of ways one could potentially analyse the support interactions of the pregnancy. The data seemed incoherent and fractured to me, and I had to remind myself that the data analysis process, as Braun and Clarke (2013) maintain, can be messy. I then wondered if it would help to analyse the participants' narratives by not only using the supportability framework as a template but also alongside a broad pregnancy timeline. I surmised that breaking the analysis into two parts, which were (1) pregnancy discovery and acceptance, and (2) pregnancy management, might help me in analysing the data more coherently. This also dovetails closely with the reproductive justice framework (Ross & Solinger, 2017): the right to have/not have a child and the right to carry a pregnancy in a conducive environment. Analysing the data this way was instructive because it laid the foundation for surfacing the complex, multiple, and shifting support dynamics between the pregnant participants and their support networks as the pregnancy progressed.

Grouping data into topic talk was helpful in really getting to know the data from a descriptive perspective, in other words, what participants talked about. This process is usually considered a trap into which researchers fall when the intended analysis is not descriptive but meant to be more interpretative and theoretically driven (Braun & Clarke, 2021). Indeed, this was partly true in my approach to the data; however, playing with the data in this manner helped me to get to know what was said across a broad range of support aspects. Nevertheless, I knew that the analysis needed to pay more attention to participants' positioning

work concerning themselves, others, and entities in talk. This is where I moved on to phase two of the data analysis, which involved developing the supportability positioning template.

Phase 2: Applying the supportability positioning template

Sufficiently steeped in the data and having split the analysis into two broad pregnancy timeframes, I developed and refined a supportability positioning template, which guided the whole analysis. This formed the inductive part of my analysis. My objective was to identify micro-narratives in participants' talk and then attach either a self, interactive or imperative position to the micro-narrative. The idea of attaching a position to the micro-narrative was to facilitate an examination of what participants were doing or accomplishing with their talk. These identified positioning micro-narratives were then deductively coded across the elements of the supportability framework. The supportability positioning template for the first phase of the pregnancy (acceptance) is shown in Figure 2.

Figure 2: Supportability positioning coding template

The development of the template involved setting up the supportability framework as the main skeletal template or codebook (Brooks et al., 2015) , consisting of the macro, micro and individual levels of support. I then inserted the positioning analytic levels according to reflexive or self-positioning, interactive (person-to-person) positioning, imperative positionings and entity positionings (located on the macro level of the template). Although the template is deductively informed (guided by the supportability framework), it nevertheless allows for an open-ended way of examining the data and approach to coding the data. I then inductively coded data by identifying micro-narratives. An example of a micro-narrative is "I am the right age to have this child". I then assigned subject positions to it that captured what the participant was "doing" with the statement. I call these positioning micro-narratives, represented thusly: [position]_micro-narrative (reproductively mature_I am the right age to have this child).

However, during this process, I found that I needed to crystallise what I understood or defined as reflexive/interactive/imperative positions based on my theoretical lens. In addition, it can be argued that all forms of positioning are interactive because they require an audience to affirm and enable their story to be intelligible (Taylor & Littleton, 2006). Moreover, as Davis and Harré (1990) argue, positions can be multiple or layered within the narrative's trajectory and interpreted differently by different audiences. Considering that I was interested in what participants were *doing* with their narratives, the positioning they engaged in needed to capture what they were trying to accomplish in their talk. I therefore refined the various positioning actions as follows:

[1] Self/reflexive-positioning: I understood these positions to be self-descriptions using I-statements. Alternatively, how the participant *actively* and *directly* positioned themselves in relation to themselves (the self), others and entities in their social support networks. There were two forms of self-positioning: in relation to the self and in relation to others.

Self-positioning in relation to the self: Although positioning work always happens within the context of others and the social environment, participants did position themselves in ways that focused on the self despite others in their social networks. These subject positions were related to I-statements such as I wish/want/think/(dis)like/believe/will [insert statement] for myself. This type of positioning surfaced reproductive agency in relation to the self: how participants were able to make decisions about their pregnancy on their terms. This usually included notions of bodily autonomy:

[Individual self-position] _micro-narrative

Autonomous decision-maker _At the end of the day, the decision is mine because it is my body that will bring the baby into the world (Sandra)

Here, Sandra adopts a position of self-autonomy in deciding to go ahead with her pregnancy and does not require others to help her do so, whereas consider the following:

Self-positioning in relation to others/entities: These self-positions and I-statements were adopted in relation to a social support member or social entity, for example:

[Self-position] _micro-narrative

Self-sufficient _I do not need anything from him if I have a job. (Thandeka)

Here, Thandeka self-positions herself, using an i-statement, in relation to her partner, who denied paternity of the pregnancy.

[2] Interactive (person to person/entity) positioning: This form of positioning involves participants positioning others and entities. In some instances, a support network member is merely positioned by the participant without the participant necessarily having to take up any position themselves. This was easy to code because it was a straightforward positioning of the other.

[Interactive position] _micro narrative

Child Caregiver _My brother's wife said she will help look after the baby when it is born. (Linda)

However, a participant often interactively positioned a support network member in response to a *perceived* position that had been imposed on the participant by that support network member, such as the following example:

[Interactive position] _ [inferred position on participant] _micro-narrative

Bossy _ Inexperienced _ My mother-in-law lectures me on what I can and can't eat during this pregnancy, but I do know what I'm doing! (Tayla)

In the above example, the participant's position as "inexperienced" is inferred; it is a form of forced positioning by the support network member. What is useful about this way of

coding is that it helps one identify interpersonal power dynamics between the participant and their support networks and structures and can surface the normative constraints (see next data phase) that may be inherent in this talk.

Whereas Harré et al.(2009) also considered how social entities (such as governments) position one another, or how they may position individuals, less attention has been paid to how individuals may position social entities and practices. I therefore expanded the positioning analytic to include this form of positioning. Coded to the macro level of the supportability framework, entities included positioning social institutions such as schools, clinics, the health system, and the home and social practices such as romantic relationships, abortion, and cultural practices. Entities and social practices were represented in the coding template as follows:

> interactive position_ [social entity] _micro-narrative
>
> Overcrowded_ [social entity: clinic] _You have to take something to eat to the clinic because you have to wait the whole day (Thando)
>
> interactive position_ [social practice] _micro-narrative
>
> Justified_ [social practice: abortion] _We thought it was best to terminate because we didn't want a child at this time (Sandra)

[3] Imperative positioning: As discussed in the theoretical chapter, various modes of forced positionings are possible. For example, dynamic instances of forced positioning occur within a specific social interaction; if a participant enters a clinic, the positioning that is forced on them is that of a patient. My objective, however, was to conduct an intersectional analysis. I was more interested in imperative forms of positioning where participants named, invoked or indexed *social characteristics* to position themselves and others in talk. This is where I drew from Wilkinson and Kitzinger's (2003) conceptualisation of positioning, where one pays attention to how speakers use social categories in talk. While coding data in this manner, I found that this positioning work was layered in some instances. For example, where participants specifically positioned men as men, other positioning attributes were also inferred on men by virtue of being a man. For example, a participant may position someone as a man but simultaneously position that man as unknowledgeable about pregnancy. This turned out to be beneficial because it revealed the gendered normative constraints that were operating in these micro-narratives:

[imperative position] _ [inferred position] _micro narrative

[Men]-[ignorant]_ men know nothing about pregnancy and can't really provide proper advice. (Siphe)

Coding data by identifying and attaching positions to the micro-narratives whilst plotting them across the elements of the supportability framework was a fine-grained and intensive process. There was a fair amount of repeat coding of data items across the supportability framework. There are two reasons for this: (1) multiple micro-narratives were running through one data segment, which related to the different elements of the supportability framework, and (2) at times, there were multiple different positionings (reflexive, interactive and imperative) in one data item or micro-narrative. For example, participants sometimes self-positioned using social characteristics (for example, I am unemployed). This meant that the coding occurred at both the self-positioning and imperative positioning levels of the framework. I did not deem this a problem as it provided opportunities to analyse the data item using different positioning lenses and expanded the ability to identify common patterns of talk across the data. In total, 1083 positioning micro-narratives were coded across the entire data set.

Individual situated knowledge is a key intersectionality tenet (Yuval-Davis, 2015) ; therefore, one of my objectives was to present the individual stories of the participants as case studies. Nvivo enabled me to run a query that collated all the coded positioning micro-narratives per participant. This query also showed how the positioning micro-narratives were organised across the elements of the supportability framework for each participant. I now had an overarching view of what aspects of the supportability framework featured in each participant's narratives and how they positioned themselves and others within their unique pregnancy context. This enabled me to write up the case studies for each participant by tracking their pregnancy stories across the supportability framework. Six of these individual case studies and the accompanying templates are presented in Chapter 8 of the analysis (while the rest of the case studies appear in Appendix 11). My next step was to identify the normative constraints inherent in the positioning micro-narratives identified.

Phase 3: Identifying normative constraints and enablements

Now that the positioning analytic had enabled a detailed and contextual overview of each pregnancy support experience, I turned the focus of my analysis to interrogate how normative constraints and enablements (socio-cultural, -political, -structural and -economic influences) played a role in the supportability of participants' pregnancies. To help me do this, I

used Patricia Hill Collins' (2000) domains of power (interpersonal, structural, disciplinary, and cultural power) as a lens to help me surface what normative constraints and enablements might be operating in the positioning micro-narratives. I also used the reproductive justice framework (Ross & Solinger, 2017) to guide me by analysing the positioning micro-narratives in the light of the right/to have or not have a child, the right to be pregnant in a conducive environment and the right to access and receive quality maternity care. Drawing again from the procedures to conduct a template analysis (Brooks et al., 2015; King & Brooks, 2017), I started clustering the individual positioning micro-narratives into narrative positioning themes. These themes were identified as normative constraints or enablements. I identified several recurring and cross-cutting normative constraint themes in the participants' talk that had a bearing on pregnancy supportability, and they included reproductive legitimacy, reproductive affordability, and reproductive responsibility. They are left open regarding whether the normative constraint speaks to supportive or unsupportable micro-positioning narratives or a combination of both supportive/unsupportive (e.g., partner support but unemployment) aspects, as understanding their complexity is key. I provide brief descriptions of these micro-narrative positioning themes as follows:

[1] Reproductive legitimacy: Participants not only questioned whether they had the physical and psychological ability to get pregnant and carry the pregnancy to a successful outcome, but also reflected on whether they were socially suitable candidates for pregnancy. Talk about whether the pregnancy was wanted or timed properly, and how participants came to accept their pregnancies featured in this talk.

[2] Reproductive affordability: All participants referred to the socio-economic implications of their pregnancy, which had a bearing on the reproductive choices they could make and the support they could expect from their support networks and structures.

[3] Reproductive responsibility: Participants attempted to position themselves as compliant and diligent pregnant subjects. This theme was generated by how participants described why they did or did not manage their pregnancies in certain ways in relation to the support they may or may not have received while pregnant.

Identifying the three main normative constraints (and enablements) themes above together was useful. However, there was copious data speaking to these constraints because the supportability framework is so broad. I also found that the above normative constraints were overlapping. For example, a single micro-narrative could be allocated into more than one

of the above-mentioned normative constraints. A template analysis, however, can enable an analyst to identify integrative themes (Brooks et al., 2015), of which they weaved their way across the elements of the supportability framework. By examining what participants were trying to accomplish with their micro-narratives, it became apparent that participants were continually engaging in accounting to us, the researchers, as to why they became pregnant and were managing their pregnancies in a particular manner. In other words, their micro-narratives were either saturated with legitimising claims or responsibilising talk, and this talk was consistent across the elements of the supportability framework. Participants not only questioned the legitimacy of their pregnancies but also themselves as legitimate pregnant subjects.

As such, these normative constraints spanned both pregnancy decision-making (the right to have or not have a child) and pregnancy management (the right to be pregnant in a conducive environment). Considering that reproductive autonomy is an essential element to achieving reproductive justice (Ross & Solinger, 2017), I therefore started paying closer attention to the coded reproductive "choice" positioning micro-narratives. This is where participants explicitly talked about decisions they made or could not make during their pregnancies, given their available support networks and structures. I then cross-checked these with the other normative constraints identified above. I found that the overlaps between reproductive agency and reproductive legitimacy were specifically in relation to accepting a pregnancy. That is, reproductive "decisions" or "choices" were mostly made in relation to socially appropriate childbearing norms when becoming pregnant. The overarching social narrative that collectively shaped these clustered narratives was: "Is this pregnancy legitimate because it was (un)intended?" These findings are presented in Chapter 9.

Regarding managing the pregnancy, I found that the overlaps between reproductive agency and reproductive affordability were consistent. Reproductive "decisions" or "choices" were made in relation to the socio-economic implications of the pregnancy with the intention to appear as responsible and dutiful pregnant subjects. Thus, the participants' agency was shaped by an intersection of reproductive affordability and reproductive responsibility. The overarching social narrative that shaped this talk was: "Stop having babies if you can't afford them". These findings are presented in Chapter 10.

These normative constraints are, however, imbued with systems of racism, sexism, ableism, nationalism and capitalism. This is where the positioning analytic was helpful as it helped me identify how the interrelated social dimensions of relationship status, socio-

economic status, reproductive maturity, nationhood and race functioned in this talk. I not only used the positioning analytic to help me surface these relationships but also used Collins' (2000) domains of power thesis to do so. I will discuss this phase of the analysis next.

Phase 4: Domains of power analysis

In phases 2 and 3, I had already identified forms of power from the positioning micro-narratives. As mentioned previously, the operation of power was made visible by the very positioning tactics deployed by the participants. In addition, the normative constraints identified in phase 3 of the analysis speak to constraints and enablements of the supportability of the pregnancy, which surfaces power on a structural level. Appropriate childbearing as a cultural form of power was particularly salient based on a micro analysis of talk about pregnancy support and across the identified normative constraints. As Collins (2000) reminds us, cultural power does not operate alone. Different vectors of power operate in relation to one another to create reproductive (in)justices. Thus, this part of the analysis sought to understand the embeddedness between the subject positions and various power dynamics underpinning pregnancy support constructions. Collins' (2000) domains of power thesis were mapped onto the identified narratives by asking the following question of the analysis: What forms of interpersonal, disciplinary, cultural and structural power are inherent in these micro-narratives, and how are these power dynamics related or co-constituted? In this way, I was able to highlight how power is productive. I infuse these aspects of power relations into my findings in Chapters 9 and 10.

Conclusion

This chapter outlined the procedure for data analysis to operationalise the supportability framework qualitatively. I first presented my research questions. I then provided a discussion of how narratives have been conceptualised within intersectionality theory traditions. I explain why, from the perspective of this study, I distinguish between identifying micro-narratives and dominant social narratives within my data set as part of my analysis procedure.

I then motivated to conduct a template analysis as the elements of the supportability framework lend themselves to developing *a priori* codes to form a code book. Next, I explained how I translated positioning theory into a positioning analytic. I outlined how I conceptualised positions (self-, interactive and imperative positions) and attached them to micro-narratives to

identify what participants were doing with their talk while simultaneously surfacing various power relations. I also explained how I incorporated these positions into the template analysis.

I then discussed the difficulty of analysing mutually co-constitutive social dimensions and how I have overcome them using the domains of power thesis and McCall's (2005) intracategorical intersectional approach. In addition, I engage with some critiques of analysing data thematically and explain how my approach is more invested in identifying what is accomplished when positioning micro-narratives are deployed in talk (not who they describe), thereby avoiding the pitfall of essentialising the individual and their characteristics.

Finally, I describe in detail the procedure for analysis, which took on four iterative phases: familiarising the data; applying the positioning supportability template analysis across two pregnancy time frames (discovery/acceptance and pregnancy management); clustering positioning micro-narratives into themed normative constraints; and, utilising Collins' (2000) domains of power thesis both to help identify normative constraints and to trace how mutually constitutive operations of power played a part in shaping the supportability of the pregnancy.

I now move on to the first analysis chapter, presenting a selection of six participants' pregnancy journeys as a case study. This was done by plotting their micro-narratives across the supportability framework. I do so because situated knowledge is important from an intersectionality standpoint in that it contributes to intersectionality's visibility project and respects individual voices in articulating their own experiences (Hancock, 2016; May, 2015; Yuval-Davis, 2015).

CHAPTER 8

Narrative forms of situated knowledge: Individual stories on pregnancy supportability

An intersectionality approach places much value on narrative forms of knowing (May, 2015). Social (in)justices and unequal power relations can be reflected through the very stories that individuals tell of their lived experiences in relation to the social locations they may occupy. In showing their photographs and telling their pregnancy stories, participants drew on multiple self, interactive and imperative positions concerning the support they may or may not have received from their support networks. This positioning work gave insights into how participants made decisions about and managed their pregnancies, given their available support networks and structures.

In this first analysis chapter, I present the case studies of six of the fifteen participants who participated in this research project. I present these case studies to acknowledge and foreground each participant's unique pregnancy story, that is, their situated knowledge (Yuval-Davis, 2015). Of course, as a researcher, I have made a subjective choice by deciding which case studies (out of the fifteen) will be presented in this chapter. This was not easy and was a source of discomfort for me because it begs answers as to why some participants' narratives made the cut while others did not. Space constraints were simply the main reason. The six case studies I selected for this chapter represent the diversity of pregnancy experiences concerning race, reproductive maturity, nationality, relationship and socio-economic status. The remaining nine case studies (and templates) can be found in Appendix 11.

As I explained in Chapter 7 (the procedure for data analysis), I coded participants' positioning-micro-narratives across the elements of the pregnancy supportability framework. Then, I ran a query in Nvivo for each participant, which gave me an overview of their stories as plotted across the supportability framework. I constructed each participant's case study from these queries whilst populating the template accompanying each narrative. For each participant, I included some of their demographics to signpost the social positions and contexts from which they speak. The findings of this chapter offer one way to utilise the supportability framework: to surface the various individual, micro and macro support

interactions that occur during the event of the pregnancy. As such, this chapter provides a broad, descriptive overview of pregnancy supportability.

However, I keep in mind that participants did not begin their narratives using this structure and that the construction of the following case studies is based on my research agenda of surfacing how these positioning narratives track and interact across the supportability framework. Although I have attempted to focus on the central issues with which participants were concerned in narrating their pregnancy support experiences (for example, partner abandonment), I acknowledge the participants may well have different views to mine as to what aspects of their pregnancy story I have chosen to foreground.

I conclude the chapter by highlighting how participants' stories pointed to the normative constraints of reproductive legitimacy, affordability and responsibility identified in my analysis. These aspects are addressed in greater depth in the final two analysis chapters.

Individual case studies of participants

The following case studies are presented alphabetically according to the participants' pseudonyms.

Case study of Anelisa

34 years-old | *Black* | *Married* | *South African* | *Employed* | *Second pregnancy*

Anelisa used her social position of being a middle-class, black South African (imperative positioning; macro-level) to contrast her experiences of her pregnancy against other pregnant women (including family members) who are poor and who used the public health system. Anelisa grew up in an informal township, went to a township school and got a tertiary education at a community college (macro-level; socio-economic and education). She met her husband, an academic, white and of French nationality (imperative positioning), at a festival. Anelisa explained that she never intended to have children but did so because she married and her husband wanted to have children (micro-level partner interaction).

Figure 3: Pregnancy supportability template, Anelisa

However, it took some time for Anelisa to become pregnant a second time, which was a source of stress for her (individual physiological/emotional). She stopped using home pregnancy tests because they always tested negative. She only found out that she was pregnant in her second trimester. She went to a private doctor because she was experiencing excruciating leg cramps. Her doctor conducted a blood test and confirmed the pregnancy.

Anelisa explained how her pregnancy was smooth and easy because she had a job (micro-level; work interactions) and a supportive husband and family (micro-level; partner and family interactions). Anelisa outlined in detail how many more choices she had because of her improved socio-economic position (imperative positioning). She used private medical health care and could choose where she wanted to give birth. This was at a private hospital close to her family in a nearby metropolitan town (macro-level structural health and micro-level healthcare interactions). She purchased her pregnancy supplements, such as folic acid, at a retail pharmacy. She described how these supplements were much easier to take than the large generic kinds available at public health clinics (macro health system structures). She ate nutritious food of her choice. She could purchase pregnancy products, such as expensive creams, to prevent stretch marks.

However, she lamented that she was not able to give birth in the town where she lived because there was no private hospital. She was also disappointed that, although she could afford an ultrasound, her local doctor would not provide a scan as he was not indemnified for obstetric care (macro-level structural health system influencing micro-level healthcare interactions). Despite these limitations in the availability of private healthcare, Anelisa expressed relief (individual emotional) that she did not have to use the public health system. She described how she witnessed (when accompanying cousins to antenatal care check-ups) the long waiting times, the lack of choice in medication, and uncaring nurses who were rude and who judged young mothers for being pregnant (micro-level healthcare interaction).

Anelisa described how much she loved her husband. She positioned him as caring and protective of her (micro-level; partner support). Being from different raced, classed, cultural, and religious backgrounds (imperative positionings), Anelisa outlined how they had to negotiate these differences as a couple and compromise on some issues. She had to reassure her family that everything would be fine when they showed concern about whether a white man would cope with staying in the township at her family home while she gave birth (macro-level imperative positioning influencing micro-level interactions). Whereas she had grown up never having nice cars or being able to try popular fast-food brands, Anelisa reported that she had to

remind her husband of this because he displayed a complete lack of interest in material items. Instead, he placed value on travel and education. Whereas her husband was a self-proclaimed atheist, Anelisa identified as Christian. Despite these differences, Anelisa positioned her husband as open-minded in that he would not stand in the way of baptising their newborn or allowing his son to follow traditional Xhosa circumcision practices should his son wish to do so (partner micro-interaction).

In navigating the differences between her husband's and her own family's expectations (micro-family interaction) concerning pregnancy practices and birth, Anelisa believed that when one gets married, one follows the family cultural practices of one's husband, which includes childbirth practices (individual cognitive interacting with macro socio-cultural practices). Anelisa explained that black African men (imperative positioning) are less involved in pregnancy and newborn care and that residing with the maternal family to recover post-partum is considered standard practice (macro socio-cultural practices). This was different for Anelisa because her husband attended every antenatal care check-up with her and expected to see his baby every day after birth (macro socio-cultural practices interacting with micro-level partner interactions).

As with her academic husband, Anelisa was also employed (imperative position) at the local university in an administrative position. She described this job as easy and her work environment unpressurised, which suited her during her pregnancy (micro work interacting with individual psychological). Anelisa desired to move on to a more challenging job after the baby was born. Although not mentioned in her narrative, Anelisa would have taken four months of maternity leave and claimed from the Unemployment Insurance Fund (UIF) (macro social policy) because she was permanently employed at a public university institution. The university would also have ensured that Anelisa would continue to receive 100% of her salary by supplementing the payout from the UIF. For example, if UIF only covered 40% of Anelisa's full salary, the university would have covered the remaining 60% of her salary.

Case study of Kerry

34 years-old | White | Cohabiting, long-term partnership | South African | Restaurant business owner| First pregnancy

Kerry and her fiancé had been together for approximately 6 years. They had been thinking about having a baby for some time, and Kerry embarked on detailed pregnancy planning before conception (individual cognitive level). She first checked to see what private

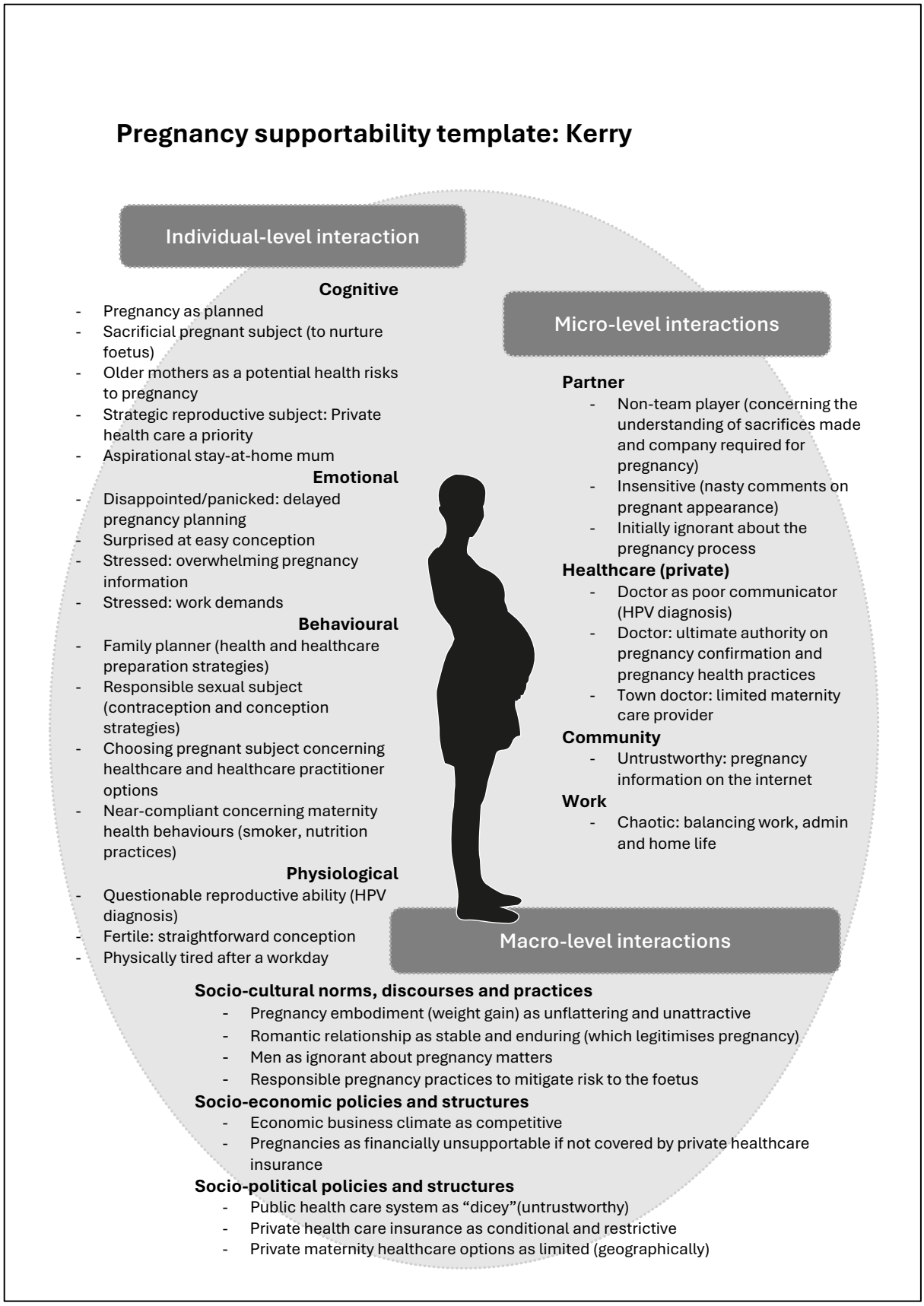
medical aids provided the best and most affordable maternity cover (macro health system). She was not sure how "dicey" it would be to receive maternity care in the public health sector. To prepare her body for pregnancy (individual behavioural), she came off her contraception (the pill) for a whole year. She used other methods of contraception to ensure that the couple "played it safe" and did not become pregnant before their medical plan commenced. She also went for health checks to prepare her body for pregnancy (individual physiological).

Unfortunately, her plans to become pregnant were delayed because she was diagnosed with HPV (which her doctor told her has a risk of cancer). She was advised that she shouldn't get pregnant until a pap smear was done to confirm that there was no cancer. Kerry did not take this news well. She described how her doctor used "completely the wrong words" to explain her diagnosis and caused her alarm for no reason (health micro-interaction). She began to question whether she would ever be able to have a baby (individual physiological). She went to another doctor for a second opinion, who offered her acupuncture and vitamin C drips to get her ready for pregnancy.

On becoming pregnant, Kerry expressed her surprise at how quickly it happened because she and her partner hadn't actively started trying (individual physiological/emotional). She also explained that she took a home pregnancy test, which was not accurate; it showed negative when she was indeed positive. She went to the doctor for "proper" confirmation of her pregnancy by getting blood tests in her second trimester (healthcare micro interaction). Kerry expressed her disappointment that the local town private doctors provided limited maternity care and no longer delivered babies (macro health system interacting with micro-level health interaction). She maintained that she did not want to travel to the nearest metropolitan city to have her baby because she would be separated from her support networks (macro health system interacting with micro community interaction). Still, unfortunately, she had no other option.

Kerry admitted that she tried hard to manage her pregnancy responsibly because she is an older pregnant mother (imperative positioning). However, she struggled to do so (individual behavioural and cognitive). Firstly, she battled with the sacrifices she had to make, which included giving up smoking cigarettes and cannabis. During her pregnancy, she allowed herself a tiny amount of cannabis on a Sunday and took a nap. However, she found it very difficult to stop smoking and admitted that she still had drags of cigarettes from her friends from time to time.

Figure 4: Pregnancy supportability template, Kerry



Secondly, she tried to adhere to a healthy diet but found it challenging. She expressed huge relief when her doctor said she could eat like usual. She celebrated by consuming camembert cheese and maintained that having a balance of healthy and "bad" foods wasn't a problem (healthcare micro-interaction interacting with individual behavioural). Thirdly, she found that there is a lot of "crap" on the internet and that pregnancy information was overwhelming (micro-interaction community). Although she had books on pregnancy, she only flipped through them because they had conflicting information, which made her worry unnecessarily (individual emotional). Fourthly, she described herself as a lazy person and lamented that she should be walking for exercise more often to improve the blood circulation in her legs. However, she found it difficult because her partner would not walk the dogs with her in the early morning as he worked late hours as a chef (partner micro-interaction).

Kerry explained that her partner's support was not quite where she wanted it to be (partner micro-interaction). Her biggest gripe was him not acknowledging all the sacrifices that she had to make to ensure a healthy pregnancy. She also described how he made nasty jokes about her appearance in that she was showing early. Nevertheless, she exonerated him by explaining that his support improved as the pregnancy progressed. He started rubbing her feet and seemed to understand better what was involved when he went with her to an antenatal check-up, where the doctor explained how the foetus was developing.

Kerry owned a restaurant and found combining her work and pregnancy stressful (work micro interaction). She described herself as a messy and lazy person. She admitted that she procrastinated on completing the restaurant's administrative work, which added to her stress. She maintained that she was exhausted after working in the restaurant and just wanted to nap rather than complete this work (individual physiological). She bought her business because she wanted to be a stay-at-home mum but realised that the restaurant was not doing well enough financially for her to do so (macro socio-economic). She was also going to move house when she was seven months pregnant, which she knew would be chaotic and stressful.

Case study of Linda

27 years-old | *Coloured* | *Single* | *South African* | *Employed* | *Second pregnancy*

Linda's narrative focused on how her unplanned pregnancy had ramifications for her reputation in her community (micro-level interaction). Linda met up with her ex-boyfriend at their child's 6th birthday party in her hometown. The couple had unprotected sexual intercourse. Linda admitted to the interviewer that she knew she was wrong and should have

used protection (individual behavioural). On returning to the town where she worked after the birthday weekend, Linda purchased an emergency contraceptive from the pharmacy. Unfortunately, she took it outside the window time for it to be effective. Linda expressed her utter disbelief and shock at finding out that she was pregnant (individual cognitive).

Linda told her ex-partner that she was pregnant, and he initially tried to deny paternity (micro-level partner interaction). Linda's ex-partner's mother and community members started gossiping about her. They claimed that she was trying to pin her unplanned pregnancy on her ex-boyfriend (micro-level community interacting with gendered reproductive norms). Because of this gossip, Linda attempted to end her pregnancy twice. The first time she tried to use the public health system, she was told that her pregnancy was beyond the nine-week time frame for the local hospital to be able to provide her with an abortion (macro level health system). However, Linda claimed that the nurse misdiagnosed her conception date by counting from her last menstruation cycle (which was irregular). In desperation and implored by her best friend not to do so, Linda investigated having an unsafe abortion. She decided against it because the illegal abortion provider made her feel uncomfortable and unsafe (micro-level "health" interaction). He used sales pressure tactics about how quickly the foetus was growing, tried not to let her leave and then extorted a "consultation" fee from her when she decided not to go ahead with the abortion.

To prove paternity to her ex-boyfriend, Linda turned to the private healthcare system and booked and paid for a local doctor to conduct an ultrasound (micro-level healthcare interaction). The doctor concurred with her about her conception date (the birthday weekend), and Linda used this scan to prove that her ex-partner was the father of the foetus. Her ex-partner accepted this, and Linda explained that although they were not together, he was supportive because he asked after her and the baby and sent her lovely messages on WhatsApp. This made her feel cared for (partner micro-level interaction). Although unemployed, he also promised that he would try to find employment so that he could help support the child. He also enlisted his father's financial help to support the pregnancy and future child.

However, the shame of becoming pregnant meant that Linda found it stressful to tell her family, especially her mother, about the pregnancy. So, she delayed doing so (individual-level emotional/behavioural interaction with micro-level family). At the same time, Linda didn't want her mother to learn from the local community that she was pregnant because of all the gossip. Linda explained that she tried to get her aunt to tell her mother. Her aunt suggested that her

brother should be the one to tell her mother as he was good at mediating family matters (family micro interacting with family planning norms). Linda explained how each time she called her brother to tell him she was pregnant, she would burst into tears because of the stress. Her brother duly told her mother, and the family rallied around Linda, confirming that she shouldn't stress and that they would help her and the future child. Linda's mother also had a word with the community rumour mongers about letting mothers raise their children in peace.

Linda's family expressed concern about taking better care of herself during the pregnancy. Linda admitted that she both smoked and drank (individual behavioural). She explained that she found it very difficult to give up smoking because it helped her to alleviate stress. Although she didn't smoke at work, her fellow flatmates smoked at home, which made it difficult for her to stop (community micro-level interaction interacting with individual behaviour). Linda also found her cousins irritating because they would come and visit and get drunk in front of her, which she found stressful (family micro-level interaction).

Linda worked at a local town restaurant at the time of her pregnancy. She reported that she would get maternity leave as per the law but would receive no pay for this time off work except for UIF (macro level socio-economic context interacting with social policy). She explained that she needed to return to work as soon as possible because she needed money for the baby. Linda explained that she felt more tired at work because of the pregnancy, but her colleagues helped her carry things from time to time (micro-level work interaction). She also reported being very sensitive and would cry easily if her boss shouted at her for doing things incorrectly (individual emotional interaction with micro-level work). Linda showed a picture of the restaurant's restrooms, which was the place where she would go and cry if she needed to, and explained that after crying, she felt better.

From a healthcare perspective, Linda mentioned that she felt scared about giving birth because she no longer had private medical care and must give birth using the public health system (macro-level health system). Linda views the South African government as uncaring, public health system nurses as careless, and that poor people get treated differently compared with those who can afford medical aid.

Figure 5: Pregnancy supportability template, Linda

Case study of Nosipho

27 years-old | Black | Recently single | South African | Unemployed | First pregnancy

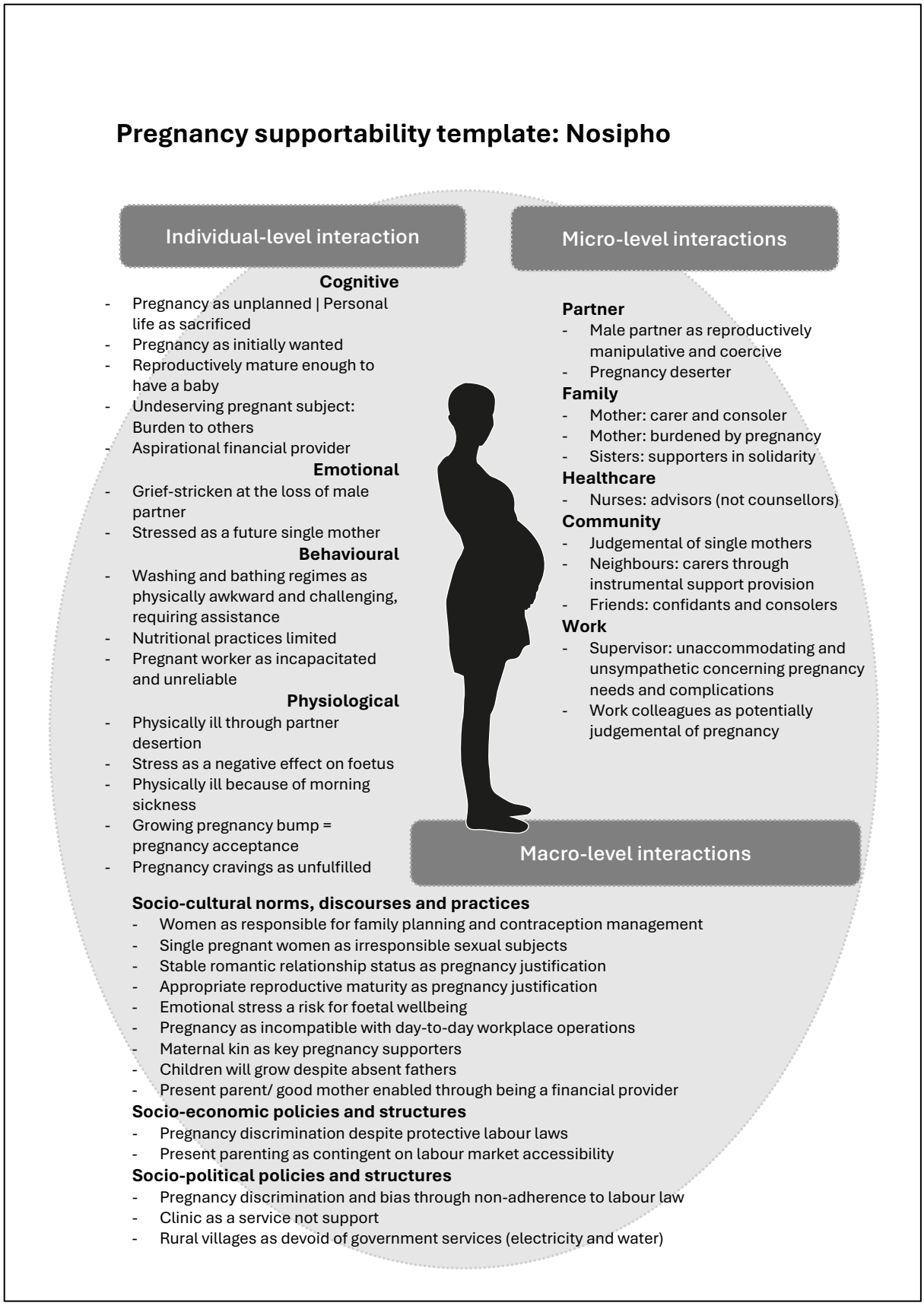
Nosipho's pregnancy was unplanned and initially wanted (individual cognitive) until her partner denied paternity and broke up with her because she would not agree to have an abortion (partner micro-interaction interacting with macro-gendered norms interacting with individual behaviour). Nosipho's narrative is one of outrage at the injustice of her situation. Although she felt that her partner manipulated her into stopping using contraception by convincing her that they had been together for a long time so that it was no longer necessary anymore, Nosipho nevertheless took full responsibility for becoming pregnant and admitted that she sacrificed her life in doing so.

Nosipho implied that her partner's rejection of the pregnancy undermined the legitimacy of her pregnancy; she felt judged by her sisters, friends, and community because she was pregnant and partnerless (macro-gendered norms concerning appropriate childbearing interacting with individual cognitive/emotional). Nosipho felt this was unfair, given that so many other women in her community have had experiences similar to hers (community micro-interaction). Nosipho sought to justify her pregnancy by explaining that she was the right age to have a child, working at the time, and one of the last women in her social network to have a baby.

Nosipho's loss of her partner also had ramifications for her well-being in other ways. Nosipho claimed that his denial of her and her pregnancy made her so physically ill that she was admitted to the hospital (micro partner interacting with individual physiological well-being). She also struggled to accept her pregnancy and found her first trimester very difficult both because of experiencing morning sickness and because of her grief in losing her partner (micro partner interacting with individual physiological, emotional and cognitive well-being).

When she saw her pregnancy bump, Nosipho finally accepted her pregnancy. Watching her belly grow excited her more about her pregnancy (physiological interaction with individual emotional and cognitive levels). Nevertheless, Nosipho expressed concern about how undue stress due to a partner's absence could harm the foetus and maintained that her foetus became distressed when she was stressed (individual emotional interacting with individual physiological).

Figure 6: Pregnancy supportability template, Nosipho



Partner denial also created complications on the work front (work micro-interaction). Nosipho and her ex-partner worked in the same spaces. He was a union shop steward, and she was a communications intern for the local municipality. She found it difficult to attend the same work events as her ex-partner and focus on her work. Nosipho reported that her supervisor knew about her pregnancy but was not particularly accommodating. He complained that her pregnancy illness was interfering with her ability to do her job (macro-gendered norms interacting with workplace micro interaction).

Furthermore, he stated that he could not provide a municipal driver to transport her to work events (this suggests that she often got lifts with her partner, who attended the same events). He threatened her with dismissal because he claimed she was slacking on the job. Because Nosipho also didn't want her work colleagues to find out about her pregnancy (and who the father was), and because she wasn't performing well in her job, she decided to terminate her internship and consequently became unemployed. Nosipho explained that she was prepared to take any job anywhere to ensure that she could provide for her child once born. She acknowledged that this might mean being separated from her child (macro socio-economic interacting with individual behavioural (present parenting).

Despite being abandoned by her partner, Nosipho reported that her mother was a significant source of support (family micro-interaction). Her mother consoled her without prying, gave pregnancy advice on going to the clinic, made sure she took her pregnancy medication and ensured that she ate nutritious food during her pregnancy. Although not living at home, her sisters kept in contact by sending her encouraging and humorous WhatsApp's to cheer her up. Her neighbour (micro-interaction community) collected firewood for her, bought her sweets and kept her company during the day. Her friends consoled her about her absent partner and reassured her that there was a possibility that the father may return after the birth, but if not, her child would still grow without a father as theirs have done.

The environment that Nosipho lived in made everyday pregnancy practices and experiences difficult. The village she lived in had no electricity and only a communal water tap. For example, her pregnancy cravings could not be satisfied because it was a long way to travel to town to go shopping, and there was no fridge to keep perishables fresh (macro-structural interacting with individual emotional and physiological). Water had to be fetched first and then warmed on the fire. Nosipho reported that the size of her pregnancy bump made it much more difficult to bathe and took her much longer; she had to put the basin of water on the bed so that she could reach it to wash. She also maintained that she didn't want to be a nuisance or stress

her mother by asking for assistance all the time, so she tried to hide some of the difficulties that she experienced while pregnant (micro family interacting with individual cognitive and emotions).

Nosipho did not focus on her healthcare experiences when showing us her pictures. When asked about her clinic experience, she explained that the clinic "was a service, not support" (healthcare micro-interaction). She said the MomConnect text program was helpful because it covered common pregnancy ailments concerning morning sickness.

Case study of Sandra

34 years-old | Hispanic | Long-term partnership | Brazilian | Unemployed | Third pregnancy

Sandra's narrative centred on coming to terms with an unwanted pregnancy (individual cognitive), the financial burden of the pregnancy, which caused much stress (macro socio-economic interacting with individual emotions), and her experiences with the healthcare system in South Africa (healthcare micro and macro interactions). Sandra was Brazilian and moved (with their two small children) to South Africa to join her South African partner, who was completing his postgraduate degree at university. Her pregnancy was unplanned and unwanted because the couple were both unemployed and had other study and work goals at the time. In addition, Sandra had a suspected health condition (Multiple Sclerosis). She believed that if she had the condition, it could seriously hinder her ability to manage her pregnancy and be a mother to her children (individual physiological). Because of her ill health and an irregular menstrual cycle, Sandra stopped taking contraception. It was also unaffordable for her partner to get a vasectomy in Brazil, and the couple, therefore, relied on the natural method for sexual intercourse (macro level health system structure interacting with individual behaviour). Sandra expressed her absolute shock on finding out that she got pregnant on her period (individual emotional). She maintained that she was initially in denial and travelled to South Africa with an "unknown" pregnancy, which was highly stressful (individual cognitive and emotional level).

Sandra decided to have an abortion because it is legal in South Africa and not in Brazil (macro-level policy structures interacting with individual cognitions/behaviours). However, this proved systemically, logistically, financially, and emotionally challenging. She first attempted to procure an abortion from the public health system. However, the nurse told her that the local town hospital only provides abortions for up to nine weeks and advised Sandra to book at a private abortion clinic located 1.5 hours away from her local town (macro-level structural

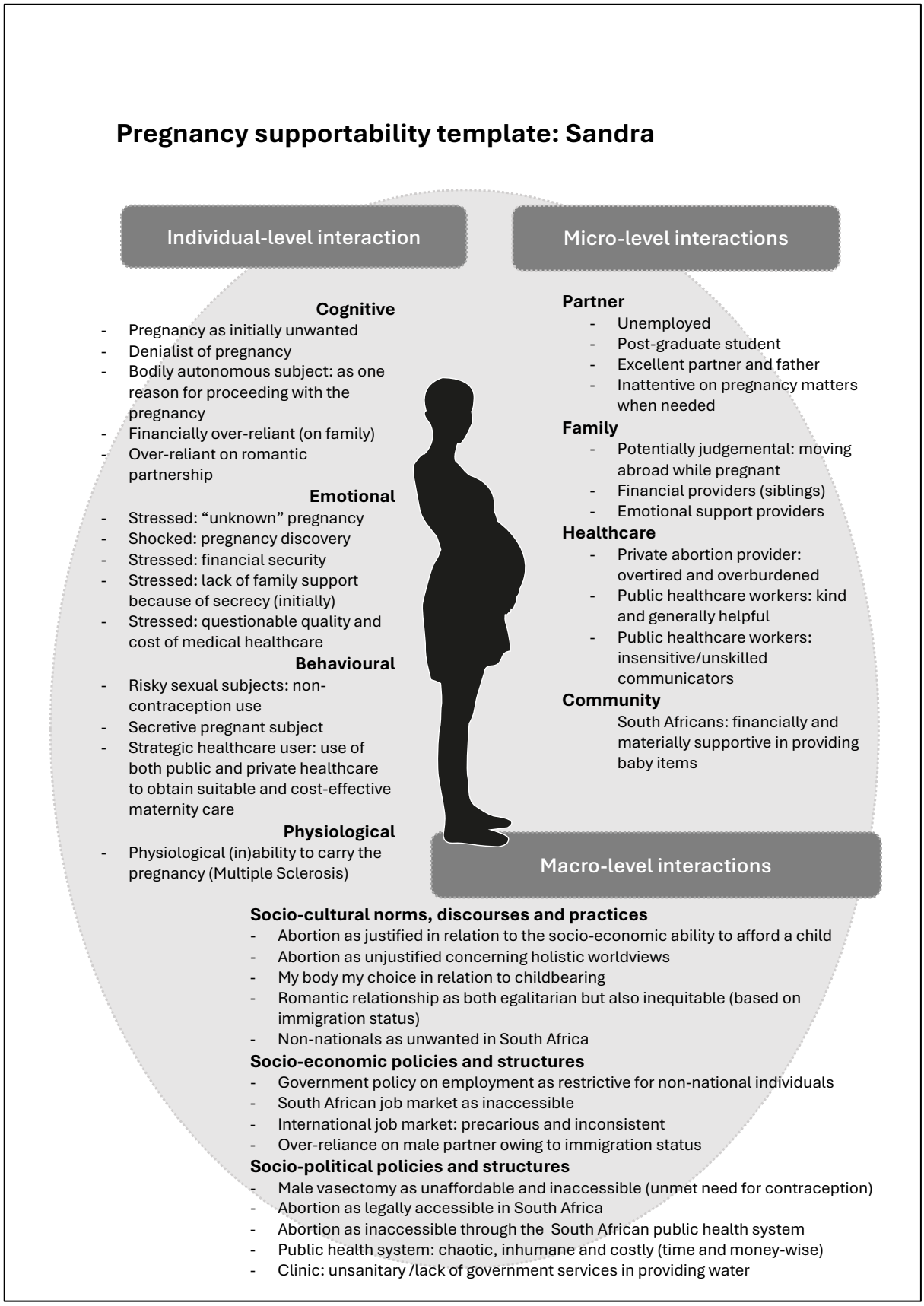
constraints). Sandra booked an appointment, organised transport with a newly made friend and arrived at the clinic only to wait for hours to be seen (micro-level interaction). Eventually, she was told that she was still 11th in the queue and that her procedure would only be completed at around 7 pm that evening (healthcare micro-interaction). She decided against having the abortion that day because she felt that she did not want to risk putting her body into the hands of an overtired and overburdened doctor. Sandra admitted that she was determined to terminate the pregnancy and re-booked but then started having doubts as she settled into her new life in South Africa (individual cognitive). She explained that rationally abortion was the best option, but having one gave her a sense of unease because she saw abortion as contrary to her values (macro-social norms of abortion as un-holistic).

In accepting her pregnancy, Sandra took up a self-autonomy position by reiterating that her body would bring the child into the world (individual cognitive). Sandra and her partner had kept the pregnancy a secret from their families so that Sandra's family did not dissuade them from moving to South Africa (family micro-interaction). However, this proved very stressful as Sandra was close to her siblings and missed their support and counsel. In breaking the news of the pregnancy to Sandra's family, Sandra reported that her siblings were very understanding, reaffirmed that abortion was not the right choice for Sandra based on how she viewed the world and offered to support the couple financially.

In managing her pregnancy, Sandra's biggest concern was the ability to provide for another child financially. She explained how she was not legally allowed to be employed in the South African formal work sector because she was a Brazilian citizen. Although she could work nomadically by bringing in work from Brazil, she explained that she had been unsuccessful because jobs were scarce (macro-structural constraint of a limited labour market interacting with individual behaviour). This inability to be self-sufficient (self-positioning) rendered Sandra overly reliant on her family for financial support was a huge embarrassment for her.

Given Sandra's unemployment status, she explained that because she couldn't afford private medical care, she used the South African public health system. She described how chaotic her healthcare interaction was, contrasting it with the Brazilian public health system, which she felt provided better care (macro-entity positioning). Firstly, she reported that the clinic conditions were unsanitary; she had to dispose of her urine sample and put the container into a bucket of solution so it could be reused. However, there were no facilities to wash her hands afterwards (macro-structural constraints).

Figure 7: Pregnancy supportability template, Sandra



Secondly, although Sandra positioned healthcare workers as very kind and helpful, she found that how they communicated with patients was deeply problematic because they diagnosed patients in an insensitive manner (health micro-interaction). This caused her to stress unnecessarily about the progression of her pregnancy because healthcare workers told her that it was a problem for her foetus to be small for its gestational age.

Finally, Sandra reported that the health system also kept losing her pregnancy test results. She had to repeat tests, which were costly transport-wise and time-consuming (healthcare system macro interaction). Based on these negative interactions with the public healthcare system and given her financial constraints, Sandra eventually resorted to a strategic combination of private and public healthcare to get the care she needed (macro-level constraints/enablement). This involved seeing a private midwife. She also negotiated with private doctors to approve pregnancy blood tests without incurring consultation charges so that they could be done at a private laboratory (micro-level healthcare interaction).

Sandra affirmed that her partner was an excellent father and very supportive. However, she admitted that tensions arose between them because he was not attentive enough to her needs, which she found very frustrating (partner micro-interaction). She also explained that because of her immigration status (imperative positioning), she depended entirely on her partner for everything, making her uncomfortable (macro-structural constraint interacting with micro-partner interaction). Sandra nevertheless positioned their partnership as an egalitarian one in that she believed that they have gone through difficult times, have come through them together and that her day will come when she gets to follow her career aspirations and be supported in that (entity positioning of romantic relationship). Sandra also positioned South Africans as very supportive because people in her community went out of their way to contribute and transport baby items to her at no cost (community micro-interaction).

Case study of Siphe

24 years-old | Black | Cohabiting with her partner | South African | Unpaid leave | Second pregnancy

Siphe crafted her main narrative around how different her second pregnancy was from her first pregnancy. This, she attested, is due to having a partner present who had not deserted her and was committed to her and her pregnancy (micro-partner interaction). This pregnancy was wanted compared with Siphe's first pregnancy, which was a teenage pregnancy at age 19 (individual cognitive and imperative positioning). Siphe described how isolating and difficult her

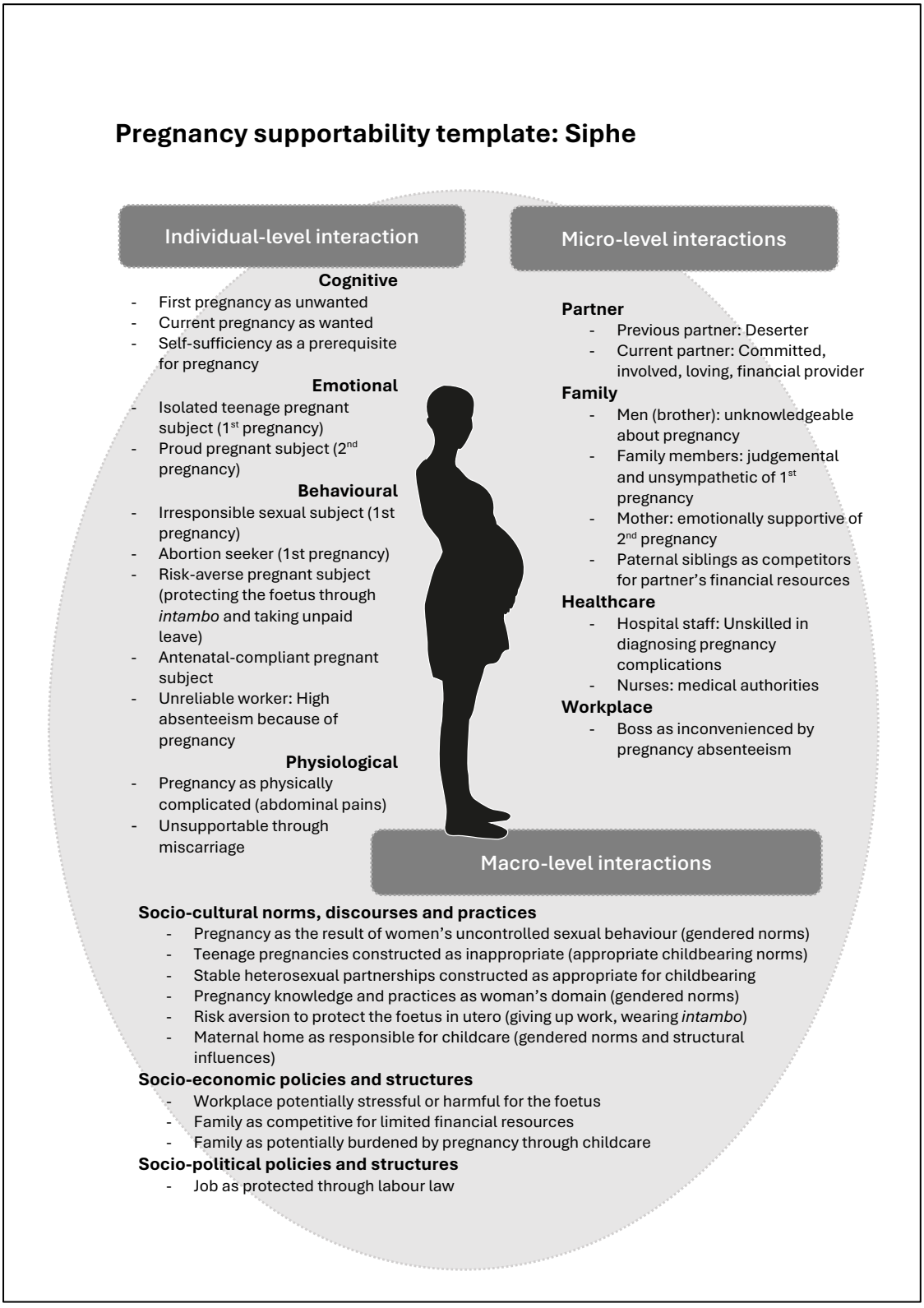
first pregnancy (individual emotional) was because she was sent from the Eastern Cape to live with her brother in the Western Cape so that she could attend school. It was at this time that she became pregnant. Siphe explained how her mother insisted that she deal with the consequences of pregnancy on her own because she was irresponsible by focusing on boys and not her schoolwork (individual behavioural interaction with micro family interaction and macro social norms concerning appropriate childbearing). She was also deserted by her boyfriend and rejected by his family at the time when she announced her pregnancy (family micro interaction). She explained how she attempted to terminate her first pregnancy by overdosing on pills from the clinic because she had no support from anyone except her brother, whom she felt was not equipped to take on such a role (individual behavioural interacting with micro family). Siphe claimed that she was forced to raise her first child on her own.

The second pregnancy, although accepted by her mother and her partner, was physically difficult on her in that she experienced a lot of abdominal pain (individual physiological). Siphe made multiple visits to the clinic and hospital and reported that the doctors or nurses did not seem to know what they were doing because they could not tell her what was wrong. Instead, they told her the foetus was fine, although it was small for its gestation.

Health workers advised her to keep warm and not urinate in public places. They prescribed more calcium tablets to ensure the growth of the foetus (micro-healthcare interaction). Siphe emphasised that she complied with all healthcare directives, yet the pregnancy was still difficult for her. Encouraged by her boss, who was frustrated by her work absenteeism, Siphe also took unpaid leave (she worked at a local retail clothing shop) to monitor and look after the pregnancy (micro work interacting with individual behaviour/physiological). In addition, Siphe used an *intambo*[22] to protect the pregnancy both from the ill wishes of others and because she feared having a miscarriage.

[22] An *intambo* is provided by a faith-based healer. It is a type of belt, cord or girdle which is blessed and is worn around the pregnant person's waist to protect them from evil spirits (see Abrahams et al., 2002)

Figure 8: Pregnancy supportability template, Siphe



She was careful to say that she did not consume any traditional medications (individual behavioural interaction with macro-cultural).

Siphe cohabited with her partner in the town centre while her partner's siblings and her family lived in the nearby township. She provided much detail on the love, care and support her partner gave her during the pregnancy (partner micro-interaction). His commitment to the pregnancy made her happy and proud to be pregnant (micro-partner interaction with individual cognitive/emotional).

However, fractious family relationships also featured in Siphe's narrative. Siphe claimed there was competition for financial resources from her partner's siblings, and fights for money were exacerbated by the pregnancy (micro-family interaction with the macro-economic environment). She also described how her older sister was judgmental of her for becoming pregnant again. She accused Siphe of putting more pressure on their mother to look after another child since it was assumed the infant would live in the maternal household (individual behaviour interaction with micro-family and macro-gendered norms). Siphe justified her pregnancy by maintaining that she was self-sufficient; she would not be a burden on her family as her partner was present and supportive. Unfortunately, Siphe miscarried seven months into her pregnancy. She did not want to talk about it with us but did let me know by WhatsApp a few months later that God had washed her tears and that she was pregnant again.

Conclusion

In this first analysis chapter, I presented six of the fifteen participants' narratives of pregnancy support as case studies. I have done this to foreground the uniquely situated knowledge of participants in how they experienced support during pregnancy. The plotting of the positioning micro-narratives across the supportability framework underpinned how I constructed the case studies. The accompanying template for each case study illustrates this. In doing so, a descriptive overview of pregnancy supportability is enabled by surfacing the various support interactions that may occur during the event of the pregnancy.

Despite each story being unique, all participants drew on common features of talk which centred on pregnancy intendedness (cognitive individual level). This was an interesting feature of the data because we intended to focus on pregnancy support during pregnancy and not on contraceptive practices or pregnancy planning. Pregnancy intendedness was intertwined with participants' emotional reactions to the pregnancy. For those pregnancies that were unintended, participants reported being shocked, stressed (Sandra and Linda) and

ashamed (Linda and Siphe's 1st pregnancy). For those who had planned or wanted pregnancies, the emotional reaction to its discovery was relief (Anelisa and Kerry) and pride (Siphe).

Pregnancy intendedness was also intertwined with participants' behavioural approaches to discovering they were pregnant. For unintended pregnancies, this included participants constructing themselves as irresponsible sexual subjects for having sex at an inappropriate time or not using contraception properly (Nosipho, Sandra, Linda and Siphe's first pregnancy). Behaviours included pregnancy concealment and seeking abortions (Linda, Siphe, and Sandra). For intended pregnancies, delays in testing for pregnancy interacted with participants' concerns about their reproductive ability to conceive (Anelisa and Kerry).

The cognitions, emotions and behaviours concerning the discovery and acceptance of pregnancy on an individual level did not occur in a vacuum. Using the supportability framework as a guide ensured that individual responses must be considered in relation to micro-level support interactions, that is, the participants' perceptions of how their support networks might respond to the discovery of the pregnancy. The male partner's reproductive wishes (whether they accepted or wanted the pregnancy) and whether the participant was in a stable heterosexual romantic relationship profoundly shaped how participants initially processed their pregnancies. The acceptance of the pregnancy by social networks such as family and community members was constructed in relation to the potential judgement of participants' reproductive decisions and sexual practices. These case studies, therefore, point to how social support was discursively constructed as conditional by examining the interactions between the individual and micro-levels of the supportability framework.

From a macro-level perspective, social support that is perceived as conditional is suggestive of social norms that sanction women's sexuality and appropriate childbearing. In the case studies presented, some participants demonstrated how their social positions were interwoven with pregnancies socially deemed problematic. Examples include Sandra's concern about being financially secure enough to have a child, Nosipho using her age to justify her pregnancy because her partner deserted her, and Linda's shame at becoming pregnant while not in a stable heterosexual relationship. In contrast, Siphe draws much attention to how her pregnancy was justified because of her stable relationship status, while Anelisa validates her pregnancy based on her marriage status. Kerry used both her mature reproductive years (older mother) and her stable relationship as justification for her pregnancy. These case studies, therefore, point to a legitimation theme that occurred across the data set, which is analysed and presented in more depth in Chapter 9.

In managing their pregnancies, another common feature of talk centred on how participants attempted to present as responsible pregnant subjects given their socio-economic contexts. Participants self-positioned as risk-averse and reasonably health-compliant pregnant subjects on an individual level. For example, Anelisa put her career aspirations on hold whilst pregnant so that she did not impose undue stress on the foetus. Siphe carefully followed all health directives to mitigate against the pregnancy complications she was experiencing and even took unpaid leave to monitor her pregnancy. Participants highlighted how their socio-economic positions both enabled and constrained their ability to achieve these ideals of healthy and responsible pregnant subjects. For example, middle-class participants (Kerry and Anelisa) demonstrated that they could choose their private healthcare (although limited by macro-structural geographical constraints). Sandra and Linda explained how they strategically used a combination of private and public healthcare to get the quality of care they needed (thereby surfacing macro-level constraints of the public healthcare system). Participants, in general, positioned the public health system as inhumane, uncaring, chaotic and of low quality whilst positioning the private health system as of high quality (but limited in service options geographically).

Male partners and families were positioned as financial providers, but unemployed participants self-positioned as over-reliant and burdensome on these support networks (Nosipho). Although much of family support was received from maternal kin (gendered macro level norms), there were also instances whereby any family members (whether on the maternal or paternal side) who had financial resources were likely to be called upon to provide financial support if required (Linda). Macro socio-economic constraints also exacerbated tensions between family members, whereby the pregnancy was viewed negatively because it meant competition for scarce resources (Siphe).

Participants focused on the future and equated good motherhood with being able to provide for the future child financially. As such, they positioned themselves as aspirationally independent but simultaneously positioned accessibility to the job market as limited (Nosipho and Sandra). Finally, in positioning the homestead as devoid of municipal services, participants (Nosipho) drew attention to how the macro-structural constraints of poor or limited government services had a bearing on self-care and pregnancy hygiene practices. In sum, the normative constraint of reproductive affordability was a continuous feature of the participants' talk. It shaped how participants tried to achieve responsible reproductive subject ideals. This

normative constraint and how it plays out across the elements of the supportability framework is addressed in depth in Chapter 10.

CHAPTER 9

"Is this pregnancy legitimate because it was (un)intended?": Intersections between reproductive legitimacy and agency and their implications for pregnancy supportability

---

A reproductive justice approach embraces the right of an individual to choose whether to become pregnant and carry the pregnancy to term. Stories about pregnancy (un)intendedness and wantedness give insights into how this right (and reproductive autonomy) may be enabled or constrained. This analysis chapter centres on participants' discovery and acceptance of their (un)intended pregnancies. I identified a pregnancy legitimation theme, or normative constraint, which I call reproductive legitimacy. This theme permeated participants' narratives at this stage of their pregnancies. Participants embarked on justifying their pregnancies to us as researchers, to themselves as future parents and in relation to the support networks and structures available to them. As such, participants discursively constructed social support conditional by questioning their legitimacy or attempting to justify their pregnancies.

Micro-narratives of reproductive legitimacy

This chapter presents the findings that speak to the normative constraint of reproductive legitimacy. The overarching social narrative that captures this theme is: "Is this pregnancy legitimate because it was (un)intended?". The eight (de)legitimising positioning micro-narratives that address this theme occur across various elements of the supportability framework. Each micro-narrative provides insights into the type of reproductive (in)justices that participants experienced concerning pregnancy intendedness and support. Implications for participants' legitimacy as pregnant subjects, their reproductive agency, and the supportability of their pregnancies are addressed.

"I knew it was risky, and we weren't being safe".

Our research intention was to focus on support received or not received during pregnancy. As such, we selected participants in their second trimester of pregnancy because we assumed that by this time, participants had accepted their pregnancies and had decided to carry their pregnancies to term. It was not our intention to focus on participants' contraceptive

practices, and we did not frame any questions around contraception adherence. Yet, participants themselves drew attention to contraception (non)adherence when narrating their pregnancy support stories. Nosipho, Kwanele and Linda all confirmed that their pregnancies were unintended and confessed to not using contraception properly:

Extract 1

Kwanele: …So, I last, I last had it [the injection] in like August last year, so then it had already uhm gone out of my body, of my system, so I should have gone to the clinic and *ja* / okay / gotten another injection.

Extract 2

Linda: …and we [Linda and ex-boyfriend] catch up and that night or the Saturday night we were together and having sex and then on Monday when I / mmhmm / when I came to Grahamstown (3) I knew that it was wrong what I was doing. I don't use anything; it's a risk for me to get pregnant.

Extract 3

Nosipho: And I know that if I had protected sex, I would not have been pregnant. But I did not, so now here is the baby.

In extracts 1-3, Kwanele, Linda and Nosipho self-position as irresponsible sexual subjects. On an individual level, there is self-blaming talk (using i-statements) about becoming pregnant. The pregnancy is framed as a negative consequence of having unprotected intercourse, as indicated by the phrases respectively: "So I should have gone to the clinic", "I knew that it was wrong", and "But I did not [use protection], so now here is the baby". On a macro-social level, these discursive tactics surface neoliberal constructions of irresponsible sexual subjects (Grzanka & Schuch, 2020) who have failed at achieving family planning norms; being sexually active requires personal reproductive responsibility, which exhorts one to make the "right" choices and practice self-discipline by using contraception. Through self-blaming talk, these pregnancies are thus presented as unintended and a negative consequence of the participants' individual failure to adhere to safe contraceptive practices. The negative framing of the pregnancy presents it as *initially* unsupportable because its legitimacy is compromised by contraceptive non-adherence.

A micro-level support interaction (partner) is not explicitly depicted in the above accounts, but its absence is significant. By taking full responsibility for not using contraception during sexual intercourse, the three participants do not position their male partners in any way as partly responsible for contraception (non)adherence or pregnancy prevention. Thus, on a macro-level, heteronormative constraints exempt male partners from responsibilised sexual subject positions in preventing pregnancy. They imperatively position women as reproductive managers, thereby making them wholly responsible for managing reproduction. Simbarashe solidifies this norm where it is seen as a woman's reproductive duty to prevent pregnancy until it is deemed appropriate:

Extract 4

Researcher: Uhm, when you guys, was your pregnancy planned, was it something you discussed that let's make a baby?

Simbarashe: Yeah, that was:: uhm, that was very important to her, that is why she said she is feeling good. Most girls now, in our generation, they just get pregnant at 15 or 14 years. But she:: she tried, she avoided it [pregnancy] up to 20 years, so she's feeling to have a child, sure we planned it.

The notion of planning a pregnancy, "sure we planned it", appears to be more of an afterthought. Simbarashe's response points to how wanted pregnancies may not always be the result of explicitly intending or planning to become pregnant (Borrero et al., 2015). Where we posed questions about whether a pregnancy was planned, we indeed put participants in a position where they had to justify their pregnancies. In not quite being able to answer this question, Simbarashe draws on normative understandings of appropriate motherhood (Macleod et al., 2020), that is, being of an appropriate reproductive age, to justify Kudzai's pregnancy. He does this by positioning Kudzai as a responsible sexual subject who chose to delay early reproduction: "She avoided up to 20 years". He also contrasts Kudzai's pregnancy against teenage pregnancies deemed inappropriate by invoking teenagers as thoughtless, irresponsible and ill-disciplined sexual subjects: "They just get pregnant". To emphasise the legitimacy of the pregnancy (although not specifically planned), Kudzai's appropriate sexual discipline is presented as somewhat exceptional by making normative generalisations about their age cohort's irresponsible sexual practices. At the same time, Simbarashe upholds gendered normative notions of reproduction by positioning Kudzai as the one who was responsible for taking steps to avoid becoming pregnant, thus absenting himself as a man, for also taking responsibility in preventing pregnancy.

The above extracts show how neoliberal framings of sexual agency are assumed; participants had free choice in preventing pregnancy simply by making sure that they adhered to safe contraceptive practices. As Bay-Cheng (2015) contends, this notion of agency overlooks the broader social dynamics that may have a bearing on sexual agency. For instance, individual choice in preventing pregnancy was complicated on a micro-level of support by male partners. Nosipho described the role of her ex-partner in influencing her contraceptive decisions and practices, which resulted in her unplanned pregnancy:

Extract 5

Nosipho: To me, 6 months was (1) a short (.) period of time, but to him it wasn't so he (.) felt that we had been dating for long. But he was (3) I don't know how to put it. We could not see eye to eye when it came to our relationship. For instance, we couldn't come to an agreement over the length of the relationship. That's exactly when I got pregnant, he saw it as a long enough period of knowing each other and I didn't. I sacrificed; I sacrificed my life.

The most common contraceptive interference (CI) behaviours are where male partners force or manipulate women into having sex without a condom. This is often done by male partners to increase their sexual pleasure (Katz & Sutherland, 2020). Katz and LaRose (2019) found that CI is associated with relational power asymmetries within heterosexual romantic relationships whereby women perceive having less power to negotiate sexual and contraception choices with their partners and resort to sexual compliance to avoid conflict. In line with these authors' findings, unequal power dynamics on a micro level are depicted by Nosipho in describing how her partner emotionally manipulated her to have sexual intercourse with him without using a condom. From a macro perspective, Nosipho's partner draws on normative notions of stable and monogamous heteronormative romantic relationships to infer that condom use is only necessary for casual sex. Not acquiescing to her partner's sexual demands implicitly positions Nosipho as uncommitted to the relationship. Nosipho's sexual agency is constrained by gendered normative constraints that privilege male sexual entitlement. Nevertheless, Nosipho still self-positions as personally responsible for "sacrificing" her life by not insisting on using protection. In this way, Nosipho is problematised as a legitimate pregnant candidate.

Micro-interactions with partners also involved mutually agreed upon contraceptive choices between couples. This was usually denoted by the word "we," as evidenced in the following two extracts. However, on a macro level, structural reproductive injustices in the form

of restrictive health policies also played a part in constraining participants' reproductive agency:

Extract 6

Sandra: ...and I didn't want to take any pills, so we were looking into different types of conception [contraception] you know, just like using the natural method [laughs] which isn't really safe. So, we were talking a lot about how we would do that / ok / we also didn't have medical aid to do a vasectomy, and I didn't want to put in a, how do you call it, an IUD, the IUD / yes / we were thinking about it you know, but we didn't want another child.

In this extract, Sandra presents her pregnancy as unwanted. Sandra explained that because she had been unwell, she had stopped using contraception as part of investigating what was causing her ill health. She demonstrates contraceptive bodily autonomy by specifically pointing out what contraception options she was not prepared to take, such as the pill and IUD. On a macro level, the Brazilian public health system (social entity) for accessing men's reproductive health is positioned as limited or inaccessible because a vasectomy was only available through paying for private healthcare. Vasectomy rates in sub-Saharan African countries are extremely low despite country commitments to improving gender-equitable contraceptive access (Jacobstein, 2015). Within the South African context, a *Spotlight* online news article (Kamnqa, 2021) reported that the Department of Health (DoH) admitted only 639 vasectomies were performed in 2020 but could not say whether these figures pertained to both the public and private health sectors. In addition, the DoH could not confirm whether the service was available at least one public health facility per district in each of the nine provinces. Thus, reproductive injustices are structural; health policy and systems do not make access to vasectomies for men readily available and affordable. Structural health constraints result in inequitable gendered dynamics whereby responsibility is placed mainly on women to control their fertility. Nevertheless, Sandra self-positions herself (and her partner indirectly) as irresponsible and risky sexual subjects for not using safer forms of protection despite health structures constraining their reproductive options.

Apart from structural constraints in the health system affecting accessibility to certain reproductive health services, health systems were also implicitly positioned as rule-based by placing constraints on when participants could become pregnant:

Extract 7

Kerry: …so what had happened was I, I had been looking at medical aids and hospital plans (1) I'd gone off my pill, just sort of getting my body ready to conceive */ja* / although we <u>were</u> using contraception <u>because</u> of my hospital plan not kicking in yet / ok / um (1) so we were just trying to be a bit safe.

In contrast to the other participants, Kerry presents her pregnancy as planned. In describing how she prepared to conceive, Kerry legitimises her pregnancy by self-positioning as a family planner and a responsible sexual subject. Her reproductive agency is assured because she is in command of all key pregnancy decisions, such as preparing her body to be healthy for pregnancy, changing up contraception and choosing the right private hospital maternity plan. This is in line with Bay-Cheng's (2015) outline of a neoliberal agentic sexual subject who is constructed as autonomous, entirely in control and an adept consumer of reproductive services. Being able to choose between various private healthcare options positions Kerry as middle class, setting her apart from public health users because she can negotiate the health system as a consumer and not as a mere recipient.

Grzanka and Schuch (2020) would, however, argue that Kerry's reproductive agency is conditional because the timing of her pregnancy is dictated by conditions imposed by the private healthcare industry. In South Africa, private medical schemes treat pregnancy as an existing condition and will not provide maternity cover to individuals if they are already pregnant when joining the scheme (a 12-month waiting period usually applies for pregnancy) (Discovery Health Medical Scheme, 2022). When Kerry explains, "So we were just trying to be a bit safe", she is implying that becoming pregnant while not on private medical health care would be a costly mistake. Thus, should the pregnancy happen before Kerry is covered by private healthcare, it would be understood as wanted but *financially* mistimed. A pregnancy occurring while not having private medical health insurance is not financially justifiable and, therefore, unsupportable. At the same time, Kerry implicitly positions the South African public health system as a non-viable option for maternity health care (elsewhere in her interview, she indeed positions it as "dicey").

In the above extracts, I have shown how neoliberal ideologies (macro-level) impose self-blame, self-responsibilisation and self-surveillance on women's sexual practices (individual level), which have the effect of positioning women as (ir)responsible or (un)disciplined sexual subjects depending on whether their pregnancy was (un)intended. Self-positioning in this way

problematises the legitimacy of the pregnancy, which has implications for its supportability on a cognitive level. These narrative constructions are prevalent despite macro-level structural (in)injustices of unequal gendered norms (partner absence from reproductive responsibilities and partner reproductive manipulation) and health system inequities (unmet need for contraception and restrictive private healthcare policies). Thus, in applying Collins' (2000) domains of power thesis, the productive forces of cultural power (representations of appropriate pregnancy candidates and heteronormative constructions of reproductive responsibility), disciplinary power (neoliberal ideologies of personal responsibility and agency which shape family planning directives issued from health systems; that is they assume pregnancy planning is based on rational choice) structural power (access to contraception options) and interpersonal power (individual ability to control fertility) create the conditions for (non)-legitimate pregnancies.

Participants not only drew attention to their family planning failures in having an unplanned pregnancy, but they and their social networks also foregrounded participants' socio-economic positions as problematic when having an unintended pregnancy.

"When you get pregnant, it is ideal that at least you have your own money".

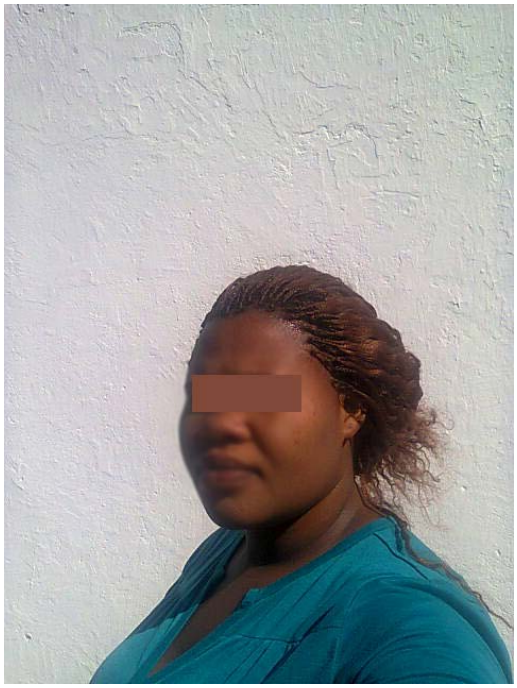
Neoliberal ideologies of self-sufficiency underpin the judgement of poor women for becoming pregnant when they do not have the financial means to do so (Katz & Tirone, 2015). The extracts that follow show how participants' socio-economic positions (imperative positioning) had the power to de-legitimise their pregnancies and themselves as legitimate pregnant subjects. The socio-economic implications of the pregnancy concerning *managing* the pregnancy featured prominently in participants' accounts, and I expand on this in the final analysis chapter. In this chapter, however, I focus on how participants questioned the legitimacy of their pregnancies in relation to their socio-economic status on *discovering* that they were pregnant. On a cognitive level, Thandeka, Sandra and Thando initially questioned the legitimacy of their pregnancies because of their unemployment status:

Extract 8

Sandra: and then <u>financially</u> as well, that's another um (2) um (1) you know / concern /worry because we came here this year for Dan to study, so obviously he's not working, <u>and</u> I'm not working, so we had the amount of money that we could spend every month, but you know that's (2). So, talking to each other, we decided to (1) terminate. We thought it would be better /ok / for our current situation.

Sandra presents her pregnancy as unsupportable because both she and her partner are unemployed (imperative positioning) and her partner is studying (imperative positioning); a legitimate pregnancy can be budgeted for, and being a student is also seen as incongruent with having a baby. Drawing on the couple's social position of being unemployed, Sandra presents their decision to abort the pregnancy as based on sound, rational economic principles. She does this by drawing on neoliberal framings of autonomous choice (Bay-Cheng, 2015) where reproductive decisions are made not only in one's best interests, "we thought it would be better for our current situation" but also as responsible citizens in that one should be self-sufficient when becoming pregnant. The social practice of abortion (entity) is positioned as an economic necessity and a justified "choice" in this instance. Here, Sandra *appears* to exert reproductive agency, but, as she reveals elsewhere in her narrative, having an abortion went against her worldview. Although Sandra might be demonstrating "choice" by deciding to have an abortion, her reproductive agency in deciding to keep the pregnancy is constrained by the couple's financial well-being. Whereas Sandra sought to remedy her non-legitimate pregnancy status by making a calculated, reasoned decision to have an abortion, Thandeka and Thando drew on "bad mother" moralising frameworks to highlight how their non-legitimate pregnancy statuses are deserving of punishment and harsh consequences:

Extract 9



Photograph: Selfie

Thandeka: I took this photo when I first discovered I was pregnant (1), it was earlier on in pregnancy. Discovering that I was pregnant was difficult for me (1) because I thought of many things like I am not working (.), when you get pregnant it is ideal that at least you have your own money (.) so that you can buy stuff and protect your child. If you don't have money, it is difficult to do those things, it's difficult most of the time (1). So I:: I decided to take this photo:: as a reminder of how difficult (.)my pregnancy was so that one day I can look and see what this time was like.

Extract 10

Thando: ...So this time around it's so different. I feel so (1) so helpless, so I sometimes ask myself, what if God took my child because he knew that we wouldn't be able to support him or her? So, I'm just scared, and I think, what if this time around the same thing happens [stillbirth]? God will take the child because he sees that we're unstable and he won't survive basically /mm / so it's just those things going through my mind...

Both Thandeka and Thando self-position as bad mothers for becoming pregnant while not being financially stable. Thandeka infers that those who cannot provide for their children will put their future children's lives at risk by being unable to protect them. In saying "it's difficult most of the time", Thandeka draws attention to how an unintended pregnancy can compound existing financial hardship. By taking a "selfie" to remember her difficulty in accepting her pregnancy, Thandeka is using it as a moralising tool: a reminder of harsh lessons learned where she should either be more sexually responsible in future or ensure that she has employment should she want to have another child. In Thando's eyes, being unemployed (imperative positioning) and pregnant is seen as such a transgression that even a higher being (God) judges the inappropriate nature of her pregnancy. This is tied in with the fear of having another stillbirth; the ultimate punishment would be for her to lose her second pregnancy because she is already a bad mother (imperative positioning) in that she cannot financially provide for it. Similarly to Thandeka, Thando equates poor mothers with bad mothers (attributional imperative positioning) and these mothers are deemed as threats to the survival of their future children.

Pregnancies that occurred while not financially stable were not only seen as non-legitimate on an individual level. On a micro level, participants' social support networks also drew on appropriate childbearing cultural normative constraints to judge participants for becoming pregnant while not employed. For example, Siphe reports how, in her first pregnancy, the paternal family used their son's unemployment status as a tool of judgment to withhold support:

Extract 11

Siphe: So he left [Cape Town] then, and every time I went to his family home to ask for money to go to the clinic for ANC, it's unlike here where you can walk to the clinic, I would be told that they [the family] didn't get me pregnant (1). So, they would tell me that I must wait for him, I got pregnant knowing that he is not working. But with this pregnancy it is very different.

To uphold their son's denial of paternity, the paternal family de-legitimises Siphe's pregnancy by blaming Siphe for becoming pregnant (micro-level interaction). Unequal gender dynamics (macro-level) ensure that no blame is apportioned to their errant son for impregnating Siphe. Instead, Siphe emphasises how the paternal family discursively shifts the responsibility of providing for the pregnancy themselves to her by retorting that "they didn't get me pregnant". In addition, their response serves to position Siphe as ill-disciplined for becoming pregnant when she was aware that the timing of the pregnancy would be financially unjustified. Thus, the pregnancy is deemed her responsibility to bear. In addition, the refusal by the family to provide material support further undermined the supportability of the pregnancy by hindering access to antenatal care.

Whereas the paternal family outwardly judged Siphe for having an unplanned pregnancy and support was purposefully withheld, Thando, in becoming pregnant again while unemployed, chose to forgo getting the necessary support for her pregnancy because she feared judgement from her boyfriend's mother:

Extract 12

Researcher: um, absolutely anything [else] you think has some kind of a significance with this journey?

Thando: Yes, um I think my mother-in-law[23], I miss her being excited like the way she was with the first baby. This time around, we haven't told her /oh ok / didn't tell her at all. We're planning to tell her once the baby is here because she told us that we shouldn't have a baby because we're unemployed and all that, she was kind of negative before even having the second baby so we kinda scared of telling her. So, I miss her being excited, calling me, giving me money, treating me, all that, her long phone calls, yeah, I think I miss her a lot.

Some research in the USA has shown how the stigmatising effects of unintended pregnancies create the conditions for pregnancy non-disclosure to key social support networks, resulting in

[23]Although not married, participants who were in stable heterosexual relationships did refer to their male partner's mothers as their mother-in-law.

a loss of social support (Moseson et al., 2018). Thando admits to the interviewer that she and her partner have transgressed by not following her mother-in-law's advice and waiting to be more financially stable before having another baby. Thando interactively positions her mother-in-law as judgemental. It is inferred that the mother-in-law will see Thando and her partner as financially and sexually irresponsible for becoming pregnant. Thando perceives the pregnancy as non-legitimate in her mother-in-law's eyes such that she keeps the pregnancy a secret, forgoing all possible support that she might have received; she even moved in with a friend rather than with family.

In some cases, however, families de-emphasised a participant's financial responsibility for an unintended pregnancy. For Sandra, her family's non-judgemental acceptance of the pregnancy and offers of financial help enables its legitimacy:

Extract 13

Sandra: Then I decided, we decided to talk to our families, we hadn't told them before and then everyone was very supportive / ok /uh, especially to ease us with the financial situation you know (.) both our families said, you know money is a thing that comes, and goes, / yes /we can help you.

As with Thando, Sandra kept her pregnancy a secret from her family (because she wanted to move to South Africa and was thinking about aborting it), thereby inferring its non-legitimacy. Sandra, being unable to procure an abortion, decides to keep her pregnancy and breaks the news of her pregnancy and the financial difficulties associated with it to her family. In interactively positioning her family as very supportive, Sandra highlights how her family specifically de-emphasises the normative requirement of having to be financially stable to have a child. In positioning income (entity) as fluid and unreliable, "you know money is a thing that comes, and goes", her family helps her to legitimise her pregnancy. Using money as a yardstick for deciding to keep a pregnancy is presented by Sandra's family as unnecessary because financial instability should resolve itself at some point in the future, and they are on hand to support her.

Thandeka also expresses relief that her family have not judged her for becoming pregnant while unemployed:

Extract 14

Photograph: Baby clothes purchase

Researcher: So, you went to the clinic and came back with the results. What did the family say?

Thandeka: No, they didn't have a problem with it (1) such that there:: is another photo with:: baby clothes here from my family.

Researcher: They are nice, hey!

Thandeka: [giggles] This one (.) as I told you that I am unemployed (.), so my parents gave me money and they said in the meantime, I should go and buy baby stuff. This they said was for just for now, so that at least when it happens, and I go into labour I at least have the baby stuff for when I get out of the hospital [sigh]. So they are very supportive (.) So whatever I need I get from them and they don't say oh:: you went and chose to [get] pregnant (.) They are very supportive.

In positioning herself as unemployed, Thandeka signals that she has erred in becoming pregnant. Nevertheless, she outlines the importance of her family's financial support in that she has been able to purchase baby items in preparation for the birth. In interactively positioning her parents as very supportive, she also discursively positions them as non-judgemental of her in becoming pregnant while unemployed; "they don't say oh:: you went and chose to [get] pregnant". Here, Thandeka hints at responses that could be expected from families where women are vilified for becoming pregnant at a financially inappropriate time.

Thus, the unquestioning support from her family legitimates her pregnancy and excuses Thandeka from being labelled as a financially and sexually irresponsible subject.

The above extracts demonstrate how cultural notions of appropriate childbearing judge individuals for becoming pregnant when they are not financially secure. These normative constraints have implications for how families provide or withhold support during pregnancy, which has a bearing on how individuals can exert reproductive agency in presenting as legitimate pregnant subjects and being able to access support from their social networks. Notably, no participants in this study motivated for becoming pregnant because they *could* afford to have a child.

Financially unsupportable pregnancies, however, were attributed to *individual* responsibility for unemployment status and not the South African macro-economic environment, which is unconducive in finding gainful employment (see details on high unemployment figures in Chapter 2). Participants upheld constructions of unintended pregnancies as non-legitimate by positioning themselves as financially irresponsible, as bad mothers due to financial incompetence, and as undeserving of support for becoming pregnant at a time when they couldn't afford to have a child. This was despite their constrained agency in being able to plan a pregnancy with affordability in mind owing to pervasive structural economic inequalities that limit their access to the labour market. As Gomez et al. (2021) found, becoming pregnant when financially secure may be an impossible ideal to attain for individuals with a low socio-economic status, which nullifies consciously planning a pregnancy. A non-legitimate pregnancy is thus produced through disciplinary power (appropriate timing and context for pregnancy; the imperative to have waged work), cultural power (poor or unemployed mothers are bad mothers), interpersonal power (perceived judgement from support networks) and structural power (lack of employment prospects).

Pregnancies were not only (de)-legitimised on account of having a poor socio-economic status. Participants, their support networks and support structures also relied on notions of reproductive maturity to justify a pregnancy.

"I'm [not] old enough to have this child."

In the South African context, teenage pregnancies are highly stigmatised because they are constructed as an urgent public health and social problem contributing to the moral and economic decay of South African society. Macleod and Feltham-King argue (2020) that these notions persist despite multiple intersecting reproductive injustices and normative

assumptions underpinning early reproduction. For example, the South African news media is peppered with teenage pregnancy disaster stories, alarming statistics and politicians who vilify pregnant teenagers, see for instance, *Adolescent/Teenage pregnancy crisis in South Africa* (Sharma, 2023)*, Teenage pregnancy rife in SA* (News 24, 2024)*,* and *Zuma: Send teenage moms to Robben Island* (The Mail and Guardian, 2015). Thus, teenage pregnancies are presented as culturally inappropriate, unsupportable, and to be avoided at all costs. Given this context, reproductive maturity was a common discursive strategy used by participants to (de)-legitimise their pregnancies.

Both Siphe and Kwanele describe how they experienced teenage pregnancy stigma, which delegitimised them as pregnant subjects:

Extract 15

Interviewer: So, when did you tell your mom that you were pregnant?

Siphe: I told my mother when I was 4 months pregnant (.)and she said she will not travel all the way from Maclear to Cape Town just because I am pregnant. Besides, she said, I was sent to Cape Town to study, and I then got myself pregnant by Cape Town boys, she is not going to travel for such (.) She told me I had two options; either drop out of school and look after my baby or I continue with school pushing that big tummy around the school grounds.

In this account, Siphe's mother emphasises that support will not be forthcoming because Siphe has become pregnant at an inappropriate time. Siphe's mother positions her as an undisciplined sexual subject over that of a responsible schoolgirl because she displayed more interest in boys instead of focusing on her studies. Blame for becoming pregnant is thus placed squarely on Siphe. The boy in this process is considered peripheral to the problem; it is entirely Siphe's own actions, by virtue of her undisciplined sexuality, that got her into this mess, as emphasised by Siphe; "I then got myself pregnant". Siphe's mother also amplifies the inappropriateness of a pregnant schoolgirl (imperative positioning) by drawing on notions of pregnancy embodiment; "or I can continue with school pushing that big tummy around the school grounds". Here, pregnancy embodiment is constructed as shameful and out of place within the school environment. Schools as social entities are thus positioned as unsuitable spaces in which to carry a pregnancy and as having no duty nor obligation to support a pregnant learner.

Kwanele also described the visible shame of an inappropriate teenage pregnancy within a primary healthcare clinic setting:

Extract 16

Kwanele*:* Because someone asked me what's going on. I'm like, what do you mean what's going on? And [they] asked me if I'm pregnant, and I was like no, and then they said no, my sister saw you, and you had that white thing…I was just, I was also ashamed of the, what they [the clinic] gave me [maternity case record] because obviously, everyone at the clinic knows what this is for, so I didn't want (.) a lot of people to see me with this.

Researcher: So "this" being the pregnancy folder / *Ja* / so why, why did you feel that you don't want people to know that why you are there, why was it important for you?

Kwanele: uhmm, I (1) I think it was my self-esteem then about (.) okay, I'm in this situation now, and then this is what's going to happen, and this is how people are going to react to what's happened, but then since my mom accepted everything, I've learnt to accept everything and the judgements.

The pregnancy folder that Kwanele is referring to is the official maternity case record (MCR) issued to all pregnant individuals attending public health clinics. All pregnancy details are recorded, and nurses reiterate to patients that keeping the MCR with them for all appointments and giving birth is essential. It is white and sized A4. It is quite distinguishable, and because of its size, it is not easy to hide from view in a handbag. According to Collins (2000), structural forms of power operate through how organisations are organised. Thus, the official health department's maternity case record not only organises and records pregnancies but also operates as a material and structural form of power by communicating who at the clinic is pregnant and attending antenatal care. For Kwanele, it is a source of shame because it is advertising her non-legitimate teenage pregnancy or her positioning as an undisciplined sexual subject to the wider community, thus prompting the judgemental scrutiny of others. Only the acceptance or legitimisation of the pregnancy by Kwanele's mother (micro-level support), however, is key to alleviating some of the shame (macro-level normative constraint) associated with the pregnancy.

Whereas Kwanele and Siphe could not overcome being branded as non-legitimate pregnant subjects because of their ages, and accepted self-blame and responsibility for their situations, Nosipho uses her age to justify going ahead with her unplanned pregnancy:

Extract 17

Researcher: So, does that mean that this was an unplanned pregnancy?

Nosipho: The baby was not planned, but because of my age:: and considering that I have completed school::, I can work for myself::; I'm not like someone or a child in Grade 11 (.) so termination was not an option.

Nosipho uses interpersonal power to contrast her more privileged position (sufficient reproductive maturity and independence) to that of a pregnant teenager to legitimate her pregnancy. In drawing on the normative constraint of culturally appropriate pregnancies, she positions an entity, school, as incompatible with pregnancy. She also presents teenage pregnancies as so unsupportable in that they are more likely to be aborted. The social practice of abortion is also stigmatised through age-related discursive tactics. Abortion is positioned as a drastic intervention because Nosipho directly links the practice to a stigmatised teenage pregnancy; abortions are for teenage (inappropriate) pregnancies and not for people who fulfil the mandate of reproductive maturity. In this way, Nosipho is using her reproductive maturity to regain some agency for having an unplanned pregnancy and a partner who deserted her because of the pregnancy.

Socially, teenage pregnancies are often deemed disastrous, but Tayla used the notion of successful teenage pregnancies to motivate legitimate her pregnancy:

Extract 18

Tayla: That magazine really motivated [Tayla sneezes] me and made me feel good about being pregnant. Because I actually thought I was still young, I haven't achieved that much yet that I want to do. But I thought no, *mxm*[24] I : : I'm : : I'm not the only one, and I'm not young. You get

[24] "Mxm" is a colloquial click sound. It can be used to express displeasure at someone's behaviour, disagreement with something or someone, and it can also be used to express impatience or dismissiveness. Tayla is dismissing her own concerns that her pregnancy is ill timed.

> younger children like my cousin, she is 15 years old, she has a baby, she is doing fine, she is a good mother so (.) I: I'll probably be a good mother, too; hopefully, I know I will.

Although Tayla was married and 25 years old, her pregnancy was unplanned. Despite the pregnancy happening within the "normative" reproductive life course stage, Tayla still felt that she did not quite have the required maturity or life experience to become a mother and struggled to see her pregnancy as justified. Not meeting one's life ambitions because of an unplanned pregnancy is represented as a loss or failure of sexual agency (Bay-Cheng, 2015; Gomez et al., 2021). To regain some agency, Tayla attempts to normalise unplanned pregnancies, "I'm not the only one", thus excusing herself from individual failure to plan her pregnancy by casting unintended pregnancies as common. Tayla also pushes against the normative cultural constraint of appropriate childbearing (cultural power) by positioning a teenager, someone who is 15 years old and who has had a baby, as a good mother. Tayla does this to allow some leeway for her lack of life experience, which she believes might negatively influence her parenting abilities.

Nevertheless, she still uses interpersonal power to contrast her reproductive maturity, "I'm not that young", with that of her teenage cousin. The right reproductive age is still a pre-condition for having a legitimate pregnancy. As Bay-Cheng (2015) argues, in trying to regain agency (from an unintended pregnancy), individuals may not only take responsibility for their actions but will also contrast their relatively privileged social positions against others who are more marginalised (adolescents in this case), thereby upholding particular oppressions (teenage pregnancy stigma). This aligns with Wilkinson and Kitzinger's (2003) theorising of positioning, where the discursive positioning of others using social categories can uphold oppressive social norms.

Another way in which participants used their self-positions of reproductive maturity to justify their pregnancies was to compensate for their lack in other social attributes, such as not being married:

Extract 19

> Ntombi: … My boyfriend kept telling me that "perhaps your family will not react as negatively as you think, because they were strict with you. And you have never really messed up or done things to disappoint your parents". And he suggested that I just give them a chance because "their reaction will oppose what you expect". And really that was the case. They really surprised me.

The fear of judgement from social support networks suggests that participants had trouble legitimating themselves as pregnant subjects. Ntombi has self-positioned as an irresponsible sexual subject by delaying the disclosure of her pregnancy to her parents. She is not married but was cohabiting with her boyfriend at the time of her pregnancy (and he lied about this to his family – see Ntombi's case study in Appendix 11). Thus, it could be argued that her lack of marriage status, together with an unplanned pregnancy, might be seen as inappropriate by her parents. In this micro-interaction, Ntombi's partner hints at her suitable reproductive age when encouraging her to disclose her pregnancy to her father: Her boyfriend counters Ntombi's self-positioning as an irresponsible sexual subject by claiming that "you have never really messed up or done things to disappoint your parents". In this way, he re-positions Ntombi as a dutiful and obedient daughter. The cultural norms of appropriate pregnancies are implicit in his argument. Because the couple cannot use the marriage institution to justify the pregnancy to Ntombi's parents, Ntombi's partner draws on her suitable reproductive age to have a pregnancy (aged 24). In explaining that she has never done things to disappoint her parents (read engaging in irresponsible teenage sexual behaviour), her pregnancy is deemed legitimate in that she has at least escaped the clutches of an inappropriate teenage pregnancy.

As with Ntombi and her boyfriend, Simbarashe and Kudzai are unmarried. Simbarashe does not focus on the couple's relationship status in explaining why he is happy about the pregnancy but instead prefers to focus on his reproductive maturity:

Extract 20

Researcher: Yeah, ok, so why is it important for you Simbarashe to be involved in Kudzai's pregnancy?

Simbarashe: Because I am the owner of the pregnancy. I'm feeling like I'm pregnant also [laughs] because this one it's me also (.) because I'm inside her, so I must be there, for everything, for her.

Researcher: So how long have you guys been together?

Simbarashe: eh, approaching 2 years.

Researcher: So, this is your first child, for both of you?

Simbarashe: Yes, my first child (1) in 27 years.

Researcher: Do you feel like it's long overdue? [laughter]

> Simbarashe: Yes, it's been very long time, because mostly at 22 years/20 years, so I passed those years. So, I'm feeling that I will be a good father.

Simbarashe exerts reproductive agency by presenting the pregnancy as legitimate despite the couple not specifically planning the pregnancy (see extract four above). Firstly, Simbarashe declares his paternity by taking "ownership" of the pregnancy, drawing on gendered social norms whereby children can be viewed as male possessions. In doing so, Simbarashe explains that the pregnancy is part of him too "I'm feeling like I'm pregnant also", thereby reaffirming that his biology is very much integral to the possibility of the pregnancy. The pregnancy, then, is seen as an affirmation of his male fertility. Moreover, it is justified because *he* is present and accepting of the pregnancy. Secondly, Simbarashe draws on normative notions of "advanced" reproductive maturity, "yes, my first child (1) in 27 years", to justify the pregnancy, thus implying that it is high time he produces offspring. According to Simbarashe, the "normal" time to have children is when one is in their early twenties. Simbarashe also positions his advanced maturity as a precondition for ensuring that he will be a good father, and thus, the supportability of Kudzai's pregnancy is affirmed.

Present and accepting partners legitimated participants' pregnancies. These are covered in more detail next.

"This is the result when you are happily married."

A present male partner legitimated participants' pregnancies whilst paternity denial de-legitimised participants' pregnancies. Heteronormativity (macro level constraint) enables the supportability of pregnancies when a pregnancy occurs within a stable long-term relationship or marriage. This is in line with other research where the acceptability of a pregnancy is based on being in a stable relationship (Gomez et al., 2021).

The traditional marriage institution can be viewed as a vehicle that upholds pronatalist ideals in that childbearing and motherhood are assumed, normalised and expected (Meyers, 2001; Morison & Macleod, 2015). Applying Collins' (2000) domains of power thesis, marriage as a social entity operates as a form of cultural power (appropriate childbearing), structural power (organised heterosexually to produce children biologically) and disciplinary power (the discipline to wait for marriage before having children or the duty to produce children within marriage). It thus paves the way for heterosexual women to have legitimate pregnancies. The two extracts below demonstrate how participants saw the marriage institution as enabling the

supportability of their pregnancies because they were able to legitimise their pregnancies, whether intended or not.

Extract 21

Photograph: So, this is the result when you are happily married

Tayla: I took this [photograph] to surprise my friends on Facebook. Because most of my friends on Facebook are people who I grew up with or people who I went to school with and just…people around my community, who know me. And, since I was far away from home, I didn't wanna just broadcast it like this "I'm pregnant". I just thought uhm let me put this in [photographs of pregnancy tests] and then I wrote a subtitle that said (.)uhm "so this is the results when you are happily married" [laughs]. And they congratulated me, and it was nice reading the comments because I actually thought that you must know what that is [laughs], I don't have to say I'm pregnant. You should know what those two lines are [giggles], like yeah, I'm pregnant.

Extract 22

Anelisa: You see my first child I had at 30, because I <u>never</u> thought I would have a baby. I didn't want a baby (2) but ever since I got married, I had to have children because my husband wanted children.

Tayla and Anelisa position the social entity, marriage, as family-centred. The social imperative to have a child is enforced through marriage, and thus, it is normal and appropriate to become pregnant or have children when married (Meyers, 2001). The legitimacy of Tayla's pregnancy is assumed, despite it being unintended, by the way in which she announces her pregnancy. In

this online micro-level interaction, Tayla encourages her Facebook friends to guess the "obvious" by directly linking her marriage status (picture caption) to positive pregnancy tests (pictures). Tayla's self-positioning as a married woman affords her power and agency to publicly disclose her pregnancy on social media and *expect* congratulatory responses from her Facebook friends.

According to Meyers (2001), childbearing decisions within heterosexual relationships might be seen as mutual but are imbued with gendered power inequities that constrain reproductive autonomy. In contrast to Tayla, Anelisa's self-positioning as a married woman diminishes her power (and agency) in choosing to be child-free. On a macro level, heteropatriarchy operates by privileging male desire to have children over Anelisa's reproductive preferences. Anelisa simply legitimises her pregnancy because she is married and because she is expected to defer to her husband's reproductive wishes. Normative sexual subject positionings are affirmed for both Tayla and Anelisa because they are expected, by being married, to achieve pronatalist marital norms.

As discussed in the introduction chapter, marriage rates are declining, and there is a high non-marital fertility rate in South Africa (Biney et al., 2021; Posel & Rudwick, 2013, 2014a). In line with these statistics, most participants in this study could not rely on the marriage institution to legitimate their pregnancies and used being in a stable romantic partnership as a basis upon which to justify their pregnancies. These extracts are discussed next.

"This baby has a father."

Kerry describes how her pregnancy is the product of a long-term, stable union with her partner:

Extract 23

Researcher: And your partner, you mentioned fiancée, so did that change happen after the pregnancy?

Kerry: No, no, I mean, we've been together for, I suppose, about roughly, almost six and a half years. So, we got engaged after, well, within the first year / ok /um so it's pretty much just been, *ja*, and we had been planning this, so it wasn't a surprise to find out that we were pregnant. It was just a surprise at how quick it happened / yes / but *ja*, so we have been sort of talking about it for a while.

In this extract, the interviewer has specifically framed her question from a normative notion of appropriate childbearing by linking Kerry's engagement status to the discovery of the pregnancy. This line of questioning infers that the pregnancy might have been unintended, which required getting engaged to ensure that the baby is born within the marriage institution. This line of questioning forces Kerry to justify her pregnancy to the researcher. She does so by positioning her romantic relationship (social entity) as committed and stable, normalising this type of relationship as a sufficient precondition for having a child. She also dispels any notion of the pregnancy being unintended by affirming that the pregnancy was not a surprise. Thus, Kerry assumes reproductive agency and self-positions as a legitimate pregnant subject because the pregnancy has come about through conscious choice and mutual pregnancy planning discussions with her partner (micro-interaction) over time. The gendered dynamics concerning individual reproductive desires appear egalitarian, as denoted by Kerry's use of "we" in explaining how the couple came to a decision to have a baby.

As with Kerry, Xoliswa also justifies her pregnancy by using the stability of her romantic relationship upon which to have a child.

Extract 24

Researcher: The way he supports you (1), eeh, when comparing the kind of support from your ex [father of the first born], how is it different or similar?

Xoliswa: Well, eeh (1), with my current partner, I haven't found anything to complain or be miserable about (1) because this is the third year since we have been together. It is the first time that I get pregnant for him, but I haven't felt any (1) regret for being pregnant with his child or being in a relationship with him.

The South African literature on fatherhood has pointed to the construction of desirable manhood as tied to the ability to father children (Hunter, 2006; Kriel et al., 2019; A. Swartz et al., 2018). In Extract 24, Xoliswa self-positions as a reproductively accomplished; she has achieved reproductive success by being able to give her partner a child, thereby affirming his fertility; "I get pregnant for him". By saying "being pregnant with *his* child", the pregnancy is seen as a form of male ownership. Thus, Xoliswa has no regrets because the pregnancy is entirely accepted and desired by her partner (which suggests that there would be regrets if he were not on board with her pregnancy). Although Xoliswa draws on the stability of her romantic relationship (social entity) as justification for the pregnancy, the normative constraint of heteropatriarchy (macro-level) is operational by privileging male desire to have children. Xoliswa frames her acceptance

of her pregnancy in relation to her partner's acceptance: "I haven't found anything to complain or be miserable about". Thus, in the absence of the marriage institution, male acceptance of the pregnancy operates as a powerful conduit to appropriate childbearing, which enables Xoliswa to position herself as the legitimate pregnant subject. The pregnancy is, therefore, supportable because the male partner desires children, has accepted the pregnancy, and the relationship is stable.

Siphe also links appropriate childbearing to having a present and supportive male partner by contrasting her two very different pregnancy experiences:

Extract 25

Researcher: Uhm, so now:: now, when you compare, because you said the father of your first born was absent, what is so different with this partner and this pregnancy?

Siphe: Well, when I look back, in the previous pregnancy, there were times when I would lock myself in the room (.), cry, hate myself, hated being pregnant and regretted it. But with this one, even when I am walking the streets, I am proud and happy. I don't have any regrets, because the father of this baby is showing me support even before this child is even born.

Siphe draws a stark contrast between what is a legitimate and non-legitimate pregnancy. Partner absence and presence are the key mediators that determine legitimate pregnancy status. Having a pregnancy where a partner is absent means isolation, shame and regret. In emphatically positioning her current partner as supportive and present (micro-level interaction), Siphe demonstrates how she has more social power by publicly showing off her pregnancy compared to hiding away in her bedroom during her first pregnancy. The legitimation of Siphe's pregnancy is accomplished by comparing her privileged position of being in a stable heterosexual relationship to that of her former self: a young, single mother.

Both Xoliswa and Siphe associate being pregnant with regret should partner presence and support be missing. It is, therefore, inferred that regretted pregnancies (read non-legitimate ones) belong to those who are not in stable relationships with supportive male partners. Thus, the spectre of the undesirable social position of single motherhood is invoked as Siphe and Xoliswa draw on their social positions of being in heterosexual, stable relationships to justify their pregnancies. Being pregnant within a stable union also protects Kerry's, Siphe's and Xoliswa's sexual agency; their sexual behaviour falls within the "charmed circle" of sexual

respectability because they conform to monogamous, stable heterosexual relationships (Bay-Cheng, 2015; Rubin, 2006).

Whereas participants who were in supportive heterosexual partnerships found it much easier to legitimise their pregnancies, those who experienced paternity denial when becoming pregnant found that their pregnancies were disastrously de-legitimised. I present these extracts next.

"He is not singing the same tune of wanting this baby."

This micro-narrative centres on how patriarchy operates on a macro-level of the supportability framework by exerting male dominance over participants' acceptance and legitimisation of their pregnancies. Unequal gendered power relations ensured that male partners had the power to reject the pregnancy, and participants had very little recourse in calling their partners to account. Male partners used reproductive coercion and control to impose their reproductive wishes on participants. According to Moore et al. (2010, p. 1378), "Reproductive control occurs when women's partners demand or enforce their own reproductive intentions whether in direct conflict with or without interest in the woman's intentions, through the use of intimidation, threats, and/or actual violence". This form of control, the authors argue, can undermine a woman's reproductive autonomy concerning pregnancy decision-making, whereby partners may exert pressure on women to either have or end their pregnancy. Participants in this study spoke to this form of male control:

Extract 26a

Nosipho: He actually said "/f you don't (.) have a 2nd option [termination] with regards to keeping this baby, just know that I won't be, will not be able to be the father to the baby and I will also not be with you. So do not tell me you need support or the child needs support; I consider myself as not having a baby". I told him it's ok.

Extract 26b

Nosipho: I think that's what damaged my life; I just became "wrong". I think the difference would have been massive if he was present in my pregnancy because he seemed supportive at the very beginning before I caught on his alternative agenda [termination of pregnancy]. I was all right in everything; I was always positive and happy.

Extract 26a shows the micro-level interaction between Nosipho and her partner regarding her pregnancy. Nosipho describes how her partner rejected her and the pregnancy by giving her an ultimatum: either abort the pregnancy or lose the relationship and expect no paternal support for the child. Thus, unequal gendered power relations (macro level) are at play whereby Nosipho's partner used verbal threats of ending their relationship and paternity denial in an attempt to control Nosipho's reproductive choice to keep her pregnancy. Although Nosipho might have demonstrated reproductive autonomy in keeping the pregnancy, this has consequences for her concerning its legitimacy.

In extract 26b, Nosipho initially self-positioned as happily pregnant. This, however, is based on her assumed belief that her partner was supportive of the pregnancy. Being "all right in everything" indicates that the pregnancy is accepted and justified despite being unplanned. However, the denial of the pregnancy by Nosipho's partner forces her into an imperative position of single motherhood. Nosipho describes how her life has been "damaged" and feels "wrong". This suggests that pregnancy has no place if it does not happen within a stable romantic relationship, thereby undermining its supportability. By contrasting the stark difference in how she perceives the value of her partner's presence in her pregnancy to her current situation, Nosipho discursively shows how her pregnancy has been delegitimised through his absence. Nosipho may have asserted her reproductive autonomy by keeping the pregnancy. However, her position as a sexual agent who has lost control of her fertility is now highlighted by her partner's absence.

Ayabonga, who did not want to become pregnant again, was manipulated into having another baby by acquiescing to her partner's reproductive wishes:

Extract 27

Researcher: So you say it's been 5 years of dating and that he wanted the baby. How did your partner communicate this with you?

Ayabonga: He would say "I want a baby". So, [deep breath] when I refuse, it would appear as if I was "busy" on the sides. But I was not busy on the sides, I just didn't want a child because I already have children. (1) But now he is not singing the same tune of wanting a baby.

Ayabonga clearly indicates she does not want to get pregnant again because she has enough children. Ayabonga's reproductive agency is constrained as she attempts to resist the stigmatising effects of being positioned as an unfaithful partner; "when I refuse, it would appear

as if I was 'busy' on the sides". Here, her partner engages in reproductive manipulation to convince her to become pregnant again. Thus, interpersonal power (male partner manipulation and dominance), disciplinary power (normative framings of appropriate female sexuality) and cultural power (positioning unmarried women as sexually loose or promiscuous) collude in forcing Ayabgonga to have a pregnancy she feels is not justified. Ayabonga's disempowerment and outrage are visible in her statement, "But now he is not singing the same tune of wanting a baby". Implicit in this statement is that despite Ayabonga not particularly wanting the pregnancy, it was legitimate because her partner had wanted it. The change in his attitude toward the pregnancy derails its legitimacy.

Father absence or denial of paternity in relation to pregnancy is a feature of South Africa's reproductive landscape (Lewinsohn et al., 2018; Nduna & Jewkes, 2012). This has been attributed to low marriage rates and an enduring legacy of apartheid that has disrupted cultural practices concerning pregnancy. It has also been shaped by high unemployment and the persistence of migratory labour working conditions that disrupt family formation for those men who do find work (Malinga & Ratele, 2022). Some male partners de-legitimised the pregnancy by denying or attempting to deny paternity:

Extract 28

Researcher: so when you found out that you were pregnant:: eeh, how did that make you feel?

Thandeka: [deep breath] (.)I was happy about it since it is my first child, but:: then(.) I started questioning myself; many questions ran through my mind (1) because I am unemployed. Additionally, the:: the father of the child is:: is far from me (.) and he is not bothered by this. So, I started asking myself questions about what I am going to do when the baby is here.

Thandeka feels that her pregnancy is justified because it is her first child (she is 28 years old and therefore of appropriate reproductive maturity). However, her unemployment status, combined with the lack of involvement of her partner, "and he is not bothered by this", makes her question the validity of her pregnancy. Although patriarchal forms of power are operational in that the partner can reject the pregnancy without being held to account, structural power in the form of the migratory labour system also plays a part in the process of delegitimising the pregnancy through the partner's absence. In describing to us, "[he] is far from me", Thandeka refers to their long-distance relationship. Thandeka's partner works in the Ceres region of the Western Cape as a migrant farm worker, while work opportunities in the same area for Thandeka are more seasonal. Limited employment prospects for Thandeka mean the couple do

not see each other for long periods. Later on in her narrative, Thandeka describes how her partner uses their long-distance relationship to question the paternity of the pregnancy and claims "that the problem is he is not sure the child is his". Thus, male partners also positioned participants as paternal fraudsters when rejecting the pregnancies. In using such positioning, male partners draw from normative cultural tropes of immoral female sexuality to avoid taking responsibility for the pregnancy. This tactic is similar to the findings from Nduna and Jewkes' (2012) study on young women's narratives of disputed paternity. Linda is put in a similar position by her ex-boyfriend:

Extract 29

Linda: Then I go to the clinic /mm / and everything come out pregnant /ok / and (2) first at night I was cool, I was fine. At night when I phoned this boyfriend that I was with /mm /I've told him I'm pregnant /ok /and he said no, he said, yeah anyway, who is the father, and I said you're the father. He said no it can't be; I said yes, it is you / mm hm / I said I didn't sleep with any man…but in that time I was with no one and that's why I said it is only you, I was with no one else, I didn't have any other boyfriends and stuff.

Although Linda's pregnancy was unplanned and came as a shock, she does describe herself as initially accepting of it: "I was cool, I was fine". As with Thandeka and Nosipho, the attempted denial of the pregnancy by her ex-partner throws the legitimacy of Linda's pregnancy into question. In this extract, Linda shows how her ex-partner attempted to deny the pregnancy by asking who the father was, thus implicitly positioning her as a paternal fraudster. In response to his attempted denial of the pregnancy, Linda is responding to cultural forms of power that stigmatise single women who become pregnant and who are represented as predatory threats to men (that is, the pregnancy is used to force commitment from unattached men) (Turney, 2011). Linda is forced to justify her sexual behaviour by self-positioning as a respectable sexual subject to resist normative immoral framings of female sexual predatory behaviour.

Male partners, however, were not the only ones to use the above-outlined strategies to de-legitimise the pregnancies of participants, as is shown in the two extracts that follow. Siphe described how her pregnancy exacerbated tensions between herself and her partner's siblings because they competed for his financial resources:

Extract 30

Siphe: ...So it's as if I am the one that says John [Siphe's partner] must get the money back from his family yet before he would not want it back. The sister will tell John that she saw me in the location [township] walking with men. She and the brother live in the location. So, he must be careful, maybe this child is not even his, probably I got pregnant in the location and now I am accusing John of being the father. So, I do not get along with them.

Extract 31

Linda: ....but it's just this thing of (.) there's now people there like his his mother and some of his friends that says, yeah I must go and look for my men that I've had (.) why must I, why must I point to [boyfriend's name] to be the father of this baby / oh my gosh /and it makes me feel so bad.

The wider community and paternal families can also uphold paternity denial. These social networks deploy strategies similar to absent partners by trying to de-legitimise the pregnancy. Both Siphe, "I got pregnant in the location [township], and now I am accusing John of being the father", and Linda, "Why must I point to [boyfriend's name] to be the father of this baby?" are positioned by social networks as paternal fraudsters. Siphe describes how she has been accused of controlling her partner's money by insisting the siblings repay the money her partner lent them. Thus, the competition between Siphe and her partner's siblings for his financial resources prompts his siblings' delegitimisation of her pregnancy. The siblings achieve this by casting aspersions on her faithfulness to their brother. As with Siphe, Linda also finds that her ex-partner's family and friends cast aspersions on her sexual conduct, "yeah, I must go and look for my men that I've had". The de-legitimising of the pregnancy in this way makes Linda feel shamed and judged by her community for becoming pregnant: "It makes me feel so bad". Thus, by drawing on sexual moralistic frameworks that position unmarried pregnant women's sexual agency as deviant, male partners and social networks discursively de-legitimised participants' pregnancies by upholding gendered norms that make pregnancies the products of women's uncontrolled sexual behaviour (Turney, 2011).

The above extracts have shown how women in unmarried heterosexual relationships and who become pregnant occupy socially precarious pregnant subject positions. Men are imbued with reproductive agency and are positioned as key reproductive decision-makers. Whereas reproductive agency is enabled for men who can "choose" whether to be part of the pregnancy, reproductive agency for participants was highly constrained based on paternity

acceptance or non-acceptance of the pregnancy. Where male partners accepted the pregnancy and remained in the relationship, participants' social positions as legitimate pregnant subjects were assured, and the supportability of the pregnancy was enabled. On the other hand, the supportability of the pregnancy was jeopardised by paternity denial. Paternity denial (instigated by both male and social support networks) delegitimised participants' pregnancies and, in so doing, forced participants into undesirable social positionings of sexually deviant, single unwed mothers.

Nevertheless, participants who experienced paternity denial sought to recover from occupying a non-legitimate pregnancy status by justifying their pregnancies through normalising single motherhood. This process of legitimisation sans a male partner is presented next.

"The child will still grow without a father."

Where male partners had rejected the pregnancy, support networks found ways to help participants legitimise their pregnancies. As with Bottoman et al.'s (2024) findings, social support networks negotiated the gender dynamics inherent in paternity denial during pregnancy by normalising the partner's absence from child-rearing. From a neoliberal perspective, reasserting reproductive agency can be re-achieved by reframing one's "mistake" (read single pregnant mother) as resilience without necessarily challenging the circumstances that played a part in shaping the mishap (Bay-Cheng, 2015). In the extracts that follow, support networks used a strategy of resilience to help participants legitimise their partnerless pregnancies:

Extract 32

Thandeka: My friends are very supportive (.). Most times, like I said before (.), when I need something for an example I need money, they give it to me (.) Even when I:: had problems with the father of my child, I told them and I offloaded all my concerns (1) and they then encouraged me (.) and consoled me. They advised me that it's not a stressor, I am not the only one (.) that is affected by this, their children also have absent fathers, and they are growing without them. They told me that my child will not be the first child to be an absent father, the child will grow.

Extract 33

Nosipho:...So, you will be fine, we have raised our children without their fathers (.) and you saw how we didn't really struggle (.) as we thought we would [when their fathers rejected us] and we were still pregnant.

Extract 34

> Linda: and my mother is also supporting me through this / ok / yeah, … she talked with this lady who is talking a lot of things about me, and then she said to her (3) you mustn't talk about others like that (.) She also got children / mm / that she is raising / right / and we don't care about them /yeah /we're gonna make this, we're gonna let this child grow and to take care of this child / yes / and she's gonna help me.

Social support networks all draw on self-positions of reproductive autonomy to legitimise the pregnancy; that is, mothers have managed to raise children on their own despite paternal non-involvement and the social judgements surrounding single or unwed motherhood. In normalising partner absence, support networks interactively position male partners as unnecessary fathers. This positioning work enables support networks to shift the interpersonal power dynamics of male control to being under their control. The imposed positioning of single motherhood on pregnant participants is cast as common as Thandeka and Nosipho's friends assure them: "I am not the only one that is affected by this" and "my child will not be the first child to have an absent father". Participants push back on the normative cultural constraint of appropriate childbearing where single motherhood is vilified. Instead, support networks position participants as capable single mothers. This form of positioning is invoked by the phrases "their children also have absent fathers, and they are growing without them" (Thandeka's friends); "we're gonna make this, we're gonna let this child grow" (Linda's mother); "we have raised our children without their fathers" and "you will be fine" (Nosipho's friends). Therefore, in showing solidarity and by elaborating on common experiences, support networks become fundamental in helping participants to justify their pregnancies thus enabling the supportability of the pregnancy. At the same time, however, this strategy of resilience serves to normalise and uphold the normative notions of male partners being positioned as absent fathers.

In addition to support networks, support structures such as cultural practices (*intlawulo*) could both enable or constrain the legitimacy of the pregnancy. I discuss how participants perceived this cultural practice as a mechanism to legitimise their pregnancies to both the maternal and paternal families next.

"Paying damages can damage good family relationships."

Talk about family reactions to the pregnancy included how cultural practices, such as *intlawulo,* had the potential to (de)-legitimise participants' pregnancies. In amaXhosa

communities, *Intlawulo*[25] is a cultural practice whereby the male partner's family pays compensation ("damages") to the maternal family for impregnating their daughter outside of marriage**.** Scholars have cautioned that *intlawulo* is not a homogenous practice and is understood and practised differently (Malinga & Ratele, 2022; Nkani, 2017). For example, the practice is understood as a form of apology for disrespecting the maternal family because the pregnancy has undermined their daughter's value concerning her virginity status and her marriage prospects (Nkani, 2017; Patel & Mavungu, 2016). It is also understood as taking responsibility for the pregnancy as the biological father (Nduna, 2014). According to Samukimba and Moore (2020), the custom enables the two families to form a connection; it marks respect for the maternal family by the paternal family and is a mechanism through which the future child can secure paternal ancestral ties and familial protection.

Research on *intlawulo* has also presented different perspectives on the practice. For example, it has been seen to reinforce gendered norms and hierarchies by positioning women as sexually amoral (Nkani, 2017) and men as financial providers (Malinga & Ratele, 2022). Other research has shown that the practice may facilitate the construction of alternative masculinities such as respect, patience, flexibility, compromise and acceptance because power is vested with the maternal kin to grant the biological father access to the future child (Samukimba & Moore, 2020).

Traditionally, the maternal family initiates the custom, and male members lead the negotiations between the two families regarding how much and in what ways the compensation will be paid. However, power is still vested in the maternal family concerning how and in what ways the father will have access to the child once he has satisfied particular compensation-related conditions (Nkani, 2017). Moreover, the child still "belongs" to the maternal family through name and lineage until full *ilobolo* (bride-wealth) is paid (Samukimba & Moore, 2020). However, a couple is not always expected to get married after paying *intlawulo* (Hunter, 2016).

---

[25] *Intlawulo* is the isiXhosa spelling of the word. Other scholars who have researched the customary practice in KwaZulu-Natal have used the isiZulu spelling which is *inhlawulo*. All participants who spoke about the practice identified as Xhosa and the isiXhosa version of the word is used in this research project.

Despite the custom mainly centring on the future relationship between the biological father and child, it could be argued that the practice operates as a cultural macro support structure or a structural form of power (P. H. Collins, 2000) which facilitates paternal acknowledgement of the pregnancy, thereby enabling a form of support for pregnant women. Of the participants who identified as Xhosa, Kwanele was the only participant who spoke about the practice without being prompted in her interview**.** We intentionally asked Xhosa participants whether they had or intended to complete the practice of *intlawulo* if they were not married. This was because we wanted to expand on the elements of the supportability framework, including cultural practices. Participants responded to our questions on *intlawulo* by positioning the practice as mostly unsupportive of their pregnancies in securing paternal involvement and support. They were circumspect as to whether the practice enabled family acceptance of their pregnancies:

Extract 35

Researcher: So, traditionally, a woman gets taken to the boyfriend's family to report pregnancy. Was that something you discussed as a family?

Thandeka: No (.) [sigh], taking the pregnant woman to the father's baby's family is not done anymore because your family is going to take you to that home, and then people there will just be disrespectful to them or tell them stuff that they never even anticipated. That will break their hearts (.), so the best thing to do is take care of their grandchildren the best way they know how. Then, if the father of that child is interested in their child, it is they who are going to initiate that and come and pay visits to the child.

Thandeka cites not adopting the practice because her partner has denied paternity. Thandeka argues that the paternal family should initiate the practice should they want a relationship with the future child. As mentioned previously, it is usually the maternal family that initiates and leads the negotiations of *intlawulo.* Scholars who have interviewed men on the practice of *intlawulo* found that men claimed that they were not able to gain access to their children until the maternal family initiated the discussions between the families. Men felt it was unprocedural to initiate the process themselves, even if they were willing to complete the practice (Samukimba & Moore, 2020). Thandeka nevertheless adopts a passive subject position concerning the practice by confirming that no discussions about *intlawulo* were instigated by anyone in her family. Because her partner has denied paternity, Thandeka positions the paternal family as potentially disrespectful and denialist toward her pregnancy. In using the phrase "telling them stuff they never even anticipated" and expressing concern that her

parent's hearts might just get broken in the process, Thandeka fears that the paternal family might humiliate and shame Thandeka's family for her pregnancy should they attempt to claim compensation. Thandeka's concerns are similar to findings in other research where maternal kin may avoid the practice and simply take on the responsibility for raising the child (Mkhwanazi & Block, 2016). As such, Thandeka sees the custom as unsupportive in restoring paternal relationships and instead may amplify the inappropriateness of her pregnancy by drawing attention to her immoral and irresponsible sexual subject positioning.

Xoliswa confirms that she did not need to complete the custom because her relationship with her partner is amicable:

Extract 36

Researcher: In Xhosa culture, your family must take you to your partner's family so that they can pay for damages. Have you done that?

Xoliswa: No, because this is my second pregnancy. If it was my first pregnancy, they [the maternal family] were going to take me.

Researcher: So, they do not pay damages when it is a second pregnancy?

Xoliswa: If we [Xoliswa and her partner] were not getting along, we are getting along.

Xoliswa dismisses the possibility of carrying out *intlawulo* by claiming that her context does not fit with the procedural requirements of the practice because she and her partner "are getting along". She positions paternal family relations as amicable and supportive, requiring no intervention. Here, Xoliswa positions *intlawulo* (entity) as an accountability mechanism (a disciplinary form of power) to call male partners to account should the relationship between the couple be under duress or have broken down. Notably, Xoliswa adopts a passive subject position in relation to the practice should it have been followed by saying, "They [her family] were going to take me". This is suggestive of the pregnant individual being a passive recipient of the practice in that they do not have any say in whether they personally want the practice to be initiated. They also do not imply they have any negotiating role in the proceedings. In this way, their reproductive agency can be construed as constrained as negotiations are carried out by the maternal kin on behalf of the pregnant individual without their direct involvement.

Two other participants, Kwanele (whose family completed the practice) and Thando (who decided on her terms not to initiate the custom), raised concerns as to how *intlawulo* would affect the overall relationships between family members. This was especially true where

a partner was present and supportive and where the paternal family already supported the couple:

Extract 37

Kwanele: … I think it's five cows, and each cow is like R2 500, it's like R10 000 as a whole and it was very surprising because I didn't even know how much you pay, and I was like, *yoh!* I wish this is not like an *ilobolo* negotiation and then the people are going to run away because you are charging them too much and stuff like that, and then they [Kwanele's family] said no, the other family knew how the Xhosa tradition goes so they just accepted the whole amount.

Kwanele demonstrates her deep discomfort with the transactional nature of the practice by raising these concerns with her mother: "… because you are charging them too much". Kwanele fears that the price charged poses a risk of damaging the relationship between the two families, given that the paternal family already knew about and had accepted her pregnancy: "People are going to run away". Kwanele also self-positioned as a passive recipient concerning the practice; she expressed surprise and lack of knowledge about the amount negotiated and did not indicate whether she had any specific wishes regarding what should be negotiated as the pregnant person. However, Kwanele's age deemed a teenage pregnancy at age 19, may have played a part in ensuring that the practice was initiated, negotiated and completed on her behalf.

Thando rejects our suggestion that *intlawulo* could be seen as a form of support and acknowledgement of responsibility for the pregnancy on the part of the male partner*:*

Extract 38

Researcher: But on a practical level, wouldn't it help with finances and the fact that he is taking responsibility for his role in the pregnancy?

Thando: Um, his support and the way he has been for me and the child, the second child, and even the support he gave us are more than money would ever pay. I appreciate that rather than having money from his family, and I know him that he wouldn't want that cause he's unemployed, cause normally the guy that impregnated you must be the one that gives the money to the family. It will be a hassle for him to get the money. It's going to be stressful for him and myself; it's going to be embarrassing to my family because he's not working, and yet his family must pay for his debt because it's more like a debt. So yeah, that kind of thing, we talked about it. We're fine with it [not going ahead with the practice].

Thando positions *intlawulo* (social entity/practice) as a transactional practice by claiming that it is like paying a debt, which her partner cannot do because he is unemployed (imperative positioning). This is in line with research where scholars have argued that the practice, in becoming more commercialised, is seen as an impediment to men's access to children given the socio-economic realities of high unemployment and precarious work (Malinga & Ratele, 2022). Thando fears that *intlawulo* will undermine the good relationship between her and the paternal family by causing "embarrassment" for her family and making it stressful for her and her partner. Elsewhere in her narrative, she draws attention to how her boyfriend's family have always been instrumental in providing support to the couple. Thus, Thando also positions the practice as undermining good family relations. By positioning her partner and his family as already supportive and involved, claiming monetary compensation to legitimise the pregnancy between families is seen as threatening. Notably, Thando assumes reproductive agency by making an active decision not to go through with the custom through a mutual discussion between herself and her partner.

It could be argued that the practice of *intlawulo*, as an accountability mechanism, enables the right of the maternal family to claim acknowledgement of paternity and support from the paternal family. In the above extracts, however, participants did not utilise any rights-based positioning strategies in their accounts when speaking about the practice. Instead, they distanced themselves by taking up passive subject positions (except for Thando, who actively decided against participating in the custom). This could suggest that despite the custom being a possible structural form of support, the practice is mainly seen to be disempowering for these participants by amplifying their transgression in having an unplanned/unwed pregnancy. This is especially true where relations between families are not amicable. Taking up passive forms of positioning in relation to the practice may be required of unmarried pregnant individuals as per the prescripts of the custom, but presenting as a passive non-participating recipient could also be used as a strategy of disengagement to protect oneself from the scrutiny and judgement of kin. Moreover, the practice can also be seen as a threat to familial relationships that are already accepting and supportive of the pregnancy. This approach to the practice and paternal familial support of premarital pregnancies aligns with findings from Mkhwanazi and Block (2016). They found that kinship ties and structures become more malleable towards the involvement of paternal families in children's lives based on the social contexts that hinder or provide opportunities for the future child. These contexts play a key role in influencing potential parents' decisions on which support networks to include. Access to jobs, education, child

caring availability, and emotional and financial support inform how these kinship networks are reconfigured.

Conclusion

This chapter has centred on participants' discovery and acceptance of their pregnancies. I found that the complex shifting dynamics of pregnancy intendedness and wantedness featured prominently in participants' accounts surfacing normative notions of what constitutes a legitimate pregnancy and exemplary pregnant subject. Social support was discursively constructed by participants as conditional in that it was based on normative notions of appropriate childbearing.

I showed how the normative constraint of reproductive legitimacy operated across the elements of the supportability framework under the overarching social narrative: Is this pregnancy (non)legitimate because it is (un)intended?

An unintended pregnancy serves as the ultimate evidence for unapproved sexual conduct: a failure both in sexual moralistic terms (respectable sexual subjects) and neoliberal terms (failed sexual agent) (Bay-Cheng, 2015). Unintended pregnancies were initially presented as non-legitimate and, therefore, potentially unsupportable. By having an unintended pregnancy, both participants' sexual conduct and their consequent pregnancy came under social scrutiny, which had implications for the support they received or expected to receive.

Participants did much justificatory discursive labour in having to reconcile pregnancies that were initially viewed as non-legitimate, but they notably also justified pregnancies that were planned by deploying similar moralistic social positions (being a married woman) and as positioning themselves as a choosing sexual agent who is in control of and responsible for their fertility. We, as researchers, contributed to this labour through our very questioning of participants as to the intendedness or wantedness of the pregnancy. This was illuminating in surfacing the various support dynamics particular to each participant's pregnancy. Participants outlined how support networks were fundamental in upholding or de-emphasising notions of appropriate childbearing. Support provision during pregnancy was also shaped by another identified normative constraint called reproductive affordability. These findings are presented next.

CHAPTER 10

"Stop having babies if you can't afford them!": Reproductive affordability and responsibility and their implications for pregnancy supportability

"This will never happen in Africa [referring to the China one-child policy], but until black Africans stop having children they can't afford, it [poverty] will continue". This quote can be found in the comments section of an online *Daily Maverick* news article (Heywood, 2023) that covered the findings of a report commissioned by the Department of Social Development (DSD). The article focused on the issue of eight million South African children facing starvation because they live in poverty. The report calls for increasing the government Child Support Grant (CSG) to mitigate the effects of food insecurity on children. An *IOL online* newspaper article (2022) reported how the Minister of Social Development issued stern warnings to South African youth to stop having babies and rely on their grandparents' pension grant money to provide for them. Another online news agency, *Briefly SA (*Sekgota, 2023*)*, reported on a TikTok video that went viral (nationally) of a South African doctor who admonished the unemployed for having babies they could not afford.

Calls for increased state assistance (for example, providing government-assisted housing or social grants) not only generate online comments that are blatantly racist, anti-poor and anti-early reproduction from ordinary individuals but are also expressed by government officials and respected professionals. Thus, "stop having babies you can't afford" is a common overarching cultural narrative that legitimises who can and who should not have a baby. This dominant narrative operates as a normative constraint of cultural power. It infers that having to depend on others or the state to help raise children is undesirable and unacceptable; legitimate pregnant subjects are those who are responsible in that they can financially provide for their pregnancies.

This analysis chapter focuses on how the normative constraint of reproductive affordability shapes the supportability of the pregnancy. The spectre of the cultural narrative, "stop having babies you can't afford", informed participants' talk about their ability to financially manage their pregnancies given the support networks and structures available to them. Despite a particularly unsupportive macro-environment, I show how notions of

(in)dependency permeated participants' talk as they strategically tried to achieve (and failed to achieve) the ideals of a responsible pregnant subject who can financially manage a pregnancy. The micro-narratives presented in this chapter are a response to this dominant cultural narrative.

Micro-narratives of reproductive affordability

The micro-narratives presented in this chapter are juxtaposed against a fraught South African macroeconomic climate characterised by high unemployment, inequality, poverty and gendered and cultural constraints, together with a developmental social welfare state that has been unable to transform the inequities of South Africa's apartheid past (Button et al., 2018). These narratives speak to the identified normative constraints of reproductive affordability and reproductive responsibility and were thematically derived across the elements of the supportability framework. These micro-narratives are presented next.

The first micro-narrative, "If you can afford it, things go smoothly", speaks to how reproductive affordability shaped individual pregnancy behaviours (individual level). The next two micro-narratives, "He gives me money now that I'm pregnant" and "I can't just depend on him", contrast how participants spoke about their dependency on financial support from their partners (micro-level partner interaction). "I don't want to be a nuisance to anyone" focuses on how participants addressed concerns about over-reliance on their families for financial support (micro-level family). "I will raise my own child" speaks to how participants rejected dependency on immediate and non-functional support networks (micro-level partner and family).

Moving on to workplace interactions (micro-level work), the micro-narrative "any job will do" speaks to the aspirations of unemployed participants to become financial providers for their future children. At the same time, "that is the stress-work element" demonstrates how employed participants negotiated their career aspirations and their dependency on the workplace in relation to ideal motherhood. In "I stopped working because of workplace difficulties", participants highlighted how their dependency on the labour market was not feasible given their working conditions and conflicted with the imperative to protect their pregnancies.

Finally, the micro-narrative focusing on the healthcare interaction "They don't care about you if you're on government" illuminates how being dependent on the state for healthcare constructs participants as undeserving of care compared with those who can pay to use the private health sector.

“If you can afford it, things go smoothly.”

Adopting pregnancy practices such as managing stress, complying with antenatal care advice and instructions, eating nutritious food and being able to prepare appropriately for the birth of the child are embedded in disciplinary notions of responsible childbearing (Lowe, 2016). The costs associated with managing the pregnancy either enabled or undermined participants’ ability to adopt responsible pregnancy practices and behaviours. Financial security was, therefore, seen as instrumental to experiencing an easy or difficult pregnancy. Zenande, Anelisa, and Sandra’s narratives show how being a financial provider is a prerequisite for achieving a stress-free and well-managed pregnancy.

Extract 1

Zenande: And [participant exhales] most of the time, when you are working .hh there is nothing that stresses you .hh that he::y when I give birth where am I going to get clothes for the baby and .hh the formula for the baby? You just know that you going to afford.

Extract 2

Anelisa: I think for one, I have got a job, /ok/ and for two, I have a husband who supports me all the way (3) yeah, and the in-laws, they are always supportive of everything we do. I think that's it. I think if you have the financial backing and the support from your husband (.) that's why maybe things (1) they just go smoothly /ok/ than if you don't have, if you don't have none of those things (2) you see /sure/ I think so.

Zenande and Anelisa affirm that pregnancy stress is avoided through *being* employed (imperative positioning). For Zenande, pregnancy stress is related to being unable to afford baby necessities financially. Being financially secure removes stressors in her pregnancy, whereby she can make responsible purchasing decisions in preparation for her baby’s birth, such as buying baby formula and clothing. Anelisa spells out what is required for an easy pregnancy. She is employed and is, therefore, financially secure (imperative positioning). On a micro-level, she also interactively positions her husband as a breadwinner (financial backing) and supportive (present and involved) together with the paternal family as supportive of the couple’s life decisions. Anelisa contrasts her solid socio-economic position and marriage status (imperative positionings) to those pregnant individuals who do not have the required financial resources and the “right” support systems available to them. Anelisa thus infers that pregnant individuals who are unemployed and partnerless will not have smooth and easy

pregnancies. In contrast to Anelisa and Zenande, Sandra emphasises how both she and her partner being unemployed (imperative positioning) creates much stress during the pregnancy:

Extract 3

Sandra: I'm sure we will be fine now /ok/ but still, it is the worry that makes pregnancy difficult as well. I think financially, money is a big problem /of course/ we think so much about it, especially because we're not working. I was supposed to be working /mm/, but I didn't find any jobs, so it's // this year was supposed to be something else; [it] wasn't supposed to be difficult, but it actually became another difficult year for us, but on the other hand, we're very happy /ok/ for being here.

The worry about not having money whilst pregnant is all-consuming: "...we think so much about it". Sandra implicitly positions herself as having doubly transgressed as a pregnant subject by becoming stressed (thereby posing a risk to her foetus) because she is not financially secure: "...it's the worry that makes the pregnancy difficult as well". Sandra attempts to recover from this transgression by demonstrating that she is responsible; she asserts that she was never *intentionally* unemployed, "I was supposed to be working", and had been proactive about job hunting, "but I didn't find any jobs", thus demonstrating that her unemployment status is not of her own volition. However, on a macro level, structural power in the form of Sandra's immigration status as a Brazilian (imperative positioning) does not allow her to legally enter the South African job market. Thus, Sandra positions the South African job market (social entity) as inaccessible to her. A limited job market overall (being able to work nomadically by harnessing working networks from Brazil) thwarted her efforts to choose the "right" path to become a self-sufficient, less stressed parent provider.

In managing their pregnancies, participants drew attention to how the normative constraint of reproductive affordability shaped their ability to comply with instructions to attend antenatal check-ups:

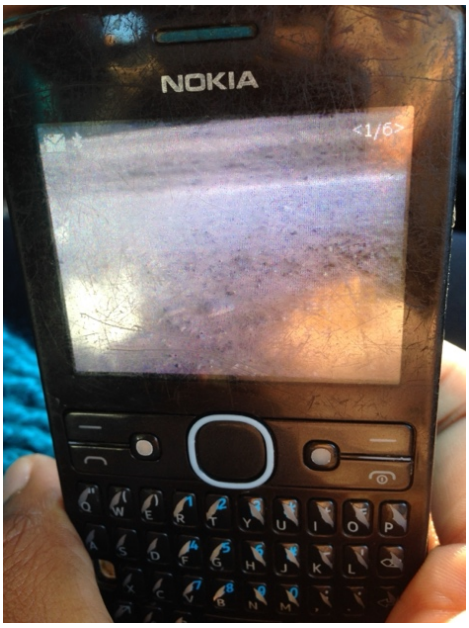
Extract 4

Tayla: ... they [the clinic] referred me to the day hospital. Since the places were so far apart from (.) from each other like they are, I didn't go on the day that they told me, so I went later because I didn't have money for a taxi, and I had to wait until my husband got paid and stuff.

Tayla's confession shows that her failure to meet antenatal check-up requirements was not intentional but due to her financial position and the distance and cost implications of travelling

to the day hospital. In this way, Tayla demonstrates that although these limitations undermine her ability to be a compliant pregnant patient (self-positioning), she still made sure she attended her check-ups as soon as she could financially. Thus, Tayla invokes a responsible subject positioning despite not initially adhering to the required check-up dates. Moreover, on a macro level, Tayla's narrative highlights how the structuring of public health as a referral system is organised around streamlining maternal care more efficiently based on the pregnancy's risk profile and resource requirements (e.g., ultrasounds) (National Department of Health, 2015). As Tayla's narrative shows, this referral system does not translate to accessible and affordable care on an individual level. Transferring Tayla from the local clinic to the day hospital had ramifications for her because she incurred additional financial costs. As with Tayla, Ayabonga positions the public healthcare system as distant and costly to access but also the public roads (entity positioning) as rough and of poor quality, making her journey to the clinic physically uncomfortable and challenging:

Extract 5



Photograph: Gravel road

Ayabonga: This gravel road is strenuous and debilitating for me (.) because I come from too far, to Ugie [town] for the ANC [antenatal] clinic. I come very far (.) and it costs too much for me (.) and I am unemployed:: As a result I use Child Support Grant to access the clinic.

In trying to comply with antenatal healthcare directives, Ayabonga admitted that she depended on the Child Support Grant (CSG), meant for her other children, to pay for transport to the clinic, which amounted to R60.00 per trip. Research in South Africa has shown how mothers

who are CSG recipients are scrutinised by communities, who judge how they spend the grant money. (Hochfield & Plagerson, 2017). Ayabonga highlights how being financially insecure (imperative positioning) undermines her ability to use the Child Support Grant money in the "correct" way; taking money meant for her other children to fund a pregnancy she can't afford, highlights her failure as a responsible pregnant subject or mother and positions her as a deviant grant recipient. Ultimately, both Ayabonga and Tayla are demonstrating how their agency in achieving reproductive responsibility is constrained because they are either unable or are forced to draw from other forms and structures of support to comply with pregnancy health directives, given their poor socio-economic positions.

Although the state provides free maternal health care as a form of social assistance, both Tayla and Ayabonga stressed how far away their respective healthcare facilities were and how difficult it was to travel to them, given that they were unemployed. The issues outlined here are similar to other research findings within the South African context, whereby participants reported that attending antenatal care was a struggle because of the additional expenditure incurred in having to pay transport costs or walk long distances to make their appointments (Scorgie et al., 2015).

Other participants drew attention to how adopting good nutritional practices was subject to being able to afford to do so:

Extract 6

Photograph: Plate full of fruit

Researcher: It is a plate full of fruits, and I think even the next picture is the same [shows pictures]

Anelisa: [laughter] it's fruits, it's good for you. It's good for your health, it's good for your baby. It makes me happy that I have to (.) that I eat fruits every day /okay /every fruit I like and (.) you know when you're pregnant, and you get cravings (.) some people they can't afford, they just eat whatever's there, so (.) at least I always have fruits at home.

Extract 7

Researcher: Okay, so, sorry, where are you working?

Zenande: At [a] school /okay/ I think that is another thing that makes it easier because .hh you don't even bother about .hh *Yoh!* How am I going to eat this fruit I have to eat? You just know that, okay, I will have to go and buy this and this and this. Because you know you have that money.

Both Anelisa and Zenande draw attention to how their stable socio-economic positions (imperative positioning) enable them to nurture the development of their foetuses because they can make responsible nutrition choices. This enables them to self-position as healthy pregnant subjects. Consuming fruit is seen as a necessity for a healthy pregnancy, but as Anelisa points out, fruit is something that other pregnant people cannot afford. Anelisa compares how her pregnancy cravings can be accommodated in contrast to poor people (imperative positioning) who lack nutritional choice, "they just eat whatever's there", thus inferring that poor people do not adopt good nutritional practices when pregnant. Zenande, in positioning herself as financially secure (imperative positioning), draws attention to how making good nutritional decisions is not a cause for stress or guilt affordability-wise, "you don't even bother about…how am I going to eat this fruit?".

In the following two extracts, both Thando and Xoliswa draw attention to how being unemployed makes them unprepared for any pregnancy emergencies or the impending birth of the baby:

Extract 8

Researcher: …the very last question, so why did you agree to do this research?…

> Xoliswa: The research needed pregnant people, and I'm pregnant, and I thought it might just help me, and it has helped me. I have some stuff for the baby because I participated; the clothes I buy will add to what you guys have given me already // If I hadn't agreed, maybe when the time comes [delivery], I would probably struggle to even have a *rompa* [onesie/ babygrow/babysuit].

In this extract, Xoliswa refers to the baby hamper items we provided to participants to thank them for taking part in the interview. Participants were not made aware during recruitment that they may receive any tokens of appreciation because we did not want this to influence their taking part in the research. What is notable is how Xoliswa perceived that the interview helped her. The interview is seen as a form of material support. This contrasts with other participants who stated that they saw the interview as therapeutic and a form of psychosocial support for them during their pregnancies. Initially, Xoliswa claimed that the baby hamper items we gave her would be added to her purchases. However, her following statement is a confession that she wasn't financially able to prepare for the birth at all: "I would probably struggle to even have a *rompa*". Xoliswa invokes how her socio-economic position is so poor that purchasing an essential item such as a baby onesie ("rompa") might not have been a possibility should she not have used the opportunity to participate in the research. Xoliswa, therefore, sees her choice to take part in the interview as a responsible one in that she envisions that it might be helpful to her pregnancy. In positioning the CSSR research unit (social entity) as a material enabler (although a paltry one), the interview becomes a mechanism enabling reproductive responsibility and the supportability of her pregnancy. The (few) material items she receives from participating in the interview help her become a more prepared and dignified mother. Thando also confesses how unprepared she is as a future mother and how careful both she and her partner are concerning financing the pregnancy:

> *Extract 9*
>
> Researcher: And in terms of finance, are you receiving any money now, or are you in a position to be able to buy these things if you had to? ...
>
> Thando: This time around, it's hard. I'm <u>forever</u> broke. Whenever I do have money, I'm too scared to use it (.) what if something happens that (2) an emergency happens where I have to (1) buy something or to do something /mm/ this time round (.) My boyfriend was a tutor [at the university]. So, he had money all the time with him, and his mother was sending him money, and I also had money (2). So, this time around, *yoh*! We're both broke. He's also job hunting now, so it's a hassle /ok/ it's a hassle, hey... Hopefully, when my boyfriend goes back home to

> East London, at least his aunt spoils him there, so whenever they give him money to go buy clothes or anything, to the beach (.), we'll save from there.

Thando firmly describes her poor financial position (imperative positioning) as seriously problematic, contrasting it with her first pregnancy, in which she had more access to financial support, including being financially secure herself. She points out that she and her partner allocate any financial resources that they receive from the family to the pregnancy. Notably, they do not reveal to the aunt that they are not spending the money she gives them on treats but are saving for a baby. By saying, "I'm too scared to use it", Thando implies that it would be irresponsible to spend the money on anything other than the pregnancy. Thando self-positions and interactively positions her boyfriend as responsible financial savers. Thando also attests that her boyfriend is trying to do something about their situation by looking for work. Thando remarks twice that "it's a hassle" for him to find work. There is an implicit positioning of the labour market as limited in job opportunities, which makes it hard for her boyfriend to find a job, undermining the couple's ability to become financial providers.

Because the state does not provide any income support to unemployed pregnant women, unemployed participants relied heavily on partner financial support during their pregnancies. They both self-positioned as financially independent (enabled by partner support) or financially over-reliant on their partners. These contrasting self-positions are explained in the micro-narratives that follow.

"He gives me money now that I'm pregnant."

Literature on male partner support during pregnancy has drawn attention to how male partners within the South African context are often constructed as financial providers, thereby upholding gendered norms about the roles of men and women in providing support and childcare (Makusha & Richter, 2016; G. Matseke et al., 2016). However, this norm intersects with the macro labour environment, which is characterised by gender inequities itself; men are more likely to be employed and be paid higher salaries than women (Casale et al., 2021). Therefore, financial support from an employed male partner would be expected and considered crucial in supporting a pregnancy. Together with other forms of support, participants in this study did position their partners as financial breadwinners:

Extract 10

Xoliswa: This is a photo of a wallet; it has my money …that I get from my boyfriend. Also, when he does not have money, he always tells me to get it from that wallet and use the money he gave me to buy stuff I need because he does not have it [money] at the moment. So, with this wallet, I am showing my money now that I am pregnant. Because when I was not pregnant, he was not giving me money or his wallet and saying "here is your money"…

Photograph: His wallet with my money

For Xoliswa, the pregnancy prompts a positive shift in her partner's behaviour toward her. She draws attention to how, before her pregnancy, she was powerless to manage her needs because her partner controlled the finances and only gave her money if and when he desired. Her reproductive ability, that is, becoming pregnant, has given her increased value or status within the relationship and therefore grants her greater interpersonal power to ask for more financial support as she explains: "Because when I was not pregnant, he was not giving me money or his wallet". Xoliswa now self-positions as independent because she reiterates twice that the money in the wallet is *hers*. Xoliswa's reproductive agency is thus enabled *within* the patriarchal power dynamics that circumscribe her relationship by giving her a semblance of financial control over her pregnancy. Meyers (2001) maintains that autonomy can be exercised with varying degrees within a specific social context despite male control. Xoliswa's new

financial independence allows her to achieve a responsible pregnant subject position because she has the purchasing power to care for her pregnancy "to buy stuff I need". Thus, Xoliswa demonstrates that she can make good reproductive choices for her pregnancy on her terms without having to negotiate with her partner for more financial support. Independence is thus interpreted as having one's *own* financial means to manage the pregnancy.

Financial support from partners enabled some forms of financial independence and reproductive agency to cover pregnancy costs. However, participants simultaneously described how they were over-reliant on their partners.

"I can't just depend on him."

Similar to findings from a study conducted on low-income pregnant women in South Africa by Scorgie and colleagues (2015), participants in this study raised concerns about their increased financial dependency on their partners:

Extract 11

Tayla: I was coz in the first few months…few weeks there was a month I was very depressed, I was like /sigh/, why did this have to happen now because I didn't plan it… it just happened, and uhm, he [husband] would like encourage me, "No, it's fine, I'm working, I'll work", and all that, and I was like, but I don't work, and we both (2) I can't just depend on him and uhm *ja* (1) I missed my mom.

Extract 12

Interviewer: When you did a computer course, did you choose that course in hopes of getting a job?

Xoliswa: I recently did it (1) I thought that it would help me find a job so that I do not rely so much on my boyfriend (.) [we could] help each other, especially now that I am pregnant. Things will not be the same, and he might struggle to support all of us. He also supports my other child. So, getting a course and finding a job will alleviate the pressure on him. I plan to go to work after I give birth.

In the above extracts, gender inequities (macro-level structural and social norms) are surfaced in participants' talk. Participants' male partners were more likely to be employed than they were, which reflects South African female labour force participation trends (Mosomi, 2019). For Xoliswa and Tayla, being unemployed (imperative positioning) while pregnant is a source of

concern, as demonstrated by Tayla, who described herself as depressed about being over-reliant (self-positioning) on her husband; “I can’t just depend on him”. Xoliswa also self-positions as overly dependent on her partner in that he will be pressured to provide for a growing family financially: “he might struggle to support all of us”. Thus, male partners are interactively positioned as overstretched financial providers in relation to the pregnancy. Tayla is somewhat fatalist in response to her situation “why did this have to happen now” but still takes responsibility for becoming pregnant, “because I didn’t plan it”, thereby making herself blameable for the couple’s current financial situation.

For Xoliswa, being over-dependent on her partner heightens her desire to rectify this imbalance by strategizing to find employment. However, elsewhere in her narrative, Xoliswa acknowledges that not being sufficiently educated (imperative positioning) has consequences for finding employment: “I never:: finished school. So, when you haven’t finished schooling, chances of any job prospects are rare”. Therefore, she decided to do a computer course (paid for by her uncle) to enable her to find employment as a cashier in a retail store after giving birth.

Despite being financially supported by their partners, Tayla and Xoliswa highlight how one income is insufficient to fund a pregnancy and a future child. These two narratives point to how, on a macro level, the structuring of the South African labour market post-apartheid is highly inequitable wage-wise (Finn, 2015) , with more than a fifth of the South African workforce earning wages that were insufficient to cover the most basic needs of household members; these workers being categorised as the “working poor” (Rogan & Reynolds, 2019).

In contrast to being overly dependent on male partners and placing additional financial pressure on them, Ayabonga’s over-reliance on her partner’s financial support meant that she had to endure an abusive relationship, as she explains elsewhere in her narrative: “because he was physically abusing me, such that my parents had to intervene, so it really hurt me”. Ayabonga also admitted that her partner was the “jealous type” and had thrown her phone against the wall, damaging it. This was why we had to take pictures of the pictures on her phone when collecting data (see extract five above). Ayabonga elaborates on how her partner only started financially supporting the baby once it was born:

Extract 13

Ayabonga: On Sunday afternoon, he came and asked to see the baby; he apologised for all the things he did while I was pregnant. I welcomed his apology because there was nothing else I could do. He supported that baby; he was buying food, nappies and everything.

In providing for her newborn, Ayabonga was forced to accept the unequal interpersonal power relations (micro-level), evident in her relationship because she is unemployed (imperative positioning). In saying, “I welcomed his apology because there was nothing else I could do”, Ayabonga self-positioned as over-reliant on her partner and demonstrated how her agency was constrained because leaving the relationship would mean forfeiting financial support for the infant. The interaction between reproductive responsibility (ensuring the infant was provided for) and affordability (being unemployed) made Ayabonga stay in a relationship in which she had been badly treated physically, emotionally and financially. Ayabonga’s social positioning and her experience of IPV during pregnancy align with the findings of a South African study which examined the prevalence of intimate partner violence (IPV) during pregnancy in a low-resourced setting (Field et al., 2018). The authors identified several risk profiles for IPV, and these included pregnant women who were unemployed and in stable (long-term) but unmarried relationships.

Whereas Xoliswa, Tayla and Ayabonga are financially over-reliant on their partners, Sandra described how being a spousal dependent because of her immigration status also created financial constraints during pregnancy:

Extract 14

Sandra: So we (3) I can't have bills on my name, I can’t have anything really, because I don't have a South African ID [identity document], and I'm not a student, so as a spouse, I’m totally dependent on him here which annoys me [laughs] because /mmhmm/ you know it’s, I don't really like it /I'm sure/ yeah, it’s a bit, I think if we decide to stay, it’s going to be not tough for me because I can bring these jobs from Brazil here [to South Africa], but for example if I wanna work, it's gonna be hard, if I want to find a job that it pays me every month.

Sandra generally positions her relationship as egalitarian and asserts that her partner is “very supportive; he's an excellent partner”. However, his more secure social position as a South African citizen (imperative positioning) and her being Brazilian (imperative positioning) create unequal gendered dynamics for the couple. Sandra expresses her frustration: “So as a spouse, I’m totally dependent on him here, which annoys me” and “I don't really like it”. She points out how, despite being in a spousal partnership with a South African, she was not legally allowed to find permanent work in the South African employment sector, which would enable a stable monthly income. As with Xoliswa in aspiring to find work, Sandra attempts to rectify this

imbalance, explaining that she could find employment by working nomadically (bringing work to South Africa from Brazil) but that the income from that work would be unstable.

Although global labour trends are moving away from the standard employment model (characterised by formal employer/employee full-time work contracts, benefits, and salaries) (International Labour Organization, 2015), the ILO (2018) reports that these trends exacerbate gendered labour market inequalities. An increase in work informality (characterised by short-term contracts, casual, part-time work or own account work) is more likely experienced by women living in "developing" or emerging countries. Thus, Sandra joins the ranks of many other women in South Africa who, when they do find employment, are more likely to take on precarious forms of work than those employed in the formal work sector (see Casale et al., 2021).

In the extracts presented above, I show how participants, positioning themselves as overly financially dependent on their male partners, discursively constructed their dependency on their partners as undesirable and in need of correction (Fraser, 2013). Whereas Tayla and Ayabonga were somewhat defeated by their situations because of their unemployment status (imperative positioning), Xoliswa and Sandra positioned themselves as aspirationally independent by expressing a desire to be employed or find employment after the child's birth. For Xoliswa, embarking on a training course to improve her job prospects reflects the developmental welfare state's approach to empowerment and human capacity building, whereby citizens are expected to engage in self-development to become more self-reliant (Patel, 2015). Achieving reproductive responsibility is therefore constructed as attainable through self-development and waged labour.

In critiquing how social welfare states promote marginality and social distance through discourses of dependency, Halvorsen (1998) notes that dependency on the welfare *state* is frowned upon. In contrast, he argues, the state does not see over-dependency on kin or the market as problematic. In providing no income support to unemployed working-age adults (which includes pregnant women), the South African state shifts this responsibility onto kin (Button et al., 2018; Seekings & Moore, 2013). Participants who were unemployed and/or partnerless (both imperative positions) had no option but to rely on kin, and they did not desire this.

“I don’t want to be a nuisance to anyone.”

In having to rely on kin for financial support, the legitimacy (see Chapter 9) of these pregnancies and the ability of participants to achieve responsible and dutiful ideals as pregnant subjects in the eyes of others (their families) was put under the spotlight. Sandra describes her emotional conflict at having to rely on her family for financial support in managing her pregnancy:

Extract 15

Sandra: We have skills and talent to be able to be [unclear] on our own foot. We don't need to, I always have to come back to family, it's embarrassing…

Sandra argues that if one has skills, one should be employable and therefore non-reliant on others financially. Sandra’s frustration centres on how responsible and dutiful ideals as a pregnant subject should already have been achieved because she and her partner have done the “right” things by improving their education and upskilling themselves in ways that enable them to be economically valuable and productive. Thus, a sure path to independence and self-reliance should be assured. Neoliberal rationalities, scholars contend, construct citizens of value or virtue as those who are capital-enhancing (Brown, 2016). Brown (2016) argues that responsibilisation, a facet of this rationality, promises self-sufficiency because it morally exhorts individuals to engage in practices of self-investment to improve themselves as human capital. For Sandra, a legitimate pregnant subject status should be a given in that she has responsibly invested in herself. She should theoretically be able to financially provide for her pregnancy instead of becoming a cost to her family. Nevertheless, there is a mismatch; poor economic prospects (structural power on a macro level) are such that Sandra and her partner have no option but to rely on their families financially despite their suitable skill sets. Continually relying on family is seen as an individual failure (cultural power), hence Sandra’s embarrassment at her situation (interpersonal power).

In the following extract, Nosipho holds herself accountable for her financial and material dependency on her family:

Extract 16

Nosipho: So, the first trimester was very difficult, and I did not want to eat. The only thing I would eat is *Amasi* [traditional fermented sour milk]. The only other thing I wanted to eat was *braaied* [barbequed] beef; otherwise, I wanted nothing else. But that was:: difficult because

> there is no electricity, so there is no fridge. In order to get those things, I have to go to town, and I am also afraid of being a nuisance to my mom as the baby's father is not in the picture anymore. I am then scared of being a nuisance to my mom, so I pretend I do not want anything. Then I would be very moody; I would cry, but I had to hide it because I did not want to stress my mom.

Nosipho interactively positioned her mother as an overburdened carer and financial provider because of her pregnancy. Nosipho draws attention to how the physiological changes during her pregnancy in her first trimester, such as experiencing cravings or not being able to eat certain foods, could not be accommodated. The food items she felt she could eat were perishables, but there was no way to store them. She positions her homestead (social entity) as limited in and distant from services; "there is no electricity, so there is no fridge", thereby invoking a government positioning (social entity) as a non-service provider. The food she craved also had cost implications. In South Africa, beef is much more expensive than other protein sources and not affordable for resource-poor households. The nearest town was an hour and a half drive from her village homestead, which would incur travel expenses to purchase the groceries she desired. Nosipho felt that she could not impose these needs on her mother, "pretended" that she did not need anything, and "hid" her emotions from her mother. In this way, by not having her own financial means nor a partner who takes responsibility for financially supporting the pregnancy, she discursively positions herself as an undeserving dependent (a nuisance). Thus, she forgoes any special privileges that she may be afforded during pregnancy.

Whereas Nosipho sees her dependency on her family as a burden because she is single and unemployed, Zenande, who was married, drew attention to how traditional cultural constraints made her overly dependent on her in-law family. In Xhosa culture, when one marries, the wife may join the paternal family and reside with them. Zenande described how, during her first pregnancy, she initially lived within this context in a rural area but found that it was detrimental to her first pregnancy in which she experienced a late pregnancy loss. She contrasts this experience with her current pregnancy because her living arrangements are now different:

> *Extract 17*
>
> **Researcher:** And this pregnancy is obviously now quite different?...
>
> **Zenande:** Well, I feel like I am tired I just sit down and rest. No one who expecting me to do a lot of work because I am *makoti* [married/a wife] .hh you see. So, I do as I please, you see. If I

> feel like to go to town and just buy a lot of fruit only – and I do that – and my husband support me from that. Then there is not that thing, whew, you thought of, I am going to buy this, but then, hey! How can I go home to eat this in front of other people because they will want this? You see? So, you end up not getting as enough as you wish you see. So::, it's different.

During Zenande's first pregnancy, reproductive responsibility, such as engaging in healthcare practices to support her pregnancy, conflicted with her duties as a daughter-in-law as she attests: "You can't just rest because you are just a daughter-in-law. hh in this home". Zenande interactively positions her in-law family structure as hierarchal and inflexible (entity positioning): "They believe in their way," as she elaborated further in her narrative. In self-positioning herself as *just* a daughter-in-law (imperative positioning), she reveals how she had no power within the family structure to make good choices about her pregnancy's well-being.

Zenande also describes how her nutrition choices were limited because certain foods were scarce; "How can I go home to eat this in front of other people because they will want this?". This statement infers that specific nutritional requirements for pregnancy are hard to come by and that they would also have to be shared amongst family members. As with Nosipho, Zenande went without certain nutrients for her pregnancy so as not to become a burden on the in-law family. Thus, the family is positioned as traditional and resource-poor (entity positioning). Dependency on her in-law family is thus *imposed* on Zenande through this hierarchy as someone who is *makoti* (imperative positioning as a wife) and by her mother-in-law, who controls the family's limited resources. Dependency in this context, according to Fraser and Gordon (2013), is understood as subordination, which denotes a patriarchal social hierarchy (a wife dependent on a husband) and, in some contexts, is considered socially acceptable and normal.

Zenande, however, rejects this form of dependency in describing how much better her experience is of her second pregnancy. Zenande's social positioning has changed because she is now employed and living alone with her husband. She asserts her independence within this living arrangement: "[there is] no one who is expecting me to do a lot of work because I am *makoti"*. She demonstrates that she now has the agency to make reproductive choices (both behavioural and financial) that suit her pregnancy: "I feel like I am tired; I just sit down and rest" and "So I do as I please, you see". Moreover, her independence in making these decisions is not only assured by having a supportive husband but also by having her own waged labour (Fraser, 2013) , which gives her the autonomy to go to town and purchase whatever she needs for her pregnancy.

Whereas Zenande, Sandra and Nosipho expressed dissatisfaction at their dependency on their respective families to provide support during their pregnancies, participants also rejected being dependent on kin and male partners by positioning themselves as independent.

"I will raise my own child."

Given the economic climate of South Africa and the high unemployment rate, there is much pressure placed on kin to provide support. Kin provision has declined, especially along patrilineal lines (Seekings & Moore, 2013). Thandeka grapples with making sense of being abandoned by her partner because of the pregnancy:

Extract 18

Researcher: How does it make you feel, knowing that he has not been involved in your pregnancy and even post-delivery, now that the baby is born, he still hasn't made any contact?

Thandeka: [deep breath] It pains me, but (2) I tell myself that when I find a job, there is nothing I am going to need from him…

On an individual level, Thandeka acknowledges the hurt inflicted on her because her partner denied paternity. On a micro-level, however, Thandeka seeks to challenge the interpersonal power dynamics by attempting to regain some agency from being abandoned by her partner because of the pregnancy. Thandeka, in self-positioning as a financial provider, asserts that her independence from her partner will be enabled through her own economic security. As a potentially employed mother (imperative positioning), Thandeka sees the role of the father in parenting as worthless: "There is nothing I am going to need from him". In attempting to position herself as self-sufficient and independent, she contrasts herself as a responsible future parent against an irresponsible and unnecessary ex-partner. Thus, to overcome heterosexual inequities, where men can choose to walk away from parenthood, the solution is to become individually self-sufficient through waged labour. However, from a macro-level perspective, this positioning is aspirational as Thandeka is surplus labour in a highly constrained labour market, particularly affecting those living in the country's rural regions (Mosomi, 2019).

Whereas Thandeka rejected having to depend on her partner's financial support by aspirationally positioning herself as economically self-sufficient, Siphe rejected being seen as dependent on kin from a financial and practical childcare perspective:

Extract 19

Siphe: I always tell them that I am not expecting anything from you because this baby has a father…I am just making sure, you know, so that you don't have stress if I will ask you for nappies, I will not ask for anything. If you want to provide for this child or give me stuff, it will be purely out of your will. It will not be like the first one [pregnancy] where I had to beg from you guys.

In the above extract, Siphe is describing an interaction with her older sister, who has accused her of becoming pregnant again. Siphe's sister claims the pregnancy will place additional care burdens on their mother. Other research in South Africa has shown how tensions about who is deserving of support and care provision arise between family members on the announcement of a pregnancy (Lewinsohn et al., 2018) and that the burden of support provision is placed chiefly on female or maternal kin (Casale et al., 2021; Hatch & Posel, 2018; Seekings, 2019). Siphe's defence in becoming pregnant is to self-position as independent in response to this judgement from her sister. Here, Siphe uses her relationship status, "this baby has a father", as the reason for self-reliance. She also achieves the position of a responsible financial planner because, by being supported by an earning and present partner, she will be able to purchase items in time for the baby's birth without having to rely on her family to assist her. Siphe thus positions her family as burden-free (social entity); they can choose to provide things for the baby of their own volition and not have this duty forced upon them compared with her first pregnancy.

In addition, participants did not want to impose childcare duties on their families. However, the migratory nature of employment (a legacy of apartheid) was another form of structural power that shaped participants' ability to present as responsible pregnant subjects. Posel and Hall's (2019; 2021) work has shown that South Africa has one of the highest proportions of children who do not live permanently with their biological parents. Childcare is enforced on extended family as parents migrate across the country to take advantage of employment opportunities (E. Moore, 2020). Ntombi, elsewhere in her narrative, tells us that her partner's presence is dependent on where he is "forced" to work, meaning that her partner will migrate to wherever in the country there is a need for construction workers. Ntombi describes how her partner's family took the news when he told them about her pregnancy:

Extract 20

Researcher: But this man [Ntombi's partner] is old [29 years old] for him to be getting cussed at?

Ntombi: It's because he has another child at home [his mother's home]. So, this child is being raised by his family. So, his mother was asking why he would do this again. So, I said that she shouldn't concern herself because I will raise my own child… I even told him to pass the message along to his mother so that they don't think that I will also dump my child there because I'm still keen on gallivanting. I want to be present in my child's life.

The news of Ntombi's pregnancy was not well-received by her boyfriend's mother despite the interviewer herself drawing attention to his appropriate reproductive age (a culturally legitimate marker for reproduction). The partner's mother clearly positions Ntombi's partner as irresponsible for impregnating her: "So, his mother was asking why he would do this again". The implication is that both his first child and the future child are seen as an imposition on the family because he is not physically present to care for them. Ntombi resists this positioning by self-positioning as independent through being a present parent: "I will raise my own child". "Dumping" one's child on others and "gallivanting" are associated with cultural representations of bad mothers who get pregnant but do not take responsibility for the care and financial duties of their children. In distancing herself from non-present parents, Ntombi constructs a physically present parent as a normative ideal of reproductive responsibility. However, this is an aspirational self-positioning because it conflicts with the South African economic landscape (structural power), which splits families apart because of limited employment prospects and the enduring nature of the apartheid migrant labour system.

In having transgressed by becoming pregnant when not in a position to provide for the pregnancy financially, unemployed participants also attempted to repair their damaged social positions by explaining how they intended to find work themselves to provide for their future child.

"Any job will do."

Casale and colleagues (2021) have found that women's unequal participation in the labour force is related to how women carry out the bulk of unpaid care work in the home, including childcare. For pregnancy, the South African constitution and labour laws are protective of pregnant individuals who are job seekers; an employer may not refuse a job seeker employment because they are pregnant, as that amounts to discrimination. In practice, it is noticeable that

unemployed participants did not go job hunting *while* pregnant. However, they had every intention of looking for work once they had given birth:

Extract 21

Nosipho: ...Now, I have to think about getting a job closer to my child, but how and where will I get this job? Sometimes, I think, as long as I work whether closer or far, as long as I would be able to provide for my child.

Extract 22

Interviewer: and (4) your plans for after the baby is born?

Thando: I don't really have plans. I'm just planning on getting a job // yeah, getting a job cause my friend told me that they're extending Spar [grocery store chain], I should give in my CV (2). I'll just go for a cashier job or something.

Extract 23

Siphe: ...When the baby is 3 months (.), then I can leave the baby... (1) and look for a job because I cannot go back to my old job because the pay is not enough. It was better when I still had one child; I could patch here and there, but when there are two, it won't work.

Extract 24

Interviewer: And what are your plans? Are you gonna go back to work after six weeks of delivery?

Linda: Yes, I feel like going back to work because I need the money /ok/for my baby.

These four extracts show how Nosipho, Thando, Siphe, and Linda intentionally positioned themselves as mothers who are financial providers. Future motherhood is directly linked to waged labour rather than relying on financial support from partners, kin or the state. Noticeably, none of the participants mentioned relying on state support, such as applying for the Child Support Grant after giving birth. Moreover, these narratives show that, except for Siphe, participants intended to find *any* job available to provide for their future child. Both Linda and Siphe can return to their previous jobs as their jobs are secured through labour law. Employers are mandated by law to pay UIF for pregnant individuals, but continued payment of salaries while employees are on maternity leave is left to the employer's discretion (Pereira-Kotze, Doherty, et al., 2022). Linda alludes to how six weeks of maternity leave post-birth

(required by law) will hurt her financially because she will not receive her full income during maternity leave. Therefore, she has no choice but to return to work as soon as legally possible. For Siphe, however, her job pays too little to support an additional child, so she does not see returning to it as a worthwhile option.

What is absent from these accounts is any articulation of the participants' *own* aspirations, hopes and dreams for *their* working futures. Lowe (2016) outlines that the ideal, responsible mother puts her child first and that having employment benefits the child. Nosipho knows that she may have to become a migrant worker to find a job and be separated from her future child; "as long as I work whether closer or far…". Thando is non-fussy, "I'll just go for a cashier job or something", whilst Siphe has designs on finding any job that pays more than her previous job at a local retail store. Reproductive "choice", in the form of having the right to parent a child in a conducive environment, (Ross & Solinger, 2017) is simply survivalist in South Africa. "Choosing" a specific career is not an option yet providing financially as a mother is an imperative. Being a present mother is conditional within a migrant labour system structure. In the South African context, the above extracts also speak to how, especially black women, are less likely to be employed in highly skilled jobs and less likely to receive a full complement of maternity protections while on maternity leave. Should these participants (all women of colour) find future employment in "any" of the types of jobs they list above, they will also suffer inequities through the gender wage gap as these jobs are based in the service industry, are considered less skilled and attract lower wages (Casale et al., 2021). On the other hand, achieving a non-stressful, work-family balance was ideal for middle-class pregnant participants Kerry and Anelisa.

"That is the stress-work element."

Whereas the previous extracts talk about how participants desired to become financial providers for their future children, the following two narratives from Kerry and Anelisa demonstrated how these participants' choices were constrained in balancing their pregnancies and future parenting desires with their work lives. Kerry, who owns a restaurant, explains how she envisioned being a stay-at-home mum:

Extract 25

Kerry: But I think lots of new places have opened up in town /ok/ and, although we <u>are</u> still doing okay/mm/ I do worry about next year after the baby comes because (.) when I bought this café I planned to become a stay home mom /mm/ and that the shop would allow me <u>to</u> do that

> (.) but if we're not covering all our bases, which we aren't in that position yet /mm/ I just worry that I'm not gonna be able to do what I wanted to do once the baby comes in April next year /ok/because of sort of financial, so that that is the stress work element /ok/ *ja*

Kerry demonstrates how she is stressed about finances and the impending birth of her first child. Her future aspiration to be a stay-at-home mum is at risk despite strategically planning around being financially able to do so. Kerry positions her *own* business, a restaurant, as motherhood enabling (social entity). Kerry's narrative transcends traditional gender norms of the family wage, encompassing the economically active husband and the dependent wife (Fraser, 2013). The script is flipped. Reproductive autonomy for Kerry in being a stay-at-home mum is *conditional* on ensuring she can continue earning income through her own business. Kerry positions the economic climate of her hometown as competitive (macro social entity), making the café's financial position precarious: "But if we're not covering all our bases, which we aren't in that position yet…". In this way, Kerry is caught between conflicting ideals of reproductive responsibility: the desire to fulfil the tenets of ideal motherhood, that is, being a more present parent and the imperative to be a full-time working mother in a tough economic climate. Given her relative privilege of economic stability as a future white mother, however, Kerry's narrative contrasts starkly with those of Thando, Siphe, Nosipho and Linda (as working-class future black mothers) in that she can articulate what she would like for her *future self* as a mother.

Anelisa, who is permanently employed at a university, envisions the possibility of finding a more exciting job, but only after she has given birth:

> *Extract 26*
>
> **Interviewer:** Okay (.), and are you finding working and your pregnancy going smoothly?
>
> **Anelisa:** It's very nice (.) the work itself is very nice. It's not demanding or anything. That's what I like, but if I give (.) that's why I'm staying at the library because it's not demanding. I am not under any pressure, so it's good. This is my last baby. So, after that, I'm gonna look for another job here at the university. (.) Yah, the work itself is very nice. It's, I'm not put under pressure at all /ok/I do the things at my own time and at my own pace (2).

Anelisa self-positions as a non-stressed pregnant worker yet at the same time as an unfulfilled career woman. The implication is that her current job situation suits her because its undemanding nature is not stressful for her pregnancy. As Lowe (2016) elaborates, there is increasing attention on how maternal stress during pregnancy is seen as a risk to the foetus.

The author contends that women are expected to make the right "choices" through sacrifice by managing their stress to protect the foetus. Anelisa thus indicates that she has put her career aspirations on hold until she has given birth. On a macro level, Anelisa is the only participant in this study who works in the formal employment sector. In so doing, she has access to state-run social insurance maternity benefits (secured through the UIF) and the maternity benefits offered by the university where she works. Thus, Anelisa has achieved reproductive responsibility by being financially secure through permanent employment and being able to adopt non-risky pregnancy work practices, such as having a non-stressful job, thereby making her pregnancy supportable. Other participants, however, were unable to depend on their working environment to support their pregnancies and left the workforce while pregnant.

"I stopped working because of workplace difficulties."

In the first section of this chapter, I showed how the ability to provide financially for a pregnancy and future child constructs individuals as dutiful and responsible pregnant subjects. However, in South Africa, duties and responsibilities are also placed on others, such as the government and employers, to provide care and assistance to pregnant workers. The role of the social welfare state is to protect a worker's *over-reliance on the marketplace* (Fraser, 2013). In the case of pregnancy, the welfare state enables pregnant workers to redirect their labour from the marketplace to that of giving birth and caring for a newborn. Structural power operates through policies whereby the South African welfare state provides social insurance (UIF) to pregnant workers in the formal employment sector for a limited time of 4 months. In addition, constitutional rights, labour laws, employment policies, and guidelines are in place so pregnant individuals' dependency on the marketplace may not be undermined or discriminated against. In this section, I analyse how participants spoke about their work environment in relation to how it was supportive or unsupportive of their pregnancies. For some participants, however, working conditions were not conducive to their pregnancies or post-partum recovery. This resulted in them having to survive on reduced pay or leaving employment:

Extract 27

Researcher: So now that you have found a job after giving birth, how were things for you there, how were they treating you in this whole ordeal?

Ayabonga: My supervisor was cruel, I would skip days especially when cold, as my c-section would act up, I would not get paid for days missed at work. At EPWP [Expanded Public Works Programme], we got paid R600.00, I would get R400 or R500 because of days missed …She

> [the supervisor] would say I should take unpaid leave if I decided I was not going to work because I was not feeling well.
>
> **Researcher:** So, she would not allow you to take off days?
>
> **Ayabonga:** Yes, she would not allow me to take off days.
>
> **Researcher:** Did the supervisor give any reasons, like company policy?
>
> **Ayabonga:** The supervisor said that at public works, EPWP does not have maternity leave, so, one takes unpaid leave and then you have to go to Maclear to sign for UIF, in order to get a few cents. So, we don't get maternity leave because this is a contract; it's just a "piece" job.

In the extract above, Ayabonga describes her working conditions after giving birth. She was a temporary worker for the Expanded Public Works Programme (EPWP). According to the government's public works and infrastructure website (South African Government, 2023), the EPWP is described as: "...one of government's key programmes aimed at providing poverty and income relief through temporary work for the unemployed". However, as Seekings and Nattrass (2015) point out, although the government's stance in providing access to work opportunities is much preferred over "handouts", it has been unable to implement the programme financially and efficiently at scale. Nevertheless, recruitment targets give preference to women (55%), youth and those with disabilities. Thus, the EPWP can be seen as an enabling structural form of socio-political power because it targets recruiting population segments who are disproportionally marginalised employment-wise. According to the most recent EPWP employment guidelines (South African Department of Labour, 2011), work in this program is defined as temporary or casual work; a worker will only be paid for tasks completed or at an hourly or daily rate for time on task. In addition, pregnant individuals enrolled in this programme are covered by the *Basic Conditions of Employment Act (1997)* and are entitled to maternity leave. However, they do not receive any income-related benefits.

In the above interaction, Ayabonga self-positions as unrecovered from childbirth because she had not completely healed from having a caesarean section, and this resulted in her not being able to attend work. This also meant that she did not get paid when she missed work. Although Ayabonga positions her supervisor as cruel or unsympathetic in not allowing her paid leave when she is not well, there is not much the supervisor could do for her, given the programme's rules. However, the supervisor does infer that Ayabonga is an unreliable worker because of her absenteeism; it is also inferred that Ayabonga has the agency to "decide" whether she will work. Thus, individual responsibility for not attending work is placed squarely

on Ayabonga. The supervisor instead suggested that Ayabonga apply for UIF (Unemployment Insurance Fund) benefits, which will pay out for pregnancy. However, Ayabonga positions UIF (social entity) as worthless; "then you have to go to [town] to sign for UIF, in order to get a few cents". The implication is that travelling to the nearest town will cost her more than the pay-out benefits she would receive from the claim. Thus, Ayabonga's reproductive agency is constrained by her economic situation. To be a responsible financial provider to her newborn, Ayabonga had very little agency but to work to earn an income despite not having appropriately recovered from childbirth. In a study which examined the South African maternity protection policy environment (Pereira-Kotze, Malherbe, et al., 2022), key government informants who were interviewed explained that UIF was not only difficult for claimants to access, but because pregnant workers did not receive their full income during maternity leave, many had no choice but to return to work before their maternity leave ended. Ayabonga's narrative demonstrates that government policies, although seemingly developed with a social justice orientation, nevertheless operate in inequitable ways for differently socially positioned pregnant workers who access temporary government-initiated work.

Nosipho worked within a government-initiated employment internship programme in the local municipality's communication department before her pregnancy:

Extract 28

Nosipho… [Nosipho's supervisor is posing this question to her] They say that the morning sickness takes a trimester, and I'm still new in my trimester, so will I cope? I was emotional, crying as he was saying this. I mean, he is a man, so he was just not coping working with me. So, he asked me: If his manager noticed that I was slacking because, indeed, work was delaying, what I will say? I said, I don't know, and he gave me two choices. He said one is my contract can be terminated in a bad light if they find out that I'm slacking on the job. I mean, there were times I had to go to hospital and sometimes get admitted for about 2 weeks, or I have to go to a doctor, or I work half day or two days being absent.

In the extract above, Nosipho relates a conversation with her supervisor about her work performance, which was compromised by her pregnancy. She left her internship because of her pregnancy, but she and her supervisor agreed that she would take up studies as the reason for her leaving so that she did not have to disclose her pregnancy to work colleagues. Unfortunately, Nosipho's ex-partner (who left her because of the pregnancy) also worked in

similar (but distinct) spaces to her, which complicated her situation as she would see him from time to time when at work, which she described as traumatising.

Nosipho's treatment by her supervisor amounts to unconstitutional pregnancy discrimination. No employee, no matter their type of employment, can be discriminated against during pregnancy. According to *The Labour Relations Act* (Republic of South Africa, 1995), it is deemed an automatically unfair dismissal if any person is forced to leave their job because of their pregnancy. Moreover, the *Code of Good Practice On The Protection Of Employees During Pregnancy And After Birth Of A Child* (South African Department of Labour, 1998) outlines how employers should make sufficient accommodations for pregnant people in the workplace, which includes allowing them time to go for antenatal check-ups and look after their health during pregnancy However, as Pereira-Kotze, Malherbe, et al., (2022) found, this code is only a guideline and is not enforceable by law, nor is there enough oversight from the Department of Labour to ensure that these practices are followed.

In the interaction, we can see the intertwining of interpersonal, structural, cultural and disciplinary power that plays out between Nosipho and her male supervisor. Her supervisor draws on ableist and gendered cultural representations of pregnancy as a sickness by positioning Nosipho as incapacitated to do her job properly because of her pregnancy: I'm still new in my trimester, so will I cope? This co-joins with structural forms of organisational power, whereby Nosipho's pregnancy is considered inconvenient to the workplace's everyday operations. Nosipho also self-positions as an unreliable pregnant worker; "because indeed, work was delaying". Implicit in his reference to Nosipho only being in the initial stages of her first trimester and being so sick already is that the continuation of her condition throughout the first trimester is untenable for her job requirements. Thus, disciplinary power operates by admonishing Nosipho for her absenteeism (due to morning sickness), which is equated with "slacking" on the job and that her contract will be terminated in a "bad light" if she continues in this fashion. As a pregnant subject in the workplace, she fails to achieve the dutiful and responsible notions of an ideal worker.

By directly positioning her supervisor as a man (imperative positioning), "he is a man, he was just not coping working with me", Nosipho draws on gendered constructions of men as peripheral and unknowledgeable with regards to pregnancy matters. In this way, she excuses her supervisor, by virtue of being a man, as to why he might not be understanding or accommodating of her pregnancy in the workplace. Thus, the duties and responsibilities (as outlined by policy and law) incumbent on him as a supervisor to accommodate a pregnant

worker within her work environment are shifted to Nosipho as a problem she must manage. As with Gattrell et al.'s (2023) findings, Nosipho does not draw on any workplace rights she might be entitled to as a pregnant person. Thus, the operation of social policy in the form of employment protections for pregnant employees is not evident in this micro-level work interaction.

Siphe also left the workforce (but with her job still intact) during pregnancy because of her pregnancy complications:

Extract 29

> **Siphe:** So, I stopped working for 2 weeks [because of pregnancy illness]. Then I went back to work and *umlungu* [white person], shop owner took me back. He said that he can't let me go even though he has already hired someone else. So, we were 3. After a while, I experienced abdominal pains and I had to go to hospital, and then when I came back at work, he said perhaps I should take leave and monitor this pregnancy because he cannot be firing other people under the premise that I am back and well, which doesn't last.

As with Nosphio, because of her pregnancy complications, Siphe often did not go to work. In this micro-interaction, Siphe positions her employer as white (imperative). In this sense, being white and an employer could be constructed as all-powerful versus the duality of Siphe's social positioning, as black and an employee, which could be constructed as subservient. This is reflected through Siphe's passive description of herself as being "taken back" into her job after being absent. This statement suggests that the decision to reinstate Siphe in her job was the shop owner's to make. There is also no suggestion in Siphe's talk of actively claiming her entitlement to a job given the employment protections afforded her by law. Instead, she is positioned as an unreliable pregnant worker. Reinstating Siphe in her job is subtly presented as a begrudging decision or favour that would not have happened if it had not been for the law. The employer is clearly aware of the labour laws in stating: "He said that he can't let me go even though he has already hired someone else". Nevertheless, the shop owner is positioned as an inconvenienced employer by Siphe's pregnancy absenteeism because it has made it difficult for him to manage the staffing requirements of his retail store.

As with the findings in Gattrell et al.'s (2023) study, this employer was fully aware of labour law requirements concerning pregnancy but, as a small business, prioritised protecting the retail store's daily operations. By suggesting Siphe takes leave during her pregnancy (which would still be unpaid), the shop owner is following the law by ensuring Siphe has her job on her

return after pregnancy whilst not being inconvenienced financially or having to make other staff arrangements because of Siphe's absenteeism. Siphe is advised to "monitor" her pregnancy and to look after her well-being. This suggestion also appeals to normative ideals of reproductive duty and responsibility. Siphe is responsible for ensuring a good pregnancy outcome by not posing a risk to her foetus. However, this requires her to leave employment during her pregnancy. This contradicts the normative requirements of being financially stable when having a pregnancy.

Ntombi, who was on a government learnership programme, decided to leave her job because of a toxic workplace and because the structural working conditions were not conducive to her pregnancy:

Extract 30

Researcher: What kind of work do you do?

Ntombi: I used to work for a construction company. I was doing a learnership programme with them. So I've just stopped working recently,

Researcher: Oh, you just stopped working? Is it because you are on maternity leave?

Ntombi: No. I stopped because I felt like I no longer had the strength to continue working /oh, okay/ because my workplace is far; it is close to Worcester Mews. So, we had to walk to and from work sometimes. And then we have to wake up early in the morning. Sometimes I get very tired.

On an individual level, Ntombi's pregnancy is strength-sapping. This conflicts with her employment duties because she must get to work on time. Ntombi positions her workplace as distant and public transport as unreliable, requiring extra effort, such as getting up early because she must walk to work. In a study that examined low-income working women's breastfeeding practices (Stumbitz & Jaga, 2020), authors drew attention to how apartheid spatial planning (where homes of black families are segregated from the centres of main cities) hindered women's ability to breastfeed after pregnancy. Women in this study reported that transport to work was one of the most significant factors that prevented their ability to breastfeed because they had to get up very early to make work on time or got home very late after leaving work. Ntombi's account demonstrates how structural obstacles, such as transport to work, may result in pregnant individuals opting out of the workplace because it is

not conducive to supporting their pregnancies yet shifts them into the undesirable position of not being financially secure enough to be pregnant.

In tracking how the normative constraint of reproductive affordability was salient across the elements of the supportability framework, participants foregrounded how their healthcare experiences were shaped by their socio-economic positions."

"They don't care about you if you're on government."

In the introductory chapter, I explained how the South African health system was stratified according to public and private healthcare provision. Although the provision of free public healthcare is meant to be pro-poor, it is experienced as dehumanising. In contrast, private healthcare is perceived as better quality but is reserved for those who can afford it. Participants in this study perceived that they may well be recipients of poor treatment because they are *dependent* on the state for their maternity healthcare. Linda and Anelisa directly compare the public and private health systems concerning what type of care they could expect to receive.

Extract 31

Anelisa:...because if I don't have money to go to the doctor first of all, to the clinic, to the public clinic, and then I will get the treatment from nurses like that. Yeah, I think so, but then the doctor that I go to, he knows that he's being paid a lot of money ... he has to do what he is supposed to do ...like the service is quite different from the nurses.

Extract 32

Linda: ...that's why I feel so scared; I'm not on medical [aid] now, but that time with my daughter, I was on medical[aid] by my mother /ok/but it will be <u>different</u> now because they said, they're very careless here at the hospital (.) if we don't have medical aid, they don't care about you...

For Anelisa, the interpersonal power dynamics between the doctor/paid service provider and Anelisa as a patient/consumer are flipped through the market interaction; because Anelisa can pay for her healthcare, the doctor has an imperative to provide a good service: "He has to do what he is supposed to do". Thus, people with medical aid insurance are entitled to good service because they have paid for it. In contrast, Linda underscores that her healthcare experience will be different this time because she is no longer on private medical aid. Here,

Linda interactively positions hospital staff as careless and the health system as uncaring. As a low-income pregnant individual (imperative positioning), Linda also indexically positions herself as an undeserving patient because she is dependent on the state, and this makes Linda feel afraid of giving birth in the public health sector.

Thando expands on this issue, having experienced rudeness and neglect from nurses during antenatal care and when giving birth with her first pregnancy (which was a stillbirth). She points out how nurses do public health patients a favour when providing antenatal care services:

Extract 33

Researcher: Why do you think that happens [asking about treatment from nurses]?

Thando: I think (3) like, from my opinion, from what I saw /mm/ I think that the nurses (1) here think that they're doing us a favour by helping us. They forget that it is their job, it's what they studied for … it's like I'm doing you a favour so, you're going to come when I tell you to come, you are going to do it when I want you to do it /mm/ so it's more of that kind of attitude…

When Thando refers to "helping us", she is indexing her social position as someone of a lower socio-economic status. Notable in her narrative is how a person of a lower socio-economic status is not entitled to patient-centred care. The interpersonal power dynamic between patient and healthcare worker is hierarchal. The nurse is positioned not as a service provider but as a discretionary medical authority, while the patient is positioned as subservient or passive, subject to instructions only. The description of the nurse's actions, such as "you're going to come when I tell you to come, you are going to do it when I want you to do it", demonstrates this power dynamic. The healthcare worker will instruct, healthcare options will be decided for the patient and the patient will comply. In this way, low-income patients have no right to make any choices concerning their reproductive health because they do not pay for the services. Thus, through disciplinary forms of power, the public health system, aided and abetted by nurses, manages low-income patients by marking them as non-legitimate patients because they are dependent on the state and, therefore, not deserving of quality healthcare.

Sandra draws a comparison between her maternity care experiences in the Brazilian public health system and the South African public health system:

Extract 34

Sandra: … But n then you decide to use the public sector but you have this other (2) mentality of the standard of how you should be treated as a person /mm/ it becomes hard because I know that most people don't complain /mm/ they're perfectly happy with what they get, but because I've had other type of service [Brazilian public health system], I know it can be better, you know /yes/ because it's very much in a personal level the way they, it doesn't matter if it's public or private but if you're not treated well that can be a huge problem /yes/ so I think that is more the biggest problem that we encounter, actually the way you're treated as a person, as a mother, expecting mother…

What is notable about Sandra's narrative is how taken aback she is by how the South African health system treats people after having accessed maternity care in the Brazilian public health system for her previous pregnancies. In using the public health sector in South Africa, she explains how the "mentality of the standard of how you should be treated as a person" conflicts with the treatment one gets from the public health sector. Sandra draws attention to how the system treats certain types of patients as non-human and thus undeserving of care. In this way, she positions the public health sector as inhumane. In drawing from pronatalist notions of how motherhood should be respected and revered, Sandra goes on to stress that the South African public health system completely disregards this; even being socially positioned as a mother is not seen as legitimate and deserving of respect by the health system.

In sum, structural power, in the form of the South African public health system, which provides free healthcare to pregnant individuals, is supposed to be enabling. However, how participants perceived they would be treated (through the availability of healthcare choices and being deserving of care) was in relation to being dependent on the state, and this was construed in a negative light. The public health system was seen to perpetuate cultural representations of poor women as being irresponsible for becoming pregnant. This cultural representation was reflected in perceptions of the type of treatment participants could expect from healthcare workers. This contrasts against those participants who could purchase their maternity care through the private healthcare system and who positioned themselves as deserving of higher quality healthcare.

Conclusion

This chapter has focused on how the normative constraint of reproductive affordability came to bear on the pregnancy management practices of the participants in this study. Participants constructed social support as subject to deservingness. As such, notions of (in)dependence permeated their talk.

Reproductive affordability shaped individual pregnancy behaviours (individual level), whereby it either enabled or constrained participants' abilities to position themselves as healthy pregnant subjects and prepared mothers. Participants linked their dependency on their own waged labour to having an easy pregnancy and having agency to cover their pregnancy needs, nutrition requirements and prepare for the birth of the child.

On a micro level, participants described in what ways reproductive affordability shaped their dependency on their male partners. Participants were circumspect about being financially over-reliant on their partners and in positioning them as overstretched financial providers, expressed a desire to become financial providers themselves. However, male partner financial support also enabled independence whereby participants could cover their pregnancy needs and did not have to rely on other support networks such as family to assist them financially. Participants also addressed concerns about over-reliance on their families for financial support. Being a single mother was seen as a transgression and burdensome on family members while being caught in "traditional" hierarchal family power dynamics was seen as an undermining of independence and agency in complying with pregnancy health directives. Participants also rejected notions of dependency on family networks by positioning themselves as aspirational financial providers and present parents. On a work micro-level, participants drew attention to the conflict between being positioned as unreliable workers and good mothers, which involved the imperative to protect their pregnancies but at the same time be financial providers. In addition, participants drew attention to structural impediments (such as lack of public transport to work) that made it difficult to manage both their work environment and their pregnancy. This resulted in some participants opting out of the workforce but then being socially judged for not financially providing for the pregnancy.

On the healthcare level, participants drew attention to how their socio-economic positions determined the quality of their healthcare. One could expect to receive poor quality healthcare if one was poor and dependent on the public health system while being middle-

class enabled choices in maternity healthcare options and expectations of good quality healthcare.

In sum, the normative constraint of reproductive affordability shaped participants' dependency on their immediate support networks, the job market, and the healthcare system. I showed how participants self-positioned themselves as (ir)responsible pregnant subjects in being able to manage their pregnancies financially. Being dependent on support networks for financial help and the state for healthcare was seen as deviant and needing correction.

CHAPTER 11

Implications for examining pregnancy "supportability"

This thesis sought to operationalise Macleod's (2016) pregnancy supportability framework qualitatively. The aim was to conduct a multi-level intersectional analysis to identify reproductive (in)justices that may operate in pregnant women's supportability narratives. As indicated in my introductory chapter, the rationale for operationalising this framework stems from disparities that affect the health and well-being of pregnant women living in rurally based locations in the South African context. This is despite a highly progressive rights-based policy environment designed to protect individual reproductive rights and well-being. In addition, the policy environment is meant to commit to addressing the social determinants of health (SDH) that contribute to maternal reproductive inequities by mobilising multi-sectoral government participation. However, maternal health policies do not particularly clarify how this should be done. As such, it was envisaged that the findings generated from this study may prove useful in informing what type of multi-sectoral SDH strategies might be required to mitigate the harms that undermine maternal health and well-being.

In using the supportability framework to guide my search of the literature, I covered a wide range of research that has examined whether social support mediates pregnancy well-being. Quantitative literature focuses on the associations between social support provided during pregnancy and its effect on psychological and physiological pregnancy outcomes and maternal behaviour. Higher levels of social support mediate against poor mental well-being, but its effect on physiological outcomes (and maternal behaviours) is less conclusive. Scholars conducting systematic reviews of this literature have noted that the variable findings are likely due to different ways of conceptualising and measuring social support (Bedaso et al., 2021b; Hetherington et al., 2020). Moreover, they concede that social support might be understood and *perceived differently* across social groups, socio-cultural settings and global regions. These findings are of importance concerning the rationale of this study because a social constructionist approach argues that the notions or understandings of social support cannot be essentialised or pre-defined neatly.

Social support has generally been conceptualised in relation to *immediate* support networks, thereby leaving *support structures* such as socio-economic policies, socio-cultural norms or institutional structures that may inform the availability and perceptions of social

support underexamined. A fair proportion of the literature on pregnancy support has highlighted how social determinants (such as living in deprived areas) and occupying certain social positions (such as low socio-economic status or being unpartnered) may play a role in whether pregnant individuals receive lower levels of social support, thereby affecting their pregnancy outcomes and well-being. For example, quantitative South African studies have found high levels of mental stress in pregnant women living in economically deprived areas and have put this down to several risk factors, including low levels of social support (Brittain et al., 2017b; Heyningen et al., 2016; Onah et al., 2017; Tsai et al., 2016a; van Heyningen et al., 2017).

Qualitative studies on social support have provided insights into the types, sources, and kinds of support that might be provided by social networks within various social settings. The vast majority of these (including those in South Africa) have conducted thematic analyses that report on the surface-level meanings of the data. Uncovering implicit meanings, power relations, and discursive constructions of social support has not been a feature of this research, except for two studies conducted in Australia (Clarke et al., 2021; Smissen et al., 2020). These two studies examined discursive constructions or representations of support when making reproductive decisions across the life course. These authors demonstrated how social support is *produced* in different ways through talk, subject to the gendered constraints of the broader social environment (for example, support is perceived as conditional or justified depending on who the supporting person is). These studies, however, did not consider how social support might be constructed in different ways owing to the social positions and social environments that women may occupy, and they did not focus specifically on the pregnancy experience. I have not found studies in South Africa that have investigated how social support during pregnancy is embedded in power relations, how it might be shaped by the wider discursive, social, political and economic environment and how it might be constructed with regard to the social positions that pregnant individuals occupy. Moreover, expanding on social support to include the broader social environment that includes support structures is another underexplored research area.

A reproductive justice approach framed this study and is informed by the intersectionality theory (Ross & Solinger, 2017). The supportability framework itself is premised on an intracategorical intersectional approach (McCall, 2005). The key intersectionality tenets I incorporated into the construction of this study were: (1) analysing from a micro-perspective, that is, an examination of pregnant women's photo-elicited narratives of pregnancy supportability to foreground participants' lived experiences; (2) conducting a multi-level

analysis to investigate how pregnant women are intertwined with their social support networks and the support structures available to them; (3) surfacing the power relations inherent in these narratives by using Collins' (2000) domains of power thesis; and, (4) using Wanda Pillow's (2003) reflexivity of discomfort to remind me of how I both share social characteristics with the participants of my study (as a cis-woman) but am also very much an outsider to the life experiences and social conditions in which most of the participants lived.

Theoretically, I also located this study within the broad philosophy of social constructionism. In drawing connections between intersectionality theory and social constructionist approaches, I adopted a critical realist stance and used Wilkinson and Kitzinger's (2003) approach to positioning theory. This was done with the different levels of the supportability framework in mind to bridge the micro (individual) and macro (social) divide. Subject positions are seen as conduits for examining the support interactions across the different levels of the supportability framework. At the same time, normative constraints circumscribed how those positions were taken up and resisted. In addition, my approach to positioning theory was to use a process-oriented way to analyse social interactions by identifying what social actors *do* with positioning work and by examining how they may use social categories in talk and for what purposes. This approach intentionally did not foreground social categories in the analysis but focused on how they were produced in talk about pregnancy support. Using positioning theory in this manner also enabled an examination of relations of power, which provided insights as to how relative privilege and disadvantage are produced concerning pregnancy supportability. In so doing, I developed a positioning supportability approach for examining constructions of social support during pregnancy. In operationalising the supportability framework, this approach extends on positioning theory by considering how individuals might position social entities in talk. In addition, I have built an analytical method to conduct intersectional analysis, which has been deemed a shortcoming of intersectionality theory. These theoretical concepts laid the groundwork to answer my research questions.

My aim, using the supportability framework as part of my analysis, was to identify reproductive (in)justices by identifying how normative constraints (or enablements) were embedded in the various facets of support available to the participants of this study. These were surfaced by conducting a positioning template analysis by plotting positioning micro-narratives across the elements of the supportability framework and clustering them into thematic groupings. I was interested in how these normative constraints were embedded within

the participants' support networks and shaped their reproductive agency in ways that had implications for the supportability of their pregnancies. That is, I specifically analysed how participants were able to make decisions about and manage their pregnancies given the social support networks and structures available to them.

The most salient normative constraints that were identified in participants' narratives were the interaction between reproductive legitimacy (appropriate childbearing), reproductive affordability (socio-economic implications of the pregnancy) and reproductive responsibility (idealised notions of an exemplary pregnant subject). Reproductive responsibility overlapped somewhat with the former two normative constraints. These normative constraints informed how participants discursively constructed social support as *conditional* and *subject to deservingness*. Participants' positioning micro-narratives also illuminated how their social positions and locations were implicated in these discursive constructions of social support and how they enabled or constrained participants' reproductive agency.

Finally, Collins'(2000) domains of power thesis (interpersonal, disciplinary, cultural and structural), used as an analytical tool, not only helped surface the three key normative constraints that operated in participants' narratives but also drew attention to how multiple reproductive (in)justices were produced. Firstly, pregnant participants were held individually accountable and responsible for becoming pregnant and managing their pregnancies. This was despite a multi-faceted, unsupportive macro-environment that undermined their ability to do so, including socio-cultural notions of appropriate childbearing, inequitable gender dynamics that control women's sexuality, fertility and pregnancy practices, high unemployment, a constrained job market (lack of decent work and pay), pregnancy discrimination within the workplace, (dis)respectful care and lack of "choice" in health settings, poor quality government essential services and infrastructure, and a lack of state social protection for pregnant individuals. These injustices interpellated back onto how pregnant participants, in constructing their dependency on their support networks and structures, were able to present themselves as exemplary and responsible pregnant subjects. I now turn to a discussion of how my findings answer my research questions and support my claim.

Situated knowledge and pregnancy supportability

In Chapter 8, I presented six case studies of pregnant women who participated in this study. I used the supportability framework to construct their case studies to present a multi-faceted view of their pregnancy experience. These case studies attended to the surface-level

meanings of the data. They aimed to foreground the visibility of the participants' unique pregnancy experiences, which is important from an intersectional stance. These case studies also partly answered the research question: How do women's constructions of support speak to pregnancy supportability?

Despite sharing the same social characteristic, pregnancy, these case studies demonstrated the variability and complexity of pregnancy support experiences amongst this social group, a key intersectionality tenet (Hancock, 2016; May, 2015; Yuval-Davis, 2015). Pregnant individuals, as a group, cannot be treated as one "master" category because these accounts were illustrative of how participants' experiences of pregnancy support were unique to their social locations and contexts (McCall, 2005). In sum, the case studies highlight how pregnancy supportability is a multi-faceted event and as such, pregnant individuals cannot be treated as a one-dimensional social category.

Although the case studies demonstrated that pregnancy support experiences cannot be essentialised, intersectionality theorists and critical realists do argue that these experiences, although varied, are entrenched in social, material, and discursive contexts that can be stable and enduring, thus having "real" consequences for the every-day lived experiences of the pregnant individuals of this study (McCall, 2005). The conceptualisation of the construct "supportability" requires that an individual cannot be examined to the exclusion of their social context. Presenting each case study, enabled by plotting the positioning micro-narratives across the supportability framework, provided evidence of how social influences were intricately intertwined with the participants' capacity to carry their pregnancies to ensure their own and future children's well-being.

As such, although the narratives were unique, commonalities shaped participants' talk about their pregnancy experiences. These were identified by examining the support interactions across the supportability framework. Common to the six case studies presented was a feature of talk which centred on pregnancy intention. The cognitive (wanted, unwanted, mistimed, planned), emotional (shocked, stressed, ashamed, relieved), and behavioural (contraception (non)adherence, pregnancy concealment, abortion seeking and testing delays) responses to the pregnancy were framed around the potential judgements and acceptance of others on a micro-level. This finding aligns with other South African studies where scholars have flagged that pregnancy stigma may play a role in informing social support provision. For example, Phiri and colleagues drew attention to how pregnant university students felt stigmatised by their pregnancies because of their age and their unmarried status and that these feelings of

stigmatisation were heightened in university and public health facility spaces. Mlotshwa and colleagues (2017) reported how women who were unmarried and pregnant experienced stigma from their families (which required seeking support from others) and the church (thereby not attending church during the pregnancy). Brittain and colleagues (2023) have reported how young pregnant women who were HIV-positive experienced high levels of stigma within their communities. Whilst these studies have drawn attention to how particular social positions, such as early and premarital reproduction and HIV-positive pregnancy status, may be subject to pregnancy stigma, the case studies in this research have shown that notions of appropriate childbearing and its implications for support affected all participants in this study and was related to their social positions in South African society.

The South African literature on social support has also flagged how the macro-social environment in the form of economically deprived contexts and unequal gendered relations shapes support provision during pregnancy (Lewinsohn et al., 2018; Phiri et al., 2023; Scorgie et al., 2015). These studies have reported how unintended pregnancies occurring in economically deprived contexts can increase discord within immediate social networks because they put pressure on scarce resources. Similarly, the case studies also revealed how a pregnancy in these contexts may result in male partner abandonment and strife between family members as they compete for resources. However, in contrast to the South African literature on social support, the case studies in this thesis also surfaced how the socio-economic implications of the pregnancy informed participants' abilities to present as *responsible* pregnant subjects in relation to their support networks. For example, over-reliance on financial and instrumental support from partners and family members was constructed as undesirable and burdensome; participants positioned themselves as aspirationally independent and financial providers for their future children. The use of the supportability framework highlighted how participants drew attention to *macro support structures* such as poor quality public healthcare, lack of government infrastructure and services, and limited access to the job market, which hindered or enabled their abilities to present as model pregnant subjects.

These case studies, therefore, contribute to the current literature on social support within South Africa by touching on the support dynamics that occur during pregnancy, and they also highlight how stigma and the socioeconomic implications of pregnancy might shape the provision of social support. However, an examination of the individual, micro- and macro support interactions using the supportability framework surfaced socio-cultural norms of appropriate childbearing through talk about pregnancy intentionality and how participants

themselves positioned the macro support environment as limiting or enabling them to present as exemplary pregnant subjects, given their socio-economic positions in South African society.

One of the objectives of this dissertation was also to understand *how* participants positioned themselves (individual level), their immediate social support networks (micro-level) and social entities (macro-level) in relation to the support they may or may not have received when pregnant. By examining participants' positioning strategies (aided by the domains of power thesis), the three key narrative positioning themes (reproductive legitimacy, affordability and responsibility), understood as normative constraints, were identified and came to bear on pregnant participants' constructions of support. The normative constraint of reproductive legitimacy (and interrelatedly reproductive responsibility) was a common theme in the participants' talk. I provide a discussion of these findings next.

Reproductive legitimacy

Participants, in finding out they were pregnant, constructed the social support they expected to receive from their networks as conditional based on their social positions in South African society. The overarching cultural narrative that guided this talk was: "Is this pregnancy legitimate because it is (un)intended?". Support provided conditionally hints at embedded power relations that shape how and in what ways individuals account for becoming pregnant. Using Collins' (2000) concept of power to guide me, I showed how a cultural form of power, "appropriate" childbearing, informed the normative constraint of reproductive legitimacy at the early stages of pregnancy. Put differently, this form of power sanctions those who make an exemplary pregnant subject and those who do not.

Ross and Solinger (2017) describe how "legitimate" mothers are constructed through racialised policies and socio-cultural mechanisms: Individuals who hold the social positions of being black, young, poor, unwed, and unemployed are not deemed legitimate mothers. Legitimate mothers, these authors argue, are mothers who are white, cis-gendered, able-bodied, heterosexual, married, middle-class and of suitable reproductive maturity. Most participants in this study, by virtue of their master social characteristics, did not quite satisfy the idealised version of a legitimate pregnant candidate. This was evidenced by how the participants perceived the legitimacy of their pregnancies by justifying them and attempting to present themselves as legitimate pregnant subjects. By constructing social support as *conditional*, reproductive legitimacy was surfaced. Participants in this study perceived that the social support they could expect was contingent upon the social appropriateness of their

pregnancy. For example, the family (a social entity) was positioned as potentially judgmental. Thus, the normative constraint of reproductive legitimacy formed a continual backdrop to participants' talk across the elements of the supportability framework, encompassing both neoliberal and moralist notions of reproductive agency, responsibility and respectability (Bay-Cheng, 2015).

Reproductive legitimacy, I argue, is not only premised on achieving a perfect score of desired social characteristics but is also premised on pregnancy intention. Unintended pregnancies are generally construed negatively (Aiken et al., 2016; Potter et al., 2019). They are said to undermine maternal well-being and pregnancy outcomes, are a threat to educational and economic prospects, and have cost implications for health systems. Framed as a poor reproductive outcome, the legitimacy of an unintended pregnancy is questioned. They infer a lack of rational planning, poor decision-making and irresponsible sexual behaviour on an individual level. Those who have unintended pregnancies have transgressed not only the logic of family planning health policies meant to help them time and space their pregnancies but also social norms (educational attainment, financial stability, reproductive maturity, long-term relationships or marriage) that sanction appropriate sexual practices and childbearing. The findings of this chapter highlighted how (un)intended pregnancies were a salient feature of participants' talk, profoundly shaping their reproductive autonomy, their legitimacy as pregnant candidates and how support networks and structures withheld or offered support.

Reproductive legitimacy was very much enabled or constrained by support networks and structures. As Myers (2001, p. 746) argues, "While it would be wrong to claim that no woman ever makes a fully autonomous reproductive decision, testimony suggests that women who do are exceptional". No participant in this study indicated that she became pregnant simply because *she* wanted a baby; this decision was always made in relation to her support networks. Using the supportability framework as a guide, I identified how individual, micro- and macro-support interactions played out in the process of (de)-legitimising participants' pregnancies.

Reproductive legitimacy as a normative constraint also had a bearing on reproductive autonomy located on the individual level of the supportability framework. A planned pregnancy demonstrates reproductive autonomy where sexuality is controlled. However, an unintended pregnancy represents a loss of reproductive agency (Katz & Tirone, 2015). Participants demonstrated that both the (un)intended pregnancy and their sexual conduct were evaluated at the same time by support networks and structures (a pregnancy is physical evidence of sexual

conduct), and this resulted in several legitimisation scripts. Thus, participants engaged in positioning work that both questioned and justified their pregnancies. This was done to manage being positioned as a sexually irresponsible subject and appear as a sexually respectable subject. Thus, on an individual level, participants with unintended pregnancies initially engaged in self-blaming talk and self-positioned themselves as irresponsible sexual subjects because they had transgressed reproductive disciplinary norms. Nevertheless, participants used their imperative social positionings of relative advantage and disadvantage to recover from these undesirable social positionings and regain some sense of agency. In so doing, they compared the legitimacy of their pregnancies to those who were "less fortunate" or "less responsible" when justifying them. Here, they drew on "master" social characteristics such as relationship status, socio-economic stability, reproductive maturity, unwed mothers and single motherhood to highlight how their situation was better than others. It became apparent, however, that participants who had planned and wanted pregnancies also engaged in legitimising talk to justify their pregnancies. Thus, appropriate childbearing cultural constraints also came to bear on all participants' timing and "reasoning" for having a pregnancy.

On the micro-level, support networks, especially male partners and family members, had the power to (de)-legitimise or participants' pregnancies. Participants interactively positioned family and community members as potentially judgmental and censorious of their pregnancies. Family support networks evaluated participants' sexual conduct (sexual responsibility and respectability) and their social positionings (socioeconomic well-being, relationship status and age) in relation to normative childbearing. Unsupportive social networks used participants' imperative positionings, such as relationship status, financial well-being and reproductive maturity, to amplify the inappropriateness of the pregnancy. Family acceptance of the pregnancy often de-emphasised undesirable social positionings pertaining to "inappropriate" childbearing. The withholding or provision of support or participants' avoidance of seeking support indicated whether a pregnancy was deemed legitimate.

As mentioned in the social support literature, male partners are considered the most important and most intimate part of a pregnant woman's support network (Battulga et al., 2021; Bedaso et al., 2021b; Dunkel-Schetter et al., 1996). The role of male partners featured prominently in participants' narratives. Reproductive legitimacy was shaped by heteropatriarchy on a macro-level, which meant that participants were highly constrained in exercising agency (interpersonal power) within the male partner support nexus to justify their pregnancies. Of particular importance is how the legitimacy of the pregnancy was premised on

participants' relationship status and the reproductive wishes of male partners. The marriage institution legitimised pregnancies whether (un)intended, (un)wanted, or mistimed. For unmarried participants, unintended pregnancies were presented as personal failures despite, in some cases, male reproductive manipulation or, in most cases, male partner absence in preventing pregnancy. Thus, male partners were implicitly positioned as non-responsible for contraception practices. Male partners' reproductive wishes were also privileged over those of the participants, and men were, therefore, implicitly positioned as key reproductive decision-makers concerning the (non)acceptance of the pregnancy. This was evidenced by participants either acquiescing to have the pregnancy based on their partner's wishes or forgoing the couple's relationship should they decide to keep the pregnancy. For unmarried participants, the mere acceptance and presence of a male partner was fundamental to paving the way for a legitimate pregnancy, while partner abandonment disastrously de-legitimised participants' pregnancies. Unmarried participants had limited structural forms of power upon which they could draw to hold their male partners to account, and this lack of structural power enabled male partners to exit the relationship and deny the pregnancy without any consequences. Paternity denial prompted the repairing of damaged social positions as pregnant subjects. Participants and their social support networks used strategies of resilience by re-positioning themselves as capable single mothers and positioning men as unnecessary and absent fathers. As such, these positioning strategies served to uphold heteropatriarchal socio-cultural norms and neoliberal constructions of responsible subjects and stereotypes of deadbeat dads and absent fathers.

Participants' narratives also surfaced how macro influences played a part in the unintended pregnancy. Participants positioned certain social entities as undermining their reproductive practices. For example, certain reproductive health services concerning controlling fertility were positioned as unaffordable (vasectomies) or inaccessible (distance). Schools were positioned as incompatible with pregnant bodies. The marriage institution was positioned as family-centred, while romantic relationships positioned as stable or long-term, legitimised pregnancies. The job market was also positioned as unreliable and difficult to access, thereby pushing unemployed participants into undesirable social positions, such as bad mothers who are financially incompetent. Social practices such as abortion were positioned as justified under certain circumstances (being financially unstable or too young). The cultural practice of *intlawulo*, a potential mechanism to legitimise pregnancies for pregnant women, was positioned as transactional and thus potentially damaging to existing family relationships that were already supportive.

In sum, participants' reproductive autonomy in being able to justify their pregnancies was highly constrained based on the operation of their support networks and structures. As Bay-Cheng (2015) argues, a neoliberal framing of sexual agency as empowered yet responsible operates in variable ways for differently socially positioned young women. To fall below this line (by having an unintended or inappropriate pregnancy) requires regaining sexual agency (or sexual respectability), and one must compare oneself to those who have failed. Thus, through the very act of justifying their pregnancies, participants themselves drew on normative notions of appropriate childbearing. My findings show that in trying to manage social judgements about their pregnancies, participants discursively reinscribed and reinforced the very reproductive injustices that demonise those who are deemed non-legitimate pregnancy candidates, that is, pregnant teenagers, unwed mothers, single mothers and poor mothers and relatedly (but more implicitly), especially within the South African context, black mothers. Using a reproductive justice lens, then, the "right" to have a pregnancy was contingent on fulfilling idealised social characteristics that were simply not on the table for the majority of the participants in this study. Therefore, the findings of this chapter present novel findings in relation to the literature on social support during pregnancy in the South African context by offering more than surface descriptions of who and what types of support are provided to pregnant women. I have demonstrated how social support is embedded in power relations and, as such, is discursively constructed as contingent on the perceived social appropriateness of the pregnancy.

The reader will remember that, in my analysis, I split the pregnancy support experience into two separate time frames because participants seemed to speak from different positions on finding out about and accepting their pregnancies and managing their pregnancies. A reproductive justice approach is also committed to carrying a pregnancy in a conducive environment. My final chapter focused on this phase of the pregnancy. The normative constraint of reproductive affordability shaped participants' narratives at this stage of the pregnancy. I provided a discussion of these findings next.

Reproductive affordability

Participants' ability to manage their pregnancies in a manner that was deemed responsible was highly constrained by the socio-economic implications of their pregnancy. I identified two intersecting normative constraints contingent upon and interrelated with one another: reproductive affordability and reproductive responsibility. Reproductive affordability (a form of structural power) is associated with the socio-economic implications of the pregnancy. In contrast, reproductive responsibility (understood as a disciplinary form of power) speaks to

adopting appropriate pregnancy practices to ensure the safety and well-being of the foetus. The cultural power of the social narrative "Stop having babies you can't afford" encapsulated the intersection of reproductive affordability and responsibility and informed participants' talk about the support they may or may not have received. These interrelated normative constraints played a role in how support networks helped or hindered participants in managing their pregnancies. "Stop having babies you can't afford" also infiltrated participants' immediate support networks as a stigmatising cultural form of power that continued to judge participants for having pregnancies deemed socially inappropriate, especially regarding their affordability. In response to this narrative, participants constructed social support as subject to *deservingness*, that is, whether someone deserves support should they not be in a stable financial position. Notably, notions of *(in)dependence* permeated participants' talk and occurred across the elements of the supportability framework.

Nancy Fraser and Linda Gordon (2013) traced how "dependency" has been discursively constructed in the United States from pre-industrial times to post-industrial capitalism. They focused on how the term has been used in relation to social welfare. They argued that capitalism has warped the notion of "dependency" for working-age adults by taking on a moral and psychological register. The notion of "dependency", they assert, has become vilified, stigmatised and constructed as a somewhat racialised and feminised personality flaw (think black welfare mother), whilst "independence" has become firmly linked to wage labour. In responding to the cultural narrative of "stop having babies you can't afford", participants in this study did much labour in trying to self-position as independent of their support networks. As such, their worthiness in receiving support or not was constructed in relation to their financial abilities.

On an individual level, participants directly linked reproductive affordability to (ir)responsible pregnancy behaviours. Participants in self-positioning as financial providers *themselves* showed how their dependency on economic security enabled appropriate pregnancy behaviours such as eating nutritious food and managing stress during their pregnancies. Employed participants also contrasted their more privileged socio-economic positions with unemployed, pregnant "others" to reinforce how they were able to achieve these reproductive disciplinary ideals. Being able to afford a pregnancy was synonymous with being positioned as a stress-free and healthy pregnant subject compared to those who could not afford a pregnancy. Notably, participants' *own* social positions of being employed were seen as key to enabling the supportability of their pregnancies. Here, their independence in making the

right choices for their pregnancy is made possible through individual waged labour (Fraser, 2013), and this financial independence imbued them with reproductive agency. Unemployed participants demonstrated how the supportability of their pregnancies was constrained due to their poor socio-economic positions. They self-positioned themselves as highly stressed, uncompliant antenatal care attendees, deviant grant holders and unprepared mothers because they were not able to make financial provisions for their pregnancies. In so doing, participants demonstrated how, as unemployed and pregnant, they struggled to achieve the ideals of a responsible pregnant subject. These self-positions allude to cultural constructions of unemployed mothers as bad or irresponsible mothers (Lowe, 2016).

Unemployed participants did, however, draw attention to how structural forms of power (social entities) hindered their ability to achieve responsible pregnant subject ideals. The labour market was positioned as limited and inaccessible, health facilities as far away and expensive travel-wise and public transport as limited. Nevertheless, participants attempted to show that they had every intention of fulfilling their reproductive responsibilities despite the structural inequities that undermined the supportability of their pregnancies. This meant they had to rely on others or the state to assist them. Attending antenatal care as soon as someone had provided them with funds, making use of state support structures (such as the child support grant), saving “treat” money received from family members and taking part in the research interview were some of the limited strategies used in trying to overcome these constraints.

Financial dependency on support networks and structures was constructed as a personal failure needing correction. Unemployed participants positioned themselves as over-reliant, a burden, and undeserving support recipients. In attempting to rectify the transgression of becoming pregnant while not financially secure or rejecting being accused of being financially dependent on their social networks, participants used aspirational subject positionings of financial providers, planners, savers, job seekers, upskilled job seekers, and heterosexually partnered pregnant subjects to shed this stigma.

Participants also used their heterosexual relationships to present as independent, choosing and compliant pregnant subjects. In so doing, patriarchal notions of the male breadwinner model were upheld (Fraser, 2013). The male breadwinner model enabled independence through the provision of financial stipends. It was interpreted as gaining newfound independence, enabling purchasing power to attend to pregnancy needs. Participants used the male breadwinner model, especially outside of marriage, to reject dependency on others (usually kin), enabling them to present as financially responsible

pregnant subjects. At the same time, however, participants self-positioned as being overly dependent on male partners for financial support, which was also seen as deficient. By interactively positioning their partners as overstretched financial providers, abusive, or financially absent, participants saw their social positioning of being unemployed as a personal failure and accessing the job market as the solution to these inequities. Being unemployed also exacerbated unequal gendered power dynamics on a micro-level by leaving pregnant participants vulnerable to domestic abuse because they could not leave the relationship or by placing more pressure on supportive partners to provide for everyone financially.

Participants were also wary of relying on their families for financial support during their pregnancy, which took different forms. Participants drew attention to how their social positions, such as being unemployed and partnerless, made them overly dependent on their families for financial support during their pregnancies, thereby positioning them as burdens. Another married participant (Zenande) positioned the patrilineal family structure as hierarchical in that power was vested within her mother-in-law and constrained her agency in being able to manage the pregnancy responsibly by attending antenatal care on time and selecting the right type and (enough) nutritious food for her pregnancy. Participants discursively constructed this dependency on support networks as undesirable (Fraser, 2013). Other participants rejected being dependent on the support from families by affirming that they would raise their own children, thereby positioning themselves as aspirational present parents.

Participants, in demonstrating their desire to be seen as responsible pregnant subjects, self-positioned as employed (thereby able to afford their pregnancy), independent financial providers (to challenge dependency on male partners), as heteronormatively partnered (thereby ensuring financial independence from family through a supportive partner) and as a present parent (so as not to depend on others to raise their children). These positions were, however, aspirational given the constraining features of South Africa's macroeconomic context of lack of employment opportunities.

Dependency on the workplace was also constructed as potentially constraining the supportability of participants' pregnancies. Participants struggled to achieve a balance between the normative constraints of reproductive affordability (financial provider) and responsibility (ideal motherhood or pregnancy practices). Contradictorily, pregnant participants' dependency on the marketplace was discouraged in two ways. Firstly, structural power (macro-level) in the form of an unaccommodating work environment had implications for pregnant workers. Distances to the workplace and a lack of reliable public transport to work

undermined participants' ability to get to work, resulting in long commute times, which were tiring for some participants. Secondly, participants interactively positioned their work colleagues as unaccommodating and discriminatory toward their pregnancy (micro-level). For participants who were employed, positioning attributes such as unreliable, incapacitated and unrecovered were attached to the social positioning of the pregnant workers (imperative positioning).

The positioning of pregnant workers in this way is based on what Gatrell and colleagues (2023) contend as androcentric constructions of a masculinist "ideal worker" who does not disrupt the everyday functioning of the workplace by bringing private reproductive demands, such as pregnancy, into the public sphere of life. Pregnant participants failed to achieve the ideals of responsible worker subjects because their pregnancies increased their absenteeism. Employers, although they were aware of employment laws, were not prepared to accommodate the pregnancy within their everyday operational requirements, so they encouraged pregnant workers to take unpaid leave to "monitor" their pregnancy or threatened to fire pregnant workers for "slacking" on the job. Thus, pregnancy discrimination in the workplace occurred despite the constitution, labour laws and labour guidelines being in place on a macro level to protect pregnant workers' rights.

Moreover, similar to other research on pregnancy discrimination in the workplace (Gatrell, 2011a), participants did not draw on the rights afforded to them as pregnant employees when experiencing pregnancy discrimination. Gatrell and colleagues' (2023) examination of pregnancy discrimination in the UK workplace points to similar findings in viewing pregnancy as incompatible with the workplace environment. In their study, pregnant women were penalised in various ways (including being made the target of jokes, threatened with their jobs, pushed out of their positions or fired) for not conforming to constructions of the "ideal worker". According to these authors, cultural images of the ideal worker are constructed as masculinist, able-bodied, healthy, and who can prioritise their jobs (without competing responsibilities) to ensure the smooth functioning of workplace operations. Pregnancy experiences such as having morning sickness, needing to use the toilet often or leaving work to go for antenatal care check-ups, together with the affective changes a pregnancy might produce, are seen to detract from this idealised image and undermine workplace operations.

Although taking part in the marketplace was generally discouraged or not accommodated, participants were nevertheless put in a double bind when making choices about their reproductive well-being and their dependency on income. In attempting to aspire to

ideals of responsible reproductive practices, participants chose to “monitor” their pregnancies by not posing a risk to them. Participants were forced to forgo income earned by taking unpaid leave, or they left employment to lessen the perceived risks to their pregnancies. However, they were then judged for not financially providing for the pregnancy. Structural power in the form of state maternity income social protections did not accommodate these participants, as they are classified as non-standard workers and are workers who were employed in state workfare programmes. This exacerbated participants’ dependency on the market by forcing them to go back to work when they had not yet recovered from childbirth.

Being able to position oneself as a present parent (i.e. responsible mother) was also contingent on participants’ dependency on the market workplace. On a macro level, the migratory nature of work opportunities undermined participants’ ability to exercise responsible reproductive ideals of present parenting, as the scarcity of jobs means that one travels to wherever in the country jobs may be available. Unemployed participants, in attempting to construct themselves as financial providers (i.e. responsible future mothers), did so from a survivalist perspective. They would take any employment available, and this stemmed from the imperative of having to provide as a mother. At the same time, personal career aspirations were the preserve of those who were already employed. For middle-class participants, being a stay-at-home mum required the financial success of an individually owned enterprise and staying in an unstimulating job so as not to create stress for the foetus.

From a healthcare interaction perspective, I showed how participants were very aware that their socio-economic positions had a bearing on how they expected to be treated by the state healthcare system. Participants positioned the public health system as uncaring and inhumane to people. In self-positioning as poor or unemployed, participants indicated that they had already failed as legitimate and responsible pregnant subjects in the eyes of the health system by virtue of being dependent on it for their healthcare. Dependency on the public health system for maternity care meant that one could expect poor treatment from healthcare providers, thus upholding notions of poor people as undeserving of quality healthcare. In contrast, participants who could afford private healthcare highlighted their relief at not having to depend on the public health system and positioned themselves as deserving of good healthcare because they paid good money for it.

Although state structural power in the form of social and health policies such as pregnancy employment protections (labour laws and UIF), social income assistance measures such as the availability of the Child Support Grant (CSG) (accessible only once the child has

been born), government employment initiatives favouring the recruitment of women (EPWP and internship programs), and free public maternal healthcare have been designed as rights-based initiatives in order to improve gender equity (and therefore, in theory, should enable the supportability of a pregnancy), participants demonstrated that these initiatives were not necessarily experienced nor particularly supportive of their day to day pregnancy experiences. As such, these participants demonstrated that pregnant women, both unemployed and non-standard workers, are a neglected social group that has fallen through the cracks of social provisioning by the South African developmental welfare state.

Nevertheless, I have shown how participants accepted individual responsibility and made themselves blameable for their (in)ability to manage their pregnancies in a way that was deemed financially and socially appropriate, and in so doing, constructed their financial dependency on others and the state as deviant. Participants' talk reflected the South African developmental social welfare state's opposition to welfare dependency through the discursive positioning of ideal citizens as self-developed and self-reliant agents (Patel, 2015). As such, the construction of social support as conditional and subject to deservingness thus featured prominently in the participants' narratives of pregnancy supportability.

Wendy Brown argues that "As it [responsibilization] discursively denigrates dependency and practically negates collective provisioning for existence, responsibilization solicits the individual as the only relevant and wholly accountable actor" (2016, p. 9). The responsiblising effect of the narratives "stop having babies you can't afford" and "Is this pregnancy legitimate because it is (un)intended" can be construed as a neoliberal rationality that places the responsibility on the individual pregnant woman to be an exemplary reproductive planner and financial provider which is akin to being a good mother. This was made clear through participants having to justify their pregnancies to themselves, their support networks, and us as the researchers. In addition, this rationality surfaced through participants' ambivalence in being dependent on financial assistance from their support networks, their dependency on the public health system for maternity care, and their desire to find employment (regardless of whether the wage is decent, allows them to be present in the lives of their children or suits their career aspirations).

In sum, the macro socio-structural injustices of socio-economic inequality and appropriate childbearing imbued by coloniality, apartheid history, capitalism, socio-economic status, race, patriarchy, nationality, maturity and ability operated in concert together to form the backdrop upon which participants presented themselves as (non-)legitimate and

(ir)responsible pregnant subjects when making decisions about and managing their pregnancies. Using Collins'(2000) domains of power thesis to guide my analysis, I showed how these two overarching injustices came to bear on controlling participants' pregnancies in ways that shaped how support was perceived and given. This thesis, therefore, highlights how these (in)justices come to bear on the supportability of the pregnancy. I argue that given the influences of the micro and macro environment, the responsibility for a "good" or supportable pregnancy outcome cannot be pinned on individual "choices" and "good" behaviours because reproductive agency is conditional on the micro and macro support environments that circumscribe it. As such, a reproductive justice approach to pregnancy supportability is required from the state. It is incumbent on the state to address a number of critical areas that are unsupportive of pregnant individuals within the South African context. These are addressed next.

Final comments and recommendations

The pregnancy supportability framework has been useful in providing insights into the complexity of the pregnancy support experience. Operationalising the framework as conceptualised has enabled an analysis of how the macro environment fundamentally shapes social support during pregnancy. As the findings have shown, this approach has highlighted some pertinent interrelated support interactions that can inform what types of multisectoral collaboration and action need to be taken between government departments to achieve reproductive justice for pregnant individuals living within the South African context.

A state-led reproductive justice approach includes (but is not limited to) addressing disrespectful care in the public health system in both labour wards and antenatal care facilities. Crucially, however, pregnant individuals across the board require better social and maternity protection. I join other scholars (Pereira-Kotze, Malherbe, et al., 2022; Scorgie et al., 2015; van den Heever, 2016) and civil society groups (South African Law Reform Commission, 2022) in calling for an overhaul of our social welfare and labour force systems as part of a social determinants approach to improving maternal health and well-being. For a start, the South African government should ratify the International Labour Organization's Maternity Protection Convention, 2000 (No.183), which specifies that maternal protection should be provided to any type of worker. In addition, as Pereira-Kotze and colleagues (2022) have asserted, improved policy coherence with regard to protecting pregnant individuals in the workplace is also required. Addressing pregnancy discrimination practices in the workplace should be a priority.

The Department of Social Development has been working on developing a maternity social grant since 2012, aimed at those who are most vulnerable, and is still, at the time of writing this thesis, waiting for cabinet approval (see Oliphant, 2024). In adopting an intersectionality praxis, this research will inform how we, as researchers, engage with the proposed policy once it is made available for public comment.

From a research perspective, the supportability framework is, however, extremely broad, which means that there are undoubtedly some aspects relating to pregnancy support structures and micro-interactions that I have overlooked. For example, in deciding to present a broad overview of pregnancy supportability across all the elements of the framework (which was the objective of this research), a chapter dedicated to healthcare interaction itself was not possible for this thesis, but is definitely a possibility for future research. Examining the interconnectedness of the healthcare interaction with the other support elements of the pregnancy experience could be very useful for informing multisectoral antenatal care support interventions. The framework also offers the opportunity to research a wide variety of reproductive issues. For example, one could explore a specific social group's pregnancy support experiences, such as those of permanent workers, informal workers, adolescents, disabled individuals and LGBTQI+ communities. Pregnant people are not a homogenous group, and the supportability framework can provide insights as to how their support experiences might be qualitatively different.

Finally, the reader will remember that in conducting a template analysis, I was open to amending the original formulation of the supportability framework. One suggestion would be to include a spiritual element on the individual level, as participants indeed drew on spiritual notions when talking about pregnancy support. Where participants spoke to their faith or spiritual wellness, I generally coded these micro-narratives to the individual emotional element of the supportability framework. Although spirituality and the emotional (or cognitive) experiences of the pregnancy are very much intertwined, it became apparent that spirituality should stand as a distinct element. For example, Thando and Ntombi spoke about how their Christian faith calmed them during their pregnancies and how they used their faith as a coping mechanism to deal with the other difficult aspects of their pregnancy. In addition, an argument could be made for including an online community supportability element because online communities are quite distinct (they are more specific, such as mom support groups) from one's general community in which one lives and works. Nevertheless, I coded any online interactions to the community level of the framework, but there were very few examples of

these. In this particular sample, participants did not engage with online communities except for Kerry, who admitted she found the online environment overwhelming and not particularly trustworthy. Nosipho and Zenande mentioned that they used Google to find information on nutrition during their pregnancies, which did not include interactions with others online. Future research using the supportability framework, however, may encounter more social support interactions with online communities. These are distinct spaces, which have the potential to contribute to how social support during pregnancy might be constructed and experienced differently.

REFERENCES

Abrahams, N., Jewkes, R., & Mvo, Z. (2002). Indigenous healing practices and self-medication amongst pregnant women in Cape Town, South Africa. *African Journal of Reproductive Health*, *6*(2), 79–86.

Accortt, E. E., Cheadle, A. C. D., & Dunkel Schetter, C. (2015). Prenatal depression and adverse birth outcomes: An updated systematic review. In *Maternal and Child Health Journal* (Vol. 19, Issue 6). Springer US. https://doi.org/10.1007/s10995-014-1637-2

Aiken, A. R. A., Borrero, S., Callegari, L. S., & Dehlendorf, C. (2016). Rethinking the pregnancy planning paradigm: Unintended conceptions or unrepresentative concepts? *Perspectives on Sexual and Reproductive Health*, *48*(3), 147–151. https://doi.org/10.1363/48e10316

Alexander-Floyd, N. G. (2007). *Gender, race and nationalism in contemporary black politics*. Palgrave Macmillan.

Alexander-Floyd, N. G. (2013). (Inter)disciplinary trouble: Intersectionality, narrative analysis, and the making of a new political science. *Politics & Gender*, *9*(4), 470–474. https://doi.org/10.1017/S1743923X13000317

Alipour, Z., Kazemi, A., Kheirabadi, G., & Eslami, A. A. (2019). Relationship between marital quality, social support and mental health during pregnancy. *Community Mental Health Journal*, *55*(6), 1064–1070. https://doi.org/10.1007/s10597-019-00387-8

Allen, L. (2015). Losing face? Photo-anonymisation and visual research integrity. *Visual Studies*, *30*(3), 295–308. https://doi.org/10.1080/1472586X.2015.1016741

Al-Mutawtah, M., Campbell, E., Kubis, H. P., & Erjavec, M. (2023). Women's experiences of social support during pregnancy: A qualitative systematic review. *BMC Pregnancy and Childbirth*, *23*(1). https://doi.org/10.1186/s12884-023-06089-0

Andrews, M. (2004). Opening to the original contributions: Counter-narratives and the power to oppose. In M. Bamberg & M. Andrews (Eds.), *Considering counter-narratives: Narrating, resisting, making sense* (pp. 1–7). John Benjamins Publishing Company.

Appleton, A. A., Kiley, K., Holdsworth, E. A., & Schell, L. M. (2019). Social support during pregnancy modifies the association between maternal adverse childhood experiences and infant birth size. *Maternal and Child Health Journal*, *23*(3), 408–415. https://doi.org/10.1007/s10995-018-02706-z

Arena, D. F., Volpone, S. D., & Jones, K. P. (2023). (Overcoming) maternity bias in the workplace: A systematic review. *Journal of Management*, *49*(1), 52–84. https://doi.org/10.1177/01492063221086243

Atukunda, E. C., Siedner, M. J., Obua, C., Musiimenta, A., Ware, N. C., Mugisha, S., Josephine, N. N., Godfrey, R. M., & Matthews, L. T. (2023). Evaluating the feasibility, acceptability, and preliminary efficacy of SupportMoms-Uganda, an mHealth-based patient-centered social support intervention to improve the use of maternity services among pregnant women in rural southwestern Uganda: Randomized controlled trial. *JMIR Formative Research*, *7*, Article 36619. https://doi.org/10.2196/36619

Audet, C. M., Sack, D. E., Ndlovu, G. H., Morkel, C., Harris, J., Wagner, R. G., & Seabi, T. M. (2023). Women want male partner engagement in antenatal care services: A qualitative study of pregnant women from rural South Africa. *PLOS ONE*, *18*(4), e0283789. https://doi.org/10.1371/journal.pone.0283789

Aziato, L., Odai, P. N. A., & Omenyo, C. N. (2016). Religious beliefs and practices in pregnancy and labour: An inductive qualitative study among post-partum women in Ghana. *BMC Pregnancy and Childbirth*, *16*(1), Article 138. https://doi.org/10.1186/s12884-016-0920-1

Balaam, M. C., Akerjordet, K., Lyberg, A., Kaiser, B., Schoening, E., Fredriksen, A. M., Ensel, A., Gouni, O., & Severinsson, E. (2013). A qualitative review of migrant women's perceptions of their needs and experiences related to pregnancy and childbirth. *Journal of Advanced Nursing*, *69*(9), 1919–1930. https://doi.org/10.1111/jan.12139

Bamberg, M. (2020). Narrative analysis: An integrative approach. In M. Järvinen & N. Mik-Meyer (Eds.), *Qualitative analysis: Eight approaches for the social sciences* (pp. 244–263). SAGE Publications Ltd.

Bamberg, M., & Andrews, M. (2004). *Considering counter-narratives: Narrating, resisting and making sense*. John Benjamins Publishing Company.

Barton, K., Redshaw, M., Quigley, M. A., & Carson, C. (2017). Unplanned pregnancy and subsequent psychological distress in partnered women: A cross-sectional study of the role of relationship quality and wider social support. *BMC Pregnancy and Childbirth*, *17*(44), 1–9. https://doi.org/10.1186/s12884-017-1223-x

Battulga, B., Benjamin, M. R., Chen, H., & Bat-Enkh, E. (2021). The impact of social support and pregnancy on subjective well-being: A systematic review. *Frontiers in Psychology*, *12*, Article 710858. https://doi.org/10.3389/fpsyg.2021.710858

Bay-Cheng, L. Y. (2015). The agency line: A neoliberal metric for appraising young women's sexuality. *Sex Roles*, *73*, 279–291. https://doi.org/10.1007/s11199-015-0452-6

Bedaso, A., Adams, J., Peng, W., & Sibbritt, D. (2021a). Prevalence and determinants of low social support during pregnancy among Australian women: A community-based cross-sectional study. *Reproductive Health*, *18*, Article 158. https://doi.org/10.1186/s12978-021-01210-y

Bedaso, A., Adams, J., Peng, W., & Sibbritt, D. (2021b). The relationship between social support and mental health problems during pregnancy: A systematic review and meta-analysis. *Reproductive Health*, *18*, Article 162. https://doi.org/10.1186/s12978-021-01209-5

Behari, A. (2021). Proving a causal link between pregnancy and dismissal: An analysis of the disclosure of pregnancy and the protection of pregnant employees in the South African workplace. *Tydskrif Vir Die Suid-Afrikaanse Reg*, *2021*(1), 106–122. https://doi.org/10.47348/TSAR/2021/i1a6

Bernstein, M., Phillips, T., Zerbe, A., McIntyre, J. A., Brittain, K., Petro, G., Abrams, E. J., & Myer, L. (2016). Intimate partner violence experienced by HIV-infected pregnant women in South Africa: A cross-sectional study. *BMJ Open*, *6*(8), Article e011999. https://doi.org/10.1136/bmjopen-2016-011999

Bhan, G., Surie, A., Horwood, C., Dobson, R., Alfers, L., Portela, A., & Rollins, N. (2020). Informal work and maternal and child health: A blind spot in public health and research. *Bulletin of the World Health Organization*, *98*(3), 219–221. https://doi.org/10.2471/BLT.19.231258

Biaggi, A., Conroy, S., Pawlby, S., & Pariante, C. M. (2016). Identifying the women at risk of antenatal anxiety and depression: A systematic review. *Journal of Affective Disorders*, *191*, 62–77. https://doi.org/10.1016/j.jad.2015.11.014

Bilge, S. (2009). "Smuggling intersectionality into the study of masculinity: Some methodological challenges" [paper presentation]. *Feminist Research Methods: An International Conference, University of Stockholm, 4-9 February 2009*, 1–20.

Bilge, S. (2013). Intersectionality undone: Saving intersectionality from feminist intersectionality studies. *Du Bois Review*, *10*(2), 405–424. https://doi.org/10.1017/S1742058X13000283

Billotte Verhoff, C., & Buzzanell, P. M. (2022). "Well, I'm going to have a baby": Navigating safety, stakeholders, and strategy in workplace pregnancy disclosures. *Communication Studies*, *73*(4), 425–440. https://doi.org/10.1080/10510974.2022.2097720

Biney, E., Amoateng, A., & Ewemooje, O. (2021). Patterns of fertility in contemporary South Africa: Prevalence and associated factors. *Cogent Social Sciences*, *7*, Article 1858575. https://doi.org/10.1080/23311886.2020.1858575

Bitew, M. S., Zewde, M. F., Wubetu, M., & Alemu, A. A. (2020). Consumption of alcohol and binge drinking among pregnant women in Addis Ababa, Ethiopia: Prevalence and determinant factors. *PLOS ONE*, *15*(12), Article e0243784. https://doi.org/10.1371/journal.pone.0243784

Blair, A., Cao, J., Wilson, A., & Homer, C. (2022). Access to, and experiences of, maternity care for women with physical disabilities: A scoping review. *Midwifery*, *107*, Article 103273. https://doi.org/10.1016/j.midw.2022.103273

Blommaert, J. (2006). Applied ethnopoetics. *Narrative Inquiry*, *16*(1), 181–190.

Bloom, G., & Mcintyre, D. (1998). Towards equity in health in an unequal society. *Social Science and Medicine*, *47*(10), 1529–1538. https://doi.org/10.1016/S0277-9536(98)00233-0

Bohren, M. A., Iyer, A., Barros, A. J. D., Williams, C. R., Hazfiarini, A., Arroyave, L., Filippi, V., Chamberlain, C., Kabakian-Khasholian, T., Mayra, K., Gill, R., Vogel, J. P., Chou, D., George, A. S., & Oladapo, O. T. (2024). Towards a better tomorrow: Addressing intersectional gender power relations to eradicate inequities in maternal health. *eClinicalMedicine*, *67*, Article 102180. https://doi.org/10.1016/j.eclinm.2023.102180

Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., Aguiar, C., Saraiva Coneglian, F., Diniz, A. L. A., Tunçalp, Ö., Javadi, D., Oladapo, O. T., Khosla, R., Hindin, M. J., & Gülmezoglu, A. M. (2015). The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *PLoS Medicine*, *12*(6), 1–32. https://doi.org/10.1371/journal.pmed.1001847

Borrero, S., Nikolajski, C., Steinberg, J. R., Freedman, L., Akers, A. Y., Ibrahim, S., & Schwarz, E. B. (2015). It just happens: A qualitative study exploring low-income women's perspectives on pregnancy intention and planning. *Contraception*, *91*(2), 150–156. https://doi.org/10.1016/j.contraception.2014.09.014

Bowleg, L. (2008). When black + lesbian + woman ≠ black lesbian woman: The methodological challenges of qualitative and quantitative intersectionality research. *Sex Roles*, *59*(5–6), 312–325. https://doi.org/10.1007/s11199-008-9400-z

Bradley, S., McCourt, C., Rayment, J., & Parmar, D. (2016). Disrespectful intrapartum care during facility-based delivery in sub-Saharan Africa: A qualitative systematic review and thematic synthesis of women's perceptions and experiences. *Social Science and Medicine*, *169*, 157–170. https://doi.org/10.1016/j.socscimed.2016.09.039

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. SAGE Publications.

Braun, V., & Clarke, V. (2021). *Thematic analysis: A practical guide*. SAGE publications Ltd.

Braun, V., Clarke, V., & Terry, G. (2015). Thematic analysis. In P. Rohleder & A. C. Lyons (Eds.), *Qualitative research in clinical and health psychology* (pp. 95–113). Palgrave Macmillan.

Brittain, K., Gomba, Y., Noholoza, S., Pellowski, J., Mellins, C. A., Bekker, L. G., Kagee, A., Remien, R. H., Abrams, E. J., & Myer, L. (2023). HIV-related stigma, disclosure and social support: Experiences among young pregnant and postpartum women living with HIV in South Africa. *AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV*, *35*(3), 399–405. https://doi.org/10.1080/09540121.2022.2121957

Brittain, K., Mellins, C. A., Phillips, T., Zerbe, A., Abrams, E. J., Myer, L., & Remien, R. H. (2017a). Social support, stigma and antenatal depression Among HIV-infected pregnant women in South Africa. *AIDS and Behavior*, *21*(1), 274–282. https://doi.org/10.1007/s10461-016-1389-7

Brittain, K., Mellins, C. A., Phillips, T., Zerbe, A., Abrams, E. J., Myer, L., & Remien, R. H. (2017b). Social support, stigma and antenatal depression among HIV-Infected pregnant women in South Africa. *AIDS and Behavior*, *21*(1), 274–282. https://doi.org/10.1007/s10461-016-1389-7

Brittain, K., Teasdale, C. A., Ngeno, B., Odondi, J., Ochanda, B., Brown, K., Langat, A., Modi, S., & Abrams, E. J. (2021). Improving retention in antenatal and postnatal care: A systematic review of evidence to inform strategies for adolescents and young women living with HIV. *Journal of the International AIDS Society*, *24*(8), Article e25770. https://doi.org/10.1002/jia2.25770

Brooks, J., McCluskey, S., Turley, E., & King, N. (2015). The utility of template analysis in qualitative psychology research. *Qualitative Research in Psychology*, *12*(2), 202–222. https://doi.org/10.1080/14780887.2014.955224

Brown, W. (2016). Sacrificial citizenship: Neoliberalism, human capital, and austerity politics. *Constellations*, *23*(1), 3–14. https://doi.org/10.1111/1467-8675.12166

Brünig, L., Kahrass, H., & Salloch, S. (2024). The concept of intersectionality in bioethics: A systematic review. *BMC Medical Ethics*, *25*(1), 64. https://doi.org/10.1186/s12910-024-01057-5

Buitelaar, M. (2006). 'I am the ultimate challenge': Accounts of intersectionality in the life-story of a well-known daughter of Moroccan migrant workers in the Netherlands. *European Journal of Women's Studies*, *13*(3), 259–276. https://doi.org/10.1177/1350506806065756

Burkitt, I. (1999). Between the dark and the light: Power and the material contexts of social relations. In D. J. Nightingale & J. Cromby (Eds.), *Social constructionist psychology: A critical analysis of theory and practice*. Open University Press.

Burr, V. (1995). *An introduction to social constructionism*. Routledge.

Burr, V. (2015a). *Social constructionism*. Routledge.

Burr, V. (2015b). Social constructionism. In *International Encyclopedia of the Social & Behavioral Sciences* (2nd ed., Vol. 22, pp. 222–227). Elsevier. https://doi.org/10.1016/B978-0-08-097086-8.24049-X

BusinessTech. (2019). The economics of having a baby in South Africa: How much it costs. *BusinessTech*. https://businesstech.co.za/news/wealth/347362/the-economics-of-having-a-baby-in-south-africa-how-much-it-costs/

Button, K., Moore, E., & Seekings, J. (2018). South Africa's hybrid care regime: The changing and contested roles of individuals, families and the state after apartheid. *Current Sociology*, *66*(4), 602–616. https://doi.org/10.1177/0011392118765243

Cai, C., Vandermeer, B., Khurana, R., Nerenberg, K., Featherstone, R., Sebastianski, M., & Davenport, M. H. (2019). The impact of occupational shift work and working hours during pregnancy on health outcomes: A systematic review and meta-analysis. *American Journal of Obstetrics and Gynecology*, *221*(6), 563–576. https://doi.org/10.1016/j.ajog.2019.06.051

Callister, L. C., & Khalaf, I. (2010). Spirituality in childbearing women. *The Journal of Perinatal Education*, *19*(2), 16–24. https://doi.org/10.1624/105812410X495514

Casale, D., Posel, D., & Mosomi, J. (2021). Gender and work in South Africa. In A. Oqubay, F. Tregenna, & I. Valodia (Eds.), *The Oxford handbook of the South African economy* (pp. 735–756). Oxford University Press. https://doi.org/10.13140/RG.2.2.32400.84483

Chadwick, R. (2017). Ambiguous subjects: Obstetric violence, assemblage and South African birth narratives. *Feminism & Psychology*, *27*(4), 489–509. https://doi.org/10.1177/0959353517692607

Chadwick, R. (2018). Thinking intersectionally with / through narrative methodologies. *Agenda*, *31*(1), 5–16. https://doi.org/10.1080/10130950.2017.1341172

Chadwick, R. (2021). On the politics of discomfort. *Feminist Theory*, *22*(4), 556–574. https://doi.org/10.1177/1464700120987379

Chadwick, R., Cooper, D., & Harries, J. (2014). Narratives of distress about birth in South African public maternity settings: A qualitative study. *Midwifery*, *30*(7), 862–868. https://doi.org/10.1016/j.midw.2013.12.014

Chamberlain, K. (2015). Reflexivity: Fostering research quality, ethicality, criticality and creativity. In M. Murray (Ed.), *Critical health psychology* (pp. 165–181). Palgrave Macmillan.

Chan, I. L. (2022). Translating international health policies into lived realities: Maternal health, social support programs, and obstetric violence in highland Peru. *Women's Studies International Forum*, *92*, Article 102600. https://doi.org/10.1016/j.wsif.2022.102600

Chersich, M., Luchters, S., Blaauw, D., Scorgie, F., Kern, E., van den Heever, A., Rees, H., Peach, E., Kharadi, S., & Fonn, S. (2016). Safeguarding maternal and child health in South Africa by starting the child support grant before birth: Design lessons from pregnancy support programmes in 27 countries. *South African Medical Journal*, *106*(12), 1192–1210. https://doi.org/10.7196/SAMJ.2016.v106i12.12011

Chiweshe, M. (2018). African men and feminism: Reflections on using African feminism in research. *Agenda*, *32*(2), 76–82. https://doi.org/10.1080/10130950.2018.1460088

Cho, S., Crenshaw, K. W., & Mccall, L. (2013). Toward a field of intersectionality studies: Theory, applications and praxis. *Journal of Women in Culture and Society*, *38*(4), 785–810.

Chou, J. L., Pierce, K. J., Pennington, L. B., Seiler, R., Michael, J., Mc Namara, D., & Zand, D. (2018). Social support, family empowerment, substance use, and perceived parenting competency during pregnancy for women with substance use disorders. *Substance Use and Misuse*, *53*(13), 2250–2256. https://doi.org/10.1080/10826084.2018.1467456

Christensen, A. D., & Jensen, S. Q. (2012). Doing intersectional analysis: Methodological implications for qualitative research. *NORA - Nordic Journal of Feminist and Gender Research*, *20*(2), 109–125. https://doi.org/10.1080/08038740.2012.673505

Clarke, S., Taket, A., & Graham, M. (2021). Optimising social support for the preservation of self: Social support and women's reproductive decision-making. *Sexuality and Culture*, *25*(1), 93–116. https://doi.org/10.1007/s12119-020-09759-9

Coast, E., Jones, E., Lattof, S. R., & Portela, A. (2016). Effectiveness of interventions to provide culturally appropriate maternity care in increasing uptake of skilled maternity care: A systematic review. *Health Policy and Planning*, *31*(10), 1479–1491. https://doi.org/10.1093/heapol/czw065

Cohen, T., & Dancaster, L. (2009). Family responsibility discrimination litigation—A non-starter? *Stellenbosch Law Review*, *20*(2), 221–240.

Cole, E. R. (2009). Intersectionality and research in psychology. *American Psychologist*, *64*(3), 170–180. https://doi.org/10.1037/a0014564

Coleman, J., Black, V., Thorson, A. E., & Eriksen, J. (2020). Evaluating the effect of maternal mHealth text messages on uptake of maternal and child health care services in South

Africa: A multicentre cohort intervention study. *Reproductive Health*, *17*(1), 1–9. https://doi.org/10.1186/s12978-020-01017-3

Collins, P. H. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. Routledge.

Collins, P. H. (2015). Intersectionality's definitional dilemmas. *Annual Review of Sociology*, *41*(1), 1–20. https://doi.org/10.1146/annurev-soc-073014-112142

Collins, P. H., & Bilge, S. (2016). *Intersectionality: Key concepts* (1st ed.). Polity Press.

Collins, P. H., & Bilge, S. (2020). *Intersectionality: Key concepts* (2nd ed.). Polity Press.

Collins, S. M., Owuor, P. M., Miller, J. D., Boateng, G. O., Wekesa, P., Onono, M., & Young, S. L. (2019). 'I know how stressful it is to lack water!' Exploring the lived experiences of household water insecurity among pregnant and postpartum women in western Kenya. *Global Public Health*, *14*(5), 649–662. https://doi.org/10.1080/17441692.2018.1521861

Comrie-Thomson, L., Tokhi, M., Ampt, F., Portela, A., Chersich, M., Khanna, R., & Luchters, S. (2015). Challenging gender inequity through male involvement in maternal and newborn health: Critical assessment of an emerging evidence base. *Culture, Health & Sexuality*, *17*(sup 2), 177–189. https://doi.org/10.1080/13691058.2015.1053412

Cooper, D., Harries, J., Moodley, J., Constant, D., Hodes, R., Mathews, C., Morroni, C., & Hoffman, M. (2016). Coming of age? Women's sexual and reproductive health after twenty-one years of democracy in South Africa. *Reproductive Health Matters*, *24*(48), 79–89. https://doi.org/10.1016/j.rhm.2016.11.010

Cooper, D., Morroni, C., Orner, P., Moodley, J., Harries, J., & Hoffman, M. (2004). Ten years of democracy in South Africa: Documenting transformation in reproductive health policy and status. *Reproductive Health Matters*, *12*(24), 70–85.

Corchero-Falcón, M. D. R., Gómez-Salgado, J., García-Iglesias, J. J., Camacho-Vega, J. C., Fagundo-Rivera, J., & Carrasco-González, A. M. (2023). Risk factors for working pregnant women and potential adverse consequences of exposure: A systematic review. *International Journal of Public Health*, *68*, Article 1605655. https://doi.org/10.3389/ijph.2023.1605655

Crankshaw, T. L., Voce, A., Butler, L. M., & Darbes, L. (2016). Expanding the relationship context for couple-based HIV prevention: Elucidating women's perspectives on non-traditional sexual partnerships. *Social Science and Medicine*, *166*, 169–176. https://doi.org/10.1016/j.socscimed.2016.08.020

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine. *The University of Chicago Legal Forum*, *1989*(1), 139–167. https://doi.org/10.1525/sp.2007.54.1.23.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, *43*(6), 1241–1299.

Crooks, R., Bedwell, C., & Lavender, T. (2022). Adolescent experiences of pregnancy in low-and middle-income countries: A meta-synthesis of qualitative studies. *BMC Pregnancy and Childbirth*, *22*(1), 702. https://doi.org/10.1186/s12884-022-05022-1

Da Thi Tran, T., Murray, L., & Van Vo, T. (2022). Intimate partner violence during pregnancy and maternal and child health outcomes: A scoping review of the literature from low-and-middle income countries from 2016 - 2021. *BMC Pregnancy and Childbirth*, *22*(1), Article 315. https://doi.org/10.1186/s12884-022-04604-3

Dahab, R., & Sakellariou, D. (2020). Barriers to accessing maternal care in low income countries in Africa: A systematic review. *International Journal of Environmental Research and Public Health*, *17*(12), 4292. https://doi.org/10.3390/ijerph17124292

Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. *Journal for the Theory of Social Behaviour*, *20*(43–63). https://doi.org/10.1111/j.1468-5914.1990.tb00174.x

Davis, E. C., Rotheram-Borus, M. J., Weichle, T. W., Rezai, R., & Tomlinson, M. (2017). Patterns of alcohol abuse, depression, and intimate partner violence among township mothers in South Africa over 5 years. *AIDS and Behavior*, *21*(S2), 174–182. https://doi.org/10.1007/s10461-017-1927-y

Deppermann, A. (2015). Positioning. In A. De Fina & A. Georgakopoulou (Eds.), *The Handbook of Narrative Analysis* (pp. 369–387). John Wiley & Sons, Inc.

Dhamoon, R. K. (2011). Considerations on mainstreaming intersectionality. *Political Research Quarterly*, *64*(1), 230–243. https://doi.org/10.1177/1065912910379227

Discovery Health Medical Scheme. (2022). *Cover for pregnancy, childbirth and early childhood [fact sheet]* (pp. 1–24). www.discovery.co.za

Ditekemena, J., Koole, O., Engmann, C., Matendo, R., Tshefu, A., Ryder, R., & Colebunders, R. (2012). Determinants of male involvement in maternal and child health services in sub-Saharan Africa: A review. *Reproductive Health*, *9*(1), 32. https://doi.org/10.1186/1742-4755-9-32

Donovan, B., Spracklen, C., Schweizer, M., Ryckman, K., & Saftlas, A. (2016). Intimate partner violence during pregnancy and the risk for adverse infant outcomes: A systematic review and meta-analysis. *BJOG: An International Journal of Obstetrics & Gynaecology*, *123*(8), 1289–1299. https://doi.org/10.1111/1471-0528.13928

Downe, S., Finlayson, K., Tuncalp, O., & Metin Gulmezoglu, A. (2016). What matters to women: A systematic scoping review to identify the processes and outcomes of antenatal care provision that are important to healthy pregnant women. *BJOG: An International Journal of Obstetrics and Gynaecology*, *123*(4), 529–539. https://doi.org/10.1111/1471-0528.13819

Downe, S., Finlayson, K., Walsh, D., & Lavender, T. (2009). 'Weighing up and balancing out': A meta-synthesis of barriers to antenatal care for marginalised women in high-income countries. *BJOG: An International Journal of Obstetrics and Gynaecology*, *116*(4), 518–529. https://doi.org/10.1111/j.1471-0528.2008.02067.x

Dudgeon, M. R., & Inhorn, M. C. (2004). Men's influences on women's reproductive health: Medical anthropological perspectives. *Social Science & Medicine*, *59*, 1379–1395.

Duggan, R., & Adejumo, O. (2012). Adolescent clients' perceptions of maternity care in KwaZulu-Natal, South Africa. *Women and Birth*, *25*(4), 62–67. https://doi.org/10.1016/j.wombi.2011.10.004

Dunkel-Schetter, C., Sagrestano, L. M., Feldman, P., & Killingsworth, C. (1996). Social support and pregnancy: A comprehensive review focusing on ethnicity and culture. In *Handbook of Social Support and the Family* (pp. 375–412). Springer US. https://doi.org/10.1007/978-1-4899-1388-3_16

East, C. E., Biro, M. A., Fredericks, S., & Lau, R. (2019). Support during pregnancy for women at increased risk of low birthweight babies. *Cochrane Database of Systematic Reviews*, *2019*(4). https://doi.org/10.1002/14651858.CD000198.pub3

Edley, N. (2001a). Analysing masculinity: Interpretive repertoires, ideolgical dilemmas and subject positions. In M. Wetherell, S. Taylor, & S. Yates (Eds.), *Discourse as data: A guide for analysis* (pp. 189–228). SAGE Publications.

Edley, N. (2001b). Unravelling social constructionism. *Theory & Psychology*, *11*(3), 433–441. https://doi.org/10.1177/0959354301113008

Elsenbruch, S., Benson, S., Rucke, M., Rose, M., Dudenhausen, J., Pincus-Knackstedt, M. K., Klapp, B. F., Arck, P. C., Rücke, M., Rose, M., Dudenhausen, J., Pincus-Knackstedt, M. K., Klapp, B. F., & Arck, P. C. (2007). Social support during pregnancy: Effects on maternal depressive symptoms, smoking and pregnancy outcome. *Human Reproduction*, *22*(3), 869–877. https://doi.org/10.1093/humrep/del432

Elundini Municipality. (2016). *Annual report for the year ended June 2016* (Issue June, p. 322).

Elundini Municipality. (2017). *Draft integrated development plan 2017-2022* (pp. 1–178).

Fair, F., Raben, L., Watson, H., Vivilaki, V., Van Den Muijsenbergh, M., Soltani, H., & the ORAMMA team. (2020). Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: A systematic review. *PLOS ONE*, *15*(2), e0228378. https://doi.org/10.1371/journal.pone.0228378

Falnes, E., Moland, K., Tylleskär, T., de Paoli, M., Msuya, S. E., & Engebretsen, I. M. (2011). 'It is her responsibility': Partner involvement in prevention of mother to child transmission of HIV programmes, northern Tanzania. *Journal of the International AIDS Society*, *14*(1), 21. https://doi.org/10.1186/1758-2652-14-21

Federation of South African Women. (1954). *What Women Demand*. Federation of South African Women.

Federation of South African Women. (1955). *What women demand. Compiled in preparation for the congress of the people*.

Feld, H., Barnhart, S., Wiggins, A. T., & Ashford, K. (2021). Social support reduces the risk of unintended pregnancy in a low-income population. *Public Health Nursing*, *38*(5), 801–809. https://doi.org/10.1111/phn.12920

Ferreira, L. (2017). *Factsheet: Social grants in South Africa – separating myth from reality*. Africa Check: Sorting Fact from Fiction. https://africacheck.org/factsheets/separating-myth-from-reality-a-guide-to-social-grants-in-south-africa/

Field, S., Onah, M., van Heyningen, T., & Honikman, S. (2018). Domestic and intimate partner violence among pregnant women in a low resource setting in South Africa: A facility-based, mixed methods study. *BMC Women's Health*, *18*, Article 119. https://doi.org/10.1186/s12905-018-0612-2

Findlay, L. (2002). Negotiating the swamp: The opportunity and challenge of reflexivity in research practice. *Qualitative Research*, *2*(2), 209–230.

Finlayson, K., & Downe, S. (2013). Why do women not use antenatal services in low- and middle-Income countries? A meta-synthesis of qualitative studies. *PLoS Medicine*, *10*(1), Article e1001373. https://doi.org/10.1371/journal.pmed.1001373

Finn, A. (2015). *A national minimum wage in the context of the South African labour market [Working paper series No. 1.]*. University of the Witwatersrand. www.nationalminimumwage.co.za

Foucault, M. (1978). *The history of sexuality volume 1: An introduction*. Pantheon Books.

Fraser, N. (2013). *Fortunes of feminism: From state-managed capitalism to neoliberal crisis*. Verso.

Gajaria, A., & Ravindran, A. V. (2018). Interventions for perinatal depression in low and middle-income countries: A systematic review. *Asian Journal of Psychiatry*, *37*(August), 112–120. https://doi.org/10.1016/j.ajp.2018.08.014

Gale, N. K., Kenyon, S., MacArthur, C., Jolly, K., & Hope, L. (2018). Synthetic social support: Theorizing lay health worker interventions. *Social Science and Medicine*, *196*, 96–105. https://doi.org/10.1016/j.socscimed.2017.11.012

Ganle, J. K., & Dery, I. (2015). 'What men don't know can hurt women's health': A qualitative study of the barriers to and opportunities for men's involvement in maternal healthcare in Ghana. *Reproductive Health*, *12*(1), 93. https://doi.org/10.1186/s12978-015-0083-y

Garman, E. C., Schneider, M., & Lund, C. (2019). Perinatal depressive symptoms among low-income South African women at risk of depression: Trajectories and predictors. *BMC Pregnancy and Childbirth*, *19*(1), 1–11. https://doi.org/10.1186/s12884-019-2355-y

Gasa, N. (2007a). Feminisms, motherisms, patriarchies and women's voices. In N. Gasa (Ed.), *Women in South African history* (pp. 207–229). HSRC Press.

Gasa, N. (2007b). Feminisms, motherisms, patriarchies and women's voices in the 1950's. In N. Gasa (Ed.), *Women in South African History* (p. 536). HSRC Press.

Gatrell, C. (2011a). Policy and the pregnant body at work: Strategies of secrecy, silence and supra-performance. *Gender, Work and Organization*, *18*(2), 158–181. https://doi.org/10.1111/j.1468-0432.2009.00485.x

Gatrell, C. (2011b). Putting pregnancy in its place: Conceiving pregnancy as carework in the workplace. *Health and Place*, *17*(2), 395–402. https://doi.org/10.1016/j.healthplace.2009.12.002

Gatrell, C. (2014). Monstrous motherhood versus magical maternity? An exploration of conflicting attitudes to maternity within health discourses and organizational settings.

Equality, Diversity and Inclusion: An International Journal, *33*(7), 633–647. https://doi.org/10.1108/EDI-07-2012-0056

Gatrell, C., Ladge, J. J., & Powell, G. N. (2023). Profane pregnant bodies versus sacred organizational systems: Exploring pregnancy discrimination at work (R2). *Journal of Business Ethics*. https://doi.org/10.1007/s10551-023-05518-6

Gebrekristos, L. T., Groves, A. K., McNaughton Reyes, L., Moodley, D., Beksinska, M., & Maman, S. (2023). Intimate partner violence victimization during pregnancy increases risk of postpartum depression among urban adolescent mothers in South Africa. *Reproductive Health*, *20*(1), 68. https://doi.org/10.1186/s12978-023-01605-z

Gomez, A. M., Arteaga, S., & Freihart, B. (2021). Structural inequity and pregnancy desires in emerging adulthood. *Archives of Sexual Behavior*, *50*(6), 2447–2458. https://doi.org/10.1007/s10508-020-01854-0

Greene, S., Ion, A., Kwaramba, G., Lazarus, L., & Loutfy, M. (2017). Surviving surveillance: How pregnant women and mothers living with HIV respond to medical and social surveillance. *Qualitative Health Research*, *27*(14), 2088–2099. https://doi.org/10.1177/1049732317725219

Greene, S., Ion, A., Kwaramba, G., Smith, S., & Loutfy, M. R. (2016). "Why are you pregnant? What were you thinking?": How women navigate experiences of HIV-related stigma in medical settings during pregnancy and birth. *Social Work in Health Care*, *55*(2), 161–179. https://doi.org/10.1080/00981389.2015.1081665

Gross, H., & Pattison, H. (2007). *Sanctioning pregnancy: A psychological perspective on the paradoxes and culture of research* (J. Ussher, Ed.). Routledge.

Groves, A. K., Maman, S., Msomi, S., Makhanya, N., & Moodley, D. (2010). The complexity of consent: Women's experiences testing for HIV at an antenatal clinic in Durban, South Africa. *AIDS Care*, *22*(5), 538–544. https://doi.org/10.1080/09540120903311508

Groves, A. K., McNaughton-Reyes, H. L., Foshee, V. A., Moodley, D., & Maman, S. (2014). Relationship factors and trajectories of intimate partner violence among South African women during pregnancy and the postpartum period. *PLoS ONE*, *9*(9), e106829. https://doi.org/10.1371/journal.pone.0106829

Gruß, I., Firemark, A., & Davidson, A. (2021). Motherhood, substance use and peer support: Benefits of an integrated group program for pregnant and postpartum women. *Journal of Substance Abuse Treatment*, *131*. https://doi.org/10.1016/j.jsat.2021.108450

Grzanka, P. R., & Schuch, E. (2020). Reproductive anxiety and conditional agency at the intersections of privilege: A focus group study of emerging adults' perception of long-acting reversible contraception. *Journal of Social Issues*, *76*(2), 270–313. https://doi.org/10.1111/josi.12363

Ha, W., Salama, P., Gwavuya, S., & Kanjala, C. (2014). Is religion the forgotten variable in maternal and child health? Evidence from Zimbabwe. *Social Science and Medicine*, *118*(C), 80–88. https://doi.org/10.1016/j.socscimed.2014.07.066

Halim, N., Beard, J., Mesic, A., Patel, A., Henderson, D., & Hibberd, P. (2018). Intimate partner violence during pregnancy and perinatal mental disorders in low and lower middle income countries: A systematic review of literature, 1990–2017. *Clinical Psychology Review*, *66*, 117–135. https://doi.org/10.1016/j.cpr.2017.11.004

Hall, K., & Posel, D. (2019). Fragmenting the family? The complexity of household migration strategies in post-apartheid South Africa. *IZA Journal of Development and Migration*, *10*(2), 1–20. https://doi.org/10.2478/izajodm-2019-0004

Halvorsen, K. (1998). Symbolic purposes and factual consequences of the concepts 'self reliance' and 'dependency' in contemporary discourses on welfare. *Scandinavian Journal of Social Welfare*, *7*(1), 56–64.

Hampanda, K. M., Mweemba, O., Ahmed, Y., Hatcher, A., Turan, J. M., Darbes, L., & Abuogi, L. L. (2020). Support or control? Qualitative interviews with Zambian women on male partner involvement in HIV care during and after pregnancy. *PLoS ONE*, *15*(8 August). https://doi.org/10.1371/journal.pone.0238097

Hancock, A.-M. (2007). When multiplication doesn't equal quick addition: Examining intersectionality as a research paradigm. *Perspectives on Politics*, *5*(1), 63–79. https://doi.org/10.1017/Si537592707070065

Hancock, A.-M. (2016). *Intersectionality: An intellectual history*. Oxford University Press.

Hankivsky, O., & Christoffersen, A. (2008). Intersectionality and the determinants of health: A Canadian perspective. *Critical Public Health*, *18*(3), 271–283. https://doi.org/10.1080/09581590802294296

Hanson, J. D., & Jensen, J. (2015). Importance of social support in preventing alcohol-exposed pregnancies with American Indian communities. *Journal of Community Health*, *40*(1), 138–146. https://doi.org/10.1007/s10900-014-9911-1

Harper, D. (2002). Talking about pictures: A case for photo elicitation. *Visual Studies*, *17*(1), 13–26. https://doi.org/10.1080/14725860220137345

Harré, R., & Moghaddam, F. (2003). Introduction. In R. Harre & F. Moghaddam (Eds.), *The self and others: Positioning individuals and groups in personal, political, and cultural contexts* (pp. 1–13). Praeger Publishers.

Harré, R., Moghaddam, F. M., Cairnie, T. P., Rothbart, D., & Sabat, S. R. (2009). Recent advances in positioning theory. *Theory & Psychology*, *19*(1), 5–31. https://doi.org/10.1177/0959354308101417

Harré, R., & Van Langenhove, L. (1999). *Positioning theory: Moral contexts of intentional action* (R. Harre & L. van Langenhove, Eds.). Blackwell Publishing Ltd. https://books.google.com.au/books?id=6nPc5iRRCuYC

Hartley, M., Tomlinson, M., Greco, E., Comulada, W. S., Stewart, J., le Roux, I., Mbewu, N., & Rotheram-Borus, M. J. (2011). Depressed mood in pregnancy: Prevalence and correlates in two Cape Town peri-urban settlements. *Reproductive Health*, *8*, Article 9. https://doi.org/10.1186/1742-4755-8-9

Hassim, S. (2006). *Women's organizations and democracy in South Africa: Contesting authority*. University of Wisconsin Press.

Hassim, S. (2014). Texts and tests of equality: The women's charters and the demand for equality in South African political history. *Agenda*, *28*(2), 7–18. https://doi.org/10.1080/10130950.2014.929360

Hassim, S., & Gouws, A. (1998). Redefining the public space: Women's organisations, gender consciousness and civil society in South Africa. *Politikon*, *25*(2), 53–76. https://doi.org/10.1080/02589349808705064

Hatch, M., & Posel, D. (2018). Who cares for children? A quantitative study of childcare in South Africa. *Development Southern Africa*, *35*(2), 267–282. https://doi.org/10.1080/0376835X.2018.1452716

Hawker, D. (2024). Inequality in parental leave – ConCourt to hear case for fathers, adoptive parents to get more leave. *Daily Maverick*. https://www.dailymaverick.co.za/article/2024-10-31-parental-leave-couples-challenge-to-laws-heads-to-the-constitutional-court/

Healy-Clancy, M. (2017). The family politics of the Federation of South African Women: A history of public motherhood in women's antiracist activism. *Signs*, *42*(4), 843–866.

Heideveld-Gerritsen, M., Van Vulpen, M., Hollander, M., Oude Maatman, S., Ockhuijsen, H., & Van Den Hoogen, A. (2021). Maternity care experiences of women with physical disabilities: A systematic review. *Midwifery*, *96*, 102938. https://doi.org/10.1016/j.midw.2021.102938

Hetherington, E., Doktorchik, C., Premji, S. S., McDonald, S. W., Tough, S. C., & Sauve, R. S. (2015). Preterm birth and social support during pregnancy: A systematic review and meta-analysis. *Paediatric and Perinatal Epidemiology*, *29*(6), 523–535. https://doi.org/10.1111/ppe.12225

Hetherington, E., McDonald, S., Williamson, T., & Tough, S. (2020). Trajectories of social support in pregnancy and early postpartum: Findings from the All Our Families cohort. *Social Psychiatry and Psychiatric Epidemiology*, *55*(2), 259–267. https://doi.org/10.1007/s00127-019-01740-8

Heyningen, T. V., Myer, L., Onah, M., Tomlinson, M., Field, S., & Honikman, S. (2016). Antenatal depression and adversity in urban South Africa. *Journal of Affective Disorders*, *203*, 121–129. https://doi.org/10.1016/j.jad.2016.05.052

Heywood, M. (2023, October 6). *Eight million hungry children: New report about the shocking impact of poverty on young South Africans*. Daily Maverick. https://www.dailymaverick.co.za/article/2023-10-06-eight-million-hungry-children-new-report-about-the-shocking-impact-of-poverty-on-young-south-africans/

Higginbottom, G. M. A., Morgan, M., Alexandre, M., Chiu, Y., Forgeron, J., Kocay, D., & Barolia, R. (2015). Immigrant women's experiences of maternity-care services in Canada: A systematic review using a narrative synthesis. *Systematic Reviews*, *4*, Article 13. https://doi.org/10.1186/2046-4053-4-13

Higginbottom, G. M. A., Vallianatos, H., Shankar, J., Safipour, J., & Davey, C. (2018). Immigrant women's food choices in pregnancy: Perspectives from women of Chinese origin in Canada. *Ethnicity and Health*, *23*(5), 521–541. https://doi.org/10.1080/13557858.2017.1281384

Hill, L. M., Maman, S., Groves, A. K., & Moodley, D. (2015). Social support among HIV-positive and HIV-negative adolescents in Umlazi, South Africa: Changes in family and partner relationships during pregnancy and the postpartum period. *BMC Pregnancy and Childbirth*, *15*(1), 117–125. https://doi.org/10.1186/s12884-015-0542-z

Hlongwane, T., & Pattinson, R. C. (2023). Time to re-think prevention of stillbirths in South Africa? [Review]. *African Journal of Obstetrics and Gynaecology*, *1*(1), 1–5.

Hoang, T.-M. H., & Wong, A. (2022). Exploring the application of Intersectionality as a path toward equity in perinatal health: A scoping review. *International Journal of Environmental Research and Public Health*, *20*, Article 685. https://doi.org/10.3390/ijerph20010685

Hodgetts, D., Chamberlain, K., & Radley, A. (2007). Considering photographs never taken during photo-production projects. *Qualitative Research in Psychology*, *4*(4), 263–280. https://doi.org/10.1080/14780880701583181

Honikman, S., Fawcus, S., & Meintjes, I. (2015). Abuse in South African maternity settings is a disgrace: Potential solutions to the problem [Editorial]. *South African Medical Journal*, *105*(4), 284–286. https://doi.org/10.7196/SAMJ.9582

hooks, bell. (1984). *Feminist theory from margin to center*. South End Press.

Howarth, G. R. (2013). Obstetric risk avoidance: Will anyone be offering obstetrics in private practice by the end of the decade? *South African Medical Journal*, *103*(8), 513–514. https://doi.org/10.7196/SAMJ.7233

Hunter, M. (2006). Fathers without amandla: Zulu-speaking men and fatherhood. In L. Richter & R. Morrell (Eds.), *Baba: Men and Fatherhood in South Africa* (pp. 99–107). HSRC Press.

Hunter, M. (2016). Is it enough to talk of marriage as a process? Legitimate co-habitation in Umlazi, South Africa. *Anthropology Southern Africa*, *39*(4), 281–296. https://doi.org/10.1080/23323256.2016.1238772

International Labour Organization. (2015). *World employment and social outlook: The changing nature of jobs* (pp. 1–155). International Labour Organization.

International Labour Organization. (2016). Women at work: Trends 2016. In *International Labour Office* (Vol. 42, Issue 12, pp. 1054–1059). International Labour Office. https://doi.org/ISBN 978-92-2-130795-2

International Labour Organization. (2018). *World employment social outlook: Trends for women 2018* (pp. 1–14).

IOL. (2022, July 1). *'Stop making babies and taking your grandparent's money'—Minister urges youth during home handover in KZN*. IOL News. https://www.iol.co.za/news/south-africa/kwazulu-natal/stop-making-babies-and-taking-your-grandparents-money-

minister-urges-youth-during-home-handover-in-kzn-ad61b9dd-0d7b-4c8f-8361-b67bc6130287

Jacobstein, R. (2015). The kindest cut: Global need to increase vasectomy availability. *The Lancet Global Health*, *3*(12), e733–e734. https://doi.org/10.1016/S2214-109X(15)00168-0

Jesse, D. E., Schoneboom, Chantel., & Blanchard, Amy. (2007). The effect of faith or spirituality in pregnancy: A content analysis. *Journal of Holistic Nursing*, *25*(3), 151–158. https://doi.org/10.1177/0898010106293593

Jewkes, R., Abrahams, N., & Mvo, Z. (1998). Why do nurses abuse patients? *Social Science & Medicine*, *47*(11), 1781–1795.

Joffe, H. (2012). Thematic Analysis. In *Qualitative Research Methods in Mental Health and Psychotherapy* (pp. 209–224).

Johnson, C. (2014). *Maternal transition: A North-South politics of pregnancy and childbirth*. Routledge.

Jonsdottir, S. S., Thome, M., Steingrimsdottir, T., Lydsdottir, L. B., Sigurdsson, J. F., Olafsdottir, H., & Swahnberg, K. (2017). Partner relationship, social support and perinatal distress among pregnant Icelandic women. *Women and Birth*, *30*(1), e46–e55. https://doi.org/10.1016/j.wombi.2016.08.005

Joseph, H. (1986). *Side by side*. Zed Books Ltd.

Jovchelovitch, S., & Bauer, M. W. (2000). Narrative interviewing. In M. W. Bauer & G. Gaskill (Eds.), *Qualitative researching with text, image and sound: A practical handbook* (pp. 57–74). Sage Publications.

Kamnqa, S. (2021, June 1). *In the Spotlight: SA's low vasectomy numbers*. Spotlight. https://www.spotlightnsp.co.za/2021/06/01/in-the-spotlight-sas-low-vasectomy-numbers/

Katz, J., & LaRose, J. (2019). Male partner contraceptive interference: Associations with destructive conflict and women's relational power. *Violence Against Women*, *25*(10), 1262–1278. https://doi.org/10.1177/1077801218818372

Katz, J., & Sutherland, M. A. (2020). College women's experiences of male partner contraceptive Interference: Associations with intimate partner violence and contraceptive outcomes. *Journal of Interpersonal Violence*, *35*(21–22), 4350–4374. https://doi.org/10.1177/0886260517715600

Katz, J., & Tirone, V. (2015). From the agency line to the picket line: Neoliberal ideals, sexual realities, and arguments about abortion in the U.S. *Sex Roles*, *73*(7–8), 311–318. https://doi.org/10.1007/s11199-015-0475-z

Kayi-Aydar, H. (2021). A framework for positioning analysis: From identifying to analyzing (pre)positions in narrated story lines. *System*, *102*. https://doi.org/10.1016/j.system.2021.102600

King, N. (1998). Template analysis. In G. Symon & C. Cassell (Eds.), *Qualitative methods and analysis in organizational research: A practical guide* (pp. 118–134). SAGE Publications Ltd.

King, N. (2004). Using templates in the thematic analysis of text. In C. Cassell & G. Symon (Eds.), *Essential guide to qualitative methods in organizational research*. SAGE Publications Ltd.

King, N. (2012). Doing template analysis. In G. Symon & C. Cassell (Eds.), *Qualitative organizational research: Core methods and current challenges*. Sage Publications.

King, N., & Brooks, J. (2017). Thematic analysis in organisational research. In G. Symon & C. Cassell (Eds.), *The Sage handbook of qualitative business and management research methods :Core methods and challenges* (pp. 219–236). SAGE publications Ltd.

King, N., Brooks, J., & Tabari, S. (2018). Template analysis in business and management research. In M. Ciesielska & D. Jemielniak (Eds.), *Qualitative methodologies in organization studies* (pp. 179–206). Palgrave Macmillan.

Koen, N., Wyatt, G. E., Williams, J. K., Zhang, M., Myer, L., Zar, H. J., & Stein, D. J. (2014). Intimate partner violence: Associations with low infant birthweight in a South African birth cohort. *Metabolic Brain Disease*, *29*(2), 281–299. https://doi.org/10.1007/s11011-014-9525-4

Kriel, Y., Milford, C., Cordero, J., Suleman, F., Beksinska, M., Steyn, P., & Smit, J. A. (2019). Male partner influence on family planning and contraceptive use: Perspectives from community members and healthcare providers in KwaZulu-Natal, South Africa. *Reproductive Health*, *16*(1). https://doi.org/10.1186/s12978-019-0749-y

Kruger, L., & Schoombee, C. (2010). The other side of caring: Abuse in a South African maternity ward. *Journal of Reproductive and Infant Psychology*, *28*(1), 84–101. https://doi.org/10.1080/02646830903294979

Kruse, J. A., Low, L. K., & Seng, J. S. (2013). Validation of alternative indicators of social support in perinatal outcomes research using quality of the partner relationship. *Journal of Advanced Nursing*, *69*(7), 1562–1573. https://doi.org/10.1111/jan.12015

Kumar, R. (2013). How are women's experiences of childbirth represented in the literature? A critical review of qualitative health research set in the global South. *Women's Health and Urban Life*, *12*(1), 19–38.

Kvale, S. (2007). *Doing interviews*. SAGE Publications Ltd.

Ladur, A. N., Colvin, C. J., & Stinson, K. (2015). Perceptions of community members and healthcare workers on male involvement in prevention of mother-to-child transmission services in Khayelitsha, Cape Town, South Africa. *PLOS ONE*, *10*(7), e0133239. https://doi.org/10.1371/journal.pone.0133239

Langmann, S., & Pick, D. (2014). Dignity and ethics in research photography. *International Journal of Social Research Methodology*, *17*(6), 709–721. https://doi.org/10.1080/13645579.2013.825473

Lavin, T., Preen, D. B., & Pattinson, R. (2016). Timing and cause of perinatal mortality for small-for-gestational-age babies in South Africa: Critical periods and challenges with detection. *Maternal Health, Neonatology and Perinatology*, *2*(1). https://doi.org/10.1186/s40748-016-0039-4

Le Roux, K. W., Almirol, E., Rezvan, P. H., Le Roux, I. M., Mbewu, N., Dippenaar, E., Stansert-Katzen, L., Baker, V., Tomlinson, M., & Rotheram-Borus, M. J. (2020). Community health workers impact on maternal and child health outcomes in rural South Africa—A non-randomized two-group comparison study. *BMC Public Health*, *20*(1), 1–14. https://doi.org/10.1186/s12889-020-09468-w

LeMasters, K., Baber Wallis, A., Chereches, R., Gichane, M., Tehei, C., Varga, A., & Tumlinson, K. (2019). Pregnancy experiences of women in rural Romania: Understanding ethnic and socioeconomic disparities. *Culture, Health and Sexuality*, *21*(3), 249–262. https://doi.org/10.1080/13691058.2018.1464208

Lewinsohn, R., Crankshaw, T., Tomlinson, M., Gibbs, A., Butler, L., & Smit, J. (2018). "This baby came up and then he said, "I give up!": The interplay between unintended pregnancy, sexual partnership dynamics and social support and the impact on women's well-being in KwaZulu-Natal, South Africa. *Midwifery*, *62*, 29–35. https://doi.org/10.1016/j.midw.2018.03.001

Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *Naturalistic Evaluation*, *Special issue*(30), 15–25. https://doi.org/10.1002/ev

Lowe, P. (2016). *Reproductive health and maternal sacrifice: Women, choice and responsibility*. Palgrave Macmillan. https://doi.org/DOI 10.1057/978-1-137-47293-9

Lundsberg, L. S., Cutler, A. S., Stanwood, N. L., Yonkers, K. A., & Gariepy, A. M. (2020). Association of pregnancy contexts with depression and low social support in early pregnancy. *Perspectives on Sexual and Reproductive Health*, *52*(3), 161–170. https://doi.org/10.1363/psrh.12155

Mabasa, R., Skaal, L., & Mothiba, T. M. (2024). Social support experiences of adolescents living with perinatal HIV in rural Limpopo, South Africa. *Southern African Journal of HIV Medicine*, *25*(1), 1–5. https://doi. org/10.4102/sajhivmed.

Mabetha, K., Soepnel, L. M., Klingberg, S., Mabena, G., Motlhatlhedi, M., Norris, S. A., & Draper, C. E. (2024). Young women's social support networks during pregnancy in Soweto, South Africa. *African Journal of Primary Health Care & Family Medicine*, *16*(1), 1–11. https://doi.org/10.4102/phcfm.v16i1.4146

Macleod, C. I. (2016). Public reproductive health and 'unintended' pregnancies: Introducing the construct 'supportability'. *Journal of Public Health*, *38*(3), e384–e391. https://doi.org/10.1093

Macleod, C. I. (2018). Expanding reproductive justice through a supportability reparative justice framework: The case of abortion in South Africa. *Culture Health & Sexuality*, 1–17. https://doi.org/10.1080/13691058.2018.1447687

Macleod, C. I., & Durrheim, K. (2002). Racializing teenage pregnancy: 'culture' and 'tradition' in the South African scientific literature. *Ethnic and Racial Studies*, *25*(5), 778–801.

Macleod, C. I., & Feltham-King, T. (2020). 'Adolescent pregnancy': Social problem, public health concern, or neither? In *Routledge International Handbook of Women's Sexual and Reproductive Health* (1st ed.). Routledge.

Macleod, C. I., Feltham-King, T., Mary-Jane, J., Mavuso, J., & Morison, T. (2020). 'Failed' mothers, 'failed' womxn: Demarcating normative mothering. In C. Zufferey & F. Buchanan (Eds.), *Intersections of mothering: Feminist accounts* (pp. 30–43). Routledge: London.

Macleod, C. I., & Howell, S. (2015). Public foetal images and the regulation of middle-class pregnancy in the online media: A view from South Africa. *Culture, Health & Sexuality*, *17*(10), 1207–1221. https://doi.org/10.1080/13691058.2015.1046138

Madisa, K., & Amashabalala, M. (2023, January 6). Half of South Africa's population are 100% dependent on state welfare. *TimesLive*. https://www.timeslive.co.za/politics/2023-01-06-half-of-south-africas-population-are-100-dependent-on-state-welfare/#

Makana Municipality. (2023). *Makana Municipality integrated development plan 2023-2024: Second edition* (pp. 1–340).

Makandwa, T., & Vearey, J. (2017). Giving birth in a foreign land: Exploring the maternal healthcare experiences of Zimbabwean migrant women living in Johannesburg, South Africa. *Urban Forum*, *28*(1), 75–90. https://doi.org/10.1007/s12132-017-9304-5

Makola, Z. S., Rudolph, E. C., & Joubert, Y. T. (2020). First-time mothers' perceptions of workplace social support: An exploratory qualitative study. *Journal of Psychology in Africa*, *30*(2), 151–156. https://doi.org/10.1080/14330237.2020.1746563

Makusha, T., & Richter, L. (2014). The role of black fathers in the lives of children in South Africa. *Child Abuse & Neglect*, *38*(6), 982–992. https://doi.org/10.1016/j.chiabu.2014.05.003

Makusha, T., & Richter, L. (2016). Gatekeeping and its impact on father involvement among black South Africans in rural KwaZulu-Natal. *Culture, Health and Sexuality*, *18*(3), 308–320. https://doi.org/10.1080/13691058.2015.1083122

Malinga, M., & Ratele, K. (2022). Fatherhood among marginalised work-seeking men in South Africa. In M. Grau Grau, J. Molins Figueras, H. Bowles, & M. Maestro (Eds.), *Engaged fatherhood for men, families and gender equality* (pp. 265–278). Springer.

Maman, S., Moodley, D., & Groves, A. K. (2011). Defining male support during and after pregnancy from the perspective of HIV-positive and HIV-negative women in Durban, South Africa. *Journal of Midwifery and Women's Health*, *56*(4), 325–331. http://dx.doi.org/10.1111/j.1542-2011.2011.00029.x

Mann, J. R., McKeown, R. E., Bacon, J., Vesselinov, R., & Bush, F. (2007a). Religiosity, spirituality, and depressive symptoms in pregnant women. *International Journal of Psychiatry in Medicine*, *37*(3), 301–313. http://dx.doi.org/10.2190/PM.37.3.g

Mann, J. R., McKeown, R. E., Bacon, J., Vesselinov, R., & Bush, F. (2007b). Religiosity, spirituality, and tobacco use by pregnant women. *Southern Medical Journal*, *100*(9), 867–872. https://doi.org/10.1097/SMJ.0b013e318137a422

Mannava, P., Durrant, K., Fisher, J., Chersich, M., & Luchters, S. (2015). Attitudes and behaviours of maternal health care providers in interactions with clients: A systematic review. *Globalization and Health*, *11*(1), 36. https://doi.org/10.1186/s12992-015-0117-9

Marais, A., Kuo, C. C., Julies, R., Stein, D. J., Joska, J. A., & Zlotnick, C. (2019). "If he's abusing you . . . the baby is going to be affected": HIV-positive pregnant women's experiences of intimate partner violence. *Violence Against Women*, *25*(7), 839–861. https://doi.org/10.1177/1077801218802640

Marecek, J. (2015). Invited reflection: Intersectionality theory and feminist psychology. *Psychology of Women Quarterly*, *40*(2), 177–181. https://doi.org/10.1177/0361684316641090

Masho, S. W., Do, E., & Adekoya, S. (2014). Social support and smoking during pregnancy. *Journal of Women's Health Care*, *03*(05). https://doi.org/10.4172/2167-0420.1000179

Matin, B. K., Williamson, H. J., Karyani, A. K., Rezaei, S., Soofi, M., & Soltani, S. (2021). Barriers in access to healthcare for women with disabilities: A systematic review in qualitative studies. *BMC Women's Health*, *21*(1), 44. https://doi.org/10.1186/s12905-021-01189-5

Matseke, G., Rodriguez, V. J., Peltzer, K., & Jones, D. (2016). Intimate partner violence among HIV positive pregnant women in South Africa. *Journal of Psychology in Africa*, *26*(3), 259–266. https://doi.org/10.1080/14330237.2016.1185912

Matseke, M. G., Ruiter, R. A. C., Barylski, N., Rodriguez, V. J., Jones, D. L., Weiss, S. M., Peltzer, K., Setswe, G., & Sifunda, S. (2017). A qualitative exploration of the meaning and understanding of male partner involvement in pregnancy-related care among men in rural South Africa. *J Soc Behav Health Sci*, 11.

Mavuso, J. (2017). *Narrated experiences of the pre-termination of pregnancy counselling healthcare encounter in the Eastern Cape public health sector [Unpublished doctoral dissertation]*. Rhodes University, South Africa.

Mavuso, J. M.-J. J., Chiweshe, M., & Macleod, C. (2020). 'Choice' in women's abortion decision-making narratives: Introducing a supportability approach. *Psychology in Society*, *59*, 20–40.

May, V. M. (2015). *Pursuing intersectionality, unsettling dominant imaginaries*. Routledge.

Mayosi, B., M., & Benatar, S., R. (2014). Health and healthcare in South Africa—20 years after Mandela. *New England Journal of Medicine*, *371*(14), 1344–1353. https://doi.org/DOI: 10.1056/NEJMsr1405012

McCall, L. (2005). The complexity of intersectionality. *Journal of Women in Culture and Society*, *30*(3), 1771–1800. https://doi.org/10.1163/_afco_asc_2291

McClintock, A. (1991). 'No longer in a future heaven': Women and nationalism in South Africa. *Transition*, *51*(51), 104. https://doi.org/10.2307/2935081

McNaughton Reyes, H. L., Maman, S., Chen, M. S., Groves, A. K., & Moodley, D. (2021). Patterns of intimate partner violence victimization among South African women and their relation to emotional distress during pregnancy and postpartum. *Journal of Interpersonal Violence*, *36*(7–8), NP4230–NP4249. https://doi.org/10.1177/0886260518786738

Mehra, R., Alspaugh, A., Dunn, J. T., Franck, L. S., McLemore, M. R., Keene, D. E., Kershaw, T. S., & Ickovics, J. R. (2023). "'Oh gosh, why go?' cause they are going to look at me and not hire": Intersectional experiences of black women navigating employment during pregnancy and parenting. *BMC Pregnancy and Childbirth*, *23*(1), 17. https://doi.org/10.1186/s12884-022-05268-9

Mehra, R., Boyd, L. M., Magriples, U., Kershaw, T. S., Ickovics, J. R., & Keene, D. E. (2020). Black pregnant women "get the most judgment": A qualitative study of the experiences of black women at the intersection of race, gender, and pregnancy. *Women's Health Issues*, *30*(6), 484–492. https://doi.org/10.1016/j.whi.2020.08.001

Meyers, D. T. (2001). The rush to motherhood: Pronatalist discourse and women's autonomy. *Signs*, *26*(3), 735–773.

Mishler, E. G. (1991). *Research Interviewing: Context and narrative*. Harvard University Press.

Mkhwanazi, N., & Block, E. (2016). Paternity matters: Premarital childbearing and belonging in Nyanga East and Mokhotlong. *Social Dynamics*, *42*(2), 273–288. https://doi.org/10.1080/02533952.2016.1218137

Mlotshwa, L., Manderson, L., & Merten, S. (2017). Personal support and expressions of care for pregnant women in Soweto, South Africa. *Global Health Action*, *10*(1), Article 1363454. https://doi.org/10.1080/16549716.2017.1363454

Modde Epstein, C., Rice, M. J., French, J. A., Kupzyk, K. A., & Houfek, J. F. (2024). Social support buffers the effects of prenatal depressed mood: A mixed-methods Study. *Journal of the American Psychiatric Nurses Association*, *30*(1), 95–107. https://doi.org/10.1177/10783903211073793

Mogawane, M. A., Mothiba, T. M., & Malema, R. N. (2015). Indigenous practices of pregnant women at Dilokong hospital in Limpopo province, South Africa. *Curationis*, *38*(2), 8 pages. https://doi.org/10.4102/curationis.v38i2.1553

Mohanty, C. T. (2003). "Under Western eyes" revisited: Feminist solidarity through anticapitalist struggles. *Signs: Journal of Women in Culture and Society*, *28*(2), 499–535. https://doi.org/10.1086/342914

Mohlabane, N., Gumede, N., & Mokomane, Z. (2019). Attitudes towards marriage in postapartheid South Africa. In Z. Mokomane, B. Roberts, J. Struwig, & S. Gordon (Eds.), *South African Social Attitudes Survey: Family matters; family cohesion, values and wellbeing*. HSRC Press. www.hsrcpress.ac.za

Moodley, J., Chb, M. B., Fawcus, S., Oxon, M. A., & Bch, M. B. (2018). Improvements in maternal mortality in South Africa. *South African Medical Journal*, *108*(3a), s4–s8. https://doi.org/10.7196/SAMJ.2018.v108i8b.13505

Moodley, J., Fawcus, S., & Pattinson, R. (2020). 21 years of confidential enquiries into maternal deaths in South Africa: Reflections on maternal death assessments [A summary]. *Obstetrics & Gynaecology Forum*, *30*(4), 4–07.

Moodley, J., & Pattinson, R. C. (2011). *Saving mothers 2011-2013: Sixth report on the confidential enquiries into maternal deaths in South Africa (short report)* (pp. 1–91). National Committee for Confidential Enquiry into Maternal Deaths.

Moore, A. M., Frohwirth, L., & Miller, E. (2010). Male reproductive control of women who have experienced intimate partner violence in the United States. *Social Science and Medicine*, *70*(11), 1737–1744. https://doi.org/10.1016/j.socscimed.2010.02.009

Moore, E. (2020). Financing social reproduction. *Revue Internationale Des Études Du Développement*, *N°242*(2), 37. https://doi.org/10.3917/ried.242.0037

Morison, T., & Macleod, C. I. (2015). *Men's pathways to parenthood: Silence and heterosexual gendered norms*. HSRC Press.

Moseson, H., Dehlendorf, C., Gerdts, C., Vittinghoff, E., Hiatt, R. A., & Barber, J. (2018). No one to turn to: Low social support and the incidence of undesired pregnancy in the United States. *Contraception*, *98*(4), 275–280. https://doi.org/10.1016/j.contraception.2018.06.009

Mosomi, J. (2019). An empirical analysis of trends in female labour force participation and the gender wage gap in South Africa. *Agenda*, *33*(4), 29–43. https://doi.org/10.1080/10130950.2019.1656090

Moyo, E., Dzinamarira, T., Moyo, P., Murewanhema, G., & Ross, A. (2024). Men's involvement in maternal health in sub-Saharan Africa: A scoping review of enablers and barriers. *Midwifery*, *133*, 103993. https://doi.org/10.1016/j.midw.2024.103993

Mubangizi, J. (2000). Too pregnant to work—The dilemma of economic rationality versus equality. Woolworths (PTY) LTD v Whitehead. *South African Journal on Human Rights*, *16*(4), 690–702.

Murray, L., & Nash, M. (2017). The challenges of participant photography: A critical reflection on methodology and ethics in two cultural contexts. *Qualitative Health Research*, *27*(6), 923–937. https://doi.org/10.1177/1049732316668819

National Committee for Confidential Enquiries into Maternal Deaths. (2018). *Saving mothers 2014-2016: Seventh triennial report on confidential enquiries into maternal deaths in South Africa* (pp. 1–139).

National Committee for Confidential Enquiries into Maternal Deaths. (2021). *Saving mothers: Annual report for 2021* (pp. 1–39). National Department of Health, Republic of South Africa.

National Committee for Confidential Enquiries into Maternal Deaths. (2024). *Saving mothers: Eighth comprehensive triennial report into maternal deaths in South Africa, 2020-2022* (pp. 1–229). National Department of Health, Republic of South Africa.

National Perinatal Morbidity and Mortality Committee. (2016). *Saving Babies 2014-2016: Third triennial report on perinatal mortality in South Africa* (pp. 1–92).

Nduna, M. (2014). Factors that hinder paternity disclosure to children: South African mothers' perspectives. *Journal of Feminist Family Therapy*, *26*(4), 218–235. https://doi.org/10.1080/08952833.2014.965114

Nduna, M., & Jewkes, R. (2012). Denied and disputed paternity in teenage pregnancy: Topical structural analysis of case studies of young women from the Eastern Cape Province. *Social Dynamics*, *38*(2), 314–330. https://doi.org/10.1080/02533952.2012.719349

Nesane, K. V., & Mulaudzi, F. M. (2024). Cultural barriers to male partners' involvement in antenatal care in Limpopo province. *Health SA Gesondheid*, *29*(0), a2322. https://doi.org/10.4102/ hsag.v29i0.2322

News 24. (2024, March 15). *Teen pregnancy rife in SA*. https://www.news24.com/news24/community-newspaper/express-news/teen-pregnancy-rife-in-sa-20230314

Ngomane, S., & Mulaudzi, F. M. (2012). Indigenous beliefs and practices that influence the delayed attendance of antenatal clinics by women in the Bohlabelo district in Limpopo, South Africa. *Midwifery*, *28*(1), 30–38. https://doi.org/10.1016/j.midw.2010.11.002

Nightingale, D., & Cromby, J. (1999). What's wrong with social constructionism? In D. Nightingale & J. Cromby (Eds.), *Social constructionist psychology: A critical analysis of theory and practice* (pp. 1–19). Open University Press.

Nkani, N. (2017). Regulating and mediating fathers' involvement in families: The negotiation of inhlawulo. In N. Mkhwanazi & D. Bhana (Eds.), *Young families: Gender, sexuality and care* (pp. 1–256). HSRC Press. www.hsrcpress.ac.za

Nutbrown, C. (2011). Naked by the pool? Blurring the image? Ethical issues in the portrayal of young children in arts-based educational research. *Qualitative Inquiry*, *17*(1), 3–14. https://doi.org/10.1177/1077800410389437

O'Donovan, D. (2006). Moving Away from 'failing boys' and 'passive girls': Gender meta-narratives in gender equity policies for Australian schools and why micro-narratives provide a better policy model. *Discourse*, *27*(4), 475–494. https://doi.org/10.1080/01596300600988655

Oliphant, L. (2024). The maternity support grant is a government initiative. *South African Government News Agency*. https://www.sanews.gov.za/south-africa/maternity-support-grant-government-initiative#:~:text=The%20Maternal%20Support%20Grant%20(MSG,maternity%20benefits%20in%20South%20Africa.

Onah, M. N., Field, S., Bantjes, J., & Honikman, S. (2017). Perinatal suicidal ideation and behaviour: Psychiatry and adversity. *Archives of Women's Mental Health*, *20*(2), 321–331. https://doi.org/10.1007/s00737-016-0706-5

Oosthuizen, S. J., Bergh, A. M., Grimbeek, J., & Pattinson, R. C. (2020). CLEVER maternity care: A before-and-after study of women's experience of childbirth in Tshwane, South Africa. *African Journal of Primary Health Care and Family Medicine*, *12*(1). https://doi.org/10.4102/phcfm.v12i1.2560

Oosthuizen, S. J., Bergh, A. M., & Pattinson, R. C. (2018). Systems thinking: A turning point for improving respectful obstetric care in South African health districts. *South African Medical Journal*, *108*(11), 910–914. https://doi.org/10.7196/SAMJ.2018.v108i11.13312

Orr, S. (2004). Social support and pregnancy outcome. *Clinical Obstetrics and Gynecology*, *47*(4), 842–855. https://doi.org/10.1097/01.grf.0000141451.68933.9f

Orr, S., & Arden Miller, C. (1997). Unintended pregnancy and the psychosocial well-being of pregnant women. *Women's Health Issues*, *7*(1), 38–46.

Oster, R. T., Bruno, G., Mayan, M. J., Toth, E. L., & Bell, R. C. (2018). Peyakohewamak—Needs of involved Nehiyaw (Cree) fathers supporting their partners during pregnancy: Findings from the ENRICH study. *Qualitative Health Research*, *28*(14), 2208–2219. https://doi.org/10.1177/1049732318794205

Pakade, N. (2020). Integration and emergence: Black lesbians re/negotiating marriage and lobola. In T. Morison, I. Lynch, & V. Reddy (Eds.), *Queer Kinship: South African perspectives on the sexual politics of family-making and belonging* (pp. 134–151). Routledge.

Paremoer, L. (2022). Between marketisation and public interest discourses in health policy delivery. In G. Onyango (Ed.), *Routledge handbook of public policy in Africa* (pp. 448–458). Routledge.

Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology*. Routledge.

Parker, I. (2005). *Qualitative psychology: Introducing radical research*. Open University Press.

Pastor-Moreno, G., Ruiz-Pérez, I., Henares-Montiel, J., Escribà-Agüir, V., Higueras-Callejón, C., & Ricci-Cabello, I. (2020). Intimate partner violence and perinatal health: A systematic review. *BJOG: An International Journal of Obstetrics & Gynaecology*, *127*(5), 537–547. https://doi.org/10.1111/1471-0528.16084

Patel, L. (2015). *Social welfare & social development in South Africa*. Oxford University Press.

Patel, L., & Mavungu, E. M. (2016). 'Children, families and the conundrum about men': Exploring factors contributing to father absence in South Africa and its implications for social and care policies. *South African Review of Sociology*, *47*(2), 19–39. https://doi.org/10.1080/21528586.2016.1161543

Pattinson, R. C., Hlongwane, T. M. A. G., & Vannevel, V. (2019). Challenges to improve antenatal and intrapartum care in South Africa. *South African Medical Journal*, *109*(11b), 15–19. https://doi.org/10.7196/SAMJ.2019.v109i11b.14248

Payne, J. G. (2013). Transgendering mother's day: Blogging as citizens' media, reproductive rights and intimate citizenship. *Citizenship Studies*, *17*(8), 928–941. https://doi.org/10.1080/13621025.2013.851143

Pereira-Kotze, C., Doherty, T., & Faber, M. (2022). Maternity protection for female non-standard workers in South Africa: The case of domestic workers. *BMC Pregnancy and Childbirth*, *22*(1). https://doi.org/10.1186/s12884-022-04944-0

Pereira-Kotze, C., Malherbe, K., Faber, M., Doherty, T., & Cooper, D. (2022). Legislation and policies for the right to maternity protection in South Africa: A fragmented state of affairs. *Journal of Human Lactation*, *38*(4), 686–699. https://doi.org/10.1177/08903344221108090

Phiri, T. M., Nyamaruze, P., & Akintola, O. (2023). Perspectives about social support among unmarried pregnant university students in South Africa. *PLoS ONE*, *18*(4), Article e0284906. https://doi.org/10.1371/journal.pone.0284906

Piccinini, C. R. P., De Castro Almeida, V., Da Silva Ezequiel, O., De Matos Fajardo, E. F., Lucchetti, A. L. G., & Lucchetti, G. (2021). Religiosity/spirituality and mental health and quality of life of early pregnant women. *Journal of Religion and Health*, *60*(3), 1908–1923. https://doi.org/10.1007/s10943-020-01124-2

Pillow, W. S. (2003). Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *International Journal of Qualitative Studies in Education*, *16*(2), 175–196. https://doi.org/10.1080/0951839032000060635

Poinsette, C. L. (1985). Black women under apartheid: An introduction. *Harvard Women's Law Journal*, *8*, 93–119.

Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology*, *52*(2), 137–145. https://doi.org/10.1037/0022-0167.52.2.137

Ponsford, R. (2014). "I don't really care about me, as long as he gets everything he needs"—Young women becoming mothers in consumer culture. *Young Consumers*, *15*(3), 251–262. https://doi.org/10.1108/YC-10-2013-00401

Posel, D. (2020). Measuring labour migration after apartheid: Patterns and trends. In L. J. Bank, D. Posel, & F. Wilson (Eds.), *Migrant labour after apartheid: The inside story* (pp. 29–43). HSRC Press.

Posel, D., & Hall, K. (2021). The economics of households in South Africa. In A. Oqubay, F. Tregenna, & I. Valodia (Eds.), *The Oxford handbook of the South African economy* (pp. 800–822). Oxford University Press.

Posel, D., & Rudwick, S. (2013). Changing patterns of marriage and cohabitation in South Africa. *Acta Juridica*, 169–180.

Posel, D., & Rudwick, S. (2014a). Marriage and bridewealth (Ilobolo) in contemporary Zulu society. *African Studies Review*, *57*(2), 51–72. https://doi.org/10.1017/asr.2014.47

Posel, D., & Rudwick, S. (2014b). Ukukipita [Cohabiting]: Socio-cultural constraints in urban Zulu society. *Journal of Asian and African Studies*, *49*(3), 282–297. https://doi.org/10.1177/0021909613485705

Potter, J. E., Stevenson, A. J., Coleman-Minahan, K., Hopkins, K., White, K., Baum, S. E., & Grossman, D. (2019). Challenging unintended pregnancy as an indicator of reproductive autonomy. *Contraception*, *100*(1), 1–4. https://doi.org/10.1016/j.contraception.2019.02.005

Raman, S., Srinivasan, K., Kurpad, A., Dwarkanath, P., Ritchie, J., & Worth, H. (2014). 'My mother, my sisters and my friends': Sources of maternal support in the perinatal period in urban India. *Midwifery*, *30*(1), 130–137. https://doi.org/10.1016/j.midw.2013.03.003

Reavey, P. (2011). The return to experience. In P. Reavey (Ed.), *Visual methods in psychology* (pp. 1–13). Psychology Press.

Redelinghuys, A., Coetzee, H., & Roos, V. (2014). First-time mothers' experiences of meaningfulness during their third trimester of pregnancy: A focus on spirituality. *Journal of Psychology in Africa*, *24*(3), 246–251. https://doi.org/10.1080/14330237.2014.906082

Redinger, S., Pearson, R. M., Houle, B., Norris, S. A., & Rochat, T. J. (2020). Antenatal depression and anxiety across pregnancy in urban South Africa. *Journal of Affective Disorders*, *277*, 296–305. https://doi.org/10.1016/j.jad.2020.08.010

Redshaw, M., Malouf, R., Gao, H., & Gray, R. (2013). Women with disability: The experience of maternity care during pregnancy, labour and birth and the postnatal period. *BMC Pregnancy and Childbirth*, *13*(1), 174. https://doi.org/10.1186/1471-2393-13-174

Redshaw, M., Miller, Y. D., & Hennegan, J. (2014). Young women's experiences as consumers of maternity care in Queensland. *Birth*, *41*(1), 56–63. https://doi.org/10.1111/birt.12084

Renbarger, K. M., Place, J. M., & Schreiner, M. (2021). The influence of four constructs of social support on pregnancy experiences in group prenatal care. *Women's Health Reports*, *2*(1), 154–162. https://doi.org/10.1089/whr.2020.0113

Republic of South Africa. (1961). *Marriages act (Act No. 25 of 1961)*.

Republic of South Africa. (1992). *Births and deaths registration act (Act No. 51 of 1992)*.

Republic of South Africa. (1995). *Labour relations act (Act No. 66 of 1995)*.

Republic of South Africa. (1996). *The constitution of the Republic of South Africa* (pp. 1–182). [Constitutional Assembly].

Republic of South Africa. (1997). *Basic conditions of employment (act no.75 of 1997)*.

Republic of South Africa. (1998a). *Medical schemes act (Act No. 131 of 1998)* (pp. 1–44).

Republic of South Africa. (1998b). *Recognition of customary marriages act (Act No. 120 of 1998)*.

Republic of South Africa. (2006). *Civil union act (Act No. 17 of 2006)*.

Reynolds, J., & Taylor, S. (2005). Narrating singleness: Life stories and deficit identities. *Narrative Inquiry*, *15*(2), 197–215. https://doi.org/10.1075/NI.15.2.02REY

Richter, M. (2009). Bread, baby shoes or blusher? Myths about social grants and 'lazy' young mothers [Editorial]. *South African Medical Journal*, *99*(2), 94–94.

Riessman, C. K. (2008). *Narrative methods for the human sciences*. SAGE Publications Inc.

Rogan, M., & Reynolds, J. (2019). Trends in the working poverty rate (WPR) in post-apartheid South Africa, 1997–2012. *Development Southern Africa*, *36*(5), 699–715. https://doi.org/10.1080/0376835X.2019.1590181

Román-Gálvez, R. M., Martín-Peláez, S., Fernández-Félix, B. M., Zamora, J., Khan, K. S., & Bueno-Cavanillas, A. (2021). Worldwide prevalence of intimate partner violence in pregnancy. A systematic review and meta-analysis. *Frontiers in Public Health*, *9*, 738459. https://doi.org/10.3389/fpubh.2021.738459

Rose, G. (2012). *Visual methodologies: An introduction to researching with visual materials*. SAGE Publications Ltd.

Rosen, H. E., Lynam, P. F., Carr, C., Reis, V., Ricca, J., Bazant, E. S., & Bartlett, L. A. (2015). Direct observation of respectful maternity care in five countries: A cross-sectional study of health facilities in East and Southern Africa. *BMC Pregnancy and Childbirth*, *15*(1), 1–11. https://doi.org/10.1186/s12884-015-0728-4

Ross, Loretta. J., & Solinger, R. (2017). *Reproductive justice: An introduction*. University of California Press.

Rubin, G. S. (2006). Thinking sex: Notes for a radical theory of the politics of sexuality. In Richard. Parker & P. Aggleton (Eds.), *Culture, society and sexuality* (pp. 143–178). Routledge.

Rural Health Advocacy Project. (2015). *Rural-proofing for health: Guidelines* (p. 50). www.rhap.org.za

Samukimba, J., & Moore, E. (2020). Understanding customary practices and fatherhood: Intlawulo, masculinities and relational power (CSSR Working Paper No. 453). In *Journal of Family Issues; Gender & Society; Critical Social Policy; and the Journal of Southern African Studies*. http://www.cssr.uct.ac.zahttp://cssr.uct.ac.za/pub/wp/453

Sarason, I. G., Levine, H. M., Basham, R. B., & Sarason, B. R. (1983). Assessing social support: The social support questionnaire. *Journal of Personality and Social Psychology*, *44*(1), 127–139.

Schaaf, M., Jaffe, M., Tunçalp, Ö., & Freedman, L. (2023). A critical interpretive synthesis of power and mistreatment of women in maternity care. *PLOS Global Public Health*, *3*(1), e0000616. https://doi.org/10.1371/journal.pgph.0000616

Schetter, C. D. (2011). Psychological science on pregnancy: Stress processes, biopsychosocial models, and emerging research issues. *Annual Review of Psychology*, *62*, 531–558. https://doi.org/10.1146/annurev.psych.031809.130727

Schneider, H., Besada, D., Sanders, D., Daviaud, E., & Rohde, S. (2018). Ward-based primary health care outreach teams in South Africa: Developments, challenges and future directions. In *South African Health Review* (pp. 1–271). Health Systems Trust. http://www.hst.org.za/publications/Pages/SAHR2018

Scorgie, F., Blaauw, D., Dooms, T., Coovadia, A., Black, V., & Chersich, M. (2015). 'I get hungry all the time': Experiences of poverty and pregnancy in an urban healthcare setting in South Africa. *Globalization and Health*, *11*(1). https://doi.org/10.1186/s12992-015-0122-z

Scott, V., Schaay, N., Schneider, H., & Sanders, D. (2017). *South African health review. Addressing social determinants of health in South Africa: The journey continues* (pp. 1–362). Health Systems Trust.

Seekings, J. (2019). The conditional legitimacy of claims made by mothers and other kin in South Africa. *Critical Social Policy*, *39*(4), 599–621. https://doi.org/10.1177/0261018319867596

Seekings, J., & Nattrass, N. (2015). *Policy, politics and poverty in South Africa*. Palgrave Macmillan.

Seekings, Jeremy., & Moore, Elena. (2013). *Kin, market and state in the provision of care in South Africa [CSSR Working Paper No. 327]*. University of Cape Town. Centre for Social Science Research.

Sekgota, H. (2023, September 16). *South African doctor drags unemployed people who are having babies, video sparks online debate*. Briefly SA. https://briefly.co.za/people/family-relationships/168901-doctor-tiktok-drags-unemployed-people-babies/

Shamu, S., Abrahams, N., Temmerman, M., Musekiwa, A., & Zarowsky, C. (2011). A systematic review of African studies on intimate partner violence against pregnant women: Prevalence and risk factors. *PLoS ONE*, *6*(3), 1–9. https://doi.org/10.1371/journal.pone.0017591

Sharma, D. (2023, June 29). Adolescent/teenage pregnancy crisis in South Africa. *SABC News*. https://www.sabcnews.com/sabcnews/infographic-adolescent-teenage-pregnancy-crisis-in-south-africa/

Shaw, D., Guise, J. M., Shah, N., Gemzell-Danielsson, K., Joseph, K. S., Levy, B., Wong, F., Woodd, S., & Main, E. K. (2016). Drivers of maternity care in high-income countries: Can health systems support woman-centred care? *The Lancet*, *388*(10057), 2282–2295. https://doi.org/10.1016/S0140-6736(16)31527-6

Sibiya, M. N., Cele, R. J., & Ngxongo, T. S. P. (2015). Assessment of the use of the new maternity case record in improving the quality of ante natal care in eThekwini District, KwaZulu-Natal. *International Journal of Africa Nursing Sciences*, *2*, 53–58. https://doi.org/10.1016/j.ijans.2015.04.002

Sigalla, G. N., Mushi, D., & Gammeltoft, T. (2018). "Staying for the children": The role of natal relatives in supporting women experiencing intimate partner violence during pregnancy in northern Tanzania – A qualitative study. *PLoS ONE*, *13*(6). https://doi.org/10.1371/journal.pone.0198098

Singh, D., Lample, M., & Earnest, J. (2014). The involvement of men in maternal health care: Cross-sectional, pilot case studies from Maligita and Kibibi, Uganda. *Reproductive Health*, *11*(1), 68. https://doi.org/10.1186/1742-4755-11-68

Skinner, D., Delobelle, P., Pappin, M., Pieterse, D., Esterhuizen, T. M., Barron, P., & Dudley, L. (2018). User assessments and the use of information from MomConnect, a mobile phone text-based information service, by pregnant women and new mothers in South Africa. *BMJ Global Health*, *3*, 1–6. https://doi.org/10.1136/bmjgh-2017-000561

Small, R., Roth, C., Raval, M., Shafiei, T., Korfker, D., Heaman, M., McCourt, C., & Gagnon, A. (2014). Immigrant and non-immigrant women's experiences of maternity care: A systematic and comparative review of studies in five countries. *BMC Pregnancy Childbirth*, *14*(152), 1–17. https://doi.org/10.1186/1471-2393-14-152

Smissen, A., Lamaro Haintz, G., McKenzie, H., & Graham, M. (2020). Discursive representations of social support for reproductive decision-making among Victorian women. *Sexuality & Culture*, *24*(3), 883–902. https://doi.org/10.1007/s12119-019-09670-y

Snyman, L. (2019). Addressing the litigation crisis in obstetrics & gynaecology [guest editorial]. *Obstetrics & Gynaecology Forum*, *29*(4), 4–4.

South African Department of Labour. (1998). *Code of good practice on the protection of employees during pregnancy and after the birth of a child* (pp. 1–10). Department of Labour. http://www.labour.gov.za/DOL/legislation/codes-of-good-ractise/Basic Conditions of Employment/code-of-good-practice-on-pregnancy

South African Department of Labour. (2011). *Code of good practice for employment and conditions of work for expanded public works programmes* (pp. 1–16).

South African Department of Social Development. (2015). *National adolescent sexual and reproductive health and rights framework 2014-2019* (pp. 1–40).

South African Department of Women, Youth and Persons with Disabilities. (2020). *National strategic plan on gender-based violence & femicide* (pp. 1–132). www.women.gov.za

South African Government. (1996). The bill of rights. In *The Constitution of the Republic of South Africa* (p. 178). Department of Justice.

South African Government. (2023). *South African public works & infrastructure*. http://www.epwp.gov.za

South African Law Reform Commission. (2021). *Discussion paper 154, project 141, medico-legal claims* (pp. 1–469). https://www.justice.gov.za

South African Law Reform Commission. (2022). *Investigation into maternity and parental benefits for self-employed workers: Draft report, project 143*.

South African National Department of Health. (2012a). *Strategic plan for maternal, newborn , child and women's health (MNCWH) and nutrition in South Africa 2012-2016* (pp. 1–49).

South African National Department of Health. (2012b). *Strategic plan for maternal, newborn, child and women's health (MNCWH) and nutrition in South Africa* (pp. 1–45). National Department of Health.

South African National Department of Health. (2015). *Guidelines for maternity care in South Africa. A manual for clinics, community health centres and district hospitals. Fourth Edition* (pp. 1–174). National Department of Health, Republic of South Africa.

South African National Department of Health. (2017a). *Improving antenatal care in South Africa*. Health.Gov.Za. http://www.health.gov.za/index.php/gf-tb-program/347-improving-antenatal-care-in-south-africa

South African National Department of Health. (2017b). *Saving Mothers 2017: Annual report on confidential inquiries into maternal death in South Africa* (p. 87).

South African National Department of Health. (2019). *National integrated sexual and reproductive health and rights policy* (pp. 1–54).

South African National Department of Health. (2021). *South African maternal, perinatal, and neonatal health policy* (pp. 1–56).

South African National Department of Health. (2024). *National integrated maternal and perinatal care guidelines for South Africa* (pp. 1–186).

South African National Department of Health, Statistics South Africa, & South African Medical Research Council. (2019). *South Africa demographic and health survey 2016* (pp. 1–626).

South African National Planning Commission. (2012). *National Development Plan 2030: Our future—Make it work.* (pp. 1–489). Government Printers. http://www.gov.za/issues/national-development-plan-2030.

Spade, D. (2013). Intersectional resistance and law reform. *Signs*, *38*(4), 1031–1055. https://doi.org/10.1086/669574

Stansert Katzen, L., Tomlinson, M., Christodoulou, J., Laurenzi, C., Le Roux, I., Baker, V., Mbewu, N., Le Roux, K. W., & Rotheram Borus, M. J. (2020). Home visits by community health workers in rural South Africa have a limited, but important impact on maternal and child health in the first two years of life. *BMC Health Services Research*, *20*(1), 1–10. https://doi.org/10.1186/s12913-020-05436-7

Statistics South Africa. (2015a). *Census 2011: Fertility in South Africa* (pp. 1–87).

Statistics South Africa. (2015b). *Millennium development goals 5: Improve maternal health* (pp. 1–34). Statistics South Africa.

Statistics South Africa. (2016). *Quarterly labour force survey [Quarter 4: 2016]*. www.statssa.gov.zainfo@statssa.gov.za

Statistics South Africa. (2019). *Sustainable development goals (SDGs) country report 2019: South Africa* (pp. 1–316). Statistics South Africa.

Statistics South Africa. (2020a). *Marriages and divorces 2020* (pp. 1–53). www.statssa.gov.za,info@statssa.gov.za,Tel+27123108911

Statistics South Africa. (2020b). *Unwanted fertility in South Africa* (pp. 1–26).

Statistics South Africa. (2024). *Migration profile report for South Africa: A country profile 2023* (Nos. 03-09–17; p. 128). Statistics South Africa.

Staunæs, D. (2003). Where have all the subjects gone? Bringing together the concepts of intersectionality and subjectification. *NORA - Nordic Journal of Feminist and Gender Research*, *11*(2), 101–110. https://doi.org/10.1080/08038740310002950

Stevens, M. (2021). Sexual and reproductive health and rights: Where is the progress since Beijing? *Agenda*, *35*(2), 48–60. https://doi.org/10.1080/10130950.2021.1918008

Strong, J., Lamptey, N. L. S., Quartey, N. K., & Owoo, N. K. R. (2022). “If I am ready”: Exploring the relationships between masculinities, pregnancy, and abortion among men in James Town, Ghana. *Social Science & Medicine*, *314*, Article 115454. https://doi.org/10.1016/j.socscimed.2022.115454

Stumbitz, B., & Jaga, A. (2020). A Southern encounter: Maternal body work and low-income mothers in South Africa. *Gender, Work and Organization*, *27*(6), 1485–1500. https://doi.org/10.1111/gwao.12527

Suandi, D., Williams, P., & Bhattacharya, S. (2020). Does involving male partners in antenatal care improve healthcare utilisation? Systematic review and meta-analysis of the published literature from low- and middle-income countries. *International Health*, *12*(5), 484–498. https://doi.org/10.1093/inthealth/ihz073

Sufredini, F., Catling, C., Zugai, J., & Chang, S. (2022). The effects of social support on depression and anxiety in the perinatal period: A mixed-methods systematic review. *Journal of Affective Disorders*, *319*, 119–141. https://doi.org/10.1016/j.jad.2022.09.005

Swartz, A., Colvin, C., & Harrison, A. (2018). The problem or the solution? Early fertility and parenthood in the transition to adulthood in Khayelitsha, South Africa. *Reproductive Health Matters*, *26*(54), 145–154. https://doi.org/10.1080/09688080.2018.1537417

Swartz, L. (2015). Thinking about culture and language in psychological research and practice. In P. Rohleder & A. C. Lyons (Eds.), *Qualitative research in clinical and health psychology* (pp. 43–56). SAGE Publications Inc.

Tamale, S. (2020). *Decolonization and Afro-feminism* (Vol. 53). Daraja Press. http://www.elsevier.com/locate/scp

Taylor, S., & Littleton, K. (2006). Biographies in talk: A narrative-discursive research approach. *Qualitative Sociology Review*, *2*(1), 22–38. https://doi.org/10.5860/choice.51-2973

Tebid, R., du Plessis, D., Beukes, S., van Niekerk, V., & Jooste, K. (2011). Implications for nurse managers arising from immigrant women’s experience of midwifery care in a hospital. *Journal of Nursing Management*, *19*(7), 967–975. https://doi.org/10.1111/j.1365-2834.2011.01310.x

Temple, B., & Young, A. (2004). Qualitative research and translation dilemmas. *Qualitative Research*, *4*(2), 161–178.

The African American Policy Forum. (2019). *Kimberlé Crenshaw profile*. http://aapf.org/kimberle-crenshaw

The Combahee River Collective. (1978). The Combahee River Collective statement. *Statement*. https://doi.org/10.4324/9780429494277-3

The Mail and Guardian. (2015, March 11). Zuma: Send teenage moms to Robben Island. *The Mail and Guardian*. https://mg.co.za/article/2015-03-11-zuma-send-teenage-mums-to-robben-island/

Thipanyane, M. P., Nomatshila, S. C., Oladimeji, O., & Musarurwa, H. (2022). Perceptions of pregnant women on traditional Health practices in a rural setting in South Africa.

International Journal of Environmental Research and Public Health, *19*(7), Article 4189. https://doi.org/10.3390/ijerph19074189

Tokhi, M., Comrie-Thomson, L., Davis, J., Portela, A., Chersich, M., & Luchters, S. (2018). Involving men to improve maternal and newborn health: A systematic review of the effectiveness of interventions. *PLOS ONE*, *13*(1), e0191620. https://doi.org/10.1371/journal.pone.0191620

Tsai, A. C., Tomlinson, M., Comulada, W. S., & Rotheram-Borus, M. J. (2016a). Food insufficiency, depression, and the modifying role of social support: Evidence from a population-based, prospective cohort of pregnant women in peri-urban South Africa. *Social Science and Medicine*, *151*, 69–77. https://doi.org/10.1016/j.socscimed.2015.12.042

Tsai, A. C., Tomlinson, M., Comulada, W. S., & Rotheram-Borus, M. J. (2016b). Intimate partner violence and depression symptom severity among South African women during pregnancy and postpartum: Population-based prospective cohort study. *PLOS Medicine*, *13*(1), e1001943. https://doi.org/10.1371/journal.pmed.1001943

Turney, L. (2011). The denial of paternity: Pregnancy as a risk to the 'pure relationship'. *Sociology*, *45*(6), 1110–1125. https://doi.org/10.1177/0038038511416151

Union of South Africa. (1950). *Group areas act (Act no.41 of 1950)*.

Union of South Africa. (1953). *Bantu education act (Act no.47 of 1953)* (pp. 258–276).

van den Berg, W., Brittain, K., Mercer, G., Peacock, D., Stinson, K., Janson, H., & Dubula, V. (2015). Improving men's participation in preventing mother-to-child transmission of HIV as a maternal, neonatal, and child health priority in South Africa. *PLoS Medicine*, *12*(4), e1001811. https://doi.org/10.1371/journal.pmed.1001811

Van den Berg, W., Makusha, T., & Ratele, K. (2021). *State of South Africa's fathers 2021* (pp. 1–93). Sonke Gener Justice, Human Sciences Research Council, & Stellenbosch University. www.men-care.org.

van den Heever, A. (2016). Pregnancy and maternal support for the protection of mothers and young children. In *South African Child Gauge: Children and social assistance*.

van Heyningen, T., Honikman, S., Myer, L., Onah, M. N., Field, S., & Tomlinson, M. (2017). Prevalence and predictors of anxiety disorders amongst low-income pregnant women in urban South Africa: A cross-sectional study. *Archives of Women's Mental Health*, *20*(6), 765–775. https://doi.org/10.1007/s00737-017-0768-z

Van Langenhove, L. (2017). Varieties of moral orders and the dual structure of society: A perspective from positioning theory. *Frontiers in Sociology*, *2*, Article 9. https://doi.org/10.3389/fsoc.2017.00009

Van Parys, A.-S., Verhamme, A., Temmerman, M., & Verstraelen, H. (2014). Intimate partner violence and pregnancy: A systematic review of interventions. *PLoS ONE*, *9*(1), e85084. https://doi.org/10.1371/journal.pone.0085084

Vincent, L. (1999). A cake of soap: The volksmoeder ideology and Afrikaner women's campaign for the vote. *International Journal of African Historical Studies*, *32*(1), 1–17.

Von Fintel, Di., & Richter, L. (2019). Intergenerational transfer of health inequalities: Exploration of mechanisms in the birth to twenty cohort in South Africa. *BMJ Global Health*, *4*, Article e001828. https://doi.org/10.1136/bmjgh-2019-001828

Wabiri, N., Chersich, M., Shisana, O., Blaauw, D., Rees, H., & Dwane, N. (2016). Growing inequities in maternal health in South Africa: A comparison of serial national household surveys. *BMC Pregnancy and Childbirth*, *16*(1), 256. https://doi.org/10.1186/s12884-016-1048-z

Walker, C. (1982). *Women and resistance in South Africa*. Onyx Press Ltd.

Wang, C. (1999). Photovoice: A participatory action research strategy applied to women's health. *Journal of Womens Health*, *8*(2), 185–192. https://doi.org/10.1089/jwh.1999.8.185

Wang, C., & Burris, M. A. (1994). Empowerment through photo novella: Portraits of participants. *Health Education Quarterly*, *21*(2), 171–186.

Wang, C., & Burris, M. A. (1997). Photovoice: Concept, methodology, and use for participatory needs assessment. *Health Education & Behavior*, *24*(3), 369–387.

Warren, Zachary., & Moghaddam, F. M. (2018). Positioning theory and social justice. In P. L. Hammack (Ed.), *Oxford handbook of social psychology and social justice* (pp. 319–330). Oxford University Press. https://doi.org/10.1093/oxfordhb/9780199938735.001.0001

Wengraf, T. (2001). *Qualitative research interviewing*. SAGE Publications Ltd.

White, D., Dynes, M., Rubardt, M., Sissoko, K., & Stephenson, R. (2013). The influence of intra familial power on maternal health care in Mali: Perspectives of women, men and mothers-in-law. *International Perspectives on Sexual and Reproductive Health*, *39*(2), 58–68. https://doi.org/10.1363/3905813

Whyle, E. B., & Olivier, J. (2023). A socio-political history of South Africa's national health insurance. *International Journal for Equity in Health*, *22*(1), Article 247. https://doi.org/10.1186/s12939-023-02058-3

Wilkinson, R., & Marmot, M. (2003). *Social determinants of health: The solid facts (second edition)* (pp. 1–33). World Health Organisation.

Wilkinson, S., & Kitzinger, C. (2003). Constructing identities: A feminist conversation analytic approach to positioning in action. In R. Harré & F. Moghaddam (Eds.), *The self and others: Positioning Individuals and groups in personal, politcal, and cultural contexts* (pp. 157–180). Praeger Publishers.

Willig, C. (2008). *Introducing qualitative research in psychology*. Open University Press.

World Health Organisation. (2014). *Review of social determinants and the health divide in the WHO European region: Final report* (pp. 1–234). World Health Organisation. www.euro.who.int

World Health Organisation (WHO). (2015). *WHO recommendations on health promotion interventions for maternal and newborn health* (pp. 1–94). World Health Organisation. www.who.int

World Health Organisation (WHO). (2016). *WHO recommendations on antenatal care for a positive pregnancy experience* (pp. 1–172). World Health Organization.

Wyllie, C. (2000). The judiciary fails working mothers. *Agenda*, *16*(44), 90–96. https://doi.org/10.1080/10130950.2000.9675838

Yamin, A. E., & Boulanger, V. M. (2013). Embedding sexual and reproductive health and rights in a transformational development framework: Lessons learned from the MDG targets and indicators. *Reproductive Health Matters*, *21*(42), 74–85. https://doi.org/10.1016/S0968-8080(13)42727-1

Yim, I. S., Tanner Stapleton, L. R., Guardino, C. M., Hahn-Holbrook, J., & Dunkel Schetter, C. (2015). Biological and psychosocial predictors of postpartum depression: Systematic review and call for integration. *Annual Review of Clinical Psychology*, *11*, 99–137. https://doi.org/10.1146/annurev-clinpsy-101414-020426

Yuval-Davis, N. (1993). Gender and nation. *Ethnic and Racial Studies*, *4*, 621–632. https://doi.org/10.1080/01419870.1993.9993800

Yuval-Davis, N. (2006). Intersectionality and feminist politics. *European Journal of Women's Studies*, *13*(3), 193–209. https://doi.org/10.1177/1350506806065752

Yuval-Davis, N. (2011). Beyond the recognition and re-distribution dichotomy: Intersectionality and stratification. In H. Lutz, M. T. H. Vivar, & L. Supik (Eds.), *Framing intersectionality: Debates on a multi-faceted concept in gender studies* (pp. 155–170). Ashgate Uk.

Yuval-Davis, N. (2015). Situated intersectionality. *Raisons Politiques*, *2*(58), 91–100.

Zungu, N. P., Petersen, Z., Parker, W., Dukhi, N., Sewpaul, R., Naidoo, I., Moolman, B., Isaacs, D., Makusha, T., Mabaso, M., Reddy, T., Zuma, K., & The SANSHEF Team. (2024). *The first South African national gender-based violence study, 2022: A baseline survey on victimisation and perpetration* (pp. 1–99). Human Sciences Research Council.

APPENDIX

APPENDIX 1: Ethical clearance from Rhodes University

RHODES UNIVERSITY
Grahamstown • 6140 • South Africa

DEPARTMENT OF PSYCHOLOGY
Tel: +27 (0)46 603 8500 • Fax: +27 (0)46 622 4032 • Website: http://www.rhodes.ac.za/academic/department/psychology

RESEARCH PROJECTS AND ETHICS REVIEW COMMITTEE

25 March 2015

Yamini Kalyanaraman
Department of Psychology
RHODES UNIVERSITY
6140

Dear Yamini

ETHICAL CLEARANCE OF PROJECT PSY2015/04

This letter confirms your research proposal with tracking number PSY2015/04 and title, 'An intra-categorical intersectional framework for understanding `supportability` in women's narratives of their pregnancy', served at the Research Projects and Ethics Review Committee (RPERC) of the Psychology Department of Rhodes University on 25 March 2015. The project has been given ethics clearance.

Please ensure that the RPERC is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators.

Yours sincerely

Dr Jacqui Marx
CHAIRPERSON OF THE RPERC

APPENDIX 2: Request for permission from the Eastern Cape Department of Health (ECDoH)

RHODES UNIVERSITY
Where leaders learn

Critical Studies in Sexualities and Reproduction research programme
CSSR house, Lucas Road, Grahamstown, 6139, South Africa
PO Box 94, Grahamstown, 6140, South Africa
t: +27 (0) 46 603 7329
f: +27 (0) 46 603 7614
e: cssradmin@ ru.ac.za
www.ru.ac.za/criticalstudies/

Senior Management Research and Epidemiology Unit
Department of Health Eastern Cape
Dukumbana Building
Independence Avenue
Bhisho
Eastern Cape
South Africa

Dear Mr. Dlamini and Mr. Merile,

Subject: Permission to use premises for recruitment of participants (accessing antenatal care) for the purpose of research

We are from the Critical Studies in Sexualities and Reproduction research programme, which is part of the Department of Psychology at Rhodes University. We are researching women's narratives of their pregnancy experience, with focus on its 'supportability' which takes into account various aspects related to their health, partner support, family support, social support, educational or work support, health services and other macro situations within which their pregnancies occur. The research will be conducted in two areas – Grahamstown and Dwesa.

Four students from Rhodes University will be involved in the research under the supervision of Prof Catriona Macleod (email id: c.macleod@ru.ac.za). Yamini Kalyanaraman (student number is G14K2501) and Megan Reuvers (15R9220) are doing their Master's degree. Phathiswa Esona Bottoman (14B8639) and Zipho Dolamo (15D7445) are doing their Honours.

We would require twelve to twenty participants for this study. We wish to place flyers (in isiXhosa and English) at the reception desk at clinics, and request nurses or community health workers to hand out the flyers to potential participants. The criteria for inclusiveness would be for the women to be: above 18 years; in their second trimester onwards of their pregnancy; and accessing antenatal care at any of the clinics in Grahamstown or Dwesa. Their participation would involve four meetings. The first will take place at the clinic after which the interviews will happen at a place convenient and comfortable to the participant.

The Psychology Research Projects and Ethics Review Committee has approved the ethics of this project on 25th March 2015. Please find attached copies of the research proposal, all consent forms, the recruitment flyer, and the ethics clearance letter.

Timeline: In Grahamstown, we hope to conduct interviews in the months of June and July 2015 and in Dwesa the research will be conducted in the first quarter of 2016. Flyers would need to be distributed to the clinics before the research commences and we would like to be present at the clinic on a few days wearing nametags, so that prospective participants can approach us should they be interested in taking part in the research project.

A report in the form of a policy brief will be provided to the Department of Health, regarding the findings of our research and we are happy to meet with departmental health officials to give feedback on our findings should the Department of Health wish us to do so.

We therefore ask for your permission to use the clinics' premises for recruitment of our participants and also to conduct any of the interviews on site, should a participant so prefer.

Thanking you.

Yours sincerely,
Professor Catriona Macleod
Yamini Kalyanaraman
Megan Reuvers
Phathiswa Esona Bottoman
Zipho Dolamo

APPENDIX 3: Approval to conduct research from ECDoH

Eastern Cape Department of Health

Enquiries: Zonwabele Merile
Tel No: 040 608 0830
Date: 01st June 2015
Fax No: 043 642 1409
e-mail address: zonwabele.merile@echealth.gov.za

Dear Prof C. Macleod

Re: An intra-categorical intersectional framework for understanding 'supportability' in women's narratives of their pregnancy (EC_2015RP45_281)

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

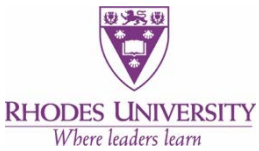
Your compliance in this regard will be highly appreciated.

SECRETARIAT: EASTERN CAPE HEALTH RESEARCH COMMITTEE

PGDP EASTERN CAPE 2004 - 2014

Ikamva eliqaqambileyo!

APPENDIX 4: Request to clinic supervisor for permission to conduct research at the clinic



DEPARTMENT OF PSYCHOLOGY

To the Supervisor of the clinic

Subject: Permission to use premises for recruitment of participants (accessing antenatal care) for the purpose of research

Dear Madam,

We are from the Department of Psychology at Rhodes University. We are researching women's narratives of their pregnancy experience.

Four students are involved in the research - Yamini Kalyanaraman, Megan Reuvers, Esona Bottoman and Zipho Dolamo. Our supervisor is Prof Catriona Macleod (email id: c.macleod@ru.ac.za).

We require six to ten participants. We wish to place flyers (in isiXhosa and English) at your reception desk. The criteria for inclusiveness would be for the women to be: above 18 years; in their second trimester onwards of their pregnancy; and accessing antenatal care at your clinic. Their participation would involve four meetings. The first will take place at the clinic, during which the aims of the research will be explained, and the participant will decide whether to participate in the project. After this, the interviews will happen at a place convenient to the participant.

The Psychology Research Projects and Ethics Review Committee has approved the ethics of this project and permission has been granted by the sub-district manager of the Department of Health.

We would like to be present at the clinic for a few days wearing name tags, so that prospective participants can identify and approach us should they be interested in taking part in the research

project. It would also be much appreciated if you could inform the women about our project and ask them to contact us if they are interested in taking part. It would be important to stress to the women that their agreement or refusal to participate will in no way affect the services they receive at your clinic.

Please grant us permission to use the clinics' premises for recruitment of our participants and also to conduct any of the interviews on site, should a participant so prefer.

We thank you for your cooperation and assistance.

Kind regards,

Yamini Kalyanaraman

Megan Reuvers

Phathiswa Esona Bottoman

Zipho Dolamo

APPENDIX 5: Flyers in English and isiXhosa

Are you 13 or more weeks pregnant?

Are you visiting your clinic for antenatal care check-ups?

Are you 18 years or older?

Would you like to take photos of your pregnancy journey with your cellphone and share your experience with Rhodes University researchers?

This project aims to explore the types of support women in your community experience when pregnant.
Tell us your story!

If you are interested in taking part in this project read more about it on the back of this leaflet . Our contact details are also on the back so give us a call.

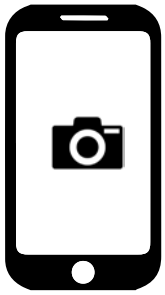
You can also speak to us at the clinic - we will be wearing name tags.

Unentsuku ezilishumi elinesithathu (13) okanye iveki ezimbini ukhulelwe?

Ingaba uyayindwendwela na iKliniki yakho ukuze uqwalaselwe indlela ononophela ngayo ukukhulelwa kwakho?

Ingaba uneminyaka elishumi elinesibhozo (18years or more) nangaphezulu?

Ungathanda na okanye ubenomdla wokuthatha ifoto (pictures) ngonomyayi wakho wabelane geziganeko zethuba lokukhulelwa kwakho wabelane ngazo kunye noophandulwazi base Rhodes University.

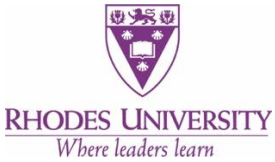


Injongo zoluqulunqo zijoliswe ekubeni iphonononge, iphanda banzi ngohlobo omama abakhulelweyo abakhuthazwa ngayo kwaye abaxhaswa ngayo ekuhlaleni ngethuba lokukhulelwa
Sixelele ngelakho ibali!

Ukuba ngaba unomdla wokuzibandakanya nale nkqubo phuhliso, funda banzi ngalo kwi mbalelwano esemveni kweliphepha. Ingcombolo okanye inkcukacha malunga noqhagamshelwano nathi nazo zingasemva. Nogoko ke sitsalele umnxeba okanye uvakalise umdla wakho konesi ekliniki.

Ukanti, ungathetha-thethana nathi sizakube sikho kwi Kliniki yakho, sobe sinxibe izazisi magama.

APPENDIX 6: Research participant informed consent



DEPARTMENT OF PSYCHOLOGY

AGREEMENT BETWEEN STUDENT RESEARCHER AND RESEARCH PARTICIPANT

I _____(participant's name), agree to participate in the research project of Yamini Kalyanaraman/ Megan Reuvers/ Phathiswa Esona Bottoman/ Zipho Dolamo on understanding 'supportability' in women's narratives of their experience of pregnancy.

I understand that:

1. The researchers are students conducting the research as part of the requirements for a Master's/Honours degree at Rhodes University. The research project has been approved by the relevant ethics committee, and is under the supervision of Prof Catriona Macleod in the Psychology Department at Rhodes University, who may be contacted on +27 (0)46 603 7329 or c.macleod@ru.ac.za. The researchers may be contacted on
    - Yamini: 079 706 3020 or yamini.arts@gmail.com
    - Megan: 084 583 2825 or m.reuvers@ru.ac.za
    - Phathiswa: 071 622 7079 or esonapatbottoman@yahoo.com
    - Zipho: 078 765 0327 or ziphodolamo@rocketmail.com
2. The researcher is interested in exploring how women experience their pregnancy with a specific focus on the support available or unavailable to them as well as the factors that affect the 'supportability' of their pregnancies.
3. My participation will involve four interviews. The first will be an introduction, signing of the various consent forms and guidelines regarding photo-taking. The second and third meeting will be approximately an hour each. The fourth will function as a follow-up and last approximately twenty minutes.
4. I may be asked to answer questions of a personal nature, but I can choose not to answer any questions about aspects of my life, which I am not willing to disclose.
5. I am invited to voice to the researcher any concerns I have about my participation in the study, or consequences I may experience as a result of my participation, and to have these addressed to my satisfaction. *The Rhodes*

University Psychology Clinic may be contacted for further support on 046 603 8502 *or LifeLine at* 0861 322 322.

6. The report on the project may contain information about my personal experiences, attitudes and behaviours, but that the report will be designed in such a way that it will not be possible to be identified by the general reader.
7. My willingness to participate in this research will in no way affect the service that I receive from the clinic.
8. I wish to receive feedback regarding the results of this research. Yes____/ No ____

   If yes, then the results may be posted to me at:
9. I am free to withdraw from the study at any time during data collection – however I commit myself to full participation unless some unusual circumstances occur, or I have concerns about my participation, which I did not originally anticipate.

Signed on (Date):

Participant: _____

Researcher: _____

APPENDIX 7: Photograph consent form

RHODES UNIVERSITY

DEPARTMENT OF PSYCHOLOGY

Photo Consent Form

I understand that:

1. I will be taking photographs of "anything that makes my pregnancy easy and anything that makes it difficult".
2. I will get verbal consent from anyone I wish to photograph, where the person is identifiable in the picture.
3. I allow Rhodes University the right to collect and analyse the photographs that I choose to share with them.
4. Should a third party or I not want a particular photograph to be used for the research, I will explain the contents of the image to the researcher and retain the photograph.
5. I have been informed that all photographs I take will be kept strictly confidential and saved in a secure location.
6. These photographs will used purely for academic research purposes and not for any commercial gains.
7. I understand that all photographs used in public research reports will have identifying features of any third party and me, removed.
8. I am aware that my participation is voluntary, and I will not be compensated for any of these images.

I have read and understand the above:

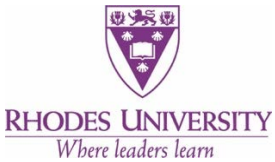
Signature _____

Printed name _____

Address _____

Date _____

APPENDIX 8: Image release form



DEPARTMENT OF PSYCHOLOGY

Image Release Form

Permission to use photographs

- I _____ (name of the participant) have taken_____ number of photographs surrounding my pregnancy experiences.

- I am sharing _____number of photographs with the researchers

- I have obtained verbal consent from identifiable other people (3rd parties) photographed in these images to share these images with the researcher and for the researcher to use the pictures in their research.

- All 3rd parties have been made aware that their identifying features will be removed in the final report.

- I am not sharing pictures of people from whom I have not received consent.

- These photographs will used purely for academic research purposes and not for any commercial gains.

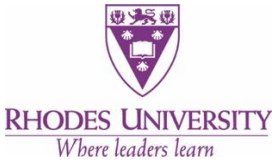
I have read and understand the above:

Signature _____

Printed name _____

Date _____

APPENDIX 9: Audio-recording consent form



Rhodes University — Department of Psychology

USE OF TAPE RECORDINGS FOR RESEARCH PURPOSES PERMISSION AND RELEASE FORM

Name of participant			
Participant's contacts details	Email address: Phone number:		
Name of researcher			
Level of research	Honours	Masters	PhD
Brief title of project			
Name of supervisor			

DECLARATION

(Please initial/tick blocks next to the relevant statements)

1.	The nature of the research and the nature of my participation have been explained to me.	verbally	
		in writing	
2.	I agree to be interviewed and to allow recordings to be made of the interview.	audiotape	
		videotape	
3.	I agree to _____ and to allow recordings to be made.	audiotape	
		videotape	
4.	The tape recordings may be transcribed	without conditions	
		only by the researcher	
		by one or more nominated third parties	
5.	I have been informed by the researcher that the tape recordings will be erased once the study is complete and the report has been written.		
	OR I give permission for the tape recordings to be retained after the study and for them to utilised for the following purposes and under the following conditions		

Signature of participant: _____ Date: _____

Witnessed by researcher: _____ Date: _____

APPENDIX 10: Transcription conventions

IAN PARKER'S (1992) TRANSCRIPTION CONVENTIONS (ADAPTED)

Symbol	**Meaning**
Round brackets ( )	Indicates doubts arising about the accuracy of material
Ellipses …	To show when material is omitted from the transcript
Square brackets []	To clarify something to help the reader
Forward slashes / /	Indicates noises, words of assents and others
Equals sign =	Indicates the absence of a gap between one speaker and another at the end of one utterance and the beginning of the next utterance
Round brackets with number inserted, e.g. (2)	Indicates pauses in speech with the number of seconds in round brackets
Round brackets with full stop (.)	Indicates pauses in speech that last less than a second
Colon ::	Indicates an extended sound in the speech
Underlining _____	Indicates emphasis in speech

APPENDIX 11: Case studies

Case study of Ayabonga

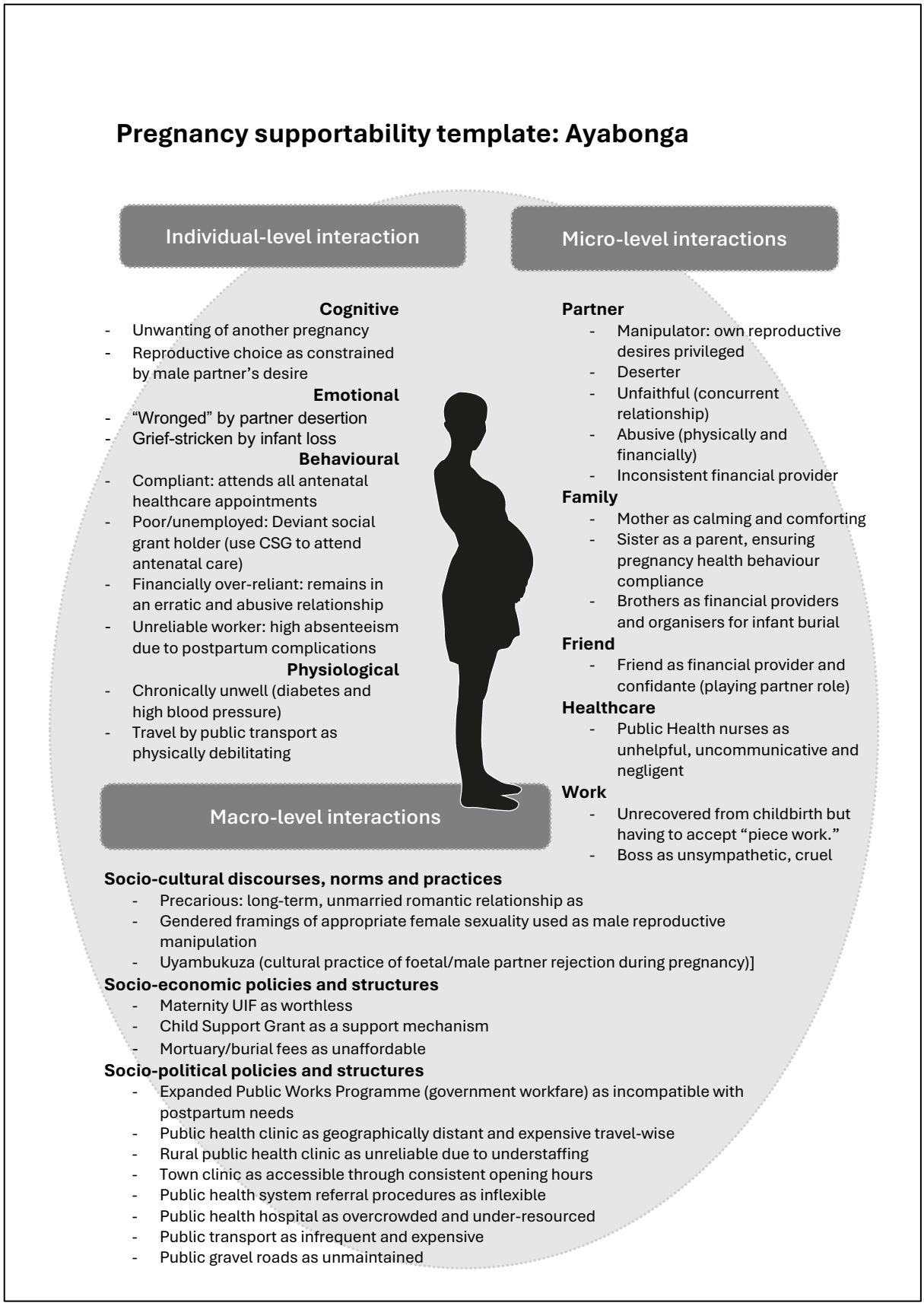
27 years-old | Black | Recently single | South African | EPWP programme (contract work) | Third pregnancy |

Ayabonga's account centred on how she was abandoned by her partner six months into her pregnancy. Ayabonga explained that she did not particularly want another child (individual cognitive) because she and her partner already had two children together. However, her partner accused her of being unfaithful because she did not want to have another child with him (partner micro-interaction interacting with macro-gendered norms). The couple had been in a relationship for approximately five years. They were not married (imperative positioning), nor did they cohabit, but when they stayed together for a few days, they mostly spent time at Ayabonga's family home. Ayabonga lived with her two children, her mother and younger sister, in a rural village, and her partner lived a few kilometres away from them.

The desertion by her partner was initially put down to *Uyambukuza* (macro-cultural practice), a phenomenon understood in Xhosa culture whereby the pregnancy mood may cause the male partner to reject the foetus (or the foetus rejects the father). The partner abandons the woman during pregnancy, returning only once she has given birth. Ayabonga described how her partner refused to answer her calls or WhatsApps, nor would he give her money to go to the clinic. He also refused to take her to the hospital to give birth, which was part of their original plan, as he had a car. Instead, she claimed she had to use funds from the Child Support Grant (macro social policy) meant for her other two children to cover her transport costs to the clinic. She also admitted that her partner was the jealous type (partner micro-interaction) and positioned him as abusive. He hurt her both physically and psychologically, which required an intervention from her family. The couple resumed their relationship once the baby was born, and her partner supported the baby financially.

Ayabonga described the support of her family as instrumental (family micro-interaction) during her pregnancy in helping her cope with the stress of being abandoned by her partner. She described her mother as a quiet person who did not talk much but still played a part in comforting and reasoning with Ayabonga about the loss of her partner. Ayabonga likened her younger sister to a parent. She described her sister as someone who did everything for her, such as making sure Ayabonga took her medication, providing her with money for airtime and consoling, comforting and talking with her about her partner's issues.

Figure 9: Pregnancy supportability template, Ayabonga



D

Ayabonga also had a friend (community micro-interaction) who was her closest confidante and provided her with financial assistance if needed. She claimed that her friend was so supportive that she had taken over the role of her partner.

Ayabonga positioned herself as a chronically unwell person (individual physiological). She had both diabetes and high blood pressure. This meant that she had to visit the clinic often for medication. She described how difficult it was to access the clinic because of the distance from her village, the high price and lack of frequent transport, and the discomfort experienced because of travelling on corrugated dirt roads (macro-structural influences). She explained that although a new clinic was closer to her village, it was unreliable because it was under-resourced, understaffed, and often closed (healthcare micro interacting with macro healthcare system structures). Instead, Ayabonga visited the town clinic much further away from her home because it was always open and offered the services she required.

Ayabonga's experience with the health system when it became time to give birth was not positive. She described how she was given the run-around (healthcare micro-interaction) when trying to book her caesarean section. She also had to find her own way to the regional referral hospital where she would have the operation (macro health policy). She told us that she hitchhiked to the hospital by flagging down an ambulance. Because the ambulance was not officially booked for her by the hospital, she paid the ambulance driver a transport fee of R30 because he needed airtime for his mobile phone. Once at the hospital, she had to fight with the nurses to get admitted (healthcare micro-interaction). They claimed that the doctor who booked her was on leave, and as such, they couldn't operate. They also claimed she was not at full gestation. Once finally admitted, the nurses also failed to give Ayabonga her chronic medication timeously, which meant that Ayabonga's sugar levels started fluctuating and delayed her operation. Ayabonga did not have a birth companion accompany her to the hospital. After having her baby, Ayabonga confirmed that she was discharged early because there were not enough hospital beds available, even though her caesarean scar was still oozing (macro-structural health system constraints).

Ayabonga was mostly unemployed (imperative position) but relied on contract work from a government-funded Expanded Public Works Program (EPWP) (macro social policy). She was not able to work all her hours because her caesarean scar had not healed properly and caused her discomfort and pain. She described how her supervisor was unsympathetic (micro-level interaction) to her plight and forfeited pay when she took leave. Workers cannot claim maternity income benefits or sick pay on these work contracts (macro-social policy). Ayabonga

maintained that the effort of travelling to the nearest town to claim from the Unemployment Insurance Fund (UIF) was not worth it because the payout would be minimal.

Tragically, Ayabonga's infant passed away from an unexplained infection at four months old. Ayabonga noticed that her baby had a fever, and despite trying all sorts of means to find transport money to get her baby to the clinic, she was unable to do so and could only access the mobile health clinic. Eventually, she managed to get to the clinic in town to get treatment for the baby (macro socio-economic interacting with macro health systems). The baby seemed fine the next day and evening, so Ayabonga planned to return to her village. However, Ayabonga sensed something was wrong when waking up and attempting to breastfeed the following morning; her baby had passed in the night. She screamed for her aunt to help her, but there was nothing anyone could do. Ayabonga's partner deserted her again when the infant died and did not make good on his promises to pay for the burial (partner micro-interaction). Ayabonga's brothers stepped in to help with burial arrangements (micro-family interaction). The family could not afford to take the body to the mortuary (macro socio-economic), so they arranged for private car hire to transport the body back to their village and buried the infant themselves on the family's land.

Case study of Kudzai (pregnant) and Simbarashe (partner)

20 years-old | Black | Long term partnership | Zimbabwean | Kudzai– unemployed / Simbarashe-employed | First pregnancy

Kudzai and Simbarashe (her partner) are Zimbabwean (imperative positioning). Simbarashe attended the interview, too, as Kudzai speaks Shona and very little isiXhosa and English. The couple were in a 2-year relationship, and this pregnancy was wanted. Simbarashe pointed out that it was fitting that he became a father because he was 27 years old. Moreover, he justified Kudzai's pregnancy by asserting that Kudzai waited until she was 20 years old before becoming pregnant (individual cognitive/behavioural interaction with reproductive socio-cultural norms). Simbarashe explained that he was a fully committed partner (partner micro-interaction) in that he was the "owner" of the pregnancy and was not likely to run away or cheat on Kudzai. He positioned himself firmly as the family's provider, ensuring they got everything they needed for a good pregnancy.

However, Kudzai was very lonely because her entire family lived in Zimbabwe (individual emotional). There were no female family members (like her sister, who was experienced in that she has had many children) to help her with pregnancy-related questions or concerns (family

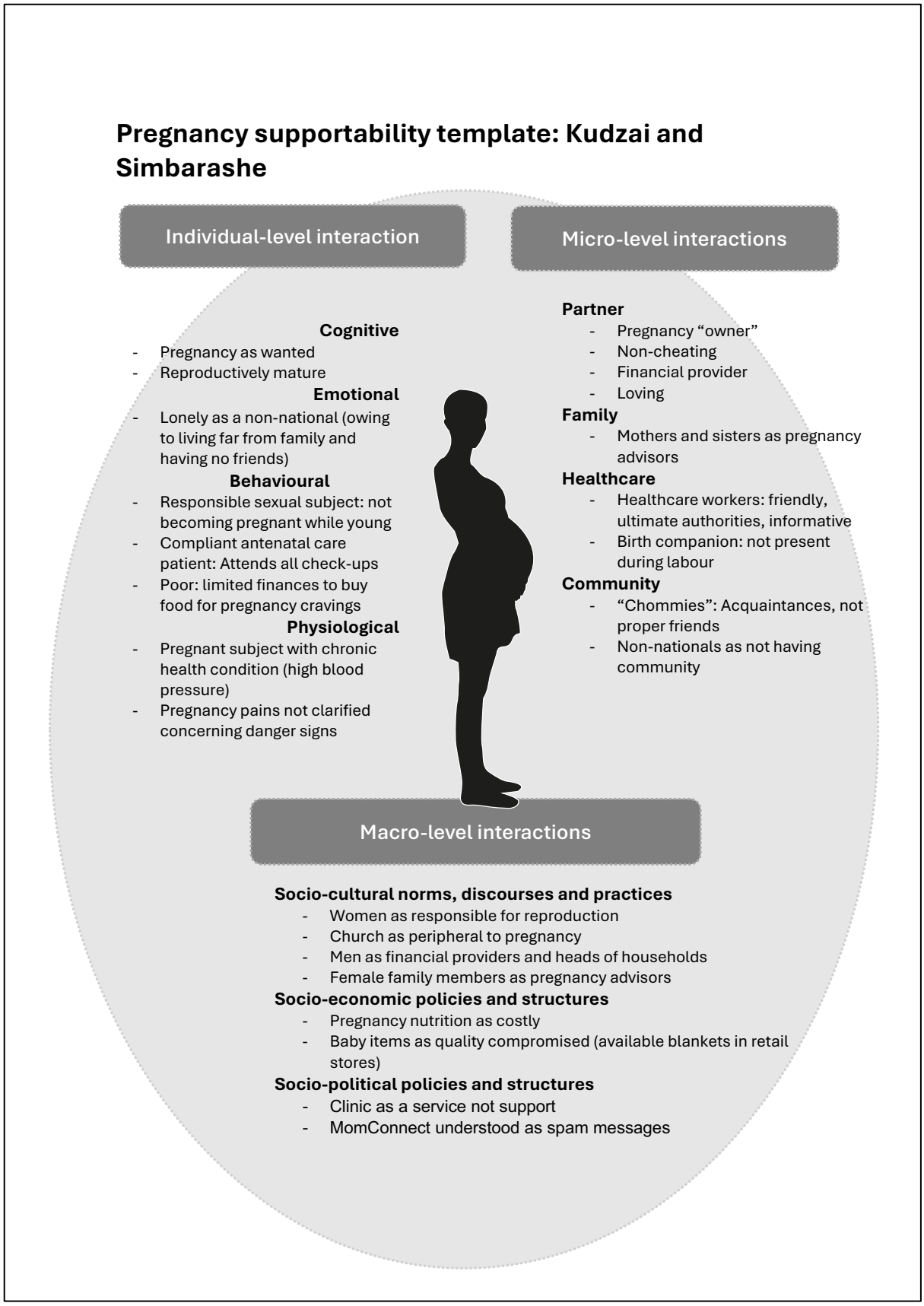
micro-interaction). Kudzai also didn't have any friends she could call on. Although the couple attended church, the church was positioned as entirely external to the pregnancy (macro-cultural). As Simbarashe pointed out, the pregnancy was none of the church's business; they just "saw" the pregnancy.

Kudzai's nutritional preferences changed with her pregnancy, and she liked eggs. Simbarashe also bought her fruit and yoghurt. He explained that their main diet was *Sadza* (a form of corn meal) and sometimes meat. However, Kudzai didn't always want to eat *Sadza*, but Simbarashe maintained that her choices were constrained owing to the affordability of food (macro socio-economic). Kudzai did not work and explained that working during her pregnancy would cause unnecessary challenges for her. Instead, she stayed home and did the housework, which involved washing clothes, cleaning and cooking.

Kudzai attended all her antenatal care check-ups once a month (healthcare micro-interaction). She reported that the healthcare workers were friendly and that she was able to understand a little of what they say in isiXhosa. The couple positioned the clinic as a service (social entity positioning) and, therefore, limited in its ability to assist Kudzai or answer any immediate concerns she may have had about her pregnancy. This made it difficult for Kudzai as she did not have easy access to pregnancy advice without her family being around; they were never sure if the physical pains she experienced were serious or not (individual physiological). In asking Simbarashe if he could ask the nurses questions at the clinic (healthcare micro-interaction), Simbarashe claimed that their role was not to ask the nurses questions but to listen to their instructions and comply with them. Simbarashe also deleted all the MomConnect messages from his phone because he thought they were spam (macro health system). He did not realise that they are a form of informational support from the clinic,

Kudzai also had high blood pressure (individual physiological). When giving birth, her BP was too high to have a vaginal delivery, and the district hospital transferred her to an academic/regional hospital, where she gave birth by caesarean section (macro health system). Simbarashe confirmed that the healthcare workers explained exactly why Kudzai had to have an operation (micro healthcare interaction). Kudzai was in the hospital for eight days. Simbarashe admitted that he felt fearful about the operation (individual emotional). He spent time travelling backwards and forwards to the tertiary hospital to check on Kudzai and eventually missed the birth. Thus, Kudzai did not have a birth companion accompanying her during birth (micro healthcare interacting with the macro health system). Instead, she phoned Simbarashe to let him know that the child had been born by operation.

Figure 10: Pregnancy supportability template, Kudzai and Simbarashe



D

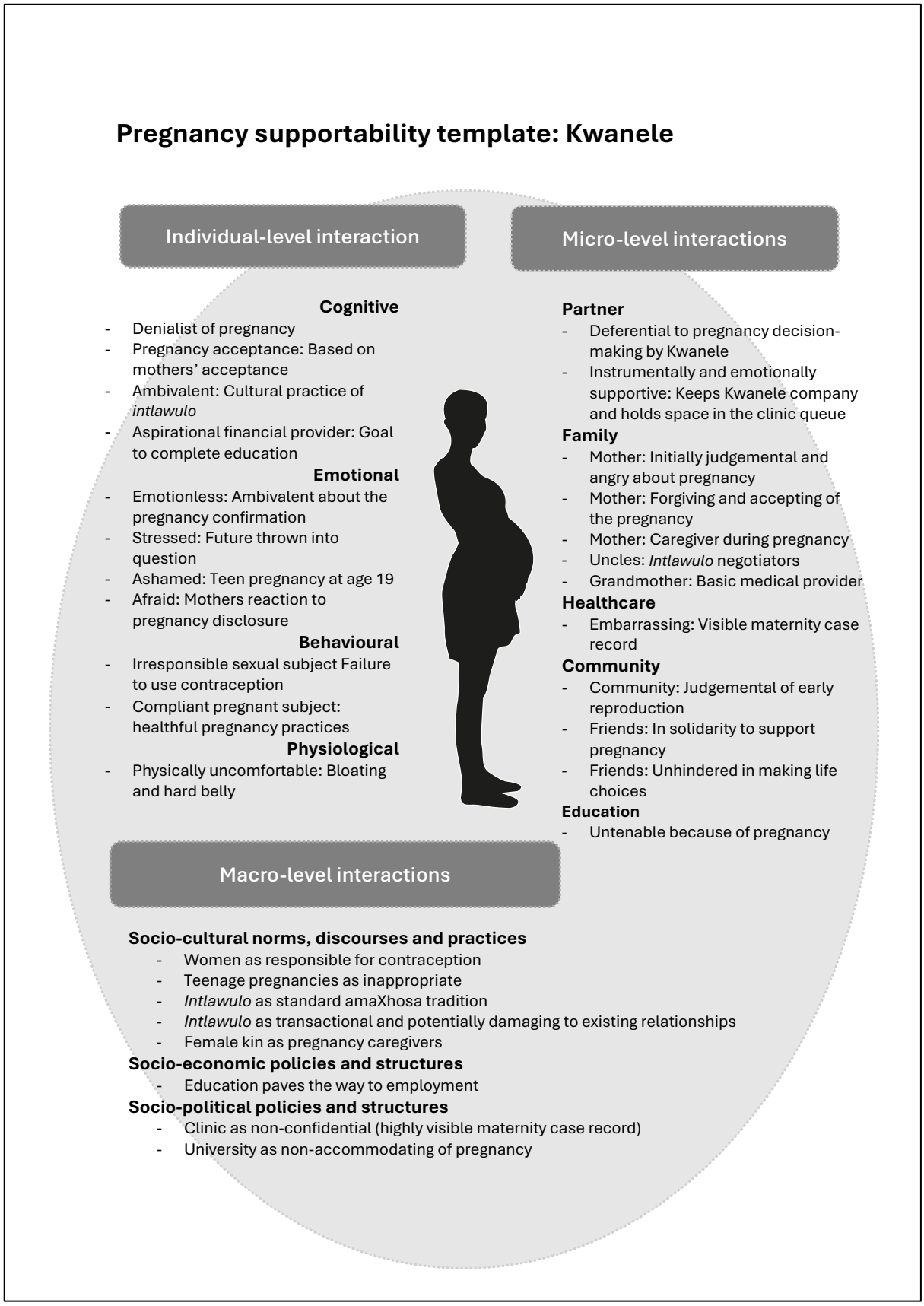
We met up with the couple when they took their newborn for her first check-up at the local clinic ten days after her birth. This was our final interview with them. The health interaction, however, was extremely awkward and excruciating to witness. The clinic sister refused to touch and weigh the baby until Kudzai changed her diaper (healthcare micro-interaction). This had to be done in front of everyone in the main clinic waiting room. As a new mother, Kudzai struggled to change the nappy and was embarrassed to ask for assistance. All we wanted to do was leap up and help her, but we realised we would be transgressing clinic protocols. Esona, my research partner, suggested to Simbarashe that he help Kudzai, but he simply told her it wasn't his job (micro partner interacting with gendered norms). Eventually, another nurse assisted Kudzai and showed her how to swaddle the baby in the blanket safely and securely. While doing this, she told us horror stories of how many babies slip out and drop on the floor. This is because the polyester blankets that patients use (and are widely available in rural low-cost retail stores) tend to be too slippery to secure properly (macro socio-economic).

Case study of Kwanele

19 years-old | *Black* | *Long term partnership* | *South African* | *Ex-student/gap year* | *First pregnancy*

Kwanele was 19 years old, a first-year university student, and classified her unplanned pregnancy as a teenage pregnancy (imperative positioning). She explained that her pregnancy was seen as scandalous in her community (micro interaction interacting with reproductive norms of appropriate childbearing). Kwanele was stressed (individual emotional) about the pregnancy because it threw her whole future and study plans into question. She had decided to take a gap year to allow her time to decide what she wanted to study (because she had failed her first year of university) before the pregnancy derailed these plans (micro-interaction education). Kwanele claimed that she didn't know she was pregnant (individual cognitive) until her mother noticed the changes in her and sent her off to the doctor to get a pregnancy test. Kwanele described her reaction to the pregnancy as emotionless; she did not know whether she was happy, sad, or angry about the pregnancy and blamed herself for not using contraception properly (individual emotional/cognitive/behavioural interacting with gendered reproductive norms). On hearing that she was pregnant, Kwanele's mother did not speak to her for a week (family micro interaction). Her mother eventually came round and explained to Kwanele that she would support her throughout her pregnancy and that Kwanele could speak to her about anything that worried her. Kwanele accepted her pregnancy once her mother accepted it.

Figure 11: Pregnancy supportability template, Kwanele



Kwanele positioned her local community as highly judgemental of teenage pregnancies (micro-level interaction). She reported feeling extremely ashamed because a community member asked her if she was pregnant when she went to the clinic. Kwanele tried to deny it, but the community member rebutted, “No, my sister saw you, and you had that white thing.”. Here, the community member refers to the maternity case record (macro health structural interaction). In carrying the white, A4-sized maternity record/book to the clinic, Kwanele told us that it was a dead giveaway that she was pregnant. Her mother’s acceptance of the pregnancy alleviated the shame and stigma Kwanele felt from her local community (family and community micro-interaction). Kwanele admitted that she was more concerned about her mother’s reaction to the pregnancy than telling her boyfriend about the pregnancy.

Kwanele had been dating the same boyfriend for eight years. He was shocked by the news but accepted the pregnancy and deferred to Kwanele’s decision on whether to continue with the pregnancy (partner micro interaction). Kwanele positioned her boyfriend as very supportive. She reported that her boyfriend would often keep her company during the day and would keep a place for her in the clinic queue when it was time for her antenatal check-up so that she didn’t have to wait for too long (micro partner interacting with macro health system). Both Kwanele and her boyfriend went through the traditional practice of *intlawulo* (macro socio-cultural practice). Kwanele’s mother instigated the practice (as is required by the maternal family), and her uncles went to negotiate with her boyfriend’s family. Kwanele expressed some concern about the high cost (five cows @ R2500 each) because she worried her boyfriend’s family might reject the price and disappear. Her family reassured her that she need not worry because the practice and negotiations are typical of the Xhosa tradition. Both families accepted the negotiations, and Kwanele expressed much relief that the process had gone smoothly. She explained that the money was for anything she needed for the pregnancy and the baby.

Kwanele’s friends were very supportive of her pregnancy (community micro-interaction). They spent time with her, did activities beneficial for the pregnancy, such as exercising, and ate healthier food in solidarity with Kwanele. However, Kwanele found it difficult to see social media posts from her friends depicting how their lives and studying went uninterrupted while she had to deal with the pregnancy. In contrast to her friends, Kwanele’s future studies depended on who could look after the child once born. Nevertheless, she still applied to various universities close to her home. She explained that the pregnancy provided her with a goal to finish studying so that she could provide for her child one day.

Kwanele used a combination of private, public and community healthcare for her pregnancy (micro healthcare interaction). She diligently went for antenatal care check-ups at the local clinic to ensure she and the baby were healthy. However, if she had any issues outside of routine pregnancy check-ups, she went to see a private doctor. Kwanele reported that she suffered from a lack of sleep because her stomach was hard and bloated. She did not consider these symptoms as part of "normal" pregnancy healthcare requiring official health interventions. Instead, her boyfriend enlisted the help of his grandmother (family micro-interaction), who gave massages by rubbing Vaseline on Kwanele's back and abdomen, which she claimed relieved her symptoms.

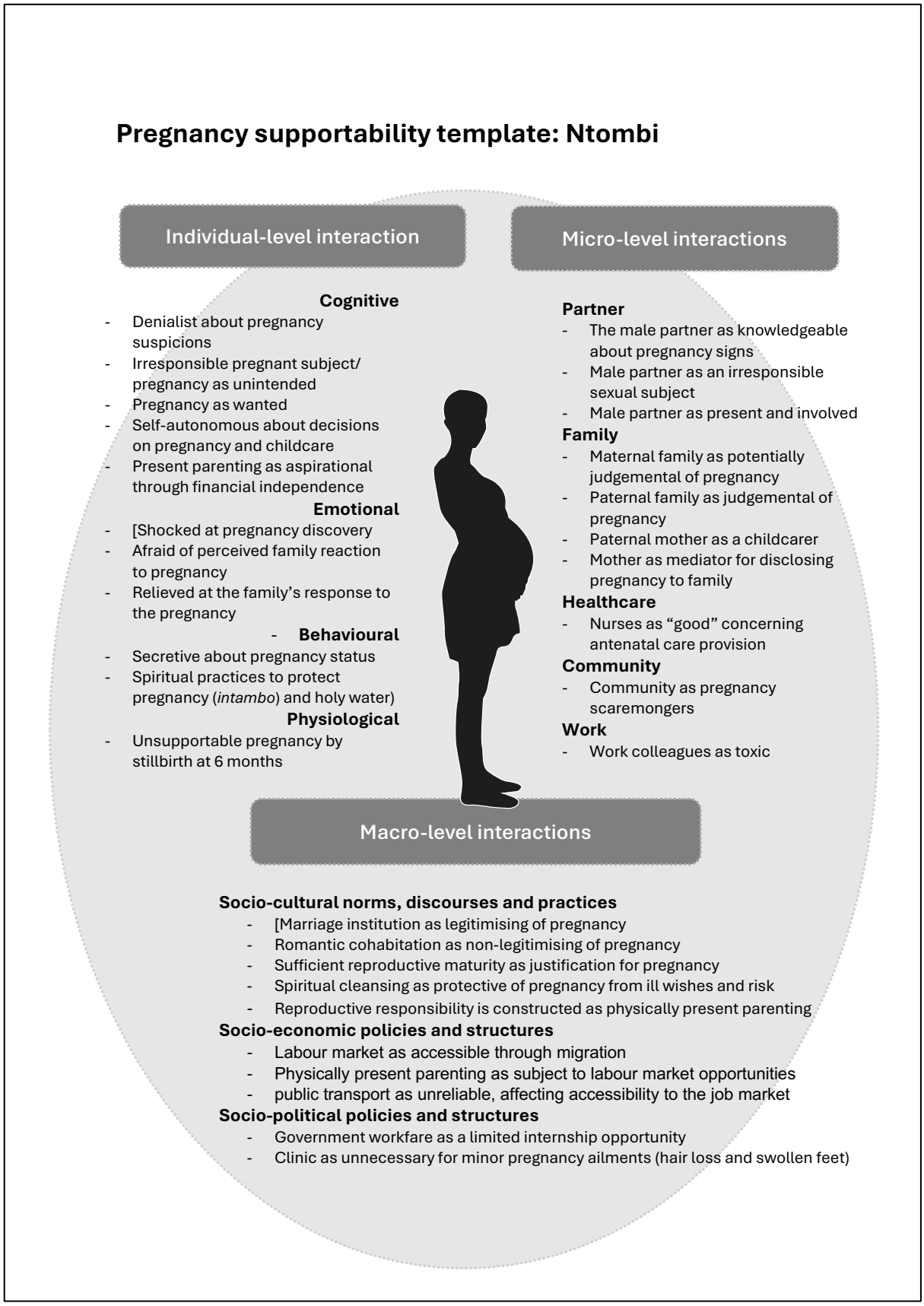
Case study of Ntombi

24 years-old | *Black* | *Cohabiting* | *South African* | *Unemployed* | *First pregnancy*

Ntombi's narrative focused on her family's acceptance of the pregnancy and the difficulties of finding and keeping employment as future parents. Throughout her story, Ntombi adopted a firm self-position of autonomy (individual cognitive) whereby decisions about the pregnancy, its management, and childcare plans were ultimately hers. Her pregnancy was unintended. She initially rejected her partner's observations that she might be pregnant and delayed testing for pregnancy. When, on her own terms, she finally tested for pregnancy, the positive test came as a shock (individual emotional). Her boyfriend laughed at the news, joked about who the father might be, and boasted about being proven right that she was indeed pregnant (partner micro-interaction).

Although unplanned, Ntombi presented the pregnancy as wanted by her and her partner. However, she reiterated that it was her decision to keep the pregnancy (individual cognitive). Ntombi's main concern was telling her family she was pregnant (micro-family interaction with reproductive norms). She feared her father's reaction to the news and that he might throw her out of the house (family micro-interaction). Her boyfriend maintained that her parents might not be as upset as she thinks because she had never messed up before (individual behavioural). Nevertheless, Ntombi tried to conceal her pregnancy until her mother questioned why she was adopting a strange posture around the family (individual behavioural).

Figure 12: Pregnancy supportability template, Ntombi



The womenfolk in Ntombi's family were first informed of the pregnancy (aunts, grandmother, and mother). Ntombi's mother broke the news of her pregnancy to Ntombi's father, thus facilitating his acceptance of her pregnancy. Both parents' simple acceptance of the pregnancy surprised Ntombi, and this was a huge source of relief for her (micro-level family interacting at an individual emotional level).

Ntombi cohabited with her partner, but he lied about this to his family (social norms governing marriage status). Her partner's mother was not happy about the news of the pregnancy and cussed at him over the phone (family micro-interaction). Ntombi explained that this was because her partner's mother was already looking after another 9-year-old child from a previous relationship. Ntombi, however, maintained that she would not dump their future child in the care of the paternal family because she wanted to be a present parent in her child's life (macro interactions between social norms of responsible parenting and access to the labour market).

Ntombi's partner is employed in construction work and is not originally from Ntombi's hometown – he is a migrant worker – and must move to wherever there is work (entity positioning of the labour market). Thus, his physical presence as a father depended on work commitments and opportunities. Ntombi explained how she worked in construction as part of a government learnership programme (macro interaction government workfare). She decided to stop working because of the toxic work environment and the long distance to travel to work; she sometimes had to walk to work, which was tiring for her during her pregnancy (macro-structural constraint through limited public transport).

Ntombi took several steps to protect her pregnancy. She attended a church to be bathed with holy water and to get her *intambo* cleaned. This practice, she explained, was to protect her pregnancy by ridding her of dirty substances that may be harmful to the foetus. Being bathed by holy water was helpful to her because it made the weight of the baby lighter (macro social practice of spiritually interacting with individual spiritual, emotional and behavioural). Ntombi was afraid of giving birth and had bad dreams about it. She reported that other women at the clinic told horror stories of childbirth, which she found off-putting (micro-level community interaction).

Ntombi did not have much to say about her experiences of antenatal care. Although she drew attention to her embodied pregnancy experiences, such as changes in her complexion, nose size and notable hair loss, she did not deem these changes worthy of asking the clinic

nurses for more information about them (healthcare micro-interaction). She simply described her antenatal care service as good when probed by the interviewers. Unfortunately, Ntombi miscarried after six months (individual physiological). The last interview was not held with her as she did not want to speak about her pregnancy loss.

Case study of Tayla

25 years-old | Coloured | Married | South African | Unemployed | First pregnancy |

Tayla's narrative was varied and spanned employment concerns, living arrangement difficulties, stressful family dynamics, a health scare during her pregnancy and her personal growth into a mature person because she was married and expecting a baby. Her pregnancy, however, was unplanned and mistimed, and she and her husband were concerned because they did not believe that they had enough life experience yet to become parents (individual cognitive). Tayla did not realise she was pregnant; she put the pregnancy signs she experienced (vomiting, nausea, and migraines) down to exceedingly bad hangovers because she and her husband's weekend socialising activities involved the consumption of much alcohol. It was her mother-in-law who suggested she test for pregnancy because Tayla also complained about having an irregular menstrual cycle. Tayla described her mother-in-law as someone experienced in life, someone she could confide in, and someone who would give her financial assistance if she needed it (micro-family interaction). Tayla got annoyed and backchatted her mother-in-law (which made her feel bad) when her mother-in-law lectured her on what she shouldn't eat during her pregnancy.

The couple initially lived in Cape Town, but the conditions were not ideal. Tayla described how she initially moved from the Eastern Cape to live with her husband in Cape Town because he had employment there and they were newly married. The couple moved in with her husband's brother and his girlfriend due to a lack of employment opportunities for Tayla. However, relationships soon soured between the two women (micro family interacting with macro job market). It was at this time that Tayla knew she was pregnant. She believed that it was her pregnancy that seemed to cause her brother-in-law's girlfriend to feel insecure and jealous, which resulted in the two women arguing a lot. In addition to fractious family relationships, Tayla reported that the area that they lived in was dangerous (full of gangsters and drug dealers and creeps) and the environment was unhealthy (wet, cold, and fungus grew on the walls of their dwelling) (macro-structural environment interacting with individual level well-being). She also explained that she found that the community kept to themselves (micro-

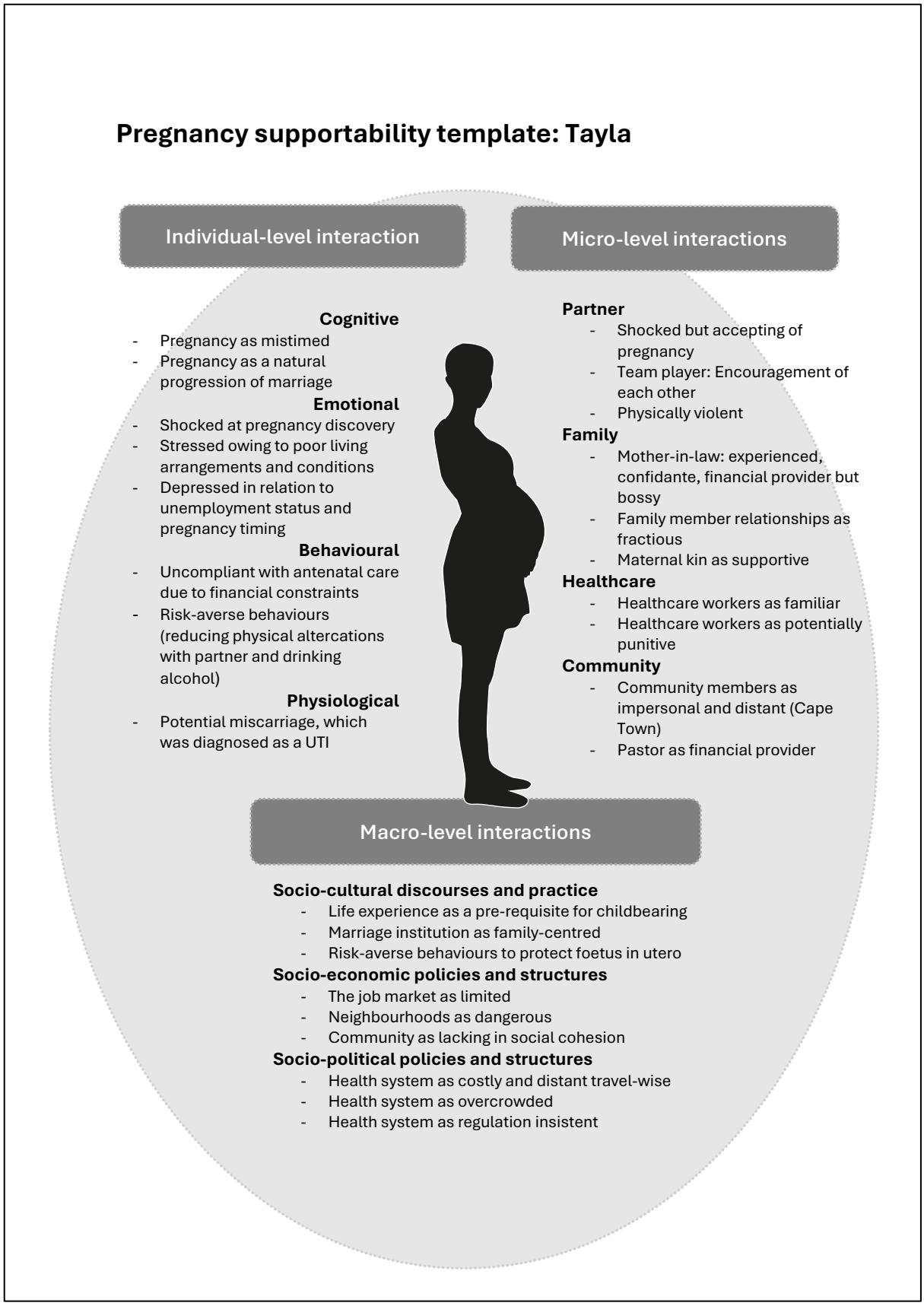
community interaction with macro-structural safety constraints), and she felt isolated and unsafe during the day whilst caring for another relative's newborn while everyone was at work.

Tayla reported that attending antenatal care was time-consuming and costly in Cape Town because the distances to the different public health facilities were far (health system and socio-economic macro-structural constraints). She was also concerned that the hospital staff would shout at her because she did not comply with appointment dates due to insufficient transport money (micro healthcare interacting with macro socio-economic constraints and individual behaviour). On one occasion, she had to ask her church pastor for money so that she could arrange transport to one of her antenatal appointments because her husband had not been paid yet (micro community interaction: Pastor as financial provider). These aspects of living in Cape Town caused her much stress, which she felt wasn't healthy for her pregnancy (macro-structural constraints interacting with individual well-being). Her mother suggested she return to the Eastern Cape (EC) to be closer to her family during pregnancy. Tayla and her husband returned to the EC, leaving them both unemployed (imperative positioning). Although Tayla's family supported the couple, their unemployment status was a significant concern for Tayla (macro-structural labour market constraints interacting with emotional individual level).

Tayla nevertheless found that moving back home was much better. She explained that everything was more accessible compared to Cape Town. She had support from her mother, cousins, and sisters, and she was a familiar face to the clinic staff because she used the clinic while growing up (micro family and healthcare interaction). She initially worried the clinic staff would shout at her because she did not bring her maternity case record from Cape Town. Instead, they gave her a new one.

Tayla had one health scare where she thought she was going to miscarry because she saw blood in her urine. Her family called an ambulance, but it took a long time to arrive (macro health system constraints). Only two people, Tayla and one companion, were allowed to travel in the ambulance, so she travelled with her mother. Her husband had to stay home because there was insufficient money to cover his transport to and from the hospital (micro healthcare interacting with macro health system-structural constraints). Once at the hospital, Tayla explained that it was frustrating because she had to wait a long time to be seen before a "young" female doctor conducted a vaginal examination and reassured Tayla that she had a urinary tract infection and was not going to miscarry.

Figure 13: Pregnancy supportability template, Tayla



Despite her pregnancy being unplanned, Tayla nevertheless linked becoming pregnant as a natural progression of marriage (macro social-cultural norms). Tayla reported that watching how her husband engaged with a relative's newborn made her want to be a mother one day. She announced her pregnancy by posting a picture of her positive pregnancy tests on Facebook and captioned it: "So this is the result when you are happily married". She asserted that, despite her husband's shock at hearing her pregnancy news, he was thrilled that he was going to be a father, and as a team, they would learn how to do parenting together (partner micro-interaction). However, Tayla admitted that they had a physical fight where her husband hurt her so badly that she thought she was going to miscarry (micro partner interacting with gendered norms). She described how they, as a couple, have called a truce by refraining from getting into physical altercations because they don't want to do anything that hurts the baby. Tayla also confirmed that she stopped drinking alcohol because it was a good sacrifice in that it was best for the baby (individual behavioural).

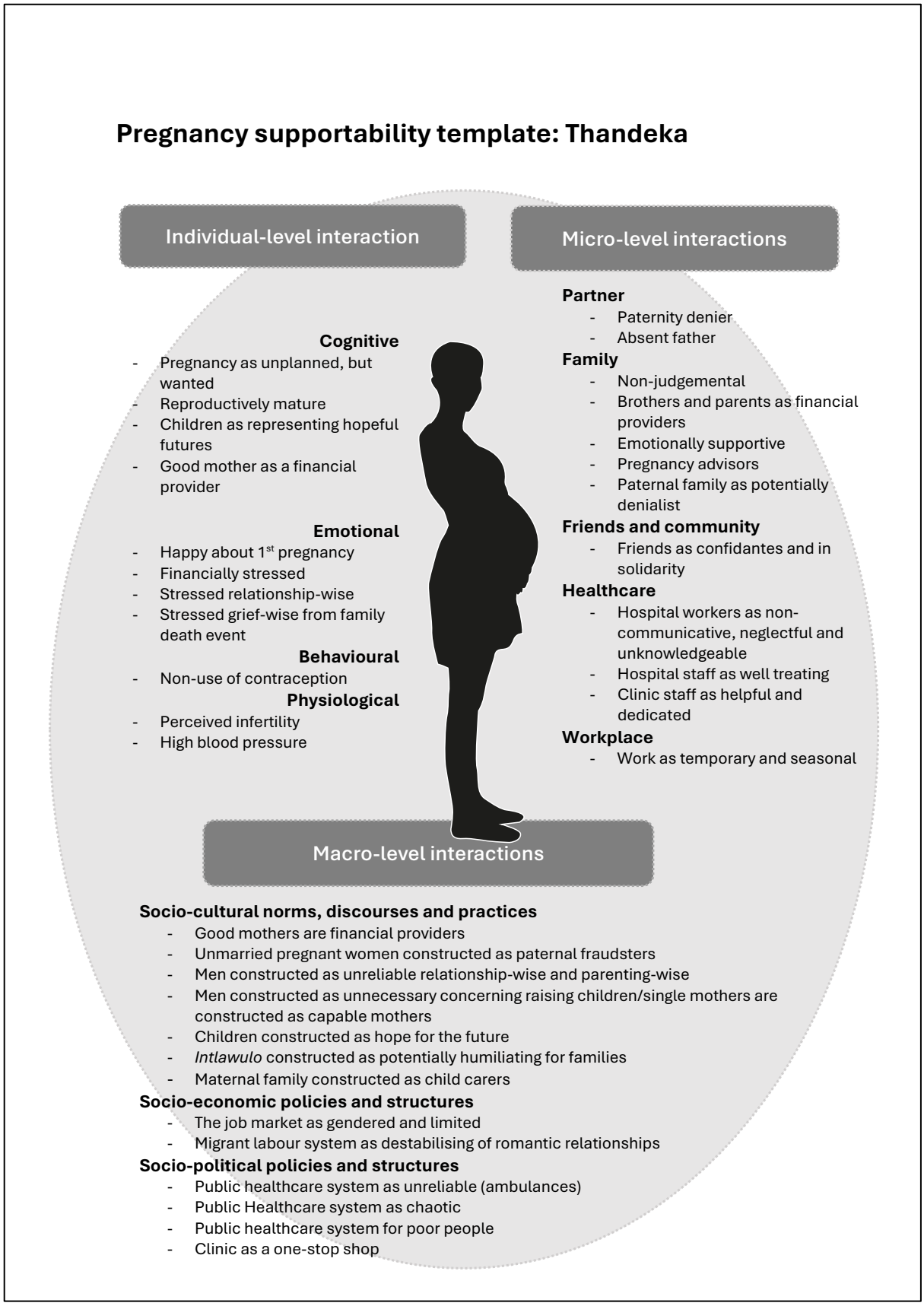
Case study of Thandeka

27 years-old | Black | Recently single (out of long-term relationship) | South African | Unemployed / seasonal farm work | first pregnancy |

Desertion by her partner (micro partner interaction) and her concerns about how she would be able to provide financially for her baby were at the top of Thandeka's mind throughout her narrative. This was a source of stress and worry for her (individual emotional). Thandeka believed that one should be in a position to be able to provide financially for a child as a parent (individual cognitive interacting with good motherhood cultural norms) before becoming pregnant. Thandeka was a seasonal farmworker who travelled to the Western Cape Ceres region during the fruit harvesting season. However, at the time of her interview, the harvesting season had ended. As such, there were no jobs specifically available for women as their role was to pick and sort fruit (macro-structural gendered job market constraint)

Despite her unemployment status, Thandeka was happy about her pregnancy because it was her first child at 27 years old (individual cognitive and emotional interaction with socio-cultural norms of appropriate childbearing). Thandeka explained that she initially thought that she was infertile because she had never used contraceptives herself and had not become pregnant when having unprotected sexual intercourse (individual physiological and behavioural). Thandeka did not realise she was pregnant until she travelled back to the Eastern Cape after completing a stint of seasonal farm work.

Figure 14:: Pregnancy supportability template, Thandeka



She explained that her family noticed her pregnancy bump and suggested that she go to the clinic to test for pregnancy (family micro-interaction with individual physiological). Thandeka positioned her family as very supportive. They assisted her financially and were non-judgemental of her pregnancy despite her unemployment status (micro family interaction interacting with macro socio-cultural norms of appropriate childbearing). In addition, Thandeka reported that her mother encouraged her to attend all her antenatal care check-ups, and her father gave her cash to hire a private car in case she needed to go to the hospital, as the ambulances were known to be unreliable (micro-family interaction with macro public health system constraint).

Despite her family's support, Thandeka explained that her pregnancy was difficult for her because her partner denied paternity (partner micro interaction). Thandeka believed it might have been the couple's long-distance relationship (he is a permanent farm worker in the Western Cape) or the pregnancy that caused his desertion (micro-partner interaction with macro-structural constraint). In denying paternity, Thandeka's partner implicitly positioned her as unfaithful because he claimed that he wanted to make sure that the child looked like his family when born (socio-cultural norms governing unmarried women's sexuality). Nevertheless, Thandeka made an autonomous decision to proceed with her pregnancy (individual cognitive). She maintained that men should not dictate whether a woman should have a child or not because women are left on their own anyway (individual cognitive interaction with socio-cultural gendered norms). In this way, Thandeka legitimised her pregnancy by rejecting being in a stable relationship as a prerequisite for having a baby (macro-gendered norms of appropriate childbearing). She asserted that having a child can be one's hope for the future, and one shouldn't resort to an abortion (individual cognitive interaction with macro-level socio-cultural pronatalist norms).

As part of our interview questions, we directly enquired whether Thandeka and her family had considered the practice of *intlawulo*. Thandeka explained that her family did not initiate *intlawulo* with the paternal family because there was a risk that they might humiliate and disrespect her family (macro-level socio-cultural interaction). In cases of paternity denial, she maintained that it is the maternal family who cares for the child and the father should initiate contact with the mother if he wants to be part of the child's life; she was not going to force the child on him although she regretted that the child would not know both parents (macro level socio-cultural interaction).

Thandeka described herself as a social person with lots of friends. Her friends were instrumental in expressing solidarity with her by consoling and reassuring her that her child would still thrive despite the disappearance of the baby's father (micro-level interaction with gendered norms). However, during her pregnancy, Thandeka experienced a great loss. Her two brothers died in a car accident on their way back home from work. In light of her partner's desertion, Thandeka reported that she felt hopeless; her brothers' financial support for the family was crucial, and she felt that the responsibility for supporting her family now weighed heavily on her shoulders (micro-level family interaction interacting with macro-structural socio-economic constraints with individual emotions). The loss of her brothers affected her physically in that she developed high blood pressure at the funeral and was admitted to the hospital (individual physiological).

Thandeka's birth experience was shaped by confusion, indecision, and lack of communication by healthcare workers (micro healthcare interaction). Thandeka reported that the staff of the local district hospital had arguments about whether she should have a caesarean or give birth vaginally. They eventually referred her to a regional hospital for a caesarean (macro-structural health system constraints). There was no opportunity for a birth companion to accompany Thandeka to the hospital. Thandeka woke up after her c-section and told us about her distress in that she could not locate her infant such that she thought she had lost her baby in labour (individual emotional interaction with micro healthcare). The nursing staff had not brought her baby to her yet. It was fellow ward patients who explained to her where she could find her baby, and once located, Thandeka had to work out on her own how to breastfeed because no one showed her what to do as a first-time mother.

Nevertheless, Thandeka maintained that the nursing staff treated her well despite the confusion at the hospital (micro health interaction interacting with macro-structural health system constraints). Thandeka reports that poor people like her must use the township clinics (macro socio-economic interacting with macro health system). She described the clinic as small but explained that the staff tried to help pregnant individuals by putting them in front of the queue. The clinic is a one-stop shop (macro health system enablement), and one always goes home helped (healthcare micro-interaction). We met Thandeka's healthy newborn while conducting our final interview with her.

Case study of Thando

21 years-old | Black | Stable relationship | South African | Unemployed | Second pregnancy

Thando's narrative covered three main aspects of her pregnancy: comparing her first pregnancy (which was a stillbirth) to her current pregnancy; financial concerns about the second pregnancy because both she and her partner were unemployed; and how secretive the couple were about the second pregnancy which had social support implications.

Thando explained that she told everyone about her first pregnancy and received much support from her social networks. Her boyfriend's mother was encouraging, a source of pregnancy advice and paid for all pregnancy-related costs (family micro-interaction). Thando had two baby showers, one organised by her local church group and the other by her study peers. Her boyfriend also helped organise one of the events (micro partner and community interaction). The couple were financially secure because Thando also had a student bursary, which helped fund the pregnancy (imperative positioning). Traumatically, however, she lost her baby while giving birth (individual physiological interaction with micro health) and her father to illness a few weeks later. Grief-stricken and having a crisis of faith, she left the Eastern Cape to stay with her boyfriend's mother in Johannesburg.

Thando became pregnant again within a year of the first pregnancy. She was in denial because she did not want another baby, wanted a fresh start in life and was looking for a job (individual cognitive). She explained how she was depressed and cried herself to sleep, suspecting that she was pregnant (individual emotional). Her boyfriend also suspected she was pregnant but waited for her to accept it (partner micro-interaction). She accepted her pregnancy when she eventually went for an antenatal care check-up in her second trimester and heard the foetus's heartbeat (individual physiological and cognitive). Having accepted her pregnancy, Thandeka explained that she was scared that God might punish her by having another stillbirth because she was not financially able to provide for the pregnancy (individual cognitive, emotional and behavioural interactions with socio-cultural norms of appropriate childbearing)

Thando was much more secretive about her second pregnancy. Thando reported that she and her boyfriend were too scared to tell his mother about this pregnancy because she had advised them to become more financially stable before attempting to have another child. Keeping the pregnancy secret, Thando moved out of her boyfriend's mother's house and back

to the Eastern Cape, where she stayed with a friend's family. A member of this family had also experienced a stillbirth, so she felt comfortable telling them about her second pregnancy. They invited her to stay with them so they could support her through it (micro-level interaction of friends or community). Thando only told her own mother that when she was six months pregnant. Thando's landlord forced her to tell her mother, insisting that Thando's mother should not hear from other people that her daughter was pregnant again (micro family interaction with socio-cultural norms).

Thando confessed that the couple's secrecy around the second pregnancy has had negative financial implications for them (micro-family interaction with macro socio-economic constraints). They saved any money any family member gave them without elaborating on what they were saving for (individual-level behaviour interacting with micro-level family). However, Thando could not afford to buy new clothes to fit her as her pregnancy progressed. She worried about where she would get money if there was a pregnancy emergency and hadn't purchased anything for the baby (individual emotional interaction with macroeconomics). Thando described her relationship with her mother as tenuous, positioning her mother as secretive, unreliable, and untrustworthy (family micro-interaction). Although Thando explained that she loved her mother despite her flaws by just being her mother, Thando knew that she couldn't rely on her mother financially, nor did she ever want to burden her mother (individual cognitive interaction with family micro-level interaction).

Thando described her partner as her best friend and the only person who understood the extent of her grief and loss over her first pregnancy (partner micro-level interaction). The couple aimed to live together because her partner wanted to be part of his child's life. However, a lack of job opportunities prevented them from doing so (partner micro-level interaction interacting with socio-economic macro-level constraints). Thando's partner was busy job hunting in another town during her second pregnancy, so the couple relied on staying in contact over social media because it was cheaper than phone calls. Thando reported that she hated it if they fought or argued. If they did fight, it resulted in her getting physically sick (partner micro-level interaction interacting with individual physiological).

We asked if the practice of *intlawulo* had been initiated for any of her pregnancies (socio-cultural norms). Thando explained that she was a Christian (imperative positioning) and did not believe in introducing newborns to their ancestors. She also thought that the transactional nature of the practice could damage family relationships when she already had her partner's full support. This meant much more to her than any monetary compensation.

Figure 15:: Pregnancy supportability template, Thando

Thando maintained that it would be embarrassing for her partner to pay damages because he was unemployed, and she did not want to put him into debt. Although the couple discussed whether they should adopt the practice, Thando asserted that she made the final decision not to go ahead with the custom (individual-level cognitive).

Thando also contrasted her experiences of healthcare between her two pregnancies. In her first pregnancy, Thando positioned the nurses at the clinic and hospital as rude, mean and having superior attitudes (micro-level healthcare interaction). She maintained that she was sent away from the clinic twice before getting a maternity case record and an antenatal care check-up for the first time (macro-health system constraint). When giving birth during her first pregnancy, she explained that the nurses did not help her when she told them that she was in much pain, failed to check up on her, and made her walk to the delivery room while giving birth because there were no wheelchairs. After having the stillbirth, she had to return to the hospital to remove some of the placenta that had remained. Thando told us that she only got special treatment then because the same doctor who attended her birth took out the remaining placenta and appeared to look guilty. Thando was adamant that she never wanted to give birth in the same hospital again and still had not been given any reason by the hospital as to why she may have had a stillbirth (healthcare micro-interaction interacting with macro healthcare system constraints).

For her second pregnancy, Thando positioned the nurses as dedicated and caring (micro-level healthcare interaction). The pregnancy was already considered high-risk because of the previous stillbirth, and the nurses gave Thando counselling and pep talks. On another occasion, the nurses interrupted their staff meeting and opened the clinic to attend to Thando because her foetus had not moved the whole day. This had caused her to rush to the clinic in a panic. Despite these positive aspects, Thando reported that although she loved going to the clinic because she would find out how her baby was doing, visiting the clinic was exhausting because one had to wait a long time to be seen (macro health system constraints).

Case study of Xoliswa

27 years-old | *Black* | *Cohabiting* | *South African* | *Unemployed* | *Second pregnancy*

Xoliswa was unemployed and relied financially on her boyfriend, with whom she lived. The couple lived in the township near the local town. Xoliswa carefully curated her photographs to present her pregnancy as a welcomed and positive experience. This is because her partner, his family, and her family had “no problems” hearing that she was pregnant (family micro-

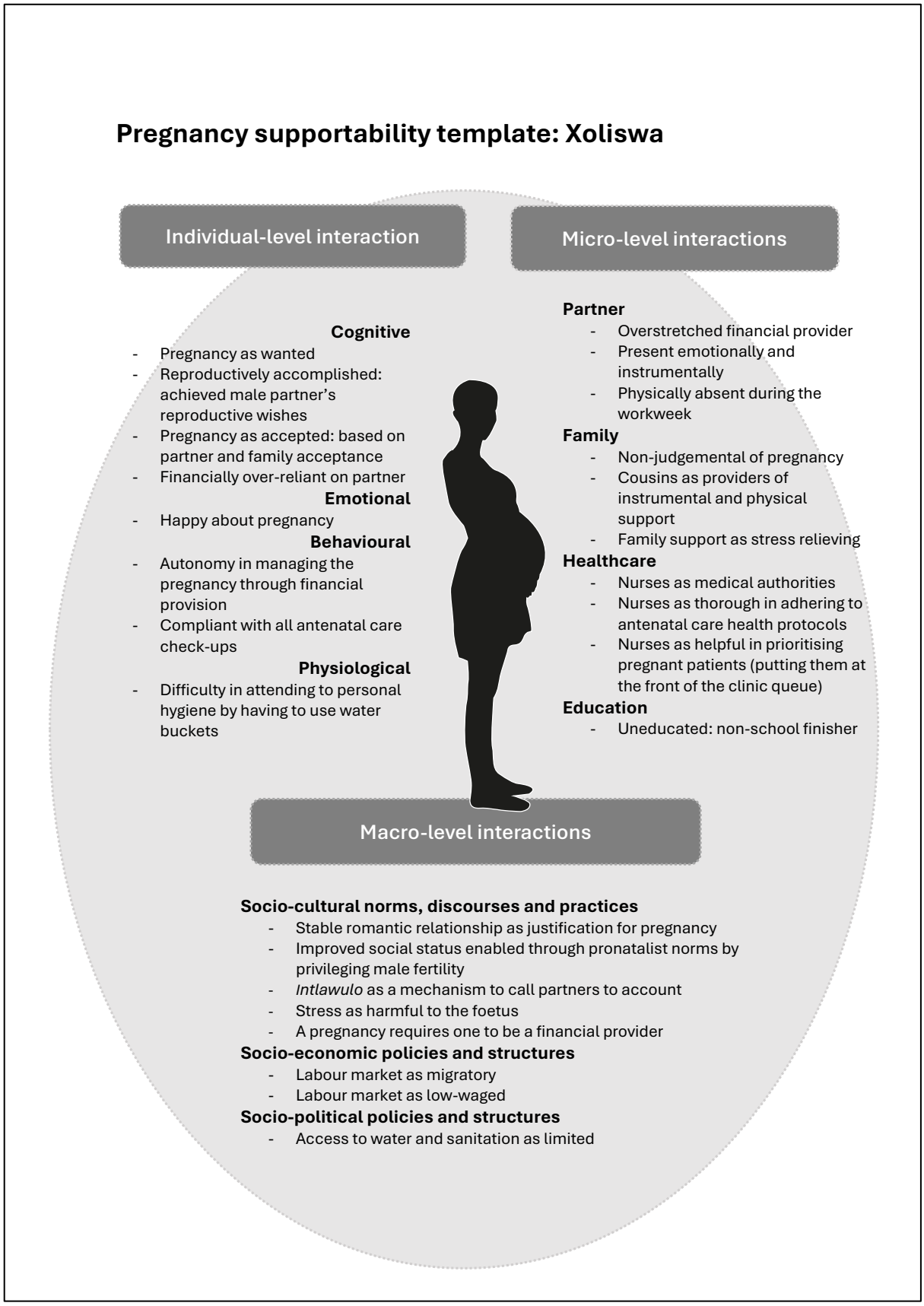
interaction). Xoliswa was thus happy about her pregnancy based on the acceptance of her pregnancy by others within her support network and because she had been with the same partner for three years (macro social norms justifying pregnancy).

Notably, and unlike other participants in this study, Xoliswa describes how this pregnancy has benefited her, especially in improving her social status in her relationship, by giving her the financial freedom to buy things she needed for the pregnancy (reproductive autonomy interaction with pronatalist norms). For example, she showed a picture of a wallet her boyfriend gave her, which contained her money for anything she needed. She explained that this is because her boyfriend often worked away from home. It became challenging when she had no food in the house and no money to buy groceries (macro socio-economic constraints interaction with individual pregnancy behaviours). Xoliswa asserted that her boyfriend never gave her anything before the pregnancy, but now that she was pregnant, he was much more generous (macro social norms related to pronatalism). He also helped her take pictures for her interview. When we asked whether her family had considered initiating the practice of *intlawulo*, Xoliswa explained that the practice was only necessary if a couple were not getting along, which, in her case, was not an issue as her partner was supportive and present.

Xoliswa did not have a separate bathroom in her main dwelling and had to fetch water from a communal tap to bathe (macro-structural constraint). However, another positive aspect of her pregnancy was the additional attention from her cousins; they helped her fetch water and wash and massaged her body during her pregnancy (family micro-interaction). Xoliswa explained that her belly got in the way, making it challenging to wash herself without assistance. If she did not have her cousins to help her, she had to put a basin of water on the bed so that she could reach it more easily to wash.

In managing her pregnancy health-wise, Xoliswa maintained that it was important for pregnant women not to stress and enlist the support of people they trust because stress can harm the baby (individual emotional interaction with micro-level support). She maintained that she complied with all her antenatal care check-ups and had not been shouted at by nurses for wrongdoing during her pregnancy (healthcare micro-interaction). She described the healthcare workers as very thorough when conducting antenatal check-ups and helpful in trying to put pregnant people at the front of the queue.

Figure 16:: Pregnancy supportability template, Xoliswa



Nevertheless, despite presenting her pregnancy as a positive experience, Xoliswa expressed concern about being unemployed and financially over-reliant on her partner (individual cognitive interaction with micro partner and macro-economic constraints). She described how the pregnancy will make it a struggle for her partner to provide for the growing family. She completed a computer course because she hoped to work as a cashier after her pregnancy (socio-cultural norms of good mothers). In addition, she expressed relief at being given a baby hamper for participating in the research interview because she was worried about not having enough baby supplies and clothes for when she gave birth.

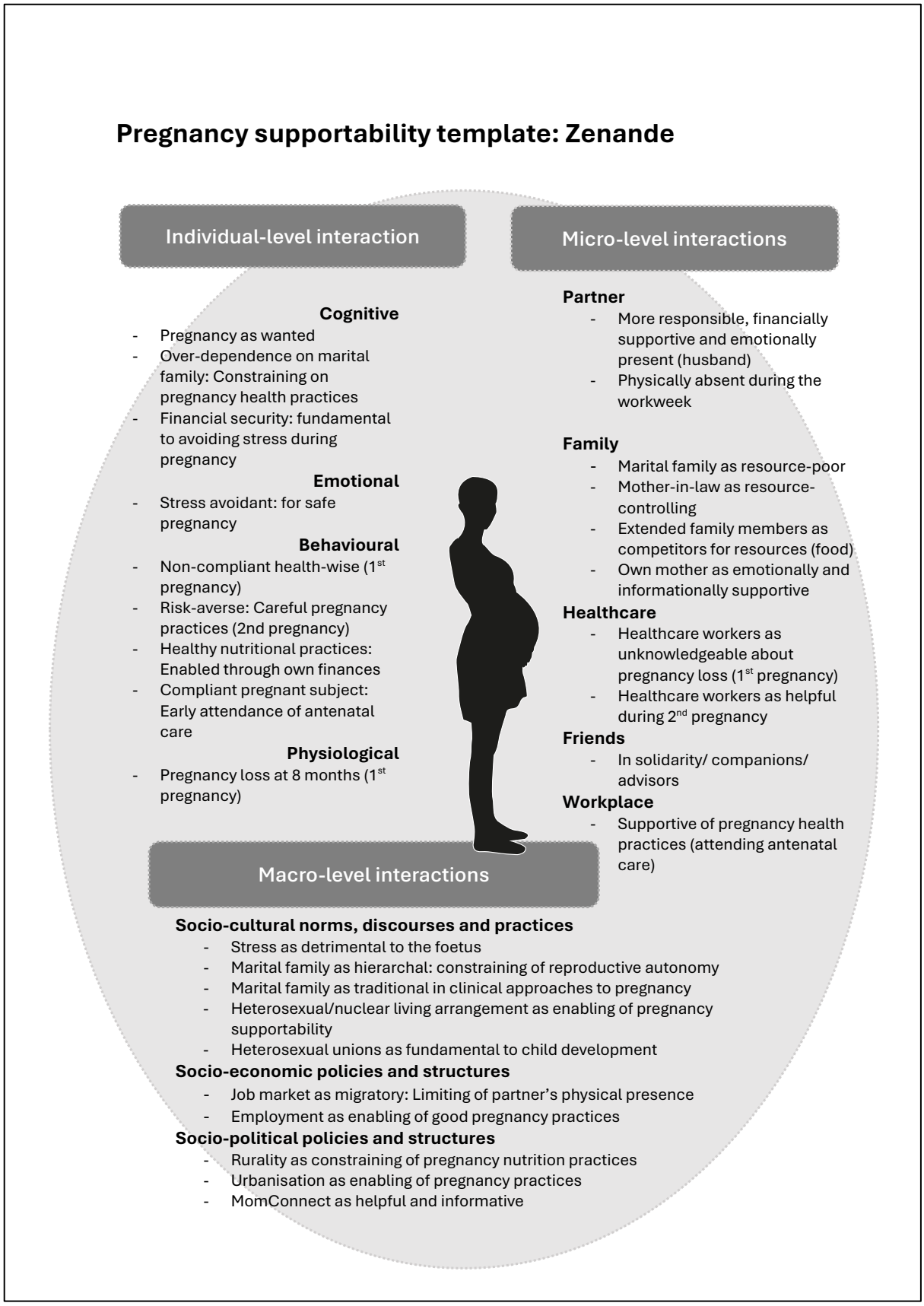
Case study of Zenande

28-years-old | Black| Married | South African | Employed | Second pregnancy

Zenande constructed her narrative around managing her stress to avoid posing a risk to her pregnancy (individual behavioural and emotional level). She explained that she lost her first baby at eight months into her pregnancy (individual physiological). Clinic staff told her that because she attended antenatal care so late (at six months into her pregnancy), they were not able to identify why the complications had arisen (micro-level healthcare interaction). According to Zenande, one day, the foetus had just stopped kicking, so she went to the clinic, and the doctor confirmed that the foetus' heart had stopped.

Zenande also explained that at the time of her first pregnancy, she was living with her husband's family in a far-flung rural area, which she believed played a part in her pregnancy loss (micro-family interaction with socio-cultural norms). She described how she was expected as *Makoti* (a wife) to fulfil specific traditional duties within the homestead. This was hard work, and Zenande reported that she could not rest when she felt tired. Zenande's mother-in-law relied on traditional healers' advice on pregnancy over clinical advice (macro cultural norms interaction with medical norms). For Zenande, traditional healing did not align with her Christian views (macro cultural norms interacting with macro religious practices and individual cognitions). In addition, Zenande explained that nutritious food was not only difficult to come by in rural areas, but it was also expected that food should be shared among family members of the household; being pregnant did not afford her any special privileges (individual behaviour interacting with macro socio-economic constraints).

Figure 17: Pregnancy supportability template, Zenande



Zenande lived with her husband (imperative positioning) in the township (macro-structural interaction) during her current pregnancy. Zenande felt that this living arrangement was much better because she could take actions that minimised her stress and any risk to the foetus. She explained that she was able to communicate often with her mother (whom she trusted with pregnancy advice) and meet her in town at month-end (family micro-interaction). Zenande could buy whatever food she felt was necessary for her pregnancy and purchase pregnancy magazines at the local shop (individual behavioural). If she felt tired, Zenande could rest when she needed to (individual behavioural). Zenande also ensured that she attended antenatal care early in her pregnancy and thought the clinic staff was supportive (healthcare micro interaction). They signed her up for MomConnect, which sent her many messages about pregnancy (macro-level healthcare system). She felt that some of the messages were helpful but deleted others that did not apply to her.

Zenande's husband worked away during the week and only came home on weekends (partner micro level interacting with macro socio-economic structures). Zenande explained that, although her husband didn't know that he should attend the clinic with her, the pregnancy had transformed him because he was willing to spend time with her during the weekend instead of meeting up with friends and drinking (partner micro-interaction). He would also go with her into town if she needed to buy things. Zenande claimed that she would never handle the pregnancy on her own without him and that a baby needs both mother and father (macro pronatalist cultural norms).

Zenande had a group of friends that supported her. They made her laugh and joked, entertained and studied with her. They also counselled her not to get too stressed out during her pregnancy because it could affect the baby (friends' micro-level interaction). Zenande was studying for a diploma to become a qualified teacher and worked at a local school (work micro-level interaction). She reported that her colleagues were very supportive and had no problem if she needed time off work for antenatal care. Zenande believes it is much less stressful for your pregnancy if you are employed because you can afford to have a baby (individual-level emotional interaction with macro-socio-economic structures).