An intracategorical intersectional framework for understanding 'supportability' in womxn's narratives of their pregnancy

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ABSTRACT

In South Africa, the current Maternal Mortality Ratio (MMR) is 135 per 100,000 live births, with a long way to go before it can achieve the Sustainable Development Goal (SDG) global target of under 70 per 100,000 live births by 2030. This research project focuses on the narratives of pregnant womxn in the Eastern Cape Province, using an intracategorical intersectional framework and Macleod's 'supportability' model as a base. The study aims to locate womxn's pregnancies within the interweaving biological, psychological, social, economic, cultural and political contexts within which they occur, while focusing specifically on the aspect of 'supportability'. Through purposive sampling and snowballing methods, the research team recruited participants who were 18 years and older, in or past the second trimester of their pregnancy, and able to access antenatal care. Research data were produced using photo-elicitation techniques on 92 photographs and narratives from 32 interviews. An intersectional thematic analysis was used to generate themes, which highlighted different aspects that enabled or hindered pregnancy 'supportability'. In accordance with prior research, it was revealed that womxn found emotional and tangible support the most beneficial. Findings from this study reveal the interconnectedness between a womxn's personal (emotional, physical and cognitive) experiences of pregnancy, the micro-interactions of support (un)available from partners, family, friends, healthcare workers, workplaces and community members, and the macro-structures of socioeconomic policies, religiosity, cultural practices and healthcare systems. For example, gendered perceptions (a macro-structure) influence the instrumental support provided by partners (a micro-interaction), which impacts the womxn's well-being (personal). Certain themes that emerged from the different narratives were: the importance of making available pregnancy-related information to the womxn; a desire for non-judgement and acceptance of their pregnancies within their community; and the need for adequate communication in micro-interactions. The findings of this research also indicate that, despite the financial tensions inherent in each womxn's life, the participants were driven by overarching hopes for their child's future.

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GLOSSARY OF TERMS USED IN THE THESIS

Term	Meaning
Ja	*'*Yes'. An *Afrikaans* word that is used in several South African languages.
Yoh	An exclamation used to express shock or surprise (both pleasant and unpleasant). Originally used by black African language groups but now used by most language groups in South Africa.
Neh	Roughly translatable to 'Is it not so' or 'right'. Of *Afrikaans* origin but used in several South African languages.
Thula	IsiXhosa word used to signal to someone to be quiet
Gonna	Going to
'Cause	Because

LIST OF ABBREVIATIONS

ACOG - American College of Obstetricians and Gynaecologists
ANC – Antenatal Care
ART – Antiretroviral Therapy
ARV – Antiretrovirals
BAM – Becoming A Mother
CTOP – Choice on Termination of Pregnancy
DOE – Department of Education
DOH – Department of Health
EC – Eastern Cape
GHQ – General Health Questionnaire
GP – General Practitioner
HIV – Human Immunodeficiency Virus
HR – Human Resources
IPV – Intimate Partner Violence
IT – Information Technology
LBW – Low Birth Weight
MDG – Millennium Development Goals
MMR – Maternal Mortality Rate
MOU – Midwife Obstetric Units
MPS – Medical Protection Society
MRA – Maternal Role Attainment
MS – Multiple Sclerosis
NCCEMD – National Committee on Confidential Enquiries into Maternal Deaths
NVP – Nausea and Vomiting in Pregnancy
NVPI – Nausea and Vomiting in Pregnancy Instrument
PA – Physical Activity
PHC – Primary Health Care
PMTCT – Prevention of Mother-to-Child Transmission
PPD – Post-Partum Depression
PPIP – Perinatal Problem Identification Programme
RPERC – Research Projects and Ethics Review Committee
SA – South Africa
SDG – Sustainable Development Goals
SES – Socio-Economic Status
SQUIN – Single Question aimed at Inducing Narrative
SSE – Social Support Effectiveness
STI – Sexually Transmitted Infections
TOP – Termination of Pregnancy
UN – United Nations
UNFPA – United Nations Population Fund
WHO – World Health Organisation

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CHAPTER ONE: INTRODUCTION AND CONTEXT

1.1 INTRODUCTION

This study explores and compares womxn's[1] experiences of their pregnancies while considering three main aspects: firstly, the womxn's personal capacity to carry the pregnancy through to term; secondly, the support available to them from their partners, family, community and healthcare providers, and the interactions they have with each of them; and finally, the socio-economic and political landscape that encompasses their pregnancies, including cultural and religious practices and discourses that affect them in both obvious and subtle ways. The following question guided each stage of research: What are the themes that emerge from a womxn's narrative of her pregnancy that speak to the promotion or hindrance of its supportability?

The main tributaries of this research are: an intracategorical intersectionality lens; Macleod's (2016) 'supportability' model; and womxn's narratives, enhanced by photo-elicitation, of the lived experiences of their pregnancies. 'Supportability' appears within inverted commas (in chapter one and two) because the term has an explicit significance in the context of this research, which I explain in the next chapter. To enable an analysis that highlights the intricacies of womxn's experiences of the event of pregnancy, I draw on a theory-driven thematic analysis (Braun & Clarke, 2006) and thereby apply an intersectional thematic analysis to the data. The result is an understanding of the intertwined aspects that create unique experiences and affect pregnancy outcomes in the lives of womxn at different social locations.

[1] I use the term 'womxn' in recognising the social construction and fluidity of sex and gender and, consequently, the arbitrariness of attaching the signifier 'womxn' (and 'man') based on the presumption of 'female' (and 'male'). My intention is to be inclusive (as transgender persons do access reproductive health services) while highlighting the prejudice, discrimination and barriers that womxn encounter on a regular basis. I also do not distinguish between 'woman' and 'women', thus 'womxn' is both singular and plural. The context generally implies which use is being applied. Finally, in line with the intersectionality lens of this study, the hope is for 'womxn' to foreground the experiences of womxn of colour.

In this chapter, in order to delve into the various social locations, I provide some context regarding maternal health in South Africa (SA). I describe the development of the 'supportability' model as a response to engaging differently with *problematic* pregnancies, underscoring the rationale for this research. I also highlight what has been put in place in South Africa to promote maternal health, the challenges faced in reproductive healthcare, and concerns surrounding high maternal mortality. Finally, I provide a snapshot of the Eastern Cape (EC) province in terms of the socio-economic status and the health systems operating in the EC.

1.2 CONTEXTUALISING MATERNAL HEALTHCARE IN SOUTH AFRICA

Eight Millennium Development Goals (MDGs) were established by the United Nations (UN) in September 2000; they were adopted by all 189 UN Member States with targets to be achieved by the year 2015 (World Health Organisation, 2010). MDG 5, Target 5A called for the reduction of maternal mortality ratio by three-quarters between 1990 and 2015. Target 5B called for universal access to reproductive health by 2015 (World Health Organization, 2010). Maternal mortality has fallen globally by 37% since 2000, and antenatal care (ANC) in developing regions had increased to 83% in 2012 (United Nations, 2019). Yet, only half the number of womxn received the recommended amount of healthcare (UN, 2019). After the deadline of the MDGs had passed, a post-2015 agenda containing 17 Sustainable Development Goals (SDGs) took their place (https://www.who.int). Under Goal 3 (Health) of the SDGs, the first target is to reduce the global maternal mortality ratio to less than 70 per 100,000 live births. Achieving this target by 2030 necessitates significant improvements in skilled delivery care (UN, 2019).

The global need for skilful delivery of care is very relevant in SA. Since the transition from apartheid to a constitutional democracy, SA has seen considerable progress in many social spheres (Whiteside, 2014). The latest *Saving Mothers* report (2014-2016) released by the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD) reveals a decrease in maternal mortality ratios (NCCEMD, 2018). This outcome is primarily due to changes in the treatment programmes for HIV-

positive pregnant womxn (NCCEMD, 2018). Overcoming SA's healthcare challenges involves not only strengthening the healthcare system, but also targeting social determinants that are outside the healthcare system, and enabling universal coverage for healthcare (Mayosi & Benatar, 2014).

In 1994, a new reproductive policy was implemented in SA by the new democratic government: removing user fees (identified by the majority of people as a main deterrent to accessing treatment) for healthcare to pregnant womxn. Free healthcare led to a considerable increase in access for black[2] Africans (Tanaka, 2014). Research conducted in 1994 also linked the high rates of maternal mortality to unsafe and incomplete abortion practices. Consequently, the government of the African National Congress passed the Choice on Termination of Pregnancy (CTOP) Act, [No. 92 of 1996] (Mhlanga, 2003). Under the Act, a termination of pregnancy (TOP) is legally permitted on the following grounds: up to 12 weeks of pregnancy, upon request from the pregnant womxn; from the 13th to the 20th week, if the pregnancy is the result of rape or incest, if continuation of the pregnancy puts the womxn's physical/ mental health at serious risk, if the unborn child is at risk of suffering from severe abnormalities, or if the womxn's social or economic status is negatively affected by the continued pregnancy; and lastly, after the 20th week, if the continued pregnancy can endanger the pregnant womxn's life, cause foetal malformation, or seriously threaten the life of the foetus (CTOP Act No. 92, 1996).

In a 19-year review of the trends in maternal deaths in HIV-infected womxn in SA, there is evidence to show a substantial decrease in the MMR between 2013 to 2015, following numerous changes in the Prevention of Mother-to-Child Transmission (PMTCT) protocol and HIV management guidelines (Mnyani, Buchmann, Chersich, Frank, & McIntyre, 2017). Since 2015, all HIV-infected pregnant and breastfeeding womxn have become eligible for lifelong antiretroviral therapy (ART); and routine

[2] I use the term 'black' to reflect a specific cultural grouping (in much the same way as I refer to 'Coloured' or Hispanic womxn). While I do not support the current political racial categorisation, I also acknowledge the social relevance that racialised categories take on, and their importance in research to understand power relations intersectionally.

retesting every three months during pregnancy and breastfeeding, with additional retesting six weeks postpartum, has been introduced (Mnyani et al., 2017).

Despite these positives – the noticeable decreases in the MMR (NCCEMD, 2018), amendments in the TOP Act (Mhlanga, 2003) and improvement in PMTCT and HIV guidelines (Mnyani et al., 2017) – there remains much to be done in order to achieve the SDG target by 2030. There are challenges relating to the quality of care, inter-facility transport, and a lack of knowledge and skill among healthcare professionals (NCCEMD, 2018). With the provision of free healthcare, there was an improvement in health within communities that had clinics, as they could immediately access health services. However, areas without clinics still had poor access and had to wait for clinics to be built (Tanaka, 2014). Mayosi and Benatar (2014), in their study of South African healthcare 20 years after the election of Mandela as President, note that "Health should be considered within the broader context of direct and indirect links between wealth and health, although these relationships are complex" (p. 1344). In other words, the economy of a country and its resources such as housing conditions, availability of clean water, nutrition and jobs, directly impact the population's health. Lower levels of poverty lead to increased access to healthcare, and, hence healthier lives (Mayosi & Benatar, 2014).

1.3 SITUATING PREGNANCY 'SUPPORTABILITY' RESEARCH WITHIN THE GLOBAL CONTEXT

The *Maternal and Child Health* Journal focused an entire issue on pregnancy 'intendedness', having noted an increased interest in the relationship between this concept and how womxn feel about their pregnancies and births (Klerman, 2000). Intendedness as a construct relates to 'wantedness' and 'timing', while unintended refers to 'unwanted' and 'mistimed' pregnancies (Klerman, 2000). To be more specific, a 'mistimed' birth is one that occurs earlier than desired and an 'unwanted' pregnancy is one that occurs when no children or no more children are desired (Santelli et al., 2003; Sedgh, Singh, & Hussain, 2014). Unintended pregnancies include unplanned births, induced abortions and miscarriages from unintended pregnancies (Sedgh et al., 2014). Appraising the frequency of unintended pregnancy

in the world can establish why family planning programmes are necessary and what their outcomes are (Sedgh et al., 2014). In 2012, approximately 40% of pregnancies worldwide were unintended (Sedgh et al., 2014). Various associations have been made between 'problematic' pregnancies (this includes pregnancies that are 'unintended', 'unplanned', 'mistimed' and 'unwanted') and negative consequences (Cheng, Schwarz, Douglas, & Horon, 2009). Interestingly, while some studies from developed countries reveal a causal relationship between 'unintended' pregnancy and maternal risk behaviour, most other studies have found no such effects (Gipson, Koenig, & Hindin, 2008). Gipson et al. (2008) advocate research from different countries to evaluate whether the effects of 'intended' pregnancy on maternal risk behaviour are contextual and, therefore, vary depending on the setting.

1.3.1 Unintended pregnancies as problematic pregnancies

Cheng et al. (2009) noted that "the impact of unintended pregnancy is a major public health concern" (p. 194). These sentiments on pregnancy intention have been echoed in numerous studies over the years. Singh, Sedgh, and Hussain (2010) observe that unintended pregnancy could have negative outcomes for the womxn and her family. One of the many concerns related to unintended pregnancies is the dire outcome for womxn who decide to have an abortion but live in a country where abortion may be illegal or unsafe (Singh et al., 2010), posing a risk to their health. Of pregnancies that result in live births in the US, about 50% are unintended (Orr, Miller, James, & Babones, 2000). Almost half of the total numbers of pregnancies in the US have been assessed as 'unwanted' or 'mistimed' (Cheng et al., 2009). Statistics also revealed that in Southern Africa, 55% of pregnancies were unintended amounting to a high number (Sedgh et al., 2014).

1.3.2 Problems with 'intendedness'

Pregnancy intendedness has been examined in literature and widely discussed in the media during the twentieth century. Definitions of unwanted or unplanned pregnancies have evolved over the years (Klerman, 2000), from an initial conceptualisation that viewed births within a marriage as 'wanted births' and those

outside of a marriage as 'unwanted' (Klerman, 2000) to a view that is beginning to consider the "affective, cognitive, cultural and contextual dimensions" (Santelli, Lindberg, Orr, Finer, & Speizer, 2009, p. 94), or a more comprehensive understanding of the complexity of 'pregnancy intendedness'. Therefore, there arises a need to redesign questions that will speak more directly to the altered meaning of the terms '(un)intended', '(un)wanted', 'mistimed' and '(un)planned' pregnancy (Klerman, 2000). Depending on the population being studied and the methodology used, different results have emerged regarding the relationship between pregnancy intention and maternal behaviour (Cheng et al., 2009). Sedgh et al. (2014) have acknowledged that it is, however, a challenge to ascertain a causal relation between unintended pregnancies and negative consequences. Another limitation of 'intentionality' is that it assumes that womxn have choice and control in their lives surrounding aspects of their pregnancy and contraception (Macleod, 2016). Most of the attention focuses on the womxn's individual cognitions and emotions, invariably making her the unit of analysis (Macleod, 2016). The 'supportability' model used in this research was hence developed in response to the plethora of research that focuses on whether pregnancy is intended or unintended, wanted or unwanted, and well-timed or mistimed (Cheng et al., 2009; Gipson et al., 2008; Santelli et al., 2009).

1.4 RATIONALE

Leading on from the development of Macleod's 'supportability' model, there is a need to understand womxn's experiences of pregnancy in a nuanced way that acknowledges the biopsychosocial nature of this event. The model, therefore, explores three levels: a womxn's personal capacity to carry a pregnancy to full term, whether that capacity is enabled or constrained by the social support available to her, and the socio-economic and political structures that her experience is embedded in (Macleod, 2016). Prior epidemiological studies around pregnancy have tended to focus on objective aspects with relatively fewer research studies being conducted on the subjective experiences concerning a womxn's pregnancy (Guendelman, Malin, Herr-Harthorn, and Vargas, 2001). Quantitative studies have

shown how social support has favourable results on the mental and physical health of pregnant womxn: group antenatal care and peer support can decrease the rates of pre-term births and low birth weight outcomes (Ickovics et al., 2007); womxn's stress levels can decrease and their health improve with better support (Kuo, Wang, Tseng, Jian, & Chou, 2007); support from the baby's father can lead to better birth outcomes (Norbeck & Anderson, 1989; Padilla & Reichman, 2001). Guendelman et al. (2001) recommend greater qualitative exploration of sociocultural concepts in order to use them as explanatory tools for health outcomes.

1.5 Provision of Healthcare in the Eastern Cape Province in South Africa

According to a mid-year statistical release, the Eastern Cape's (EC) population increased from 6.6 million people in 2011 to 7 million in 2016, making it the third most populous province in the country. It accounts for 11.5% of the country's total population (Statistics South Africa, 2017). Demographically, 86.2 % of the population in the province is "Black", 8.2% is "Coloured" and 4.7% is "White", with "Indian" and "Other" representing 0.43% and 0.33% as reflected in a 2011 census. In terms of languages spoken, isiXhosa is the language spoken by a majority of the provincial population (78%), followed by Afrikaans (10%) and English (5.6%) with the remainder speaking other languages such as isiZulu, Sepedi and Sesotho (Frith, 2011).

1.6 Site for data

According to the EC Department of Health Annual Report for 2014/15, there are 772 primary healthcare (PHC) facilities across the EC (731 Clinic and 41 Community Health Centres) and 143 Mobile Units and 65 District Hospitals that attend to emergency care, obstetric care and other inpatient and outpatient services. The province is characterised by poor social determinants of health such as high unemployment, inadequate housing, poor water and sanitation, and low socio-economic indicators with high poverty rates. The huge population has very limited medical aid coverage, and most people depend on government health services or pay for their medical bills in private health facilities. The MMR in the EC is currently

reported at 159, of which 54 were due to non-pregnancy-related infections (NCCEMD, 2018). Only a few procedures followed during ANC have demonstrated a major impact on perinatal morbidity, with some showing no effect. This implies that other components are at play, since different criteria of care are adopted across populations during pregnancy and childbirth (Dowswell et al., 2015).

1.7 Overview of the thesis

In chapter two, the Theoretical Framework, I lay out my usage of an intracategorical intersectional framework, guided by Macleod's 'supportability' model, and the adoption of narratives as a tool that supports qualitative intersectionality research. In chapter three, the Literature Review, I present literature related to topics listed in the 'supportability' model. In chapter four, the Methodology, I describe a step-by-step account of the methods of data collection, the use of photo-elicitation as a tool to elicit womxn's narratives, and the ethical procedures undertaken during the entire research process. Chapter five contains the Data Analysis using an intersectional thematic analysis. In the final chapter, the Discussion and Conclusion, I provide a table of findings that emerged from this research, and provide recommendations based on them.

CHAPTER TWO: THEORETICAL FRAMEWORK

2.1 INTRODUCTION

My research specifically considers the aspect of 'supportability' while exploring the narratives that womxn share about their experiences of pregnancy. I begin the chapter by introducing the concept of intersectionality along with a detailed explanation of the framework that it provides to my research, elaborating on the particular type of intersectionality that I employ, namely, an intracategorical intersectional approach. Subsequently, I present Macleod's (2016) model of 'supportability' that complements intersectionality and underpins my data analysis. I focus on the role of narratives in my research, describing how they link with my theoretical framework and how they enable the collection of rich, in-depth data. Womxn's health is a central component of this research and I briefly address the role of intersectionality specifically in the context of health and healthcare. While I acknowledge the limitations of intersectionality, I simultaneously discuss how my approach overcomes the recurrent criticism regarding the lack of methodological guidelines of this framework.

It is crucial to understand the stories of these pregnant womxn in their entirety, including their access (or lack thereof) to various support structures and relationships. In aiming to grasp the multi-layers of human experience, I explore their stories at three levels: how they experience their pregnancy journeys (the personal level), the social facets intertwined in their lives and health decisions (the micro-level), and the issues of different discourses, culture and politics that impact them (the macro-level). For this purpose, my research is examined through an intracategorical intersectional lens, which challenges single axis frameworks (McCall, 2005) and "focuses on examining how social locations and structural forces *interact* to shape and influence human experiences" (Hankivsky, 2012, p. 1713).

2.2 INTERSECTIONALITY

Intersectionality came to the fore in the late 1980's, shedding light on the complexity of differences and sameness within the context of anti-discrimination and political social movements; it underlined how single-axis thinking diluted social justice (Cho, Crenshaw, & McCall, 2013). Scholars taking feminist and critical race theory perspectives identify intersectionality as an analytical approach that simultaneously focuses attention on the meaning of multiple categories of social identity and on the consequences of these interactions (Cole, 2009; Hankivsky, 2012). Fotopoulou (2012) gives this complicated theory a relatively accessible definition and states that "intersectionality is the systematic study of the ways in which differences such as race, gender, sexuality, class, ethnicity and other socio-political and cultural categories inter-relate" (p. 19). Essentially, in this definition, intersectionality aims to comprehend the nuanced relations between gender and other social categories in multicultural societies.

Although several scholars use intersectionality as a theory based in identity categories, McCall (2005) asserts that it comprises any perspective that refutes the separateness of analytical *and* identity categories. Indeed, Knapp (2005 as cited in Christensen & Jensen, 2012) refers to intersectionality as a "travelling concept" which has adopted new meanings based on the context (p. 109). Since its inception, it has been adopted in academic disciplines ranging from psychology, anthropology, sociology and geography to feminist, queer, ethnic and legal studies (Cho et al., 2013). While different scholars have utilised various metaphors to describe intersectionality, such as the road intersection, the matrix and the intertwined image of oppression, the concept's capability has widened into an analytical tool based on what people are employing it to do, which predominantly involves contextual power dynamics (Cho et al., 2013).

2.2.1 Origins of intersectionality

Historically, this framework has been based on black feminist epistemology, which exclusively considers the standpoint of black womxn and/or other oppressed groups

(Collins, 1990). The Combahee River Collective manifesto is recognised as one of the earliest expressions of intersectionality (Cole, 2009). This manifesto was conceived by a collective of black feminists who began meeting in 1974 to discuss and fight against class, race, sexual and heterosexual oppressions (Collective, 1977). These womxn articulated how major systems of oppression are interlocked and argued that they found it hard to separate "race from class from sex oppression because in our lives they are most often experienced simultaneously" (Collective, 1977, p. 213). Although intersectionality as a concept had existed for a while, Kimberle Crenshaw is credited with coining the term in 1989 (Cole, 2009; Fotopoulou, 2012; Jordan-Zachery, 2007).

In her paper, Crenshaw (1991) delved into the intersection of race and gender in relation to male violence against womxn. She spoke of three categories of intersectionality - structural, political and representational. The first category speaks to the social location of womxn of colour at the intersection of gender and race, which creates a lived experience very different from that of white womxn. Often, feminists' emphasis on womxn's experiences and anti-racists' emphasis on experiences of people of colour are expressed as though these experiences occur independently of one another (Crenshaw, 1991). The outcome is that the experiences of womxn of colour are often disregarded, as their intersectional identity of being both 'womxn' and 'of colour' featured in discourses that were wrought to respond to either one or the other. Racism and sexism, however, are concurrent in people's everyday lives (Collective, 1977; Crenshaw, 1991).

Crenshaw's (1991) second category highlights how feminist and anti-racist politics have, ironically, further marginalised the issues of violence against womxn of colour. Finally, Crenshaw's (1991) third category engages with how the cultural construction of womxn of colour has become another space of disempowerment.

Crenshaw (1991) observed that the growth of identity politics, which recognised the role of social systems of domination, was empowering for different groups of people. While shedding light on the distinctive experiences of womxn of colour,

black feminist critiques of feminist theory and anti-racist policy began to grow (Fotopoulou, 2012). However, a major cause for concern was its tendency to conflate or ignore differences within a group. The solution put forward was to begin to understand the differences both between and within groups through intersectionality (Crenshaw, 1991).

2.2.2 Tenets of an intersectionality framework

Hankivsky (2012) notes that while intersectionality has been conceived of in several ways, there are certain distinguishable principles: that the prioritisation of a single category or aspect does not sufficiently describe human experience; and that social processes and structures are interwoven and do influence social locations. A primary aim within feminist knowledge has been to respond to differences among womxn, and this concern has gained momentum in more recent feminist theories (Davis, 2008). Zack (2007 as cited in Davis, 2008) remarks that the main problem in contemporary feminism is "the long and painful legacy of its exclusions" (p. 70). The exploration of how womxn are marginalised and how each category of inequality renders womxn more vulnerable and subordinate is an integral strand of intersectionality (Davis, 2008). The way in which various categories interact in womxn's lives both create and alter power relations (Yuval-Davis, 2006 as cited in Davis, 2008). Research that has focused on members of subordinate or privileged groups disrupts norms and acknowledges how multiple identities define status (Cole, 2009). It is important to take note that while some groups carry multiple disadvantaged statuses, select members of a disadvantaged group might possess privileged identities, as in the case of black middle-class womxn or white womxn (Cole, 2009). Hence, this framework lends itself to comprehending the experiences of both oppressed and privileged groups (Cole, 2009).

2.3 APPROACHES TO INTERSECTIONALITY

As intersectionality engages with the complexity of multiple dimensions of social life, the methodological demands for such kinds of analysis intensify. Based on the premise that different methodologies produce different types of knowledge, McCall

(2005) describes three approaches that aim to respond to the complexity of intersecting social relations. They are based on how each approach views categories. I describe the first and third approach briefly and elaborate on the second, as it is the methodological approach that I employ in this research.

2.3.1 Anticategorical and intercategorical complexity

The first approach, termed anticategorical complexity, is placed at one end of a continuum. This approach rejects analytical categories (McCall, 2015). Social life is considered too complicated for fixed categories, which can neither account for nor explain such complexity sufficiently (McCall, 2015). Based on McCall's (2005) key argument that different methodologies generate different knowledge, the anticategorical approach is based on a methodology that deconstructs analytical categories. Highlighting the artificiality of social categories can be seen in history via a genealogy method, and in literature through the method of deconstruction (McCall, 2005). The third approach, at the other end of the continuum, is referred to as an intercategorical complexity, which utilises existing analytical categories strategically to document unequal social relationships (McCall, 2005). For this method, McCall (2005) begins by using traditional analytical categories as a point of departure, classifies individuals into these categories, then examines a particular topic (such as wage inequality among groups) and arrives at a conclusion that highlights various intersecting and conflicting dimensions of inequality.

Neither of these approaches are used in this thesis on the basis that social categories like race, gender, class and ability are socially constructed, flexible and fluid, rather than being innate human characteristics (Cole, 2009; Hankivsky, 2012). Although feminist and critical race theorists understand this artificiality, the political use of such imagery or symbols are real, and form an integral part of marginalised womxn's lived experiences, which then produces real consequences (Jordan-Zachery, 2007). Social locations are, thus, moulded by multiple social processes, and no one category gains precedence over another (Hankivsky, 2012).

2.3.2 Intracategorical approach/complexity

The second approach lies in the middle of the continuum between the first and the third approaches. Similar to the first approach, it challenges the boundaries that distinguish categories, but like the third approach, it also recognises the role that social categories indeed play in people's lives (McCall, 2015). As Mehrotra (2010) explains, an intracategorical approach is positioned in the middle and interrogates essentialised social categories and also recognises the political requirement of such identity-based groupings. In an intracategorical intersectionality approach, the primary focus of analysis is "a single social group at a neglected point of intersection of multiple master categories or a particular social setting" (McCall, 2005, p. 1780). This type of approach emphasises diversity within social groups, and brings to the fore the personal lived experiences, multiple identities and different standpoints of womxn who are situated at a particular social location that typically involves multiple oppressions (Mehrotra, 2010).

Drawing on this description, my research begins with a unified intersectional core, which in this case is the *event of pregnancy*. Based on the womxn's descriptions of pregnancy support, the approach moves outwards to gain clarity on the role of interweaving categories of class, race, age, partner status, ability and how the social location is shaped by macro-structures such as socio-economic policies, cultural practices and healthcare systems (Macleod, 2016). Hence, the event of pregnancy is taken as a point of departure and understood through personal narratives that include their interactions with family, healthcare providers and community members amongst others, within the context of their economic, social, historical, cultural and political location.

2.4 MODEL OF 'SUPPORTABILITY'

Previous work on intersectionality has revealed that a single-axis framework tends to exclude groups that face multiple oppressions (Crenshaw, 1989 as cited in Cole, 2009). Health researchers and experts studying sex and gender are acknowledging axes such as class, income, age, sexual orientation, education, ethnicity and

geography as important factors that shape lives and health (Hankivsky, 2012). As discussed in the introductory chapter, the majority of the recommendations and interventions for 'problematic pregnancies' target the individual womxn with little emphasis on changing social and structural issues within which womxn's lives, health and their ability to make decisions are located.

Macleod (2016) theorises 'supportability' as a womxn's capacity to carry a pregnancy in a manner that has positive health and welfare outcomes for both the womxn and the infant. The model is made up of two intersecting axes: the signifiers 'supportable' and 'unsupportable' appear on the X axis and include the personal aspects of a womxn's pregnancy in relation to her physiology, cognition and emotion; the signifiers 'supported' and 'unsupported' lie at two ends of the Y axis and include all micro-level interactions that are situated within macro-structures (view Fig. 1 at the end of the chapter). The model facilitates an analysis of the womxn's narratives of their mental, physical and emotional capabilities to carry the pregnancy, of their micro-level interactive spaces such as family and healthcare, and of their location within macro-level structures such as government policies and cultural discourses (Macleod, 2016). 'Supportability' comprises two inter-related terms: a pregnancy may be supportable or unsupportable (or both) depending on individual physiology, cognitions, emotions and behaviour of the womxn, while a supported or unsupported pregnancy depends on the womxn's interpersonal and social environment (Macleod, 2016). Having explained the meaning and significance of 'supportability', I will no longer use quotes for this term in the remainder of the thesis.

Researchers have emphasised the need for considerations of social support during pregnancy to be more nuanced and to include complex and interweaving social issues than is usually the case. Social support is closely tied to individual beliefs, changing gender roles, conventional discourses on motherhood, financial resources, and stress during pregnancy (Guendelman et al., 2001). The multi-dimensional ability of supportability to link the physiological, emotional and cognitive needs of a pregnant womxn with her micro- and macro-environment creates a setting for a

dynamic analysis of pregnancies (Macleod, 2016). Where race, sex, gender, class were initially the specific axis of inequality, intersectionality now challenges this thinking. In other words, a supportability framework enables an intersectionality paradigm.

2.5 NICHE OF NARRATIVES IN INTERSECTIONALITY

A narrative psychological approach largely stems from a social constructionist paradigm, in that it takes into consideration the cultural structuration of individual experience (Crossley, 2003). While my research does not adopt a narrative methodology or analysis, I utilise narratives as a tool to elicit the personal meaning womxn ascribe to pregnancy support (or lack thereof), while gaining a broader understanding of the manner in which their social location alters their experience. The strength of narratives lies in their ability to focus on an individual and gain a rich insight into the broader social location and context of the individual's lived experience. They enable researchers to describe lived experiences at certain neglected points of intersection and specifically to characterise womxn's experiences, which have often been misrepresented (McCall, 2005). As intersectionality gained momentum, Steedman (1987) indicated that feminist research needed to work against generalisation, universalisation and the inevitable simplification in narrating settings of inequality. Womxn's studies had highlighted the lack of womxn as subjects of research in existing fields (McCall, 2005). As a result of this, womxn's unique experiences gained importance.

Christensen and Jensen (2012) assert life-story narratives as crucial to the development of qualitative intersectionality methodology. In linking narratives to this framework, an intracategorical approach is understood to challenge the nature of essentialised, standardised social categories of gender, race, class, etc., while simultaneously acknowledging the need for strategic essentialising of identities and communities to achieve specific political goals (Mehrotra, 2010). Narratives are known to illuminate not only individual lives, but also broader social processes (Andrews, Squire, & Tamboukou, 2013). Hence, a combined value of intersectionality

and narratives appears to be one that stops essentialising differences. This quality places the research within an intracategorical intersectional framework, since the narratives work to uncover the distinctions and complexities of a single group (namely pregnant womxn) at the intersection of multiple categories (McCall, 2005). The intention of this research is to elaborate on womxn's narratives of how they experience 'support' in their pregnancy. Furthermore, the supportability model underscores various categories, social locations and structures that need to be considered in order to be able to plot the supportability or unsupportability of each womxn's pregnancy story.

2.6 INTERSECTIONALITY IN HEALTH RESEARCH

Fotopoulou (2012) recognises that the concept of intersectionality has been articulated in varying ways, ranging from that of a crossroads, to a dynamic process, to 'axes' of difference by various authors. This is possibly one of the reasons why McCall (2005) points out that intersectional research practice is not straightforward. Yet, its utility in public health research has been burgeoning. Bowleg (2012) notes that the first step to comprehending health inequalities in groups of people who have been oppressed historically is in recognising that multiple intersecting identities do exist. Researchers have advocated for the use of intersectionality in the public health domain as it provides an understanding of the multi-dimensional reality of human lives and also broadens the understanding of what is typically considered a 'problem' in the public health system (Hankivsky, 2012). Intersectionality enabled a study on HIV to move beyond individual focus and also consider issues of poverty, unemployment, the global economy and state policies, and how all these aspects related to each other (Browne, Varcoe, & Fridkin, 2011). Hankivsky (2010) acknowledges the benefits of such research while stating the importance of reframing public health problems in order to develop primary health services that can target illness and health as well as the underlying issues of such problems. This framework is, thus, being recognised as a research paradigm that is crucial to understanding the complexity of health in different population groups.

2.7 CRITICISMS OF INTERSECTIONALITY

As the focus of intersectionality as a key research approach in womxn's studies has advanced, so have its challenges (Jordan-Zachery, 2007). One of the main criticisms is its ambiguous and open-ended nature (Davis, 2008; Jordan-Zachery, 2007). Davis (2008) argues that it is precisely this ambiguity that allows intersectionality to be deployed in an array of contexts and fields. As identified by Cho et al. (2013), it may be loosely utilised in three sets of ways: to investigate intersectional dynamics; in an array of discursive debates about the scope of its methodology; and lastly, for any political intervention that requires such a lens. My research falls within the first engagement of applying such a framework to explore intertwined complex dynamics of social categories, location, and power relations.

Another recurrent criticism is the lack of methodological guidelines on how to study intersectionality (Fotopoulou, 2012; Jordan-Zachery, 2007; McCall, 2005), which categories to use, and when to stop, as there are "endless constellations of intersecting lines of difference to be explored" (Davis, 2008, p.77). Christensen and Jensen (2012) have acknowledged that the number of categories can be a methodological task. However, as demanding as it may seem, these need not necessarily be viewed as challenges so much as points to be considered. McCall (2005) addresses the issues on how to study intersectionality by providing three possible approaches that are not exhaustive but tactfully deal with the challenges regarding categories and ways to engage with their complexity. In line with her suggestion, this research adopts an intracategorical approach, for reasons stated previously under section 2.3.2.

Jordan-Zachery (2007) claims that intersectionality as a political framework can challenge several oppressive structures that black womxn encounter, and, as an analytic framework, can help understand the lives of these womxn. Carbado (2013) raises concerns of various scholars critiquing intersectionality for its primary focus being black womxn (thereby only capturing race and gender) with an overemphasis on subjects. A table in the methodology chapter under section 4.5.7 depicts the

diversity of the participants' particulars and emphasises that my research does not only focus on race and gender. I believe that by using the event of pregnancy almost as a fixed category, my research provides room for multiple categories to organically evolve depending on the narrative, while being guided by the supportability model. Additionally, although the focus is on the pregnant womxn, the emphasis broadens to examine the social location of this event within micro-interactions and macro-structures.

A key point regarding intersectionality is that it is not to be mistaken for an additive approach. This means that the factors under consideration (whether social categories or processes) are not added up to arrive at the final outcome. Rather, intersectionality questions how different aspects inter-relate with one another and how "social locations and structural forces interact to shape and influence human experience" (Hankivsky, 2012, p. 1713). While scholars continue to grapple with its value and usage, Jordan-Zachery (2007) encourages researchers to engage in thinking about the future of intersectionality.

Carbado (2013) suggests that the growth of intersectionality depends on further conceptualisations and mobilisations of the theory. In fact, she advocates that scholars apply the theory alongside an alternative framework. This falls in line with the theoretical lens of my research, which utilises Macleod's (2016) supportability model, as one that lends itself to an intracategorical intersectionality framework while strengthening the overall research paradigm.

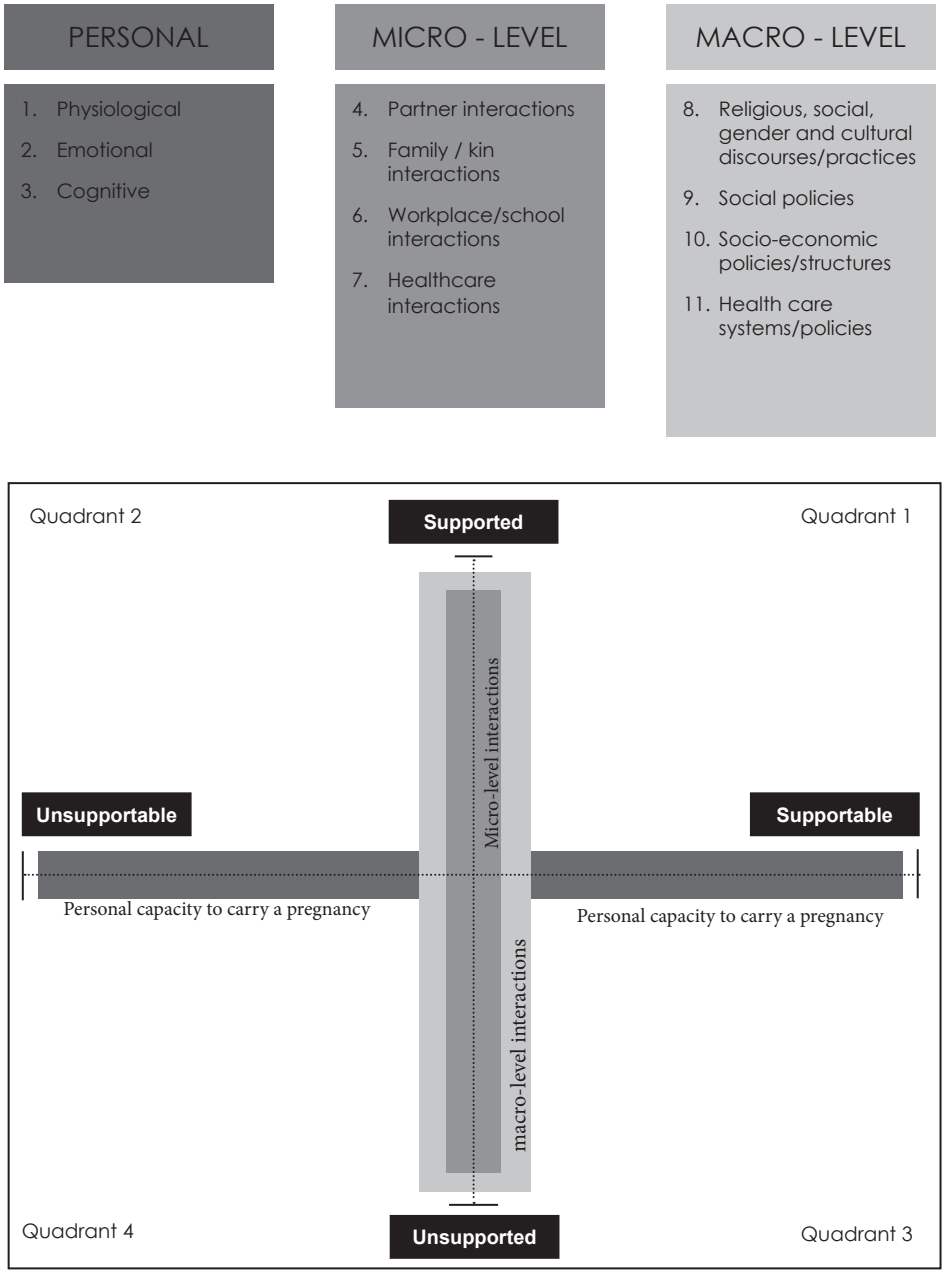
2.8 Conclusion

The increasing focus on intersectionality has been regarded positively since it takes into consideration the intricate relationships between various dimensions of social relations and the influences in multi-cultural societies (Christensen and Jensen, 2012; McCall, 2005). What becomes evident through an understanding of intersectionality is that womxn are situated differently in the economic, social and political world (Crenshaw, 1991). In this chapter, I started with the emergence of

intersectionality, which is the paradigm that underlines my research. As highlighted earlier, when addressing problems faced by womxn, the intersectional location of each womxn needs to be taken into consideration (Crenshaw, 1991). My research is built on the narratives of pregnant womxn of varying ages, races, abilities and cultural influences. Using pregnancy as an event, and with the selected framework and supportability model, I aim to understand how their multiple categories of identity and social location might create distinct and complex experiences for each of them. Having discussed the role of categories, the nexus of power and oppression, and the importance of acknowledging the effects and complexities of multiple identities in multicultural societies, I explained how my research overcomes some of the listed criticisms of intersectionality. My intention is this chapter was to bring together all the aspects of my research paradigm and emphasise how intersectionality theory, the supportability model, and narratives as a tool complement each other. In the following chapter, I survey literature in and around maternal health and pregnancy, using the headings listed in the supportability model as guidance.

2.9 'SUPPORTABILITY' FRAMEWORK FIGURE

Figure 1: Pregnancy supportability



CHAPTER THREE: LITERATURE REVIEW

3.1 INTRODUCTION

The aim of this chapter is to highlight the areas of pregnancy research that are relevant to this study. In the previous chapter, I introduced Macleod's (2016) pregnancy supportability model that has the potential to shed light on pregnancy-related health experiences of womxn in a multi-faceted way. It allows for a multi-layered analysis of pregnancy by bringing to the fore intersections between *personal space*, *micro-level interactions* and *macro-level systems*. In this chapter, I use the same model to conduct and present a review of literature surrounding pregnancy and pregnancy support. I begin by discussing the *personal space* of the pregnant womxn, which comprises the physical, emotional and cognitive aspects of her pregnancy. I proceed from *personal space* on to *micro-level interactions,* examining literature on the interactions and exchanges between the pregnant womxn and her partner, family, workplace and healthcare provider. I then delve into the *macro-level systems*, looking at the socio-economic structures, healthcare systems and government policies that impact pregnant womxn, as well as exploring the religious, social, gender and cultural practices that affect them (Macleod, 2016).

3.2 THE PERSONAL

In relation to the supportability framework, the signifiers 'supportable' and 'unsupportable' at either end of the X axis refer to the individual's own capacity to carry her pregnancy to term. Thus, a pregnancy, in personal terms, encompasses a womxn's *physiological*, *cognitive* and *emotional* state of being, and her individual behaviour whilst pregnant (Macleod, 2016). Rubin (1976), in her seminal study on 'Maternal tasks in pregnancy', noted that "the presence, growth, and behaviour of the developing child within the pregnant womxn becomes progressively a part of the womxn's experiential self" (p. 367). Rubin identified four tasks that guide and motivate maternal behaviour during pregnancy, namely: seeking safe passage for herself and her child through pregnancy, labour, and delivery (antenatal care); ensuring the acceptance of her child by significant persons in her family; binding-in

(referring to the bond) to her unknown child; and learning to give of herself (providing nurturance). Of these four tasks, two orient towards the external world in order to guarantee the child's safety and acceptance, while the other two relate to the creation of the maternal role and mother-child relationship (Rubin, 1976). Linked to the task of ensuring a safe passage, is the expectant mother's desire for a healthy child, for which she might change her health behaviour; this "altered mode of being involves body changes, variations in mood, and worries" (Bondas & Eriksson, 2001, p. 824). During the transition to motherhood, Sawyer (1999) found that womxn integrate motherhood into their sense of self and identity rather than perceiving it as just an additional new role. These findings suggest that the *process of pregnancy* is, in itself, significant to the extent that a womxn not only experiences bodily transformations, but also begins to embody motherhood.

In the following sections, I outline a brief chronological account of research on the physical symptoms of pregnancy, starting from the late 1980's. Research and policy interest in sexual health and pregnancy burgeoned during that time due to an emphasis on family formation and planning (Miller & Moore, 1990). I place the physical aspects of pregnancy under one heading and combine the cognitive and emotional experience with womxn's behaviour under the next heading. This is not to say that bodily changes do not alter individual moods and behaviour, or vice versa. However, there has been some research that speaks exclusively to physical symptoms, while much of the research on the emotional and cognitive aspects invariably link with the behavioural outcomes of the pregnancy.

3.2.1 The physical experience

The physical aspect of a womxn's pregnancy is possibly the most noticeable one, growing more so as the pregnancy progresses. The most visible sign is, of course, her growing belly, which is known to produce a mixture of emotions in womxn ranging from joy and anticipation to disgust and frustration (Bondas & Eriksson, 2001). In their paper that focused specifically on the physical and physiological symptoms of womxn during pregnancy, Drake, Verhulst, and Fawcett (1988) argued that while

maternity and obstetrical textbooks spoke of various minor physical discomforts that womxn go through during pregnancy, there was, at the time, little research done to support such claims. They described a range of physical symptoms that included frequent urination, heartburn, morning sickness, backache, edema and increase in appetite. Other common physical discomforts included constipation, aches and pains, swelling and varicosities, vaginal discharge, pigmentation, dizziness and fainting, bleeding gums, leg cramps, haemorrhoids, headaches, rhinitis, stretch marks, nausea and vomiting (Biringer, 1988). An increase in research over the next decade showed that every pregnancy is unique, with different womxn having varied experiences in the number, quality and severity of discomforts in their pregnancies, as well as a multiparous womxn experiencing differences within her pregnancies (Davis, 1996). Connections were made between maternal fatigue and antenatal morbidity (Luke, Avni, Min, & Misiunas, 1999), with fatigue being the most frequently reported discomfort (Kamysheva, Skouteris, Wertheim, Paxton, & Milgrom, 2010). Though nausea and vomiting in pregnancy (NVP) is commonly termed “morning sickness”, several studies argue that it does, in fact, occur anytime during the day (Chou, Lin, Cooney, Walker, & Riggs, 2003). Insomnia and sleep deficiency are also normally reported, with a tendency for these to become more predominant as the pregnancy progresses, perhaps due to other pregnancy-related discomforts (Reichner, 2015). Today, it is a well-accepted fact that several changes — immunological, metabolic, endocrinal, and vascular — accompany pregnancy and are viewed as adaptations of the mother's body to accommodate the foetus' growth (Tahmasbi, 2017). It is important to understand most of these changes as to be expected, transient and non-pathological. Biringer (1988) asserts that a physician can provide reassurance and counselling after having distinguished between normal pregnancy-related changes and pathological conditions, and can thereby become a source of support to the pregnant womxn.

3.2.1(i) Physically unsupportable pregnancies

Within the realm of the supportability model and, in relation to pathological illnesses, pregnancies that are physically unsupportable include those that are ectopic (that require intervention) or those that might end in a miscarriage due to

other complications. An ectopic pregnancy is one that occurs outside of the uterine cavity, with over 98% implanting in the Fallopian tube (Varma & Gupta, 2009 as cited in Shaw, Dey, Critchley, & Horne, 2010). It is said to account for 4% to 10% of pregnancy-related deaths (Marion & Meeks, 2012) and is a common cause of maternal mortality in the first trimester (Shaw et al., 2010). A systematic review examining the causes of maternal death globally found that, apart from ectopic pregnancies, some of the major reasons were haemorrhages, hypertensive disorders (high blood pressure), sepsis, abortion and embolism (Say et al., 2014). Specific to South Africa, HIV-infected womxn are at high risk of indirect maternal death (possibly from tuberculosis) or from direct obstetric causes (Department of Health [DOH], 2015). With the expansion of antiretroviral (ARV) treatment and HIV testing, however, the maternal mortality rate (MMR) has substantially decreased, as was evident from an audit from 2003-2012 at a tertiary-level hospital (Black et al., 2016).

3.2.1(ii) Pregnancy and exercise

One feature of the physical aspect of pregnancy relates to physical activity (PA). Exercise during pregnancy has been understood to mitigate several symptoms such as back pain, fatigue, constipation and nausea (Wallace, Boyer, Dan, & Holm, 1986). However, there have been conflicting views over the years surrounding its significance (Hatch et al., 1993). Since the onset of pregnancy itself affects the maternal cardio-respiratory system with increased heartrate, cardiac output, consumption of oxygen and stroke volume, maternal exercise was found to create greater physiological stress in the third trimester; and moderate to high levels of exercise were associated with lower birthweight, foetus hyperthermia and increased uterine contractions (Bell, Neill, & Rehab, 1994). Later studies indicated a statistically insignificant difference between the birthweight of babies and the level of exercise reported by the mother (Bell & Palma, 2000).

On the contrary, in more recent studies, participation in exercise began to be linked to fewer perceived pregnancy discomforts, with scientific reviews not supporting any previous claims connecting PA in pregnancy to hyperthermia, decreased birthweight and lower gestational age (Brown, 2002). These studies showed that PA in pregnancy

had benefits such as prevention of hypertension, prevention of excessive gestational weight gain, and reduction of comorbidities related to risk for chronic diseases (Barakat et al., 2016). Interestingly, despite the non-disease nature of pregnancy, in Western culture it has been bio-medicalised to a large extent (Bondas & Eriksson, 2001), and hence, there is a tendency to view many of the physical discomforts as pathological. The new understanding of PA during pregnancy points to its ability to alleviate several typical physical discomforts, and shows it to be an effective and natural way to cope with symptoms.

3.2.1(iii) Pregnancy and bed rest

In contrast to the role of PA during pregnancy, physical inactivity or bed rest is another feature cited as aiding the ongoing physical changes experienced by a womxn during her pregnancy. Since the formalisation of prenatal care at the beginning of the 1900's, maternal bed rest became an obstetric tool and a typical form of care, more so towards the end of pregnancy, and particularly in complicated cases such as pre-eclampsia and preterm labour (Bigelow & Stone, 2011). With fatigue being a commonly reported symptom (Kamysheva et al., 2010), bed rest is recommended by gynaecologists and obstetricians in nearly twenty per cent of pregnancies (Goldenberg et al., 1994; Poudevigne & Connor, 2006). While there is a sparse amount of literature that speaks to the benefits of antepartum bed rest (Bigelow & Stone, 2011; Goldenberg et al., 1994; Poudevigne & Connor, 2006), the various consequences of bed rest have been acknowledged: these include physical, psychological, familial and financial strains, and the breakdown of social relationships (Bigelow & Stone, 2011). While the fear of not receiving an income is a major cause for many of the above-mentioned pressures, much of the ownership of a safe pregnancy and pressure of a positive birth outcome fall on the expectant mother. This argument was highlighted in the introductory chapter under section 1.3.2. Brown (2002) argues that pregnancy is an ideal time to urge womxn to be active, as they are more likely to be receptive to messages concerning health. Ultimately, once a pregnant womxn feels physically better, her stress levels decrease, and she is then better-equipped to manage the different physical and psychological changes that pregnancy brings (Biringer, 1988).

Having examined some of the physical aspects of a pregnancy, it is noteworthy that some studies have focused on the connection between the physical discomfort experienced by a pregnant womxn and her psychological state. A significant correlation was found between the scores of the *General Health Questionnaire* (GHQ) and the *Nausea and Vomiting in Pregnancy Instrument* (NVPI), indicating that high GHQ scores were associated with more severe NVP (Swallow, Lindow, Masson, & Hay, 2004). However, research is divided about whether NVP causes higher psychiatric morbidity (revealed through the GHQ) or whether psychiatric morbidity aggravates the NVP (Swallow et al., 2004). Similarly, while depression has been linked to physical symptoms, it remains ambiguous whether depression led to, or was caused by, the symptoms such as nausea and fatigue (Chou et al., 2003). It appears that in studies that examine the physical and the emotional aspects of pregnancy, it is a challenge to establish the direction of cause and effect.

3.2.2 Emotion, cognition and behaviour in pregnancy

Looking at literature that considers the cognitive and emotional experience of a pregnant womxn reveals not only the intensity of the experience, but also a range of often-conflicting emotions. In terms of the emotional experience, Bondas and Eriksson (2001) found that pregnancy brings about huge changes in womxn's lives, with its onset marked, ironically, with deep joy and suffering. There appear to be fewer articles on the feelings of elation during pregnancy as compared to those that discuss various stressors. One possible reason for this, from a public health perspective, could be the requirement to increase the number of positive pregnancy outcomes by identifying, and thereby eliminating or reducing, aspects that lead to negative outcomes. It has been established that a pregnant womxn's mental and emotional health can influence the development and health of her unborn baby (Federenko & Wadhwa, 2004).

Sugawara et al. (1997) noted that the different physiological, endocrinological and psychosocial changes that occur during pregnancy do cause stress to womxn. Their

findings are further endorsed by the results of a later study that conducted a socio-demographic analysis to examine the prevalence of happiness among pregnant Indian womxn. The results reveal that support from family, fewer work responsibilities, PA without complications, and being of a younger age lead to a positive emotional state in pregnant womxn (Malhotra, Mudgal, Dharmarha, Mehta, & Bhola, 2015). A quantitative study focusing on happiness found that womxn who experienced higher levels of happiness while pregnant had better labour pain coping mechanisms (Golmakani, Asl, Sajadi, & Ebrahimzadeh, 2012).

3.2.2(i) Transition to motherhood

Another part of literature that relates to the emotional and mental aspects of the pregnancy experience is on *Maternal Role Attainment* (MRA), framed and guided by the four goals identified by Rubin (1976) and described earlier in this chapter under the heading 'The Personal'. These four directional goals are understood to intensify as the pregnancy progresses (Rubin, 1976). Rubin's goals were reassessed by Mercer (2004), who argued for the term MRA to be replaced with *Becoming a Mother* (BAM). Researchers have emphasised the significance of how a pregnant womxn prepares herself to become a mother and have highlighted the aspects that allow or hinder this process of transition (Mercer, 2004). From an attachment perspective, secure womxn showed a stronger attachment to their foetus, described their mental health as positive more often, and were more likely to pursue support through the entire pregnancy as compared to avoidant or anxious-ambivalent womxn (Mikulincer & Florian, 1999). In fact, the connection between a pregnant womxn's interpersonal relationships and her antenatal attachment to her baby has been shown to be highly influenced by her own representation of her mother (Priel & Besser, 2001). A study of first-time mothers' depression revealed connections between lower levels of maternal efficacy measured prenatally and higher levels of anxiety, depression and marital struggle postpartum (Porter & Hsu, 2003). Apart from the findings of these studies, other factors such as a womxn's personal situation, cultural beliefs, socio-economic status, information available and the social environment, also influence the transition phase to motherhood (Meleis, Sawyer, Im, Messias, & Schumacher, 2000 as cited in Mercer, 2004). Hence, it can be seen

that a pregnant womxn's behaviour and her motivation to BAM are inevitably based on a variety of intersecting elements.

3.2.2(ii) Pregnancy behaviour: intrinsic or socially induced

Studies (Rubin, 1976; Stainton, McNeil, & Harvey, 1992) indicate that the intrinsic motivation to achieve maternal goals is present in expectant mothers, barring high-risk pregnancy cases, as Mercer (2004) found that uncertainty of motherhood could modify the aforementioned tasks. However, these goals are not entirely developed innately. A pregnant womxn's behaviour is known to receive an increased level of societal attention, with the added expectation that she will continuously make healthy choices in order to boost the newborn's health (Bondas & Eriksson, 2001; Reszel, Peterson, & Moreau, 2014). Consequently, womxn may be consciously or subconsciously pressurised into adopting a certain type of behaviour. A pregnant womxn "introjects observed behaviours of others, projects how those behaviours would be for her, and rejects behaviour she judges as inappropriate for herself" (Mercer, 2004, p. 226). This links to feminist arguments that problematise womxn's motivation and questions how, as individuals with agency, womxn invariably undertake the very roles that might further lead to their subordination (McMahon, 1995). As McMahon (1995) states, motherhood produces not just babies, but also womxn. Mercer (2004) notes that a womxn constructs the perfect self-image as a mother based on elaborate psychosocial work done during her pregnancy as well as postpartum, thus incorporating the maternal identity into her system.

Findings from studies (Porter & Hsu, 2003; Mercer, 2004; Reszel et al., 2014) point to the role of social influences and other micro-level components (indicated in Macleod's model) within the personal experience of pregnancy. Delving into stressors during pregnancy reveals links between two indicators of mental health in pregnancy, namely perceived psychosocial stress and social support (Federenko & Wadhwa, 2004). I discuss each of these aspects below.

3.3 PSYCHOSOCIAL ASPECTS OF PREGNANCY

According to Mercer (2004), a pregnant womxn's transformation and self-development in her efforts towards BAM is consistent with psychosocial development theories. This preparation is understood to commence even before or during pregnancy, as the womxn begins to seek out information to better look after herself and the baby (Mercer, 2004). For numerous womxn, though, psychosocial issues impede their access to medical care and negatively impact their pregnancy outcomes (Culpepper & Jack, 1993). These issues could be poverty or multiple trauma, among others, which are difficult to overcome (Woods, Melville, Guo, Fan, & Gavin, 2010). Ruiz and Fullerton (1999) later identified stress to be "one of the biopsychosocial factors that contributes to adverse pregnancy outcomes, such as preterm labour and low birth weight (LBW)" (p. 19). A statement released by the American College of Obstetricians and Gynaecologists (ACOG) says that psychosocial stress could predict how attentive a pregnant womxn would be towards her own health and that of her newborn, as well as her usage of antenatal services (Woods, Melville, Guo, Fan, & Gavin, 2010). Psychosocial stress in pregnancy is said to occur when a womxn experiences any imbalance due to managing the different demands made of her, and conveys this both physiologically and through her behaviour (Ruiz & Fullerton, 1999).

Some research exists on the psychosocial aspects that influence psychosocial stress during pregnancy. Gottlieb and Mendelson (1995 as cited in Chou et al., 2003) found a significant correlation between maternal fatigue and a lack of support. NVP has been linked to a womxn's social and economic conditions (O'Brien & Relyea, 1999 as cited in Chou et al., 2003) as well as poor communication between the womxn and her spouse, and the womxn and her obstetrician (Iatrakis, Sakellaropoulos, Kourkoubas, & Kabounia, 1988 as cited in Chou et al., 2003). Lancaster et al. (2010) in their review of 159 articles examining risk factors for depressive symptoms during pregnancy, found that depression has important correlations to life stress, lack of social support, relationship issues and domestic violence. They also noted that, except in two studies, no connections were found between socio-economic status

(SES) and postpartum depression, but postulate that this could be due to the identification of a true mediator like chronic stress (Lancaster et al., 2010). A lack of income is known to cause financial stress (Bigelow & Stone, 2011), indicating that psychosocial aspects do influence a pregnancy as well as a womxn's response to it. While the assessment of daily stressors can sufficiently predict antenatal stress, Ruiz and Fullerton (1999) assert that it is crucial to include stressors uniquely pertaining to culturally diverse pregnant womxn of varying socioeconomic populations in order for the concept to develop. This study furthers their call by viewing womxn's pregnancy via an intra-categorical intersectional lens that acknowledges the fluidity of social locations and categories, and that recognises their function in people's lives.

Woods et al. (2010) have argued that research on high psychosocial stress during pregnancy must inform interventions, thus improving maternal health and possibly lowering unfavourable birth outcomes. Social support is one way of enabling this goal. In considering social support as a "psychosocial asset", an early study by Nuckolls, Cassel, and Kaplan (1972) demonstrated that womxn with fewer psychosocial assets and high levels of stress experience more complications in their pregnancy than womxn with low stress and high psychosocial assets. A recent study in an urban setting in South Africa revealed a range of depressive and anxiety disorders in pregnant womxn living in low-resource settings, and these were exacerbated due to high levels of psychosocial adversity, rendering womxn vulnerable to multiple risks (van Heyningen et al., 2017). Psychosocial resources such as social stability and social involvement are understood to increase maternal emotional comfort (Glazier, Elgar, Goel, & Holzapfel, 2004) while perceived social support can reduce the risk for antenatal anxiety (van Heyningen et al., 2017).

3.4 SOCIAL SUPPORT

Social support and pregnancy are closely interlinked, since the availability (or lack) of support alters how the pregnancy is experienced by a pregnant womxn. Apart from decreasing physical and emotional stress during pregnancy for womxn, social support is understood to reinforce positive changes in health-related behaviours

(Dunkel-Schetter, Sagrestano, Feldman, & Killingsworth, 1996; Harley & Eskenazi, 2006) such as a better diet and a lower likelihood of smoking (Harley & Eskenazi, 2006). Cobb's (1976) frequently-cited definition states that social support is "information leading the subject to believe that (she) is cared for and loved, esteemed, and a member of a network of mutual obligations" (p. 300). To elaborate further on this 'network' in relation to my research, a pregnant womxn is most likely to approach her partner, family and healthcare provider for assistance based on her requirements. Hence, the different micro-level spaces identified in Macleod's model form part of this network. Finfgeld-Connett (2005) also refers to this mutual obligation network as an "advocative interpersonal process" (p. 4). Advocacy becomes an important attribute of social support since social support providers serve as advocates who offer comfort, validation, strength and encouragement to the recipients (Chan, Molassiotis, Yam, Chan, & Lam, 2001; Finfgeld-Connett, 2005). The definition of social support includes available/perceived support and enacted/received support (Dunkel-Schetter & Bennett, 1990 as cited in Dunkel-Schetter et al., 1996). This infers that support need not necessarily be tangible for a pregnant womxn to feel or experience it. Active listening, being non-judgmental, providing information and relevant help all comprise social support during pregnancy (Oakley, 1992).

3.4.1 Types of social support

Three types of social support have been identified in research literature, namely: *emotional*, *instrumental* and *informational* (Dunkel-Schetter et al., 1996; Finfgeld-Connett, 2005). In a review of articles to clarify the concept of social support, Finfgeld-Connett (2005) found that *emotional support* includes attentive listening; comforting gestures that can reduce stress, anxiety and depression; encouragement; sharing of thoughts and experiences; normalising of situations; and at times just the awareness that help is available, implying that physical presence is not always needed. *Instrumental support* was found to comprise tangible commodities like childcare products; provision of services such as transportation; physical care; and financial assistance (Finfgeld-Connett, 2005). An important characteristic of social

support as a process is that a "reciprocal exchange of information" takes place (Finfgeld-Connett, 2005, p. 8). *Informational support* can include advice or guidance, information-sharing and personal knowledge development (Evans, Donell, & Hume-Loveland, 2012). The inter-relation of the different forms of support is acknowledged by Reszel et al. (2014), who note that 'informational support' may be empowering for womxn only if they have resources such as 'emotional support' to put the information into practice. A combination of emotional and informational support is considered to be psychological support, and is indicated to have an inverse connection with emotional disequilibrium (Norbeck & Tilden, 1983). While the usefulness of informational support is likely to depend on the context and who provides it, studies show that pregnant womxn find instrumental support (Dunkel-Schetter et al., 1996; Negron, Martin, Almog, Balbierz, & Howell, 2013) and emotional support (Dunkel-Schetter et al., 1996; Houts, Barnett- Walker, Paley, & Cox, 2008) the most valuable.

3.4.2 Categories of studies on social support

In their comprehensive review of social support focusing on ethnicity and culture, Dunkel-Schetter et al. (1996) found that research on social support during pregnancy and births has revolved primarily around three areas: the relationship between prenatal support and pregnancy outcomes; the effectiveness of social support programmes for pregnant womxn; and the involvement of a supportive companion during delivery. Most studies within these broad categories have typically had results that demonstrate the favourable effects of social support on the mental and physical health of pregnant womxn. Womxn's stress levels decrease and their health improves with better support (Kuo et al., 2007). Womxn who experience high stress levels and/or less social support are at greater risk for premature babies or babies with low birth weight, even after having accounted for other risks related to biomedical, sociodemographic and behavioural aspects (Federenko & Wadhwa, 2004). A prenatal intervention study involving periodic house-visits from midwives to pregnant womxn with a history of LBW babies, concluded with a lower likelihood of hospital admission, a greater likelihood of spontaneous onset of labour and delivery,

as well as the delivery of significantly larger babies (Oakley, Rajan, & Grant, 1990). An intervention study involving the presence of a supportive person during delivery revealed consistent positive outcomes such as a shorter duration of labour, lower likelihood of invasive deliveries, a shorter stay at the hospital, and the pregnant womxn feeling less "alone and needy" (Kennell, Klaus, McGrath, Robertson, & Hinkley, 1991, pg. 2201 as cited in Dunkel-Schetter et al., 1996).

While the general conclusion of studies within these categories point to the benefits and positive outcomes of having someone present and involved in a pregnant womxn's life, research in this area and their findings are not without complications. Some of these are described below.

3.4.3 Social support as culturally and contextually specific

Social support is culture-specific and context-specific. In fact, these two features (cultural and contextual specificity) contribute to some of the research challenges in this field. Collins, Dunkel-Schetter, Lobel, and Scrimshaw (1993) argue that a womxn's sociocultural background needs attention since social support is frequently researched from the perspective of an individual rather than as an interpersonal exchange between people. Social support is often assessed as though it is "a property of the person rather than an environmental resource" (Gottlieb, 1985, p. 357 as cited in Collins et al., 1993). With more research on the subject matter over time, social support has been found to be most effective when people share similar sociocultural, religious and demographic settings, and face similar challenges (Chan et al., 2001), and when a person's needs are anticipated, understood and responded to because of a shared common ground (Simich, Beiser, & Mawani, 2003 as cited in Finfgeld-Connett, 2005). In certain cases, the *amount* of social support rather than who provides it is crucial, while in other cases, more emphasis is placed on the *source* of support (Furham, 2012). Hence, one can assume that the context within which the social support takes place is as significant as the support itself.

3.4.4 Complexity of social support

With social support being culture-specific, it becomes difficult to define (Oakley, 1985). All recipients do not perceive or experience social support in the same way. A womxn's mental state can impact perceived support. For example, one study revealed that having a larger number of supportive persons during pregnancy helps protect against postpartum depression, and the effect was greater in depressive than non-depressive pregnant womxn (Morikawa et al., 2015).

The definition of social support appears to be fluid. With a deeper understanding of the concept, it becomes evident that different dimensions of support (such as the quantity, quality and purpose) have different outcomes on the physical and psychological outcomes of pregnancy (Dunkel-Schetter et al., 1996; Park et al., 2013). Further, Dunkel-Schetter et al. (1996) highlight the need to overcome various methodological flaws, create clearer distinctions between high-risk and low-risk pregnant womxn, conduct impactful interventions and ensure sufficient sample sizes and comprehensive research designs. Otherwise, studies fail to demonstrate the benefits of social support. Being aware of existing discrepancies in the comprehension, measurement and functions of social support (Collins et al., 1993) as well as considering conceptual, methodological and theoretical issues (Sarason, 2013) is essential in this line of research, as the definition continues to evolve into a more comprehensive and consistent one.

In further distinguishing social support, Finfgeld-Connett (2005) argues that it must not be confused with the concept of care. As Swanson (1993 as cited in Finfgeld-Connett, 2005) suggests, although caring is likely to be an element of social support, not all recipients might experience social support as caring. This is understandable, since social support is perceived differently depending on individual traits and how a person deals with stress during pregnancy (Guendelman et al., 2001). It is therefore important to listen to a pregnant womxn to understand what type of support she most requires (Gottlieb & Mendelson, 1995 as cited in Bondas & Eriksson, 2001). Pregnant womxn and "their families exist in a cultural milieu, wherein cultural values

and norms influence their attitudes and behaviours" (Dunkel-Schetter et al., 1996, p. 376). In relation to this, I move onto examining other micro-level interactions within which a pregnancy takes place.

3.5 MICRO-LEVEL SPACES

Sagrestano, Feldman, Rini, Woo, and Dunkel-Schetter (1999) state that "the impending birth of a child symbolises a new life, often beginning within the context of a family and community" (p. 870). These contexts comprise the different micro-level spaces identified in the supportability model and include *partner interactions*, *family/kin interactions, workplace/school interactions* and *healthcare interactions*. Sagrestano et al. (1999) claim that these contexts explicitly influence the psychosocial resources that are available to the womxn during her pregnancy and thereby create a distinct environment for the delivery of her baby. Consequently, these contexts possibly impact maternal attitudes, birth outcomes and mother-infant interactions. As stated in the previous chapter, the signifiers 'supported' and 'unsupported' that lie on the Y axis of the supportability model are dependent on the womxn's interpersonal and social environment (Macleod, 2016). Studying social support in pregnancy is valuable, as pregnancy and birth are both biopsychosocial events (Dunkel-Schetter et al., 1996). Having examined the biological (physical) and psychological changes, I now look at the social aspects related to pregnancy.

3.5.1 Partner presence

Partner support is considered especially meaningful during the period of pregnancy (Dunkel-Schetter et al., 1996). Rini, Schetter, Hobel, Glynn, and Sandman's (2006) longitudinal study examines multi-dimensional Social Support Effectiveness (SSE) and includes a pregnant womxn's perceived quality and quantity of partner support. Their study concentrated on partner support because marital or partner interactions are ranked as the primary source of support in adult life (Beach, Fincham, Katz, & Bradbury, 1996 as cited in Rini et al., 2006). Close links have been found between support from the baby's father and better birth outcomes (Norbeck & Anderson, 1989; Padilla & Reichman, 2001). One such study by Zambrana, Dunkel-Schetter, &

Scrimshaw (1991 as cited in Padilla & Reichman, 2001) revealed that frequent contact with one's partner during pregnancy was linked with an increase in use of antenatal care (ANC). Padilla and Reichman (2001) found that the father's involvement had a strong relation to LBW, where receiving financial support from the partner led to lowered likelihood of LBW. In relation to available support, womxn perceiving effective partner support stated that they experienced lower anxiety levels from mid- to late pregnancy (Rini et al., 2006). The timeframe was then extended from earlier in the pregnancy to postpartum as well. This implies that the influence of perceived and received support from one's partner during pregnancy has positive implications after delivery for the mother and the infant. Other studies indicate that partner support has a considerable impact on womxn experiencing postpartum depression (PPD) and on womxn with depressive symptoms and other psychiatric conditions (Misri, Kostaras, Fox, & Kostaras, 2000; Gremigni, Mariani, Marracino, Tranquilli, & Turi, 2011). Support from a womxn's partner enables postpartum adjustment in a positive way (Martini et al., 2015; Stapleton et al., 2012). These findings suggest that maternal emotional health is positively influenced by interpersonal security and satisfaction in relations (Martini et al., 2015; Rini et al., 2006). Partner involvement impacts a range of health outcomes including anxiety, stress and depression, as well as birth outcomes such as birthweight and mother-child interactions.

It is also useful to acknowledge that while most studies point to the positive influence of partner support on maternal health and birth outcomes, there are a number of noted barriers that contribute to low involvement of partners during pregnancy. At the other end of the spectrum relating to partner involvement is the possibility of intimate partner violence (IPV) during pregnancy. Physical, sexual and psychological IPV during pregnancy are associated with fatal and non-fatal adverse health outcomes for the pregnant womxn and her baby, including higher levels of depression, anxiety and stress for the pregnant womxn (Martin et al., 2006). IPV is also linked with several negative health behaviours in the womxn, which further cause poor pregnancy and newborn outcomes (Bailey & Daugherty, 2007). While some of the barriers are interpersonal and have to do with the dynamics within the

relationship, other reasons are contextual and fall under other micro- and macro-aspects of unsupported pregnancies. These will be discussed in the related sub-headings 3.5.3 and 3.6.3.

3.5.2 Other significant relations

Nearly forty years ago, Leifer (1980) noted that major changes occur in a pregnant womxn's interpersonal relationships from a psychological perspective, in particular with her mother and her partner. The quality of a womxn's relationship with her mother is understood to influence her own role and behaviour in motherhood (Ballou, 1978 as cited in Leifer, 1980). Other more recent studies indicate that during pregnancy, challenges in relationships with individuals such as relatives or friends could increase prenatal depression, while support from the womxn's mother and partner could lower depression levels (Pajulo, Savonlahti, Sourander, Helenius, & Piha, 2001 as cited in Rini et al., 2006). The vast majority of womxn identify family members, especially their own mothers, to be a vital source of instrumental and emotional support (Negron et al., 2013).

Leifer (1980) had asserted that changes occur in female friendships during pregnancy and that these relationships can considerably impact a womxn's pregnancy experience. In the absence of a partner or family, pregnant womxn especially emphasise the importance of different forms of support from friends (Mlotshwa, Manderson & Merten, 2017). Group antenatal care and peer support have been shown to decrease the rates of preterm and low-weight births (Ickovics et al., 2007).

Although infant birth weight has typically been the way to depict levels of antenatal support, viewing pregnancy as a biopsychosocial event means taking into account a nuanced understanding of various contributing aspects. Oakley (1985) stated while preventing LBW is important, it needs to consider the multifaceted causes of LBW, since pregnancy is a sociobiological process. While a significant effect on birth weight may not always be visible, other outcomes such as increased parental confidence (influenced by the pregnant womxn's relation with her own mother),

decreased postpartum depression (influenced by partner support) and lower rates of infant hospitalisations have been observed (Oakley, 1985). Orr's (2004) review also revealed other benefits of social support to include decreased smoking (also supported by Elsenbruch et al., 2006) and improved health behaviours in pregnant mothers.

3.5.3 Antenatal care (ANC)

Although considered a "continuous normal process" from a biological perspective, there exists a fine line between health and disease in pregnancy (Townsend, 1978, p. 85). The main reasons for ANC are to maintain the general health of a pregnant womxn, including screening, risk identification and diagnosis; prevention and management of pregnancy-related or concurrent diseases; and health education and health promotion (World Health Organization, 2016). ANC also aims to improve health outcomes for both the mother and infant (DOH, 2015). Dowswell et al., (2015) divide outcomes into primary (pre-eclampsia and maternal death) and secondary (gestational hypertension, anaemia, caesarean section amongst others) for the womxn; and primary (neonatal death, infant death, stillbirth, preterm) and secondary (low birth-weight, measure of growth and development) outcomes for the infant. Carroli et al. (2001) note that, more recently, ANC enables HIV prevention and care, especially the prevention of HIV transmission from mother to child. The antenatal period is viewed as a good opportunity to reach out to pregnant womxn and provide interventions that ensure their well-being and the health of their infants (World Health Organization, 2003). This includes providing information on birth spacing and nutrition, prevention and treatment of malaria, treatment of sexually transmitted infections (STI) and management of anaemia (World Health Organization, 2003). Therefore, womxn accessing ANC are expected to demonstrate low rates of maternal mortality and positive pregnancy outcomes.

In terms of clinic visits, check-ups include history-taking, abdominal palpation, and measurement of blood pressure and maternal weight (Magadi, Madise, & Rodrigues, 2000). A new model from the World Health Organisation (WHO) divides pregnant

womxn into two groups: those in need of routine ANC, and those with specific risk factors needing special care. WHO recommends a programme of four antenatal visits for the first group (World Health Organization, 2003). However, in assessing the impact of reduced antenatal visits, studies have found that while this could lower costs, there was an indication that womxn across both high-income and low-income settings were less satisfied with fewer visits and perceived the gaps to be too long (Carroli et al., 2001; Dowswell et al., 2015). Urban womxn, however, are twice as likely as rural womxn to report more than four antenatal visits (World Health Organization, 2003).

There remains a stark difference and inequality in maternal health between developed and developing nations (Simkhada, Teijlingen, Porter, & Simkhada, 2008). In at-risk families when there is insufficient support from other sources (such as one's partner or family) support from healthcare professionals could considerably improve maternal and child outcomes (Olds et al., 1997 as cited in Stapleton, et al., 2012). While early and appropriate ANC is considered important in identifying high-risk pregnancies and reducing risk factors, many pregnant womxn in developing nations do not receive this (Magadi et al., 2000). Data from developing countries point to one-third of womxn in rural areas and two-thirds of womxn with primary or no schooling receiving no ANC, demonstrating that rural and uneducated womxn have the least access to it (World Health Organization, 2003). An analysis of trends in antenatal care between 1990 and 2000 revealed the smallest increase in use of ANC to be in sub-Saharan Africa (World Health Organization, 2003). However, there appear to be some shifts due to extensive investment by the South African government in public health. Recent findings show that about 94% of womxn in South Africa attend at least one antenatal visit and 84% of womxn give birth in a health facility. This proportion is made up of 17% of births at clinics, 42% at district hospitals, 30% at regional hospitals, and 11% at tertiary hospitals (Thomas, Jina, San Tint, & Fonn, 2007). As distribution and access to these services are unequal across South Africa's nine provinces and 52 districts, Thomas et al. (2007) advocate for a new culture of monitoring and evaluation to gauge the quality and content of antenatal services for pregnant womxn. The DOH in SA has decided that as from 1st

of April 2017, all pregnant womxn will be encouraged to have at least 8 antenatal care visits so as to further reduce infant and maternal mortality in the country (World Health Organization, 2019).

Similar to issues of psychosocial stress and pregnancy support, various intersecting aspects influence the usage of ANC. Ethnicity, socio-economic status, geographical location and demographic aspects impact (and impede) the use of maternal healthcare in developing countries (Magadi et al., 2000). Access in itself is a multi-dimensional concept and Simkhada et al. (2008) acknowledge different factors that hinder the use of ANC, which include: physical accessibility of services, distance and time to a clinic, cost, cultural and social aspects. For example, in a study of male participants' involvement in their partners' maternity check-ups in Ghana, it was concluded that even factors at health centres impede partners' involvement through unfavourable working hours, the poor attitudes of healthcare providers towards womxn and their partners, and even a lack of space to accommodate male partners in the health facilities (Ganle & Dery, 2015). The barriers to early ANC identified in South Africa include womxn contemplating an abortion; fear of HIV testing and jealousy (as pregnancy is viewed as a sign of fertility); and fear of bewitching and other psychological stress owing to a positive HIV test result (Haddad, Makin, Pattinson, & Forsyth, 2016). In their conclusion, Haddad et al. (2016) advocate not only for improved access to contraception and pre-pregnancy counselling to encourage early ANC attendance, but also for the importance of addressing cultural concerns and fears.

3.6 MACRO-LEVEL SYSTEMS

It has been asserted that "evolving societal myths and rituals and technological and scientific development surround pregnancy" (Bondas & Eriksson, 2001, p. 824). This statement alludes to the milieu of pregnancy that encompasses the people in an environment, their culture, changing belief systems, medical advancements and technical developments. It perhaps also refers to this setting as one that invariably aims to control the event of pregnancy and ensure that it takes place in a methodical

and systematic manner. This places it in within the macro-level systems highlighted in the supportability framework. Social locations, structural forces, government reforms and socio-economic policies have a major impact on maternal health. More subtle in comparison, but influential nevertheless, are cultural and religious discourses acutely embedded in the environment.

3.6.1 Systems and policies

Precluding and reducing the number of unintended pregnancies has been high on the agenda of various campaigns. 'Safe Motherhood' was launched in 1987, over thirty years ago, by three UN agencies - the World Bank, United Nations Population Fund (UNFPA) and World Health Organisation (WHO). The campaign aimed to increase awareness of the number of maternal deaths due to pregnancy and childbirth complications (Starrs, 2006). The main reproductive health objective of 'Healthy People 2010' aimed to decrease health threats, based on research that linked unwanted and mistimed pregnancy with unhealthy perinatal behaviour (Cheng et al., 2009). South Africa was one of the 189 countries to sign the UN Millennium Declaration in 2000 that translated into eight Millennium Development Goals (MDGs). MDG 5 (improved maternal health) aimed for a 75% reduction in the maternal mortality ratio (MMR) from 1990 to 2015, while MDG 4 (reduced child mortality) aimed for the reduction of under-5 years mortality rate by two-thirds between 1990 and 2015 (Reszel et al, 2014). The reality, however, has been somewhat different.

The legacy of Apartheid continues to hamper development, and even with the transition to democracy in 1994, health services in South Africa have not transformed sufficiently and continue to struggle (Feltham-King, 2016). The recent level of maternal mortality (at 269 maternal deaths per 100,000 live births) is still higher than the MDG 5 of 38 maternal deaths per 100,000 live births (Thomas et al., 2007). The Perinatal Problem Identification Programme (PPIP), a tool developed in South Africa to audit perinatal deaths at all facilities catering to antenatal care and newborns, was made mandatory in the country only in 2012 (Rhoda et al., 2014).

Due to the high rates of maternal mortality in South Africa, distinct sets of clinical and prevention packages, such as the Basic Antenatal Care Package, which are in line with WHO recommendations, have been implemented. Antenatal clinics are widely distributed as stand-alone units or within hospitals. Furthermore, womxn can also deliver at Midwife Obstetric Units (MOU) that are managed by midwives and deliver 24-hour service (Thomas et al., 2007). It has been noted that in spite of adopting a rights-based approach to sexual and reproductive healthcare for womxn, the implementation is often not achieved at local and community levels (Rhoda et al., 2014). The main criticism of the Safe Motherhood Initiative is that a one-size-fits-all approach does not take into consideration the local context (Thomas et al., 2007). Under-utilisation of MOUs, inadequate record keeping, poor levels of clinical knowledge and insufficient supervision prevail, as was revealed in an intervention study in a health district in Gauteng Province (Thomas et al., 2007). The researchers highlighted complex structural problems that created challenges for the intervention: knowledge of data collection and analysis was absent; healthcare programmes worked in isolation and programme managers did not share common goals (a process for co-ordinating this at a senior level is suggested); services in South Africa are provided by different authorities where the district-level system is used nominally but not set up functionally. In spite of policies and strategies, healthcare providers face various challenges to render services in clinics as they are often over-subscribed and under-resourced (Feltham-King, 2016).

3.6.2 Working womxn and pregnancy

While the number of employed mothers is on the rise, the shift towards motherhood necessitates "profound challenges and changes, particularly for working womxn" (Sayil, Gure, & Ucanok, 2007, p. 75). A biomedicalised risk model appears to guide much of the quantitative research around working conditions and adverse pregnancy outcomes. Observational studies highlight links between physically demanding work, prolonged standing, long work hours and collective work fatigue and negative outcomes such as preterm birth, hypertension or pre-eclampsia (Mozurkewich, Luke, Avni, & Wolf, 2000). The quantitative research conducted has

found correlations between night work or shift-work schedules, standing posture, lifting loads, noise, and high job strain (combined with low or moderate social support) and an increased risk for preterm and low birth weight deliveries (Croteau, Marcoux, & Brisson, 2006; Croteau, Marcoux, & Brisson, 2007). Maternity leave in late pregnancy has been shown to reduce caesarean deliveries and prolonged gestation in occupationally-strained womxn (Guendelman et al., 2009). One study considered environmental characteristics in relation to first-time mothers' anxiety and depressive symptoms across their transition to motherhood; the conclusion was that social policymakers in a particular culture should take specific socio-contextual influences on maternal well-being into account when implementing parental leave policies. (Sayil et al., 2007). For some womxn, work attachment and fear of missing out on career growth opportunities prevent them from taking leave (Guendelman et al., 2009). For others, a lack of paid benefits to cover leave before 36 weeks of gestation and being under financial strain compel them to carry on with their job (Guendelman, Pearl, Graham, Angulo, & Kharrazi, 2006).

3.6.3 Cultural and social discourses/practices

Pregnancy and childbirth are viewed as significant and enriching social and psychological life events for a womxn (Etowa, 2012 as cited in Redelinghuys, Coetzee, & Roos, 2014). Bondas and Eriksson (2001) point out that "culture provides a mirror for pregnant womxn's experiences" (p. 824). While a changing social context has influenced the maternal role, most research from a psychological perspective highlighted reproductive challenges in addition to other mental illnesses (Leifer, 1980), setting the stage for a bio-medicalised model of pregnancy. Pregnancy within a psychological framework has been conceptualised using crisis theory (Bondas & Eriksson, 2001) and risk. The outcome of this is that the *type* of information that gets internalised into a pregnant womxn's psyche includes the notion of being a good mother and making healthy choices during pregnancy, which can often provoke feelings of guilt or shame in a womxn should there be any sort of deviation from such idealised and expected behaviours. Leifer (1980) points out that pregnancy is the one stage in a womxn's life that is rife with cultural stereotypes.

This assertion remains intact as Sayil et al. (2007) note that a pregnant womxn's welfare in her transition to motherhood is closely interconnected with the society's cultural and political beliefs. Research from certain non-Western, collectivist societies (such as Malaysia and Korea) reveals how certain cultural facets play a protective role but others can hinder the well-being of working mothers (Sayil et al., 2007). Over the past few decades in western, industrialised societies, three issues – drinking during pregnancy, exposure to second-hand smoke, and over-nutrition/obesity – and their negative health outcomes in infants have been extensively debated (Bell, McNaughton & Salmon, 2009). The outcomes of these debates have led to the medicalisation and criminalisation of these issues, along with a strong emphasis on maternal responsibility, while failing to adequately consider structural and contextual factors that produce and increase ill-health in womxn, children and families (Bell et al., 2009). In addition, these kinds of punitive discourses notably end up singling out womxn in poverty, single mothers and womxn of colour specifically (Bell et al., 2009).

There is also an emphasis on spiritual influences on health in Southern Africa, with inseparable links between the biological, spiritual, social and interpersonal functioning of an individual (Chalmers, 1990). While there is a belief that ancestors may cause illness, it is believed that they can prevent it too. This has led to the usage of dual healthcare systems, both Western and traditional, running concurrently (Chalmers, 1990). Staugard (1981 as cited in Chalmers, 1990) advocates for a combined approach that exposes Western doctors to more holistic attitudes towards health and one that considers the influences of traditional healthcare beliefs and socio-cultural effects on health. A recent study with a homogenous Afrikaans-speaking group of first-time mothers showed that womxn experienced a new-found spiritual awareness of the presence of a Divine reality in their lives (Redelinghuys et al., 2014). Through their pregnancies, they experienced links between meaningfulness and spirituality and as a giver of life, felt responsible for the birth of the child (Redelinghuys et al., 2014).

While attitudes towards pregnancy tended to become a source of discrimination against womxn (Leifer, 1980), the dominant discourses of motherhood as submissive to patriarchal authority (Walker, 1995) filtered through into pregnancy. This occurred in spite of womxn's gradual but increased economic independence, remoteness from their partners and an increase in female-headed households (Walker, 1995). These impact not only womxn's experiences but also those of their partners. For example, there are perceptions of pregnancy being a female role while men provide for the family (Ganle & Dery, 2015). Other views pertain to men being seen as controlled or dominated by their wives if they accompany their partners to ANC services (Ganle & Dery, 2015). This notion impedes partner support during ANC. Based on a study in South Africa, authors Bhana, Morrell, Shefer, and Ngabaza (2010) argue for state intervention at an economic and political (structural) level as well as a social (intimate relations) level to address the gendered social environment where circumstances of poverty, patriarchal cultural practices and violence continue to burden womxn in townships during pregnancies and parenting.

3.7 CONCLUSION

This literature review surrounding pregnancy is not exhaustive. However, it encompasses aspects identified in the supportability framework and will be used in linking womxn's pregnancy experiences from their interviews to personal, micro- and macro- aspects of Macleod's model. What comes to the fore are notions of pregnancy being medicalised, the majority of pregnancy research being quantitative research, and too much responsibility being placed on the pregnant womxn. While physical symptoms may create discomfort for womxn, it is typically the emotional and mental experience of pregnancy that enables them to cope with everyday stressors. While pregnant womxn's behaviour attracts increased attention, the socio-cultural milieu within which the pregnancy occurs may, at times, be beneficial, and at others, punitive. Certain qualitative studies have emphasised the role of womxn as agents who adapt to all the changes that pregnancy brings, and who convey spiritual meaning to the process. The significance of social support during pregnancy

is well-acknowledged, along with the fact that it is culturally specific and dependent on the needs of the individual.

Research over the years has highlighted the different lenses through which pregnancy has been viewed, the complexity of pregnancy-intendedness, and how culture and context (historical, social and political) influence social support. These aspects generate discourses that infiltrate and shape a womxn's pregnancy experience. The narratives from the participants in this research will hopefully emphasise the meaning and value that is assigned to various facets of support in a womxn's pregnancy, not only in terms of what is shared but also in terms of what is not spoken about. This will be discussed in chapter four, the Analysis.

In the following chapter I examine in depth the methodology employed in this research for data collection and data analysis.

CHAPTER FOUR: METHODOLOGY

4.1 INTRODUCTION

My study employs a qualitative methodology to understand the multifaceted accounts of supportability in womxn's narratives of their pregnancies. This exploratory research was conducted using an interpretive qualitative design, based on an intracategorical intersectionality framework. An interpretive position entails that the researcher understand the subjective meaning of social action (Bryman, 2012). Crenshaw (1991) stressed how the intersection of racism and sexism as a location "resists telling" (p. 1242). In other words intragroup differences are conflated and, often, the experiences of intersecting identities are ignored and rendered invisible. In my research, intersectionality provides a lens through which womxn's lives are studied at neglected points of intersection. A qualitative design aims to construct an in-depth understanding of the perceptions, experiences and reflections of the research participants, interpreted within their own frame of reference. Keeping this in mind, I have combined an intracategorical intersectionality approach, a supportability model, and the narratives and photographs of participants, to advance an understanding of how lived experiences, social locations and social processes are intertwined. Merging these specific elements provides insight into the distinctive experience of each womxn and generates contextual information based on personal stories.

This chapter describes the different methods that were used to collect data. I commence with the description of my research question. Photo-elicitation and narrative interviewing were employed to collect data over four sessions with each participant. An intersectional thematic analysis was conducted, underpinned by a supportability model. I describe the data collection process followed by an explanation of the 'theory-driven' thematic data analysis. I discuss the ethics and the validity of this research, concluding with a segment on reflexivity, which has played a central role throughout my research process. Drawing from the 'outsider-within' status described by Collins (1986), I continually acknowledge my positions as a

researcher on one hand and my own social location on the other: a non-national of Indian race and a mother, amongst other intersecting identities. I tended to fluctuate between the two statuses so as to gain acceptance with the participants, while staying dedicated to my main research requirements, which required a certain level of objectivity (see further discussion below).

4.2 RESEARCH QUESTION

Broad collective facets, as well as a womxn's own beliefs and feelings, underwrite the way in which she will experience her pregnancy. A womxn's sentiments and outlook are invariably grounded in the economic, political, social and cultural environment of which she is a part. My research studies the narratives of womxn in their second trimester of pregnancy onwards; it explores how they experience the pregnancy personally as well as in relation to interpersonal and macro-level issues. As described in the previous chapter titled 'Theoretical Framework', a womxn's personal experience encompasses her emotional, cognitive and physiological capacity to carry the pregnancy; the interpersonal issues relate to micro-level interactions with her partner, family, healthcare facilities and educational or work interactions; and the macro-level issues include healthcare systems, socio-economic policies, socio-political structures, gendered power relations, and discourses surrounding religion, culture and race (Macleod, 2016). The research question thus is: What are the themes that emerge from a womxn's narrative of her pregnancy that speak to the promotion or hindrance of its supportability?

Using an intracategorical intersectional framework, my objective is to understand womxn's pregnancies as (un)supported or (un)supportable (or complexly, a combination) by locating the aspect of supportability within the interweaving biological, psychological, emotional, interpersonal, social, economic, cultural and political contexts within which they occur.

4.3 PHOTO-ELICITATION AS A TOOL FOR ELICITING NARRATIVES

Photo-elicitation is the use of photographs in research interviews (Harper, 2002). Images are understood to produce richer depictions of human consciousness than words and to extract not just more information, but also a "different kind of information" (Harper, 2002, p. 13). In this study, photo-elicitation was implemented as a means to enable in-depth narratives of the progression of the womxn's pregnancy. Photographs illustrate nuanced layers of the social milieu that includes family relations, other close social groups, images of oneself and one's body. This aspect is significant to my research, which investigated how different womxn perceive 'support' within their context, whilst undergoing bodily, emotional and cognitive changes in their pregnancy. Photo-elicitation interviews have the ability to connect "the self to society, culture and history" (Harper, 2002, p.13).

In contrast to researcher-produced photographs, which are considered ideal for theory-driven research (Clark-Ibanez, 2004), 'auto-driven photo-elicited' interviews involve photographs taken by the interviewees themselves, the underlying notion being that these photos are the closest to reflecting and representing the participant's world (Clark, 1999; Samuels, 2004). An auto-driven method is, therefore, seen as an inductive research approach where interviewees self-select relevant information from their lives (Clark, 1999). Therefore, within the method of photo-elicitation, my research implemented auto-driven photographs to understand the participant's frame of reference. Finally, apart from the ability to generate deeper and more emotionally-enriching accounts (as compared to word-only interviews) through auto-driven photo-elicited interviews, Samuels (2004) highlights a distinct characteristic of this approach, which is its power to connect the culturally diverse worlds of the researcher and the researched. As a non-national living in South Africa, I found that this characteristic of photo-elicitation enhanced my methodology and authenticated my research (see further discussion below).

4.4 NARRATIVES AS A TOOL

Narratives involve the study of an individual's experiences as told to a researcher (Creswell, 1998) and enable a systematic viewing of personal experience and meaning (Riessman, 2002). A narrative interviewing technique was considered appropriate in this research to generate inductive, exploratory data.

Within a narrative approach, individual experiences are studied to see how they are socially constructed and culturally structured (Crossley, 2003). Parker (2014) argues that the ability to be reflexive is what connects an individual to the social. Crossley also (2000) asserts that human experiences are comprehended and interpreted in relation to an activity (or possibly an event such as pregnancy) while incorporating 'time' and 'sequence'. The sequence of events is, thus, considered important, as the meaning-making of experiences occurs once the complex connection between temporality and identity is understood (Crossley, 2000). These features facilitated data collection involving womxn's narratives of their everyday routine surrounding their pregnancies. The interviews allowed for contradictory layers of meaning to emerge so as to gather a rich understanding of the individual and the social (Squire, Andrews, & Tamboukou, 2013).

4.5 DATA COLLECTION

The research team consisted of the main researcher (myself) who conducted the interviews, and two co-researchers who assisted with the interview process. The co-researchers who participated alternatively during the data collection are both isiXhosa speaking; they worked as translators from isiXhosa to English wherever necessary. Both of them used some of the data generated for their Honours degree mini-dissertations and were hence equally invested in the interview process. We jointly worked through the ethics protocol, agreeing that ethical responsibility is a continuous process (Orb, Eisenhauer, & Wynaden, 2001), and deliberated extensively on the implications of photographs in our research. In working as a team, we strove to create an ironclad ethics proposal. The co-researchers also formed part

of the pilot role-play interview so that we were jointly prepared for the interview process.

4.5.1 Sites for recruitment

As a first step, permission was sought – and granted – from the Eastern Cape Department of Health (Appendix 3) to approach clinics to recruit participants (Appendix 2). Seven primary healthcare facilities offering free antenatal care were identified within an approximately 15-kilometre radius of the main city. Intersectionality theory utilises differences to decentre views that claim to be dominant and calls for narratives that are local, and that reflect the "multiple realities that arise from diverse social locations" (Mann & Huffman, 2005, p. 65). Keeping this in mind, it was important to acquire participants from across clinics. Historically, the population had been segregated under the 'Group Areas Act of 1950' which led to different amenities for different segments of population due to the residential arrangements (Townsend, Madhavan, Tollman, Garenne, & Kahn, 2002). Consequently, although none of the identified clinics limit their services, they do cater to a homogenous demographic with respect to the socio-economic status, primarily due to their location. The staff at six of the clinics were approachable and allowed us to place flyers at the reception desks. Their head nurses agreed to inform their clients about our research work.

4.5.2 Methods for acquiring auto-driven photographs

For the process of photo-elicitation and choosing an appropriate device for taking pictures, we first contemplated the use of disposable cameras. However, this option was vetoed due to: the limited number of pictures that each camera could take; increased costs (the cost of the camera as well as the cost of developing the photographs); the necessity of sending the cameras to another town for developing, increasing the potential for lost photos or mix-ups between photos from different cameras; the ethics surrounding the visibility of these pictures before participant faces could be pixelated; a longer time-frame, as we would require the prints before commencing interviews. Camera phones were considered as the next option. A

market survey, in which I tested different phones and assessed the quality of the photographs, showed that this option was cost-effective. The process of transferring pictures from phones to the researchers' laptops was also straightforward. It was also far more likely that a womxn participant would have her phone readily available to take a picture, as opposed to carrying a disposable camera around. It was decided that participants could use their camera phones if they owned one; otherwise, we would provide them with a camera phone for this study. Additional requirements would then include procuring camera phones for participants who did not possess one, along with the acquisition of a copy of their identification documents and a utility bill as proof of address.

4.5.3 Pilot role-play interview

The benefits of a pilot study in qualitative inquiry for culturally competent research include: gaining insight into the considerations for recruiting participants; engaging as a researcher in a culturally-appropriate way; reflecting on the process and any challenges during inquiry; and finally, modifying interview questions (Kim, 2010). The co-researchers and I simulated a role-play of the first two sessions that were to take place with prospective research participants. I requested a bilingual (isiXhosa and English) colleague named Zanele (name changed) to play the role of an interviewee. At our first meeting, I shared with her the requirements for auto-driven photo-elicitation and provided her with the instructions that we planned to give all the research participants, which was to take photographs of anything that made her pregnancy easy or difficult. She confirmed that she would use her camera phone.

Role-play activity in interviews enables an assessment of whether the actual process coincides with the stated aims of the pilot interview (Okada, 2010). The pilot interview role-play between the co-researchers, myself and Zanele took place within a week of my first meeting with her, and the session was observed by our supervisor and another colleague. We introduced ourselves to Zanele, gave her the details of our research, and explained what would be required of her as a participant in this study. She signed the four consent forms (refer to sections 4.6.4 and 4.8) presented

to her. We repeated the guidelines on taking photographs in the interests of keeping to the stated aims of the session, although we had already given her the instructions in our previous meeting. We then requested Zanele to describe each photograph she had taken, and why it had meaning for her. We did not move into the third part of data collection, since our objectives in this pilot exercise was to examine the coordination between us researchers, our connection with the research participant, how our instructions were received, and how to conduct the interview sessions. All these objectives were met, and hence, we concluded the role-play.

We asked Zanele for her thoughts on the process, specifically about how the interview was conducted, and whether the information shared with her at the outset was sufficient. Zanele gave us useful feedback on several aspects of the interview. Firstly, she suggested that the researchers clarify an approximate number of photographs that we hoped to receive from participants, as she was uncertain that she had taken enough photographs. We, therefore, decided to specify eight to ten photographs during data collection. She also recommended that we elaborate further on our guideline to "take photographs of anything that makes your pregnancy easy and anything that makes it difficult," to include depictions of the range of emotions experienced by the participants, and features of their daily routines. Another suggestion was for the researcher to do a voice-over describing each picture, before the participant conveyed the meaning behind it. This suggestion was particularly useful because it assisted in linking the narrative to the corresponding photograph during the subsequent transcription and analysis stage. We were encouraged to add a statement such as, "We want you to be comfortable," and to offer the participant a choice of venue for conducting the interviews, such as the clinic, the research office, or their own home if they so preferred. We were reminded to provide a detailed explanation of the methods by which confidentiality would be maintained. The benefits of focusing instructions on the ethical aspects of photo-taking, rather than the technical aspects of photography, also surfaced. Lastly, the importance of probing and keeping our questions open-ended, such as, "Tell me more about..." was underscored.

The pilot interview served several purposes. It allowed certain dynamics between the researchers to emerge, giving us an opportunity to practice effectively working together without intimidating the participant. We experienced how the flow of the interview would be affected by the process of translation from English to isiXhosa and vice versa. I had speculated over whether I would lose control of the interview since the participant and I could not communicate directly. However, I found that maintaining eye contact while nodding was a sufficient response for Zanele to feel acknowledged, while her focus shifted between the co-researcher and myself. I hoped that the participants' experiences would be similar when the co-researcher translated their responses into English for my benefit.

4.5.4 Sampling

A purposive sampling strategy was employed, which took into account the availability and willingness of the participants and ensured that the selected cases fit the purpose of the research (Terre Blanche, Durrheim, & Painter, 2006). Eight willing participants were identified and interviewed. In my research, purposive sampling enabled me to select womxn who met the following three requirements: aged 18 years and over; in their second trimester of pregnancy or later; and currently accessing antenatal care. The reason for the exclusion of minors in this study is that 'adolescent pregnancy' is a distinct entity with a voluminous body of literature and complex debates concerning outcomes and the unique support needed by young mothers. By choosing womxn who were already in or past the second trimester, the hope was to eliminate as far as possible the chances of a spontaneous miscarriage, or a womxn's decision to have an abortion in the first trimester, as well as to provide a reasonable amount of time to have experienced the pregnancy.

4.5.5 Recruitment of participants

The co-researchers and I commenced our data collection by meeting the gatekeeper at each clinic who, in most cases, was the clinic supervisor. We handed them a letter (Appendix 4) requesting permission to use the premises to recruit participants. We described our research and provided them with the advertisement flyer printed in

isiXhosa and English. The flyer stated the three requirements for recruitment (Appendix 5). We informed them that we had received ethical clearance and permission from the Department of Health to conduct the study. We were given permission to use their premises, distribute flyers and approach prospective participants. We requested nurses to hand out the flyers to patients and visited the clinics ourselves, approaching pregnant womxn about our research. In this manner, we were able to put the word out regarding our study.

Each clinic managed our requirements in a different way. In two of the six clinics, the head nurse grouped the pregnant womxn together and introduced us to them, stating that they must come to us. Prior research has revealed the kind of power that gatekeepers exercise over participants (Miller & Bell, 2002 as cited in Watts, 2006); this became evident through the above action. As researchers, we made it a point to clarify that participation was voluntary, and that agreeing or not agreeing to participate would in no way influence the services they received from the clinic. In two other clinics, we were offered a private room where the head nurse sent clients to meet us individually after their consultation was complete. At another site, the head nurse handed us a dial to use in determining the due date of the baby based on the womxn's last menstrual cycle, helping us find participants who fit our criteria of 12 weeks and over.

4.5.6 Attrition of prospective participants and further sampling

The initial response from most of the pregnant womxn was positive. Within the first two weeks, 14 womxn verbally agreed to participate in the study. I collected the address and contact number of each prospective participant, with the intention of meeting them at a time and place convenient for them, to gain written consent. However, several womxn were not contactable on their phones either because they were uninterested and hence cancelled our calls, or due to poor connectivity, or because the contact number was incorrect. Over a period of three months, the initial number of willing participants decreased to ten womxn who signed consent forms and, finally, three womxn who commenced the interview process.

I also posted the research requirement on an online Parents' Network to target womxn of a different socio-economic status. Yuval-Davis (2011, as cited in Christensen & Jensen, 2012) has argued that for intersectionality to be viewed as a framework for understanding social stratification, it is essential to embrace all members of society and not only marginalised people. In addition, diversity of the narratives would support the intersectionality framework and not work against the research objectives. One participant - who was Hispanic and, therefore, a foreigner in South Africa – responded to my post on the Parents' Network. This participant (Sandra) was accessing antenatal care in the region where I was conducting my research and hence, her narrative would reflect her experience of micro- and macro-level issues related to healthcare and government policies, while bringing diversity to the pool of participants. As research interviews commenced with these participants, I simultaneously used 'snowballing' with the prospect of recruiting more womxn. Snowball sampling is a type of purposive sampling procedure in which the researcher uses the initial contact to establish contact with other people who are relevant to the research (Bryman, 2012). Sandra, who was part of a yoga group for pregnant womxn, referred two womxn for the study, and both agreed to participate. At the same time, further clinic recruitment resulted in another two womxn joining the study. This brought the total number of participants to eight.

4.5.7 Particulars of participants

I have replicated the following table, which, during data collection, allowed me to scan through participant characteristics succinctly. It includes their age, race, marital and employment status, amongst other features. The table is followed by a brief description of each womxn.

TABLE 1: DETAILS OF PARTICIPANTS

NO.	PSEUDO NAME	AGE	PARITY	RACE	PARTNERSHP STATUS	EMPLOYMENT STATUS	TRIMESTER	PARTNER EMPLOYMENT STATUS	HEALTHCARE ACCESS
1	Ntombi	24	1	Black	Partner/ Non-cohabiting	Unemployed	2nd (6 months)	Employed	Public
`2	Tayla	25	1	Coloured	Married/ Co-habiting	Unemployed	2nd (5 months)	Unemployed	Public
3	Kwanele	19	1	Black	Boyfriend/ Non-cohabiting	Unemployed	2nd (5 months)	Studying/ Unemployed	Public
4	Sandra	34	3	Hispanic	Married/ Co-habiting	Unemployed	3rd (9 months)	Studying/ Unemployed	Public (and doula)
5	Kerry	33	1	White	Engaged/ Co-habiting	Employed	2nd (4 months)	Employed	Private
6	Anelisa	34	2	Black	Married/ Co-habiting	Employed	2nd (6 months)	Employed	Private
7	Thando	21	1	Black	Boyfriend/ Non-cohabiting	Unemployed	3rd (32 weeks)	Studying/ Unemployed	Public
8	Linda	27	2	Coloured	Single	Employed	2nd (6 months)	-	Public

Ntombi: lived in an extension of the main town. Our first interaction took place in my car, where she signed the consent forms. Her only interview took place at clinic 2. Ntombi was employed at a construction site but stopped working there during her sixth month of pregnancy. She stated that she was unhappy due to work politics between employees and with management, and did not want to return to work after her baby was born. Ntombi suffered a miscarriage in her seventh month. She later moved house and invited the co-researchers and myself to visit her at home, where we went to convey our condolences for her loss and show our support.

Tayla: just relocated from the Western Cape with her husband due to the high level of crime and drug-peddling in their area. They had lived with her husband's brother, sister-in-law and their child, which often led to disputes. They moved to the Eastern Cape to live with her mother and continue the pregnancy in a less stressful and more supported environment. Although the pregnancy was not planned, Tayla stated that she and her husband were both happy and that she felt very blessed.

Kwanele: was a student at a university in another town and was struggling with several subjects. At the start of the academic year, her parents advised her to temporarily stop her studies and return home. She moved back in with her mother, reconnected with her boyfriend and, shortly thereafter, fell pregnant. She went through stressful episodes until her mother suspected she was pregnant and advised her to visit the clinic. The emotional support from her mother and her family claiming 'damages'[3] to the tune of five cows, strengthened her standing in the neighbourhood. She indicated that she aspired to continue her studies

[3] refers to the father of the child and his family accepting responsibility for the pregnancy and offering financial support.

once her baby was born, and hoped to receive support from her mother and her boyfriend's mother in caring for the child.

Sandra: moved from Brazil to South Africa a year earlier, for her husband to pursue his studies. They had two children aged five and seven. At the time of moving from Brazil, she suspected that she was pregnant but decided not to share this information with her family lest they refuse to let her travel. Once in the Eastern Cape, she initially decided to have an abortion. This proved to be logistically, emotionally and mentally challenging, and she decided instead to have the baby. She worked as a journalist and continued to freelance using her laptop at home. She accessed public health at clinic 2 and planned on a home delivery with the assistance of a doula.

Kerry: owned a business in town. She and her fiancé worked together in the service industry. While they had been planning to have a child for a while, it took longer than anticipated for her to become pregnant due to health-related complications. She accessed and received acupuncture (as an alternative form of medicine) to treat an illness and found it beneficial. She visited a local general practitioner (GP) for her periodic check-ups. She indicated that she would travel to the closest town, approximately 135 km away, to see a gynaecologist for her delivery. She planned to continue with work after her delivery and to take her baby to work, when necessary.

Anelisa: worked in an administrative role and was married to a Frenchman. She visited a GP at a local clinic for general monthly check-ups and planned to travel to a town approximately 175 km away for the delivery, where her mother and extended family lived. She had visited her husband's family overseas often. She found it important to raise her children according to the environment she lived in, and to expose them to the culturally diverse backgrounds of their parents. Anelisa felt supported by her husband. She hoped to, at a later point, study further and move away from the administrative tasks of her current job.

Thando: was registered as a critical case when I first met her at clinic 3. She had lost her first baby in the ninth month. At the time of her first pregnancy, she had been in the middle of her under-graduate studies. Due to her academic performance, she had to drop out of university. For her current pregnancy, she moved in with a friend and her friend's mother who insisted on looking after her during her pregnancy. This suited her, as it was closer to the clinic and the public hospital where she was to have her delivery. Her own mother lived in another town and though they kept in touch, she stated that they did not have a good relationship. She indicated that she found her boyfriend supportive and believed that the pregnancy had brought them closer. She spoke of receiving much support from the grandmother in the house where she lived and referred to her as her own mother.

Linda: worked as a waitress in a coffee shop in town and lived with friends. She had a daughter aged six, who lives with Linda's mother approximately 55 km away. Linda tried to visit her daughter at least once a month. On one such visit to celebrate her daughter's birthday, she reconnected with her daughter's father. She did not expect to fall pregnant and had been anxious about what everyone around her would say. She had also faced a lot of taunts from the family of her daughter's father, causing her to feel stressed. She continued to work at the café although she finds the work very tiring, and intends to return there once her maternity leave (unpaid) is over.

In terms of the contextual backdrop of the eight participants in this study, their social locations influenced the different levels of care that each womxn was able to

access. Most of the womxn in this study saw nurses in the public health sector. A couple of participants, especially those from resourced families, had access to General Practitioners (GPs) and gynaecologists via private medical aid. A couple of the participants accessed doulas and one participant sought acupuncture (to overcome a health issue), highlighting how each experience is unique. Based on the intracategorical intersectionality approach, which emphasises differences within one category (McCall, 2005), these eight womxn at multiple social locations create a sample that is diverse, and that potentially complements an intersectional framework and facilitates an intersectional thematic analysis.

4.6 DATA PRODUCTION

My research data were produced through approximately thirty-two interviews with eight pregnant womxn. Six participants already owned camera phones and two participants proposed using a relative's phone. While the research team had been willing to purchase a phone for participants if they needed it, there was no need in this case. Ninety-two photographs were generated through the photo-elicitation technique. Four (and sometimes five) meetings transpired with each participant. This is because the first session was divided into two sub-sessions, depending on whether the participants signed the consent forms at our first interaction or whether we needed to meet them again to obtain written consent. We wished to interview participants in a location in which they felt comfortable. Four of the clinics offered us a space, in case any of the participants preferred to be interviewed at the clinic. We also obtained permission from a Development Centre in the township that was affiliated with the university, as another possible venue for interviews. Ultimately, data were collected from womxn sourced from three clinics (in rural and urban areas), from a parents' network, and through snowball sampling.

Crossley (2000) recommends that all narrative interviews be tape-recorded to allow for an accurate record of the raw material. Material was translated to English where necessary. The interviews were transcribed verbatim (Crossley, 2000). Where data were in isiXhosa, they were simultaneously translated and transcribed by the

bilingual co-researcher. The second co-researcher would then check the translated, transcribed text against the recordings. Any linguistic or conceptual discrepancies were resolved through discussion between the co-researchers. For example, certain isiXhosa words do not directly translate to an English word. Therefore, certain words like 'inhlawulo' or 'intambo' (refer sections 5.12.2 and 5.12.3) warranted descriptive explanations.

4.6.1 Session one

The first sub-session was an initial meeting which took place at either the clinic or at a location convenient to the participant - typically their house or a coffee shop. This involved an introduction to the research project, where the aims and requirements were laid out. The second sub-session was to get signatures on the consent forms and to share guidelines for taking photographs. Participants were asked to use their camera phone to take photographs within a specified time frame (as per Mitchell, DeLange, Moletsane, Stuart, & Buthulezi, 2005; Skovdal, Ogutu, Aoro, & Campbell, 2009; Skovdal, 2010). We shared basic instructions on how to take a good photograph, such as not pointing the camera towards the sun, and having a light source behind them. The emphasis, though, was on sensitising them to the ethics surrounding photo-elicitation. This included the importance of acquiring verbal informed consent from any person being photographed and to avoid taking photographs that could portray someone in a negative manner (Wang & Redwood-Jones as cited in Skovdal et al., 2009). I proposed, as an example, that a person that the participant wanted to represent could be captured symbolically in a picture, via a chair the person sat on often, or footwear that the person wore. I expanded my photo-elicitation guidelines to include feedback from the pilot-interview and instructed the participants to "take photographs of anything that makes your pregnancy easy and anything that makes it difficult; or things that make you happy or sad; also include pictures of your daily routine; and essentially anything else that has meaning for you in your pregnancy." Asking womxn to take pictures of their routine would represent their typical day, but also possibly reveal what they hold significant at a subliminal level.

4.6.2 Session two

The second and third session with participants involved open-ended interviews that ranged between twenty minutes and just over an hour. The second interview started with a single question called a SQUIN (Single Question aimed at Inducing Narrative) designed to produce a complete narrative (Wengraf, 2001). Participants were asked to tell the story of their pregnancy from before conception up until their current situation, including discovery of the pregnancy. They then proceeded to the photo-elicitation narratives. Participants were encouraged to explain each photo and how its object made their situation easier or harder. The photographs thus served as a storytelling device to gain an in-depth understanding of their pregnancy (Mitchell et al., 2005). Prior to each photo explanation, I did a voice-over of the photograph content, based on feedback from the pilot-interview.

4.6.3 Session three

At the third meeting, participants were asked to talk about any aspects not covered by any of their photographs. It included people, places or objects: anything or anybody with whom they interacted. Some participants had taken a few extra photographs, even though they had not been requested to, which they shared in this session. I also used the session to ask questions on aspects of supportability not referred to by the participant in the previous interview, as recommended by Wengraf (2001).

4.6.4 Session four

A fourth and final meeting took place after the translation and transcription of the material had been completed. This was an opportunity to clarify any doubts that arose post-transcription. I also asked the participants if they wished to add or retract any information. Each participant signed a final 'Image Release Form' (Appendix 9) stating how many photographs they had taken in total and how many they were willing to share. Except for one photograph by one participant, none of the participants held back any photos. Participants were also handed a surprise baby shower hamper that contained utility items for the 'mum-to-be' and her baby, as a

token of appreciation for their effort, time and energy in sharing their stories and experiences.

4.7 DATA ANALYSIS AND INTERPRETATION

In order to interpret the data acquired from the participants' narratives, I adopted an intersectional thematic analysis. I first engage with the notion of a basic thematic analysis and then explain the applicability when it is theory-driven, in this case with an intersectionality lens. A thematic analysis identifies, analyses and reports patterns within the data with a theme acknowledging a crucial aspect of the data in relation to the research question (Braun & Clarke, 2006). Riessman (2002) describes a thematic analysis as one possible model for the analysis of narratives, with emphasis on the content of a text or 'what is told'. In this research, it would also include the stories behind each photograph. A basic thematic analysis broadly entails: the breakdown of text by coding the material, identifying themes and constructing thematic networks; the exploration of text by discovering and describing the thematic networks; and the interpretation of the patterns in order to go back and address the research questions (Attride-Stirling, 2001). Braun and Clarke (2006) distinguish a theoretical thematic analysis from an inductive one, with the former being driven by the researcher's theoretical or analytical interest. The latter does not attempt to fit into a pre-conceived coding frame. The sampling and data analysis in this research is approached through an intersectionality lens. The strength of an intersectional analysis, per se, lies in its "openness towards the unpredicted and in its ability to understand the specific and the local" (Christensen & Jensen, 2012, p. 112). Basing my analysis on McCall's (2005) intracategorical approach that rejects categories while recognising the role they play in people's lives, the intention is for new dimensions of meaning to emerge from the narratives. Macleod's (2016) supportability framework guides the analysis, as it did the literature review. Hence, the type of analysis employed is an intersectional thematic one that is theory-driven.

Braun and Clarke's (2006) method of thematic analysis entails six phases. Phase one involved familiarising oneself with the data (this occurred during interviews and

transcribing) and observing the initial patterns that emerged after re-reading the transcripts. I adapted Ian Parker's (1992) transcription conventions (view Table 1 at the end of the chapter). The supportability model as a reference (refer section 4.6.3) lent fluency to the data during the interviews itself, since it required a level of engagement to know which aspects of supportability had been discussed and which ones had been left out. Phase two related to the creation of initial codes, which involved organising the data into meaningful groups (Tuckett, 2005). In this research, the process of coding was theory-driven (Braun & Clarke, 2006) with a specific research question in mind. The topics in the supportability model either became, or helped to generate, the initial codes (Phase 2), which I marked with different highlighters. In other words, each colour represented a topic under the headings in the supportability model, such as purple for *personal-emotional*, *yellow for micro-healthcare worker interactions*, and orange for *macro-religiosity* aspects. The process of coding flowed into Braun and Clarke's (2006) next two phases, which are searching for (Phase 3) and reviewing (Phase 4) the themes that emerge. I listed out all the headings from the supportability model, and laid out the themes below each topic, dividing them into two groups: those that promoted supportability and those that hindered it. For example, *partner interactions promoting supportability* or *work/school interactions hindering supportability*. Therefore, certain sub-headings denote the codes generated while others represent themes. I justify the emergence of themes and my deductions by adding extracts from the various transcripts. The extracts in the analysis chapter follow this format: extract in italics; brackets under the extract that include the participant's name, page number and the line numbers of the extract (example, *Tayla, p. 19, l 642-651*). In addition to the transcription conventions (Parker, 1992), I mark certain words in the extract in bold. These words inform the analysis that follows. Phase five involved defining and naming themes while shedding light on the overall story told by the analysis (Braun & Clarke, 2006). In this research, this step meant generating themes across categories, while aiming to highlight the links that emerge when using an intersectionality lens. Phase six entailed the production of the report that aims to convince the reader of the rationality and value of the analysis, while providing a "concise, coherent, logical, non-repetitive and interesting account of the story the data tell – within and across

themes" (Braun & Clarke, 2006, p. 93). This is achieved not only in the analysis chapter, but also through the validation process in the methodology chapter and the arguments made in the final discussion and conclusion chapter.

As themes occur in texts at various levels, and a thematic network enables one to extract, arrange and depict these themes (Attride-Stirling, 2001), I highlight the complex inter-relations regarding the supportability of pregnancy by placing the event of pregnancy within the model proposed by Macleod (2016).

4.8 ETHICAL CONSIDERATIONS

One of the main aims of research ethics is to protect the participants' welfare (Wassenaar, 2006). In order for this study to take place, a full ethics protocol served at the Research Projects and Ethics Review Committee (RPERC). Ethical clearance was received from the RPERC (Appendix 1). This allowed us to obtain permission from the Department of Health to recruit participants (who were 18 years and older, whose pregnancies were 13 weeks or beyond, and who were already accessing antenatal care).

Codes of ethics emphasise certain guidelines, and these were adhered to throughout the process of my research. According to Wassenaar (2006), four philosophical principles underline the different ethical guidelines, namely: autonomy and respect for the person's dignity; non-maleficence; beneficence; and justice. Autonomy was achieved by ensuring that participants could exercise their rights as autonomous persons to voluntarily accept or refuse to participate in the study if they felt uncomfortable. Justice implies that the research participants be treated fairly and equally. To facilitate this, all participants followed the same procedure, were informed about the nature and consequences of the research interview, and signed three consent forms at the onset of the process. They were also made aware of a fourth form, which would require their signature at the last meeting between researcher and participant. Non-maleficence, which supports the principle of autonomy, ensures that no research participant is harmed in any way (Wassenaar,

2006). The four consent forms aimed to inform, but also to safeguard the interests of, the womxn in this study. In retrospect, it is possible that the attrition of four womxn, after having signed consent forms, was due to the extensive level of detail in each form and the detailed explanations surrounding the process and ethics. Therefore, the number of forms might have worked as a deterrent. However, it was safer to go through the process and allow the womxn to make an informed decision about their participation, rather than to withhold information that could later cause them discomfort and harm, as outlined by Orb et al. (2001). Beneficence takes non-maleficence a step further and aims to ensure that participants benefit from the research (Wassenaar, 2006). At the macro-level, this will be in the form of a policy brief directed to the Department of Health. At a micro-level, the significance of a narrative cannot be underestimated, as it functions as a tool that enables a person to make sense (Riessman, 2008). The provision of a safe space for womxn to tell their story may be considered a benefit for the participants. In fact, three participants emphasised the therapeutic aspect of narrating their story and the importance of 'feeling heard' (refer section 5.9.3). All the womxn were surprised and grateful for the 'baby shower' hamper presented to them at the end of the interview process; this may be counted as a tangible benefit. Anonymity was maintained by altering identifiable information. Although some of the participants allowed the use of their names, I preferred to give all pseudonyms, should they ever feel differently in the future.

In aiming to focus attention on the various aspects that influence a womxn's pregnancy, and to move the focus of problematic pregnancies away from the 'individual womxn' as a unit of analysis, the hope of this research is to shed light on significant matters in maternal health that can ultimately empower and equip womxn to have a healthy, safe and supported pregnancy.

At the onset, full informed consent was gained from participants from the first form (Appendix 6). The second form related to Photo Consent (Appendix 7) and obtained their consent to take photographs related to their pregnancy. This form also stated the ethical requirement of receiving verbal consent from a third party should they

wish to photograph someone else. Although these photographs would be used only for academic research purposes and not for commercial gain, the participants were informed that images of any person's face would be blanked out and pixelated to safeguard their identity. Accuracy is another ethical requirement, which ensured that participants' contributions were faithfully recorded. Tape-recording the interviews, and not relying on mere notes and memory, enabled an accurate collection of data. Hence, a consent form permitting the audio recording of interviews was signed by participants (Appendix 8). Participants were made aware that all their data would be appropriately stored in password-protected computers. Any hard copies of the material would be stored in locked cabinets at the research unit for a period of five years, after which all material would be destroyed.

The manner in which a researcher gains access to a specific group can possibly lead to ethical conflict (Orb et al., 2001). While I obtained appropriate clearances from the Department of Health and the clinic supervisors, it was the gatekeepers at the clinics who arranged meetings between prospective participants and myself. In most cases, the gatekeepers were the clinic supervisors or head nurses whose authority might have played a role in some womxn feeling pressurised into participating. As stated earlier in this chapter, I reiterated to all the womxn that their participation was purely voluntary, and that the decision not to participate would not affect the services that they would receive from the clinic. Wassenaar (2006) also emphasises the leverage that researchers possess to influence the reader and the public, and urges researchers to exercise this power in a responsible and sensitive manner. I was aware that the participants opened up their homes and lives to me – a complete stranger – and shared their stories in a candid way. Orb et al., (2001) stress that researchers need to be conscious of a participant's vulnerability and rights while maintaining a moral obligation to refer participants to counselling. Keeping in mind how personal their experience was, as well as the potentially sensitive nature of the material they shared through photographs and words, I referred all participants to the Rhodes University Psychology Clinic in case they experienced any discomfort or wished to consult a professional. They were also given the contact number of *Lifeline* that offers free phone or face-to-face counselling.

4.9 VALIDATION

Polkinghorne (2007) states that the concept of validation in qualitative research requires that the data and findings are well-grounded and supported. Adding photo-elicitation to the methodology of this research created another layer of credibility, as each photograph was grounded in the everyday reality of the participants' lives. The validation process is done to convince readers that the support for the claims made is strong enough to serve as a basis for understanding human action (Polkinghorne, 2007). To support the analytical findings of this research, I include appropriate quotations from the transcripts that also reinforce the conclusions I have drawn. It is important to note that while all readers may not interpret the data in a similar manner, it is, nevertheless, essential for them to determine and identify the means by which the interpretations were reached (Houghton, Casey, Shaw, & Murphy, 2013).

Another key principle of validity is that of coherence and transparency, which involves strong, logical arguments and clarity on the research methods (Bryman, 2012). I have specified this through a detailed methodology which involved a description of: the use of narratives, photo-elicitation and Macleod's supportability framework; the process of participant recruitment; the methods of interviewing; and conducting an intersectional thematic analysis. Outlining my decisions worked as a rationale for sound arguments.

Finally a completeness of data increases the credibility of the findings and mainly involves gathering multiple perspectives from different sources in order to display a complete picture of the phenomena (Houghton et al., 2013). The ethnically diverse research participants from varied social locations added to the richness of the data. Multiple sessions with each participant provided opportunities for them to augment or remove material as they considered the issues that were raised. These points enabled a comprehensive study with different viewpoints of the same experience, namely, pregnancy.

4.10 ROLE OF REFLEXIVITY

Reflexivity is a key consideration while validating one's research. I introduce reflexivity under its own heading, stressing the importance of this feature and its presence right from the conception of this research topic to the submission of the final draft. According to Crossley (2000), reflexivity should be paramount, as the narrative material used in analysis is influenced deeply by the researcher. Crossley (2000) recommends that the researcher consider the implications of selection, interpretation and representation of the analysis. The selection and interpretations were made keeping in mind my own subjectivity, which can influence the findings.

Interestingly, an experience-centered approach claims that narrating one's experience in a sequential fashion is not just a human trait, but actually *makes* one human (Squire, 2008). Open-ended interviews and semi-structured follow-up interviews allowed the dynamics between the participant and myself to develop organically, as research containing narratives recognises that narratives are co-constructed. In fact, the co-construction of knowledge itself in qualitative research impacts data collection and analysis, and it is important for a researcher to be aware of this aspect in order to enhance the trustworthiness and accountability of data (Finlay, 2002). Hence, I was constantly aware of two aspects: firstly, my role as an audience member when the participants shared their experience with me, and secondly, my need to connect with the participants at a personal level.

In the first instance I aimed to be open, as objective as possible and research-oriented, focusing on all the methodological aspects and the implications of all interactions. This was relatively easy, since the research proposal created a logical step-by-step process that could be followed. I am aware that my researcher role framed all interactions with the participants as stated by Watts (2006). Retrospectively, I also became aware of my tendency to inform the participants early on in our interactions that I was the mother of an eight-year-old girl. This is not something I did consciously at the time. This speaks, however, to the second aspect that involved a subjective, personal stance in which I naturally wished to connect

with each participant. When one of the participants (Ntombi) lost her baby at seven months, it was a time when I, as a researcher, had to put aside my research requirements, introspect and grieve the loss of the infant, and mourn the loss with Ntombi. The co-researchers and I went through several failed attempts at contacting Ntombi, before successfully relating to her that we did not want to interview her, but simply wanted to pay her a visit to see how she was. Perhaps this request made all the difference, as she agreed. We saw her over a month after her loss. Although we did not ask her, she related what had transpired at the hospital. We neither recorded this conversation nor took notes. It was hard not to 'probe' and ask questions, since there appeared to be a drastic lack of information from the hospital staff to Ntombi. Bryman (2012) proposes that researchers show sensitivity to the context in which the study is situated. I imagine that in our endeavour to connect with Ntombi at a humane level, we were able to stay sensitive and empathetic in her hour of need and continue our research process ethically and with integrity. Finlay (2002) challenges researchers to use introspection, not as an end product, but as a catalyst for further insights and interpretations. In the same chain of thought, while we did not pursue Ntombi as a research subject after the loss of her pregnancy, we did use her first interview in a principled manner. Her narrated experience from her first interview has a space in the research for which we have her informed consent, while respecting her need for privacy after her miscarriage.

In reading Collins' (1990) *Black Feminist Thought* at the same time as writing this chapter, I reflected on the two aspects stated above. I became aware of "how an outsider-within stance functions to create a new angle of vision" (Collins, 1990, p. 11) and can create a distinct and unique angle of interpretation and analysis. I understood the tendency to fluctuate between the two aspects (mentioned earlier), as my need to shift from an outsider to an insider to gain an intimacy with the participants by informing them that I understood certain aspects of their experience first-hand, as I have been through a pregnancy as well. Yet, considering my theoretical framework of intersectionality, my outsider stance remained prominent. This included being Indian, a foreigner, a research student and the fact that although I was from India, the participants themselves would not know that immediately as

there is, of course, a reasonably large Indian community in South Africa (although perhaps not as many in the Eastern Cape).

4.11 CONCLUSION

A methodology chapter aims to provide a 'recipe' for the research that may be adopted by the research community to replicate in a different or similar context for further knowledge production. It helps in understanding the procedures that were followed, why certain decisions were made and to situate the analytical claims made by the researcher, while making the entire process transparent.

In this chapter, I provided an account of the methods that supported my data collection, as well as a step-by-step explanation of the data collection process itself. Mann and Huffman (2005) point out that bringing differences to light certainly challenges predominant discourses and that "no one view is inherently superior to another and any claim to having a clearer view of the truth is simply a master narrative" (p. 65). With regard to the sampling, the table of participants' particulars highlights the diversity of the participants. There is a tendency to acknowledge oppressed groups only when ideas are outlined in ways that are familiar to a dominant group (Collins, 1990). By placing the event of pregnancy itself at the center of analysis, I avoided comparing a womxn's narrative against another, more 'powerful', narrative and focus instead on privileging each account. I then covered the aspects of a thematic intersectional analysis and incorporated separate sections on validating the research, the ethical principles and an ethical dilemma that I faced in this research. I concluded with a segment on how being reflexive enabled me to better understand the participants and, in turn, enhance my research.

TABLE 2: 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

CHAPTER FIVE: DATA ANALYSIS

5.1 INTRODUCTION

This chapter analyses the collected data to understand the multilayered accounts of supportability in womxn's narratives of their pregnancy. The intracategorical intersectionality framework of this research emphasises how social locations and structural forces can influence the experiences of a single social group (pregnant womxn) going through the same event (pregnancy). In using such a framework, I hope to situate womxn's pregnancies as being (un)supported or (un)supportable (or perhaps unevenly both) by locating supportability within the interweaving biological, psychological, social, economic, cultural and political contexts within which they occur. An intersectional thematic analysis enables me to unpack the narratives of the research participants to achieve a complex and nuanced understanding of their pregnancies.

My analysis broadly occurs in two phases: the first phase is a thematic analysis of the narratives using Macleod's supportability framework to examine these themes through an intersectionality lens; while the second part explores the common themes that cut across social categories and locations. The analysis is structured according to the order in Figure 1 (in chapter 1) and describes the topics under each heading as follows:

- Personal experience: whether the physiological, emotional and cognitive aspects hinder or enable supportability.
- Micro-interactions: whether the interactions with partner, family, community, workplace/school and healthcare workers hinder or enable supportability.
- Macro-structure: whether the socio-economic structures and policies, health systems, work and school systems, and cultural, religious, social and gender practices hinder or enable supportability.

The analysis also includes a section on the role of information and information technology during pregnancy.

Each sub-heading in this chapter stems from the supportability framework. While this framework predetermined many of the main codes in this analysis, it was interesting to note that hardly any stand-alone themes emerged. More often than not, the physical experience is closely linked to the emotional experience, which is interconnected with the cognitive meaning-making process. Notions of BAM are strongly influenced by one's social environment, micro-spaces of healthcare interactions and macro-constructs such as discourses of risk, responsibility and what it takes to be a good enough mother. Although the aim is to present results in discrete categories, there is some overlap (as suggested by the model). Therefore linkages are spoken to where relevant.

5.2 SUPPORTABLE AND UNSUPPORTABLE PREGNANCIES

Macleod (2016) asserts that "the construct supportability is not meant to be seen as dichotomous (either supportable or unsupportable), but rather consists of two inter-related continua — 'unsupportable - supportable' and 'unsupported - supported', each forming an essential part of the analysis" (p. 3). To begin, I first examine what womxn say in relation to the first continuum (supportable/unsupportable), which refers to her ability – physical, emotional and mental – to carry the pregnancy to term. Some of the photographs taken by the pregnant womxn are included in this chapter to demonstrate how these pictures elicited their pregnancy experience. The photos contributed to a form of meaning-making not just for the participants but also myself, the researcher.

5.3 PHYSIOLOGICAL ASPECTS

5.3.1 Physiologically unsupportable pregnancies

In relation to the physical aspects of their pregnancy, only one pregnancy was unsupportable in an absolute sense. Ntombi's miscarriage in her seventh month made her pregnancy unsupportable. Although the pregnancy had been unplanned, she gained acceptance, and transitioned to emotionally and mentally wanting a

baby. At a later stage, she shared how devastated she was about the miscarriage and that she was still waiting for a report from the hospital regarding the cause.

In Sandra's case, she disclosed how the possibility of a Multiple Sclerosis diagnosis could lead to a potentially unsupportable pregnancy.

"I was extremely tired. I have um a condition that might be MS (2) so that was the biggest reason that I was thinking about terminating uh being unable to do (.) to look after (.) the children properly, if I am diagnosed with multiple sclerosis because I'm still under observation…so that's why they're still monitoring me and I have to go to the doctors every six months and (.) but it hasn't been diagnosed (.) but it hasn't been cleared out either…so that's another thing that wasn't easy for me to deal with um (1) pregnancy and (1) being sick."
[Sandra, p. 3, l 91-103]

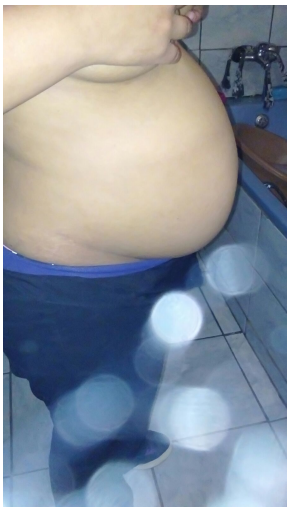
Sandra successfully carried her pregnancy to term. From her words, it is evident how the physical aspects are intertwined with healthcare, which can make shift a potentially unsupportable pregnancy to a supportable one; and that the physical aspects of childcare are also interwoven with the supportability of pregnancy.

5.3.2 Physiologically supportable pregnancies

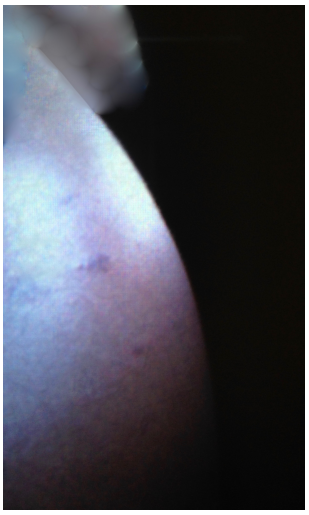
The other participants conveyed a range of grievances about their physical discomforts and changing bodies, but none serious enough to cause harm or permanent disability to their own or their infant's life. The negative physical symptoms reported by the participants included: hair loss and cramps (Ntombi); difficulty sleeping (Tayla, Kwanele); fatigue (Sandra, Kerry, Thando); nausea (Tayla, Sandra); and heartburn (Linda, Kwanele). Thando made reference to "the physical part of me getting fat, tired, headaches" (p. 3, L 118), which speak to the different physiological changes that can make a pregnancy tiring or uncomfortable. In the literature, frequently-reported physical symptoms that cause uneasiness include nausea, fatigue, aches and pains (Whitaker, Wilcox, Liu, Blair, & Pate, 2016) as well as sciatica, leg cramps and varicose veins (Hall, Lauche, Adams, Steel, Broom & Sibbritt, 2016). The physical supportability of a pregnancy is intricately interwoven with quality of healthcare available; one of the major factors in the drive against maternal mortality is to address the preventable causes thereof. While these participants' symptoms did not constitute a threat to the pregnancy, foetus or

mother (and cause physiologically unsupportable pregnancies), good healthcare can alleviate the symptoms. Some of the participants did refer to this aspect, which is highlighted under the healthcare interactions that promote supportability (section 5.9.2).

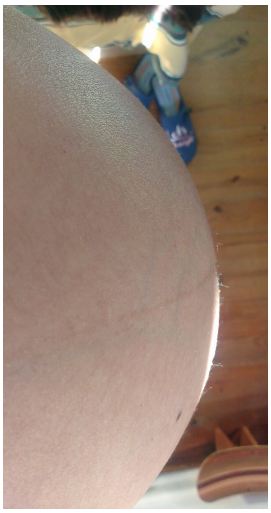
All the participants in this study described the physical experience of their pregnancies. Weight gain and the resulting larger body size were part of the most recognisable aspects of pregnancy for the womxn. This was evident in their narratives and their images (three of which are included on this page).



Linda



Ntombi



Kerry

"How much more will it (my body) change? I mean how will I be looking at nine months? Maybe I will be looking ugly, I'm not sure…"
[Ntombi, p. 12, l 382-384]

"I was always scared to look at my stomach because I wasn't used to the body."
[Tayla, p. 11, l 358-359]

"I started gaining weight like on a big scale =ok= I was fat, I was ugly, everything depressed me, I think I was very emotional with my first pregnancy."
[Thando, p. 1, l 38-39]

Gaining weight is a normal part of pregnancy, yet, what stands out in the womxn's descriptions is the emphasis on their body image and even body-shaming. Vivid words like 'fat' and 'ugly' are used to describe how they view themselves, perhaps also referring to the extra attention by others who comment on the weight gain, and their own perceptions of how others view them during this stage. Thando, in her

narrative, describes her clothes as being tight and how that creates discomfort for her.

*"Basically, it's too small. I'm **fat** now and I hate it so much =really?= um…it's because I'm uncomfortable with the size that I am now and my clothes, like all of it (.)…It's like a hassle for me to get something to wear on Sundays when I have to go to church =ok= or when I have to go to, let's say, hospital or clinic =um= cause you have to look proper at least."*
[Thando, p. 11, l 443-452]

"My friends said, oh, your stomach is growing now… then she took a pic =em= and I told her - yoh! It's really big."
[Linda, p. 13, l 531-534]

Pregnancy weight gain has been commonly cited as the cause of physical discomfort, negative psychological influences such as struggling with one's body image, and lower self-esteem (Whitaker et al., 2016). The extracts illustrate the intersection of certain macro-system discourses that influence a womxn's pregnancy experience. Despite the corporeality of this transition phase, womxn's descriptions of being depressed by weight gain and their changing appearances seem to be embedded in ideas of the non-fat body being desirable, and of gendered understandings of appropriate clothing. This is in line with findings by Earle (2003) around womxn's pre-occupation with bodies, clothing and appearance during pregnancy.

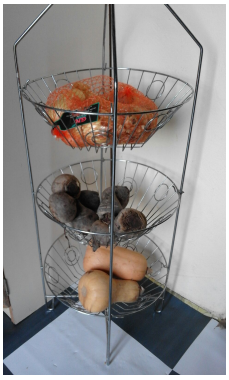
Previous studies (Brown, 2002; Stephenson et al., 2014) have highlighted how pregnant womxn are motivated to adopt healthy behaviours. Eating habits were the first marked change for many of the womxn in this study, with various behavioural changes promoting supportability. Most participants shared photographs of food, which immediately highlighted its importance in their pregnancies.

"Everything I eat now, I have to eat and think about the baby, I just can't eat anything…even if I eat an apple, I will feel the baby kicking, so I think food is very important, even though (2) she is not like literally eating the food but then the vitamins and all the nutrition, it's going straight to her."
[Anelisa, p. 4, l 129, p. 5, l 143-144]

"Those are just the healthier healthier elements that again I'm trying to…I'm sort of hoping that staying on that whole healthy healthy vibe...you know my body just stays as strong as it can and =ok= and ja the fruits are, I'm definitely eating more fruits than I've ever eaten in my life...not snacking junk all the time…you become a bit sort of more baby-orientated in a way."
[Kerry, p. 11, l 469-484]

Anelisa

Anelisa



Kwanele

Kerry

The above-mentioned changes are all indicative of physically supportable pregnancies. However, food habits were also a conflicted space, as Kerry shared images of the struggles she underwent between cravings (for 'junk' food) and healthier options.

Kerry's images of 'junk' versus 'healthy' food

5.4 EMOTIONAL ASPECTS

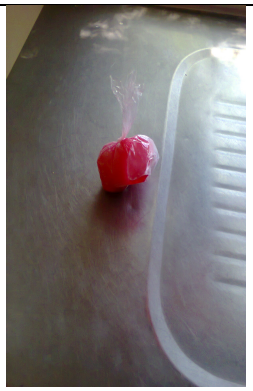
As highlighted in previous research, pregnancy can lead to a range of often-conflicting emotions for womxn (Bondas & Eriksson, 2001). Womxn in this study spoke about becoming hypersensitive around people, being scared of the responses of others to their pregnancy status, feeling depressed in relation to their bodily changes, experiencing fear of the delivery process and being uncertain about finances and the future. While these could constitute emotions that hinder supportability, they are also closely tied to their social location where other categories can either increase (such as a harsh working environment, IPV) or alleviate (such as family support, access to good health services and information) their psychosocial stress.

5.4.1 Emotional aspects hindering supportability

Although finances are closely tied to macro-policies and structures of unemployment and poverty, this subject created emotional stress for most of the womxn in this study. Thando shared her worry about having no income.

"The only thing we're stressing about...that concerns us both, without me having to tell him that you not working or me not working is stressing me. But you can feel it in the relationship, that we're both worried, what's going to happen?"
[Thando, p. 28, l 1194-1196]

Other macro-systems also play a covert role in womxn's behaviours. Constructs of motherhood may be imposed externally by doctors, nursing staff or friends, which then become internalised.



Thando

*"But here in the townships =it's locally made= yes, I like it so much =ok= but I was told at the clinic <u>not</u> to eat it again because it's too cold for the baby =is it?= Yes (1) and once you eat too much of it =em= it could cause you to have um **pneumonia** =ok= it's dangerous. I like it so much sometimes I **steal** it (.) when there is nobody here, I steal it. I go <u>buy</u> it and then **lock myself inside** here and just eat it."*
[Thando, p. 11, l 478-482]

"When I stress, neh, I've had this thing, then I go by myself (and smoke) and the smoking is the main thing because I can smoke like two cigarettes, which I know it's unhealthy."
[Linda, p. 5, l 195-197]

In the two extracts, Thando's need to 'lock' herself and Linda's going away 'by herself' to smoke (which she realises is unhealthy) indicate 'hiding away' behaviour to preclude any remarks lest they be viewed as bad mothers. Discourses around being a good mother can feed into self-deprecating beliefs that can lead to guilt and even shame in pregnant womxn.

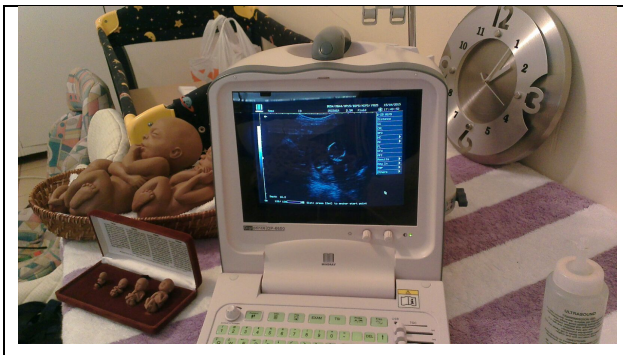
5.4.2 Emotions promoting supportability

Some womxn described how making a connection with the baby led to feelings of joy and excitement. Kwanele shared her amazement at feeling the first kick.

"It's much better than when it was still developing for the first scan…it was exciting because I could hear the heartbeat and I saw the heart...It's very amazing, because he just kicks very hard!"
[Kwanele, p. 25, l 1034-1040, p. 26, l 1083]

Sandra and Linda, who had both initially considered a termination of pregnancy (TOP), described their feelings of relief and comfort at the first scan.

"When I found out that I was pregnant then I consider (2) an abortion, but after going to the doctor then I said yoh (.) because then I saw the baby that was moving =em= [laughs] then it was so nice…when I saw that scan…then I realised that this is the reality (.) this is true be// When I saw the scan, when the baby was moving, the doctor was showing, there's his head, there's his bones =um= and everything."
[Linda, p. 7, l 281-291]



Sandra

"And this ultrasound was very special because it was, (1) I was I had just decided to keep the baby."
[Sandra, p. 2, l 61-62]

The reality of the pregnancy appears to sink in when womxn experience a physical and emotional connection with the growing foetus. These emotions (positive or

negative) are rarely experienced in isolation. An increased physiological and emotional connection brings about behavioural changes that womxn feel inclined (and sometimes compelled) to adopt, as illustrated by Kerry below.

"But out of everything, I suppose, that I partake in, even alcohol =em= ciggies were the thing that my body wanted =ok= and my head wanted and I wanted =ok= so that's been the toughest sort of thing, is to stop smoking cigarettes."
[Kerry, p. 9, l 389-391]

The womxn seemed to construct an image of a 'perfect' or 'good' mother based on their own understanding and assumptions. These are, to a large degree, based on what Mercer (2004) describes as the elaborate psychosocial work done by a womxn during her pregnancy. For example, in the extract below, Kerry outlines mothering behavior that she admires and that she would like to emulate.

"I really love how um African, like black African mothers um seem to be quite abrupt with their children =em= and it definitely makes these kids listen…you know a mother standing in a queue and she'll have a baby tied around her back with a towel and the baby will start crying...she literally stamps her foot, turns her head and she says 'Thula' and the baby stops crying…I've always said that I really want to have that with my baby."
[Kerry, p. 17, l 705-712]

5.5 COGNITIVE ASPECTS

5.5.1 Pregnancy intentionality hindering cognitive supportability

A major theme that emerged from the interview data about the womxn's mental (and emotional) experiences revolved around the moment they found out they were pregnant. By placing supportability at the center when examining pregnancy, the framework incorporates and expands on pregnancy intentionality. 'Intentionality', 'plannedness', 'wantedness' and 'timing' strongly feature in each womxn's narrative. The point in her life trajectory in which the pregnancy occurred held value and meaning for each participant in this study. For example, the photograph below defines Tayla's meaning-making process at the time of finding out.

"And when it appeared, like those two lines I was shocked, 'cos I was like this was not what I was expecting…honestly I was praying that it should be one line, 'cos it wasn't planned."
[Tayla, p. 22, l 771-774]

Tayla

Tayla's image of the pregnancy test underlines it as a defining moment that would alter the course of her life. She added:

"At the time when I did find out that I'm pregnant it was a huge shock...because we both didn't plan it, we both didn't expect it to happen at that time."
[Tayla, p. 26, l 910-912]

Six of the eight participants described their pregnancies as unplanned, and hence, Tayla's sentiment was echoed in many of the narratives. This aspect could have lead to unsupportable pregnancies for any or all of them. However, often with the right resources and timely support (including acceptance of their status by others), many of the womxn's perceptions and attitudes towards their pregnancy underwent changes.

5.5.2 Cognitions promoting supportability

A theme of *moving from rejection to acknowledgement* strongly runs through the personal aspects of pregnancy. So whether or not a pregnancy is planned, rejection at a cognitive level is still experienced by most womxn – of her changing body, of her fluctuating emotions and of the need to alter her behaviour. However, this feeling shifts from rejection to acknowledgement of the new way of being (and the new being), especially with the support of family and friends or/and the pregnant womxn's own wisdom. Most of the participants seemed to accept these discomforts through a cognitive sense-making process. As Ntombi states,

"I just thought that my hair loss is part of the process of pregnancy…It's life."
[Notmbi, p. 1, l 28-31]

"I haven't achieved that much yet that I want to do. But I thought no… I'll probably be a good mother too, hopefully, I know I will."
[Tayla, p. 12, 396-400]

Tayla's excerpt above is from the very beginning of her road to motherhood, shaping her desire to be a good mother. The journey appears to commence at a cognitive level and includes acceptance, which then leads to positive behavioural changes that enable the pregnancy. The acknowledgement of the baby in an unplanned pregnancy seems to be a social process (acceptance from her mother and partner allows for easier acceptance for the pregnant womxn). The role of partners, kin and other forms of social support will be analysed in the next section on micro-interactions.

5.6 SUPPORTED AND UNSUPPORTED PREGNANCIES

This part of the analysis examines the second continuum (supported/unsupported), which involves interactive spaces and how "macro- and micro-level support enables or constrains the supportability of a pregnancy" (Macleod, 2016, p. 2). Once again, photographs serve to enrich the narratives and analysis.

5.6.1 Partner interactions hindering supportability

As the literature suggests, the role of a partner during pregnancy is especially significant (Dunkel-Schetter et al., 1996; Rini et al., 2006). In this study, too, it was evident that the role of the womxn's boyfriends or spouses could bring about huge shifts in their mood, stress and comfort levels. Ntombi and Linda (both unmarried) describe the moment of sharing the news of their pregnancy with the father of their child as hurtful.

"I just sat on the toilet and phoned to tell him. He laughed and said 'Oh, so you are pregnant? Who got you pregnant?' after I told him I dropped the phone. I was shocked."
[Ntombi, p. 14, l 463-464]

"At night when I phoned this boyfriend that I was with =em= 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…I was with no one else, I didn't have any other boyfriends and stuff."
[Linda, p. 2, l 61-67]

"Because he <u>was</u> a bit mean to me in the beginning about the fact that I was showing early =em= and you know he said he was joking but I really didn't take it as a joke… I'm really trying to look after myself and the least he could do is be a bit more supportive...so I've kind of said...you just need to be nice to me. You don't need to do <u>that</u> much, just don't be <u>nasty</u> like passing those comments."
[Kerry, p. 19, l 806-814]

There are two aspects highlighted in these narratives that can deter supportability. Firstly, establishing paternal identification has long-term social and economic consequences; research has shown that, often, boyfriends may not want to shoulder the financial and social responsibilities of parenthood (Kaufman, De Wet, & Stradler, 2001). Financial consequences act as a major deterrent to declaring paternity (Kaufman et al., 2001). Secondly, accusations of multiple partners and statements focused on weight gain and body image are experienced as degrading and hurtful. Whether the partner's responses were genuine concerns or a joke (Ntombi later disclosed that "the father has no problem with us having a baby", p. 5, l 153), they had a negative impact on the womxn's self-worth and created a sense of loneliness for the womxn.

Moving along further on the unsupportable continuum, arguments and fights can lead to feelings of physical sickness and distress in pregnant womxn.

"Whenever I fight with my boyfriend like, a stupid argument or something stupid =um= and we don't talk for the whole day, I just get to feel so sick like literally sick, I get to vomit…I hate fighting with my boyfriend at this stage of my pregnancy."
[Thando, p. 32, l 1340-1343]

"I was forgetful because I didn't think about myself, I didn't think about my pregnancy as well…we were both acting out of anger…I thought I was gonna have a miscarriage at that time...he rushed me to my mother-in-law's place 'couse I was having pains at my back after the little fight that we had because he had grabbed me very hard so that's when I felt the pain and that's when I told him that he had hurt me… That's when we both realised that it could actually affect the pregnancy and the child as well…But I had those pains for like two or three days and during that time we both realised that it wasn't fair towards this pregnancy or towards this unborn child that we still have to raise and grow, grow inside of me."
[Tayla, p. 26, l 922-933]

Tayla alludes to the possibility of experiencing intimate partner violence (IPV). While conflicting evidence exists about whether IPV increases or decreases during pregnancy (Jasinsky, 2004), it has been noted that depending on the type of the violence, it is not just the abuse itself, but the interpretation of the abuse that is tied to negative outcomes (Bailey & Daugherty, 2007). In their ability to acknowledge and communicate about the gravity of the situation, Tayla and her husband altered the pregnancy experience. Tayla spoke of his supportiveness after the incident.

The excerpts demonstrate how a partner's presence affects a pregnant womxn's mental, emotional and physical health, as well as her physical safety.

5.6.2 Partner interactions promoting supportability

The partner's positive regard and concern for the pregnant womxn seem to play an important role in fostering supportability. Anelisa demonstrated how her partner's support and care contributed to her well-being:

"He is my rock, he is my strength, he's my everything (2) Yesterday we were walking home because...we didn't have the car and it was raining and he was so worried about me and I was so happy that I was walking next to him whilst on the rain and he was there for me…I didn't care if I got wet or whatever, as long as he was there for me…'Anelisa eat this, Anelisa don't eat that'…he is very caring."
[Anelisa, p. 6, l 189-204]

A partner's presence can also alleviate various forms of distress. This presence can include making frequent contact and offering tangible support, as experienced by Kwanele and Sandra.

"He does come and see me like three times a week but he calls every day and uhm we have spoken about our future…we've just decided next year what's going to happen next year, and ja, how everything is going to go...I experience his support by him (1), he calls and asks what I want, or what the baby wants, uhm he asks me about my uhm clinic dates, because at the clinic you have to uhm first stand out, wait outside and then he goes and stands there before I wake up and then I wake up, I wash and then I just go and I have my place already there…Ja so it's very supportive in that way, about the healthcare of the baby and my health… like he really doesn't want me to stress so most of the time he calls me, what are you doing now, uhmm if he is available he comes and he chills with me and then ja he goes."
[Kwanele, p. 16, l 659-683]

"It's been overall a good pregnancy =em= although we're dealing with so much variables in our lives. It's always been like that you see [laughs] in our lives =em= we've always gone through so many difficulties but we're still together and I think it made us stronger this is another, specially as a couple you know =em= to be able to carry on."
[Sandra, p. 25, l 1025-1028]

Sandra's husband helping with house chores

For Kwanele, in spite of not meeting her partner everyday, the fact that he called once a day and that they had jointly discussed plans for their future was experienced as supportive. Both Kwanele and Sandra partners' also offered instrumental support, such as holding a spot in the clinic queue and helping with household tasks, which they found beneficial. Experiencing support also seems to include communication in terms of encouragement, non-judgement and showing an interest in the pregnancy.

Photo of Tayla taken by her husband on a day when she was depressed about how she looked; unexpectedly, this photo uplifted her spirits.

"In the morning I felt really depressed. I didn't want to get up I just wanted to lay in bed. I didn't even want to eat. And then my husband played with me and he was like 'Come on man, there's nothing wrong with you' and I was like 'I'm getting fat' [giggles]. And he was like 'You're not fat, you're fine'…he just encouraged me to feel better about myself again."
[Tayla, p. 19, l 642-651]

The extract above clearly shows how closely the physiological is linked to the emotional, and how positive partner interactions can help alleviate depressive symptoms. In a gendered society, fat is often viewed as ugly, funny, repulsive and something to lose (Braziel & LeBesco, 2001). Hence, normalising the process can go a

long way in helping a pregnant womxn overcome concerns about her physical changes. Communication and connection between partners during pregnancy promotes supportability, as seen below.

*"He's supportive, he's actually what motivates me to wake up the following day with this pregnancy =ok= yes, he's the best, hey! He's the only form of support I have emotionally…he's my partner...actually he's my best friend eh…**we talk a lot**…and I think the loss of our first baby formed a stronger bond between us."*
[Thando, p 14, l 589-593, l 606-610]

*"**We're chatting more** than we used to chat before =ok= and sometimes he phones and asks me why am I so quiet, is the baby still fine? I can't say we're together but it's...like support (.) He's always checking on me…then I feel happy 'cause I'm smiling that time."*
[Linda, p 10, l 396-408]

While staying connected appears to be prominent for all the womxn, this does not necessarily have to be in person, as even a message or image seems to have an impact on the pregnant womxn's emotional and mental state. For Linda, after the initial insensitivity she experienced, the father of her child became more involved in her life. His text message was experienced as a sign of care.

Linda

"One day also when I was also stressing =ok= // and then he sent me this after say 5 minutes (.) then I saw this picture coming through then this picture makes me feel nice happy, it's a nice picture like… it makes me feel good and happy cause it shows that he cares for me."
[Linda, p. 9, l 380-391]

The images and extracts above highlight how support, whether tangible or intangible (even just the knowledge that someone is there) is experienced positively by the participants (Finfgeld-Connett, 2005). Being able to voice concerns and fears, share experiences and create a plan for the future together is experienced as equivalent to support. Tayla described the importance of setting aside anger and jointly finding solutions in order to be "on the same page again" (Tayla, p. 26, l 937).

*But when it happened and I showed him and he saw the results he was very, very, very thrilled and…scared, just as I was…But we **discussed** it and we just basically encouraged each other and told ourselves that we'll make it through no matter what. 'Cause everyone starts at some point. You don't know how to handle it but as you go on you learn every day."*
[Tayla, p. 26, l 912-917]

The theme of communication (or lack thereof) appears in different ways. From initially sharing the news of one's pregnancy, to arguments, and negotiating the future, all appear to have a direct effect on a pregnant womxn's reported wellness.

5.7. KITH AND KIN

The theme highlighted above sheds light on the permutations of interconnectedness between the personal and micro-level spaces in the supportability model. For example, in a pregnancy, the physical changes can create cognitive dissonance for the womxn, partner acceptance can lead to a positive emotional experience, access to quality ANC can shift pregnancy 'wantedness', and so on. The extent of these linkages continues through interactions with family members, friends, community members and midwives, amongst others.

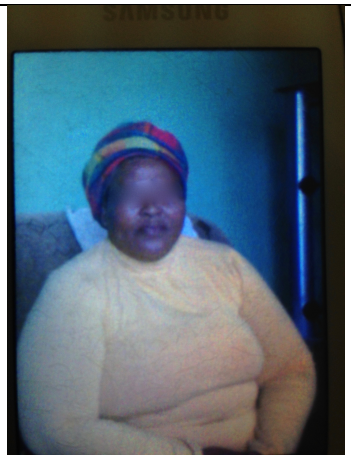
5.7.1 Family involvement promoting supportability

In most of the narratives, a significant person that emerged was the pregnant womxn's mother, especially her reaction when she heard of the pregnancy. A womxn's interpersonal dynamics and 'antenatal attachment' [4] is said to be influenced by her own relationship with her mother (Priel, & Besser, 2001). This became apparent because almost all the womxn (with unplanned pregnancies) spoke about the stress around revealing their pregnancy to their mothers and how the mother's response affected their own response to the pregnancy.

[4] This is understood to be a uni-directional embodying of maternal cognitions and emotional responses to the pregnancy that develops between the pregnant womxn and her growing foetus, that taps into maternal attitudes (Redshaw & Martin, 2013).

"And after having expressed my fears to my mother, she told me that it is no problem..."
[Ntombi, p. 5, l 161-163]

"She is very supportive. Her and my dad…It is the opposite reaction that I had expected from them."
[Ntombi, p. 10, l 301-303]



Ntombi's mother

Kwanele shared that she "feared for her (mother's) rejection" but that they "have a very close relationship" (p. 17, l 720-727). So, once her mother had come to terms with the pregnancy, Kwanele felt less stressed.

"She gave me money to go to the doctor, then I went to the doctor then I found out that I was pregnant and then I came back to her and...she didn't talk to me for about a week…but then she came about to accept it…and then she sat down and then she talked…gave me support that she kind of knows what I'm going through uhm, so she wants me to know that (.) uhm I'm not alone and that I can talk to her…she doesn't want me to stress…I can share with her and be open with her, ja."
[Kwanele, p. 9, L 356-378]

"I was scared. My landlord forced me. She phoned my mum and she told my mum, that Thando wants to tell you something… She was shocked. She dropped the phone. Then she phoned me later on =ok= telling me that I should go to the clinic, how far am I she was mad at me for that but she was fine afterwards, she was very supportive and she asked for my boyfriend's phone number and it went fine after that…'Cause I was very scared that somebody might tell her =ok= before I told her but luckily nobody told her."
[Thando, p. 2, l 70-84]

"My mother is also supporting me through this =ok= 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…we're gonna make this...let this child grow and to take care after this child =yes= and she's gonna help me."
[Linda, p. 4, l 135-139]

The first extract highlights the benefits of financial support in being able to access timely antenatal care. The second and third extracts highlight the role of a mother as someone who intervenes with others (a boyfriend or neighbours) in order to ease emotional stress. In many ways, a mother's acceptance of the womxn's pregnancy leads to her own acceptance of it (in cases when the pregnancy was unplanned).

Visible, again, is the impact of communication (or lack thereof) in the relationship between a pregnant womxn and her mother. This occurs in the form of silences interpreted as anger or disownment (Ntombi feared being "chased out of home" p. 5, l 161), advice to the pregnant womxn, and negotiating the pregnancy with other family members on behalf of the pregnant womxn.

While both families may initially find it difficult to accept an unplanned pregnancy for different reasons, there is a tendency to eventually approve the event. Childbearing is a sign of fertility and marks the start of adulthood and responsibilities (Kaufman et al., 2001). For Kwanele (aged 19 and the youngest in this study), family acceptance of her pregnancy also marked the possibility of going back to school as both families encouraged her to apply to university and assured her that "we'll make a plan" (p. 28, l 1202).

"After a month of having to (1) stress about what's going to happen next, what my future is going to be (.) and why God chose me...why I didn't use contraceptives, all those kind of questions and then after that ***I just accepted it because both families had accepted the whole thing*** *so there was uhm no turning back because this had happened and I just had to find a way to get through it and to think of not only myself now, the baby too, ja, it's basically been like that."*
[Kwanele, p. 17, l 710-715]

Participants also spoke of the value of care from their mothers-in-law (Tayla, Sandra and Anelisa), for which they expressed gratitude. As these three were the only married womxn in this study, this may be a reflection of the status they acquire post-marriage, which can increase their standing in society and in the family environment. This indicates that partner status as a category is worth considering when examining pregnancy support. The legitimacy of the relationship (through the institution of marriage) can increase a womxn's level of social support during pregnancy.

A picture of Sandra's mother-in-law who visited them during the time close to delivery

"Yeah she came specially to give us a hand for…the birth so I think she's an important person to be there… she offered and then we said yeah…and she's staying for 3 months, which is great."
[Sandra, p. 13, l 525-531]

Thando felt gratitude towards her grandmother (image below) who came to help her as well as her cousin sister[5], who was also expecting.

Thando's grandmother

"She's spoiling me…she came to help us out since we're pregnant (.) You know grandmothers =em= she came to help us out and then she does the laundry for me and I hate doing the laundry when I'm pregnant…and she's helping me so much now =ok= I don't mind doing other things like cleaning up, cooking but it's the laundry, I can't take no more =ok= it's too much for me =ok= and she's helping me."
[Thando, p. 13, l 537-544]

[5] In isiXhosa culture, it is common for cousins to be viewed and referred to as sisters/brothers.

The two extracts above depict tangible support – doing the laundry, for example – which were appreciated by the womxn. Tayla felt uplifted by her cousin's presence and actions at a time when she felt stressed about the pregnancy and all the changes that it brings.

"So my cousin did my hair and wanted to make-up me [giggles] but I let her do the mascara thing and the eyelashes and stuff and we were just chilling, like giving me compliments the whole day…my cousin is very younger than me, uhmm, she also, she has a child already. So she told me, she encouraged me, she talked some sense into me she said 'It's fine to feel that way sometimes, don't be afraid, don't think too much, just live each day as it comes and don't…' (.) Like she just encouraged me to feel better about myself."
[Tayla, p. 19, l 653-657, p 20, l 669-672]

From the excerpts under this section, the role of the immediate, extended and in-law's family are all underscored as potentially supportive. Their involvement in terms of offering tangible help (assisting with house chores) and emotional help (encouragement, listening) links to literature that emphasises emotional and instrumental support in pregnancy, as the most valuable (Dunkel-Schetter et al., 1996; Houts et al., 2008; Negron et al., 2013). This link is also featured in the role of friends under section 5.7.3.

5.7.2 Family attitudes hindering supportability

Most participants feared and felt stressed about paternity being denied by the father's family, in contrast to legitimising the relationship by claiming damages (refer footnote 2, p. 54). As stated under 5.6.1, financial consequences that may need to be shouldered by the partner or the partner's family act as a deterrent to paternity claims. Research has found that premarital birth is not necessarily followed by marriage; hence, tensions exist around the social and cultural identity of the unborn child in the community in addition to the added economic pressure (Kaufman et al., 2001). Linda divulged how upset she felt at judgemental comments from the father's mother and sister regarding the paternity of the baby.

"She's going to be the grandma of this baby. This is the one that's speaking lots of nonsense and stuff…She's talking a lot of things behind my back =em= like as if I've, like I said before as if it's not her son's child this and I must go and look for a father for my baby like that. Looks like I was with other men = ok, that must be terrible= she talks bad things about me, I hate her really, I don't like her."
[Linda, p. 13, l 541-558]

Clearly, accusations of multiple partners and statements focused on weight gain and body image are experienced as degrading and hurtful to a pregnant womxn, which can lead to anguish and more stress. Insensitivity from extended family members seems to essentially involve a disregard of the pregnancy and its value to the pregnant womxn. Linda shared an image and expressed annoyance at her cousin who often visited her when under the influence of alcohol.

Linda's cousins and friends

"This is my other cousin =ok= she is very irritating =ok= she likes to drink a lot =ok= and she's she's irritating me when she's drunk =ok= she won't go, she will sit here, come in, make like this my stomach =em= and how's the baby doing, how are you like the innocent look. Come let me hear if the baby's kicking it's like that irritating…she likes to come every time when she's drunk."
[Linda, p. 11, l 447-455]

The extracts above display how disrespect and indifference from a family member may be experienced by a pregnant womxn, inevitably hindering the supportability of a pregnancy.

5.7.3 Friends' interactions promoting supportability

The role of friends in enabling a womxn's pregnancy ranges from providing emotional support to tangible support. In the extract below, Thando, who was in denial of her pregnancy and experienced negative feelings about her changing body, found solace in having a friend to talk to.

"It's my friend…we became closer and closer and closer...she's the one I talk to, she's the one I told that I am suspecting that I'm pregnant. She's the one that accepted me. She's the one that was just there all the time…she's the one that was encouraging me…the thing is that I don't see her as a friend anymore, she's my sister."
[Thando, p. 29, l 1229-1247]

Timely advice or a timely gift is also well-received by pregnant womxn. Kerry described the impact of receiving a thoughtful gift from her best friend

"She phoned me last night and she was like 'Kerry, I've got a present for you and baby'…and ja, I went by and (2) I collected this gift and when I got home I opened it…and it was just the most amazing present you know…and just realising that I actually have the most amazing friends that offer <u>all</u> support anywhere =ok= you know ones that have babies and ones that don't =ok= and I think I'm very lucky in that regard."
[Kerry, p. 13, l 511-518]

Friends also had the ability to encourage positive health behaviours in the pregnant womxn.

"Basically it's my friends, that I live with here…the kind of support that they bring...they lift my mood or something…like they say let's basically take a walk like for exercise and stuff like that, yeah. And they encourage me to eat healthy, to yeah. And they compromise whatever they gonna buy, they get me something healthier...I think it basically makes it easier because they are there for me, every step of the way."
[Kwanele, p. 23, l 969-983]

For Linda, who experienced judgemental comments about the paternity of her child, having a space to vent appeared to be extremely beneficial. Stress caused by criticism from partners, relatives and friends, was overcome by being able to confide in someone. Simply being present or providing a listening ear can be comforting and reassuring (Green, Hayes, Dickinson, Whittaker, & Gilheany, 2002 as cited in Finfgeld-Connett, 2005).

"But it's just this thing of (.) there's now people there like his mother and some of his friends that says, yeah I must go and look for my men…and it makes me feel so bad…Sometimes at night // I'm crying but my friend is always supporting, she likes to come to me and sit here by me (3) and speak with me and she's making me laugh."
[Linda, p. 3, l 127-132]

Acceptance from family and friends is experienced as a form of social support. Although the majority of the pregnancies in this study were unplanned, social support from family and peers seems to shift the mentality for a pregnant womxn from one of denial to acceptance. Womxn internalise the pregnancy to the extent that the acceptance of the pregnancy by one's kith and kin (and even ancestors, as shared by Ntombi under 5.12.3) is experienced as self-acceptance.

5.7.4 Friends' interactions hindering supportability

In contrast to the above, if family and friends reject the pregnancy, the womxn tends to take it as a personal rejection and, hence, feels isolated. Thando shared how

emotional she felt during her first pregnancy, as her friends did not understand the changes she was undergoing. This led to her losing touch with them as she shared that, "They've done studying, we've done our things, moved on with our lives" [p. 28, l 1223-1224]. This can create a sense of seclusion and sadness, making a pregnancy harder.

"My friends would just make fun of me like being lazy or something and I would cry."
[Thando, p. 1, l 40]

Linda's friends continued to socialise with her while drinking and smoking, thereby making it extra-challenging for Linda to alter her ways. She added:

"I don't know sometimes it's just the influence 'cause like whole day, I didn't smoke for the whole day (.) maybe if I go next door now (.) then someone smoke then I also want to smoke."
[Linda, p. 22, l 941-943]

Owing to the health recommendations for pregnant womxn, many have to give up activities like smoking and drinking in which they previously engaged. Socialising with friends who still engage in these activities makes it difficult for the womxn. Interactions with partners, family and kin clearly indicate how kindness, words of encouragement and acts of assistance all qualify as social support, while negativity, gossip and judgement can easily be experienced as hurtful and cause feelings of dejection and rejection.

5.7.5 Community members' role in promoting supportability

Sandra, who is from South America and was living in the city in which this research was conducted at the time of this study, alluded to the importance of a 'network of care'.

*"That's another thing that made me feel very um (2) grateful because then I found that in South Africa, people help each other a lot =ok= when they see that you need you know, so I got everything for the baby for **free**…these people really helping to make us feel you know comfortable because they are aware of our situation financially specially =ok= and then the cot and the chest of drawers I also got from friends…so we didn't have to buy the //so this is very nice thing that happens (here), that I find in that you don't expect anything from the government so you kind of created this web =network= of people that help each other n then eventually we will be able to help other people."*
[Sandra, p. 11, l 446-462]

It is noteworthy that the other participants did not speak of the community in the same way. This might be her experience due to her status as: a married womxn and being married to a white, educated man; living in an affluent area of a small city; and having access to a variety of resources. However, it also points to a culture of care. Sandra's excerpt highlights how macro-policies (or lack thereof, if we consider her reference to not expecting anything from the government) impact individual lives and can complicate a person's experience. Community members may then make an effort to bridge gaps and collaboratively provide support, especially in terms of tangible commodities. It may also be that the other participants have a larger network of extended family care, whereas in Sandra's case, this was taken over by others.

5.7.6 Community members' role in hindering supportability

With respect to the role of community members in hindering pregnancy support, participants reiterated their feelings of being judged about various aspects of the pregnancy, such as the act of falling pregnant itself, their physical appearance, eating habits and the compulsion to adopt appropriate and healthy behaviours. For example, Kwanele felt embarrassed by her clinic folder as she felt it overtly revealed the purpose of her visit.

"I was also ashamed of the, what they gave me, because obviously everyone at the clinic knows what this (pregnancy folder) is for, so I didn't want (.) a lot of people to see me with this…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."
[Kwanele, p. 11, l 454- 467]

"I think this this is a negative thoughts and people saying, telling you bad stories this all affect pregnancy in a very bad way."
[Sandra, p. 10, l 380-382]

"It's the people is, is [sighs] it's just that stressing, when they tell like to speak nonsense especially there in our place then I am stressing."
[Linda, p. 5, l 202, 203]

A lack of sensitivity in the larger community can impede a womxn's wellbeing. When the general public speaks negatively to or about a pregnant womxn, it can lead to

emotional stress. The pregnant womxn often feels lonely, in that the pregnancy calls for a change in lifestyle that is expected solely of her. At such times, partners may continue to smoke and friends may continue to drink in a pregnant womxn's presence (as highlighted under 5.7.4), which can make her attempts to adopt healthy behaviours much harder. Kerry stated that a fight with her partner made her realise the deep impact of the pregnancy on her alone.

"It was sort of like you are not supporting me and I am like going through all these big changes and as much what you think we are having a baby, your body is not having a baby and your emotions are not, you know…"
[Kerry, p. 20, l 825-827]

As a biopsychosocial event, pregnancy can lead to isolation and stigma when the partner's role or the womxn's circumstance is ignored (such as Kwanele feeling humiliated and embarrassed by her very visible pregnancy folder). These feelings can hinder supportability.

5.8 WORKPLACE AND SCHOOL INTERACTIONS

This section examines the everyday one-on-one interactions experienced by pregnant womxn in their work or school environment. Often, participants did not speak about policies and rules unless specifically asked.

5.8.1 Interpersonal work dynamics hindering supportability

Linda, who works as a waitress, said she was emotionally sensitive due to her pregnancy and, hence, being criticised by her boss usually left her feeling miserable.

"If I do something wrong maybe my boss, not like in really shout, maybe this is wrong what you have done or if I make a mistake then I can, I go and cry =em= when I do something wrong…I am very sensitive…it's now with this pregnancy…I wasn't like that before."
[Linda, p. 9, l 355-365]

Ntombi was part of a 'learnership programme' in carpentry. High stress levels and work politics led her to stop work during her pregnancy.

"We work as girls…there was a lot of friction [disgruntlement] between the girls because we have been separated into two groups at the construction site…So I just thought to myself that perhaps I should just stop this job, because I have to work for so long and it's hard. And we don't get paid the same salary. Sometimes our group works harder than the other group but when it is time for us to get paid, then their salaries are generous and ours are less…but there is no way that we can vocalise our grievances."
[Ntombi, p. 8, l234-249]

Linda's concerns are about the internal relationships within the work place, which, given that she feels more emotionally sensitive, are difficult to handle. Ntombi, though, speaks to structural inequities, hard work, and the inability to raise grievances. In general, work places are not spaces that accommodate both production and reproduction. While research has linked work-related psychosocial stress in pregnant womxn to negative birth outcomes, the authors Croteau et al. (2007) argue that the associations are stronger for womxn whose work conditions do not change during the course of her pregnancy (except through reassignment or job withdrawal). In the excerpts above, neither womxn entertains the possibility of their work environment undergoing any changes. While Linda was resigned to unavoidable manual labour (lifting crates) and work stress, Ntombi choose to resign from a job that was not conducive to her health while pregnant. For Ntombi, this further meant that she would have fewer financial resources to support her pregnancy.

5.8.2 School interactions hindering supportability

Thando (the second youngest participant in this study at 21 years old) described indifference from her friends, and a tendency in them to mock her 'laziness' (described under 5.7.4). This behaviour from her friends, along with a failing grade in one subject, made her drop out of school during her first pregnancy.

"I told my mother at six months that I am pregnant (1) and I was still studying then, that is why I failed accounting and I decided that I am not going back to school for the second term =ok= and I didn't go to school. That was basically it."
[Thando, p. 2, l 45-47]

In SA the likelihood of a young teenage mother falling pregnant and not finishing school is high (Morrell, Bhana, & Shefer, 2012). This may be due to the challenges of time management that womxn face in terms of parenting and schoolwork, which

could lead to the possibility of falling behind in their studies and the risk of being teased by classmates and teachers (Kaufman et al., 2001). Kwanele, too, decided against applying to university, much to the dismay of her friends who kept coaxing her.

"They have been pressurising me to apply, apply, apply, apply, apply...Ja they're keen for me to come back, and they're keen for me to study again…Because they don't want me to just sit around while they're in progress and stuff."
[Kwanele, p. 14, l 600-607]

Although the encouragement from friends may be seen as supportive, Kwanele experienced it as pressure and, hence, it added to her stress. Sadly, the solution was not straightforward, as it involved making alternate childcare arrangements if she did return to school.

"I'm not really sure actually… uhm I do want to go study and my mom does want me to go study but the problem is we don't have a person who is going to be the caregiver of the child, if you get me, because uhm she hasn't really spoken to my boyfriend's family about okay what's going to happen with the child if I, if it happens that I go back to school or something."
[Kwanele, p. 5, l 184-190]

The overall sense for a pregnant womxn seems to be a need to put one's plans on hold or temporarily 'not progress'.

5.8.3 Work/school interactions promoting supportability

The only mention of a work interaction that enabled supportability was of that of a colleague who assisted Linda (a waitress) to carry crates from the garden into the café at the end of the day. It is noteworthy that Linda needed to ask him for assistance, instead of her employer making alternate arrangements for her during her pregnancy.

5.9 HEALTHCARE INTERACTIONS

Under this heading, I examine micro-interfaces that include face-to-face interactions with healthcare workers and discuss healthcare policies in section 5.11. I include excerpts that represent the interactions (and interviews) of the womxn with my co-researchers and myself as a supportive space under this section, since in certain

ways, their acknowledgment of our presence underscores a lack of psychosocial support within the healthcare system.

5.9.1 Face-to-face interactions that hinder supportability

The term 'antenatal *care*' is paradoxical to a degree in that most of the womxn in this study viewed it as crucial and a necessity, but not necessarily as a caring or attentive space. Although there is an appreciation of the expertise of the nurses and doctors, the overall experience seems skewed in a negative way. Anelisa pronounced her nurses as being judgemental and rude. Her extract below also describes a delay in receiving care. This points to the macro-structures being under-resourced, under-staffed and overburdened, which all have a direct impact on the type of healthcare that can be provided under the circumstances.

"You'd sit there like for hours waiting for the nurses but they would always be on their lunch or then they would say, 'Oh, you're so young and you're pregnant' and things like that, they would make comments that (2) I don't think it's necessary for them to make because =em= I mean it's your life why would someone else make comments. It's your problem if you are pregnant. Maybe it's not even a problem."
[Anelisa, p. 17, l 592-596]

Thando experienced rudeness and judgement about her age from the hospital staff during her first delivery (in which she lost the baby) as well as what she interpreted as an assumption of guilt, on the part of the doctor.

"I gave birth on Sunday and then the night after my baby's funeral, I had to go back to the hospital. There were still some pieces of placenta in me coming out of, I saw it while I was bathing. Then I had to go back to the hospital and I got the same doctor that was there in my delivery, he was actually very nice to me and he gave me special treatment as if there was some guilt going on and I didn't like it…it was horrible…Like a lot of people would tell me that I should go sue them because the nurses were actually very nasty. They were rude, they were very mean."
[Thando, p. 3, l 124-134]

She approached a different clinic when she fell pregnant for the second time. However, the dismissiveness of the clinic staff led her to change her clinic for a third time.

"The sisters were very rude, they were mean. I think I went there two times before they gave me a book, before they checked on me, before they did anything, 'cause I would go there then they'd tell me that tell me that you are too late, come on Monday. I go on Monday, no come on Friday. I would go on Friday, no ante-natal date is on that day…from my opinion, from what I saw =em = I think that the nurses (1) here thinks that they're doing us a favour by helping us…it's more of that kind of attitude."
[Thando, p. 8, l 318-331]

Changing clinics or doctors seemed common in order for some of the participants to find a comfortable and reassuring space where they know their needs will be met. Thando's experience at the third clinic, where she was recruited for this study, was positive. She believes this is due to her pregnancy being viewed as high-risk and so the staff and doctors were helpful. In relation to doctor interactions, Kerry decided to get a second opinion regarding a physiological issue, when the information from her doctor created anxiety.

"I kind of loved my doctor, I think he really just chose the wrong words… I mean I was gonna change doctors (1) because of that information =ok= um I mean, he just completely freaked me out unnecessarily."
[Kerry, p. 2, l 56-57, 64-66]

Her second doctor provided her the reassurance she hoped for, which clearly indicates the kinds of face-to-face interactions that lead to pregnancy support.

5.9.2 Face-to-face interactions promoting supportability

The advice received from doctors and nurses plays a key role in assisting with the pregnant womxn's physical experience and discomfort. Kerry's interactions with her second doctor included a joint decision "to treat her condition internally" [p. 1, l 30], when she experienced an infection during her pregnancy. She appreciated the open communication and positivity from the doctor.

"With all the…positivity and getting through it...was all very reassuring as well."
[Kerry, p 2, l 60-61]

"Like you go visit your doctor and your doctor completely puts your mind at ease, that is quite wonderful =ja="
[Kerry, p. 6, l 224-225]

During the interview, when Ntombi shared her fear of giving birth and was asked whether she felt adequately supported at the clinic, she replied,

"Everything is fine here, and the nurses are also good."
[Ntombi, p. 31, l 420]

Confidence is not only gained from the professional expertise and advice of doctors and nurses, but also from a level of familiarity with the clinic staff.

"The people from the clinic know me uhm I'm a regular face since I grew up here…I always went to the same clinic I go to now so ja (1)… they feel very welcome and any questions I ask uhm, I'm free to ask 'couse they'll always have an answer for me and they'll help me."
[Tayla, p. 4, l 105-109]

Knowing that her medical needs will be met appears to have immense value for pregnant womxn and this contributes to a sense of feeling supported.

5.9.3 Midwives promote supportability

The role of a midwife was viewed in a positive way and experienced as supportive, with some of the participants using their services in varying degrees. While nurses in antenatal care and in obstetric units (public healthcare) may be midwives, there are also private midwives. For Tayla, consultations with a midwife in her community eased her physical discomfort. Sandra chose to have a home birth with the assistance of a private midwife.

"So I went to this midwife, my mother took me and then she told me that I was at the edge of losing my baby because I had a serious bladder infection…but then, ***she fixed me*** *// she's very good and after that I felt all (fine)…She rubbed my belly and rubbed the child to be in its position again… All the stiffness also in my body, she rubbed them out of my body as well…she told me to take things easily this time, laid back and relaxed…she is well known also =em= a lot of people in my community went to her…Yeah, she's also very good at knowing what child you're carrying =em= so she told me that I am carrying a girl child, hopefully [laughs]."*
(Tayla, p. 32, l 1120-1139)

Sandra's input (photo follows) shows how midwives may play a role sanctioned by cultural practices while also being a medical practice. They are able to assist with a range of grievances, to ease discomfort in a culturally acceptable way and to facilitate childbirth in a manner that lowers various stressors related to accessing health care, including finances.

Image of Sandra with her two children and her midwife at the first check up

"With the midwives they are, they don't need to see you as often as the doctors, so that was something that made us, it possible as well because it's cheaper."
[Sandra, p 9, l 373-375]

5.9.4 Researchers' interactions as enabling supportability

Some of the womxn shared that their involvement in this research study made them feel supported in terms of feeling heard.

*"It helped me I think at some point because it was more like therapy for me. That's how I take it. Cause we talked about things that I wouldn't talk about to anyone… I can't put it in words now but to me I felt like I'm talking to a total stranger about my feelings and what's happening with me, things that I never shared with anyone. That's it. At some point I thought that people didn't care how I feel cause nobody ask me about it, they'd rather worry about are you fine with the baby? Are you guys going for check ups? and what not. But what about **me** somewhere, somehow 'cause if I'm not fine the baby will not be fine. Do you understand =of course= so I'm grateful for that cause you talked, we talked mostly about me rather than the babies =em= so it was more of a me situation and I appreciate that =ok= [laughter]."*
[Thando, p. 33, l 1387-1389, l 1396-1402]

"I think I am ready to go through everything again so it's been good for me to see from different perspective…there is a therapeutic aspect of narrating your story as well! So this interview was helpful."
[Sandra, p. 26, l 1075-1079] [2, P 30, L 1082, 1087-1092]

"I would have loved to take a picture with you guys actually [giggles]…because you helped me to speak out…you listen and that what makes you guys so important to me. And you also helped me psychologically and emotionally."
[Tayla, p. 30, l 1082-1092]

These extracts were placed under this heading because the acknowledgement of support received from the researchers alludes to a lack of receiving psychosocial support from elsewhere (such as healthcare interactions). The fact that Thando felt

comfortable talking to the researchers about things that she would not speak to anybody else about, and that the interview was experienced as helpful; the fact that the researchers concentrated on the womxn's thoughts and feelings; the fact that the sessions were experienced by some as akin to therapy (despite being clear from the outset that this was research and not therapy); all these demonstrate a need for more formalised, non-judgemental psychosocial support.

5.10 THE ROLE OF INFORMATION AND IT DURING PREGNANCY

The role of information technology (IT) in the lives of pregnant womxn is being increasingly researched. Access to information appeared as a dominant theme in this research and was experienced in both extremes, in that participants spoke of either a *lack of* or *too much* information. Sandra felt that it was "quite difficult for modern womxn to give birth and I think that's why we need information. It doesn't come very naturally anymore, first to accept, to feel, to connect with the body" (p. 15, l 615-617). Hence, she hoped to receive relevant information from healthcare providers.

The South African National Department of Health started 'MomConnect', which is an initiative that aims to support maternal health through the use of cell-phone based technologies. It provides information and sends out periodic text messages to pregnant womxn who register. However, not all participants view the information on MomConnect as relevant. This is in spite of access to communication via mobile phones being viewed as an essential component to improving maternal health, based on research from low- and middle-income countries (Noordam, Kuepper, Stekelenburg, & Milen, 2011). In terms of emotional support, Tayla and Linda both shared the significance of being able to communicate with their families over the phone regarding their pregnancy. In relation to information support, Tayla also shared that she benefitted from 'Google', although this was only possible on occasion when she had airtime (highlighting the links to, and repercussions of, financial constraints).

"Sometimes when I have airtime I would go onto sites and Google stuff. I just want to know about…more about the pregnancy…I also learnt about that it's a phase that the child moves and goes into a new position yeah."
[Tayla, p. 12, l 404-409]

5.10.1 Aspects of information that hinder supportability

Sandra stated that culture influenced the type of information being provided and wished for relevant information.

"It is very much related to the culture of South Africa, so for example HIV is a big thing here =em= and then they talk about it, don't forget to use condoms every time you have a sexual relation because you can still have HIV // get it while pregnant and they are quite adamant about asking you to use (condoms) with your partner and husband…how you should cook your food, be not to be too close to the smoke of the wooden stoves =ok= I think many womxn don't have gas stove or electricity =em= because some place don't even have electricity yet eh."
[Sandra, p. 25, l 1045-1052]

Some of the participants shared that posters at clinics and flyers dealt with messages around HIV, sexually transmitted diseases (STDs) and tuberculosis. Apart from wanting reduced waiting-times and better care from clinic staff, womxn are hoping for information that is pertinent to *their* pregnancy journey. While there is a need for contextually-relevant information that can cater to a range of queries and doubts (and social locations), there is also the possibility of an overdose of information. Kerry spoke about too much "crap" and "nonsense" on the internet and hence battling with "just hopping on to my phone and sort of getting maybe the wrong information and then freaking out about it" (p. 5, l 222-223).

5.10.2 Information as support

Having access to information resources does play a role in alleviating anxiety: Kerry also stated flipping through books to learn more about healthy eating; Anelisa and her partner cleared several doubts via resources online; Tayla asked us (the researchers) for any magazines on pregnancy (she was keen to learn more about the growth and development of her baby in utero). While most of these narratives highlight the complexity of support (as described in the literature review) in that it varies according to the individual, it is useful to note that sharing of information is typically experienced as positive for many of the womxn.

5.11 MACRO-LEVEL SYSTEMS

Macro-level influences are expected to filter down and impact the lived experience of the participants. While the womxn typically spoke of interactions in their personal and micro-environment, the indirect influence of structures and policies was evident in their narratives.

5.11.1 Socio-economic structures hindering support

Macro-economic policies in South Africa have been found to focus on growth rather than redistribution, which has perpetuated economic disparities between races despite an increase in social grants (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). Unemployment was the main stressor and a major deterrent to supportability. Sandra and Thando spoke about the difficulty of neither them nor their partners (both students) working.

"But still it is the worry is that it makes pregnancy difficult as well. I think financially, money is a big problem…we think so much about it especially because we're not working. I was supposed to be working =em= but I didn't find any jobs so it's // this year…wasn't supposed to be difficult but it actually became another difficult year."
[Sandra, p. 6, 225-229]

Thando also emphasised that she did not subscribe to the tradition of 'inhlawulo'[6] as she knew this would add to the financial strain, due to her partner's unemployed status.

"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 to him and myself, it's going to be embarrassing to my family 'cause he's not working and yet his family must pay for his debt, cause it's more like a debt. So yeah that kind of thing we talked about it."
[Thando, p. 26, l 1109-1113]

However, it is important to note that Thando responded differently (as opposed to Kwanele, who found it beneficial) to this custom. This might be due to her lived experience of various intersecting aspects: the loss of her first baby in the ninth month, a different degree of communication with her partner, support from her

[6] In isiXhosa inhlawulo refers to 'damages' paid to the family of a womxn who became pregnant out of wedlock by the father of the future child.

partner's mother and also her own belief system. There is a tendency for interactions from particular spaces (such as community members) to compensate for a lack of support in other spaces (such as government policies).

5.11.2 Socio-economic policies promoting support

Womxn who also accessed private healthcare spoke of the difference between their public healthcare and private care health interactions. Anelisa expressed her relief, as she displayed an image of doctors, at being able to afford private medical care and compared it to the service she received in the public sector.

"I've seen people that, like my friend, my best friend has got four babies now, I've, we've (.) I've walked her to the clinic and I've seen how the nurses (.) how they treat the patients and how they don't care and I knew from then that I didn't want that for myself (.) I didn't want that for my babies."
[Anelisa, p. 9, l 302-305]

"These are doctors from a magazine, it makes me happy =um hm= that I will be giving birth, I have a choice to go to the hospital because some people give birth at home… yah I'm happy that I can afford to go to, I can choose who is gonna deliver my baby and things like that."
[Anelisa, p. 8-9, l 290-299]

What emerges from the transcripts is the gross disparity in services offered in public and private care. This explains how social locations can affect pregnancy, as not everybody can afford medical aid and private care. In the 1980s, there was a rapid increase in the number of private hospitals due to the possibility of desegregation, lasting through the 1990s; this reflected a climate that favoured private healthcare (Stuckler, Basu, & Mckee, 2011). While apartheid health policies enabled this bifurcation, the legacy of the past lingers. Harris et al. (2011) found that barriers to healthcare in South Africa were associated with one's socio-economic position, race, insurance status, and urban-rural location, with uninsured, rural and low economic status black Africans facing the most challenges.

5.11.3 Health systems preventing supportability

South Africa's troubled history has created several challenges for the healthcare system that exist even today. These challenges have prevented the country from achieving many of its health-related MDGs (and will probably affect the achievement

of SDGs). Coovadia et al. (2009) found that while public health has become a comprehensive national service since 1994, there has been a lack of implementation of these policies due to poor management and an absence of good leadership. These aspects permeate into the lived experiences of womxn seeking antenatal care, with long waits for an ambulance (if and when necessary), long queues at the clinic, and antenatal care being offered only on one day of the week.

*"I hate, I don't hate going to the clinic. I love going to the clinic cause I'm going to find out how my baby is doing! Hear his heartbeat and all that. =em= but **here we have one specific day for pregnant** Monday =ok= but you have a date, a specific date, according to how far you are, so when we go there, it's a lot of us and they take approximately of 30 minutes to help one patient, a pregnant person. So it takes time, you can spend the whole day at the clinic, it's stuffy…No, it's patients. They're rude, they don't have the patience to wait, they want to be helped as soon as they get into the door, =em= it's very uncomfortable for me to wait there, and I hate sitting, it irritates me =em= I can sit in the couch but those chairs are hard and you have to wait there."*
[Thando, p. 20, l 837-848]

Thando raises two issues in her narrative. One is the discomfort of a pregnant womxn, who needs to cope with hunger and nausea (reported also by Tayla). The other refers to other patients who are kept waiting at the clinic, who become impatient and are, in turn, rude to the clinic staff, emphasising the immense pressure under which clinic staff work. Understaffing may be an explanation as to why antenatal care is not being offered every day of the week. Tayla reported feeling "paranoid" after finding blood in her urine. Concern about physiological issues led to a need for assurance and frustration when there was no immediate response from the healthcare system. She "just wanted to know if my baby was alive and if I was okay" [p. 1, l 22-23]. However, the wait for the ambulance and at the hospital was long, highlighting under-resourcing within the public health sector.

"I waited half an hour there for the ambulance, started getting hungry so I decided no, let me just come home and eat something so I can have the energy 'cos I knew I was gonna have to wait at the hospital."
[Tayla, p. 3, l 69-71]

For Thando, the long wait has in the past prevented her from clarifying doubts with the nurses.

"By the time they help me out I'm too exhausted hey to ask anything. I just want them to tell me that my baby is fine and just leave."
[Thando, p. 19, l 810-811]

The nexus of antenatal care and pregnancy is a space that highlights how macro-systems infiltrate everyday interactions. Kerry, Anelisa (both accessing private care) and Sandra (accessing a midwife) discussed the impact of a dramatic increase in insurance fees that private doctors in SA need to pay to the Medical Protection Society (MPS), to protect themselves from malpractice lawsuits. In order to be covered for such high-risk operations such as childbirth, private practices have to pay a significantly higher fee than practices that do not provide such procedures ("No more deliveries for doctors", 2015). This has led to a cessation of private doctors delivering babies in town. While this feature of medical insurance is being tackled in parliament, the womxn shared that they had no option but to either choose a state-run facility or travel a long distance to a hospital in another town where a private doctor may offer this service.

"I believe that it's quite a costly thing =ok= um like when we found out we were pregnant it was a Saturday and the doctor explained that him and his partner were out the entire day, the day before delivering one baby, that they get paid 3000 rand to deliver =ok= which means their practice is closed for an entire day and can't see other patients because they are busy delivering a baby =ok= And the medical insurance is just too costly for the amount of money that they're making =ok= and they are apparently fighting it out in Parliament cause it's like a, a new legislation um but my doctor doesn't see anything budging there so basically you know my options are that I have to go through a doctor in either Town XX or Town YY."
[Kerry, p. 15, l 621-629]

Anelisa blamed this policy for the inability to see her baby in a scan and that she had to make do with hearing the heartbeat.

"Yes it's like da [heartbeat sounds]. That's it and you can't see the baby and with (the first) baby I was so used to seeing him every time I visit the doctor but now I can't see this one. So that is the saddest part of…I should have put a photo of Dr X's practice because it makes me sad really. It makes me sad."
[Anelisa, p. 7, l 222-225]

Tayla spoke positively about the flyer for this research study, saying it gave her a space to share her pregnancy experience, emphasising the lack of such avenues available otherwise, possibly due to an over-burdened public health system.

*"And people never really asked you questions about (.) what do **you** want to do while you're pregnant or stuff like that and um (.) when you (the researcher) came about…I was like this could also help me as well cos I've never actually had anyone to talk to…about where I come from, how it went about with my pregnancy, how it started and the journey that I'm going through on a daily basis as well."*
[Tayla, p. 24, l 839-844]

It is obvious from the excerpts above that womxn found the long waiting periods very tiresome. This led to rushed sessions where there was a lack of space and energy to voice their concerns and gain clarity. Often, the womxn accepted what was given to them (in terms of information or pills) without question. Sandra was frustrated at the clinic for losing her blood test results, for maintaining a low standard of hygiene (no soap to wash one's hands after a urine sample test), and for now accepting blood samples only at the hospital and not at the clinic, "because they are trying to cut costs, so there is just one driver that is going to go from XX to YY" (p. 8, l 321-322). She narrated the differences between healthcare services in the two countries that she had lived in.

"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 =em= it becomes hard because I know that most people don't complain =em= they're perfectly happy with what they get but because I've had other type of service, 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."
[Sandra, p. 10, l 390-396]

Coovadia et al. (2009) note that fundamental aspects of primary healthcare are missing in the health sector, leading to a human resources crisis.

5.11.4 Health systems enabling supportability

Private care features under what makes a pregnancy easier, although, of course, not everyone can afford or has access to medical insurance. Anelisa (the only participant in this study with medical aid) was grateful for smaller tablets that she could swallow easily, and the shorter queues she had to face.

"It makes me happy that I can afford these pills instead of going to the clinic and waiting there the whole day for the nurses to give me, my pills =ok= I just go to clicks and then I buy them."
[Anelisa, p. 4, l 106-108]

Participants do not see themselves as having a choice in the matter of public health. Being able to see a nurse or doctor in a timely manner holds a lot of weight as far as a womxn's pregnancy experience is concerned. Finding helpful staff seems to be a luck factor that not everyone can count on.

5.11.5 Workplace/school systems hindering supportability

With regard to company and school policies, once again the participants spoke of not having options. Sandra and Thando describe how the unexpectedness of the pregnancy required a readjustment of their future plans. Recent research has linked work-related psychosocial stress in pregnant womxn to negative birth outcomes, such as gestational age (raised by Kwanele and highlighted in her extract below) and birthweight (Lee et al., 2013); it appears that workplace and educational institutions policies may not be accommodating pregnancy and childrearing sufficiently. The quotes below show how learning/working and having a baby are seen as incompatible. While this may be the personal views of the womxn, it is likely to have filtered down from institutions not providing a sufficient space for pregnancy and childbearing.

"Finding that I was pregnant that's just stopped me from doing the yoga teaching course…That's why I didn't go all the way because I found out I was pregnant and the universe has other plans…But one thing I am working on now is (1) which I think the pregnancy brought as well, how am I going to be able to achieve what I wanted to achieve this year with another baby.'
[Sandra, p. 19, l 772-779]

"I was really depressed =ok= I couldn't sleep at night, I cried myself to sleep 'cos I really didn't want a baby and I was planning on having a job…they gave me like counselling sessions…since I had a stillborn before = I'm so sorry = so after that everything went fine up to till today."
[Thando, p. 1, l 20-30]

For Kwanele, falling pregnant meant putting her plans for further studies on standby for the next year. Kwanele's narrative (extract and photo follow) links to the claim that there is a prominent dropout rate in SA, despite the guidelines issued by the Department of Education (DoE) in 2007 and policies protecting young pregnant learners' rights under the South African Schools Act, No 89 of 1996 (Morrell et al., 2012).

Kwanele

"Before the pregnancy I was happy, I was living my life, uhm (.) I was thinking of options, of what I'm going to do with my extra year…I think everything stopped after I found out."
[Kwanele, p. 17, l 707-710]

"It makes my pregnancy harder because I get stressed out that okay maybe I might not get a chance to study next year [nc] and stuff like that, so (4) the stress is what makes uhm (.) the pregnancy harder, because I mustn't stress because I might give birth early or something, or the child might die or something, so ja it's something that some days I wake up thinking ooh [sigh], what am I going to do next year, my plans and stuff like that, who am I going to get to take care of the child, am I going to switch universities and stuff like that, ja."
[Kwanele, p. 2, l 69-74]

5.12 CULTURAL, RELIGIOUS, SOCIAL AND GENDER DISCOURSES/PRACTICES

When the participants spoke of any of these aspects in relation to their pregnancy, it typically led to one of two responses - either they shared a communal belief system with their ethnic group and subscribed to family and cultural traditions, or they spoke individualistically in terms of what their own value system was, which involved spirituality or faith in alternative medicine. Irrespective of the perspective, most of these aspects like religion and faith seem to have an enabling effect on their pregnancy, with exceptions for context-specific culture and gender norms.

5.12.1 Culture as a deterrent to supportability

As an expatriate accessing public health in South Africa, Sandra referred to the comprehensive health service she had received in her own country.

"I was used to being um as a pregnant person in Brazil you get served first everywhere =ok= supermarket, banks, post-office, everywhere you don't queue at all =ok= and I'm quite surprised that in South Africa, they still, they don't do that, they see a huge [laughs] belly and they don't (permit) let you to go first =ok and that's the same at the clinic =ok= so you have to wait you know and then you move the seats."
[Sandra, p. 7, l 272-276]

The implication of under-staffed and under-resourced clinics is a strain on the 'culture of care' highlighted under section 5.7.5. Sandra, however, indicates that this lack of care is general, extending to a range of public spaces. Linda spoke of cultural influences making it difficult for her to adopt healthy behaviours.

"Our culture neh, it's like that, they don't mind…the others they smoke, they drink while they're pregnant =hm= their religion is others // it's a bit different here by us. And the parents know these things…I need to stop this (smoking) 'cause I know it's not good."
[Linda, p. 22, l 950-953]

As a pregnant womxn struggling to quit smoking, Linda seems to police herself about her own smoking, within an environment (that she refers to as 'culture') that undermines her efforts to stop it.

5.12.2 Cultural practices enabling supportability

A high degree of kinship is underscored in many of the narratives, with a culture of care, comfort and community being experienced across ethnicity, class and geographical location in this study. Participants living in township areas alluded to help from a cousin, grandmother, sister or parents-in-law, especially in relation to helping to look after the baby after delivery. The value of the tradition of 'ukusiwakwetyala'[7] was conveyed by some of the participants. Kwanele recounted how her mother made the decision to have it done, and that it took place between the two families. She shared that "it was a form of them accepting that they know me and… my boyfriend having notified them that he has done something like this and stuff" (p. 4, l 171-173). As revealed earlier, acceptance goes a long way in helping a pregnant womxn cope with the different changes that pregnancy brings about in her body and routine. In some cases, the tradition of 'paying for damages' becomes a concrete form of acceptance.

[7] As explained by the co-researcher (also the translator), this is a form of the boy's family accepting responsibility for impregnating the girl.

"I was nervous of what they're going to say, how much they're going to charge… and then my mom told me no they said that they knew you and they had already been told by their son and that they charged, I think it's 5 cows and each cow is like 2,500, it's like 10,000…the other family knew how the Xhosa tradition goes so they just accepted the whole amount…so ja, I'm at ease now that everything is sorted… like if something happened, or if I'm feeling something then I can take from the money that they gave my uncles, go to the doctor and then get that sorted, I could buy baby stuff and ja"
[Kwanele, p. 19, l 800-824]

With matters relating to damages, Ntombi was also open to the process but preferred that her mother broach the topic with her father (highlighting again the vital role of a pregnant womxn's mother in the pregnancy). For both Kwanele and Ntombi, this tradition is experienced as tangible as well as intangible support.

Anelisa, who is married to a French national living and working in SA, spoke in detail about her need to marry the two cultures to keep both sides of the family happy. She acknowledges accepting suggestions from both families.

"Maybe if I was in ZZ (town omitted), maybe I would listen to my aunts and my mom because they would say don't eat food from yesterday, don't eat this and that so I didn't…here I would listen to the doctor and my husband and things… You see I followed what my husband's mom was telling me through skype…I didn't question anything because she was there, she was helping me…sometimes my mom and my aunts would say do this and do that and I would say okay, I will do that but once I leave ZZ and I come here, I would leave all of that. I'm happy. I think I have found the balance between the two."
[Anelisa, p. 10, l 338-363]

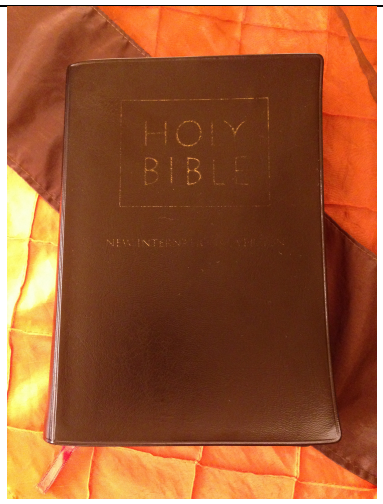
Her decision to follow advice based on which family she was staying with at the time helped Anelisa to cope with the varying cultural notions of what to do or eat whilst pregnant. Apart from this conflict of cultural practices, there was no indication of any other such conflict in any of the womxn's pregnancy experiences. Chan et al. (2001) acknowledge the multifaceted nature of social support and how its perception is influenced by culture, which becomes evident in this section where the womxn describe such varied experiences of cultural support.

5.12.3 Religion as enabling of pregnancy

A womxn's culture appears to be a mostly supportive space. When a participant differed in opinion regarding traditional cultural practices, she then typically found strength in religion. Thando, who experienced a miscarriage in her previous

pregnancy, spoke of *living and eating* the Bible now and revealed that she had "an intimate connection with God now and it's happened with my pregnancy in so many ways." (p. 19, l 820). The quotes and photos below highlight the power that religion can have in a person's life, whether it is a customary practice or one's own decision, as a way to find solace.

"No, my only culture is Jesus (3)…I'm a born again, I don't believe in ancestors and introducing the child before it's even born to the family and going to the (Kraal) and doing all that… that's the process I think in this lobola[8] and damages for the baby 'cause you go to the boyfriend's family, introduce yourself, introduce the baby that is unborn, they go to the (Kraal) and introduce to the ancestors and then they pay money for you. More like they paying you for getting pregnant. So it's that kind of thing and I'm not about that life."
[Thando, p. 25-26, l 1093-1102]



Thando

There has been an increased focus on religion and reproductive health in recent years with literature underscoring the influence that a womxn's religious affiliation has on her physical and mental health (Larson & Koenig, 2000 as cited in Gaydos, Smith, Hogue, & Blevins, 2010) and her decision-making about various daily health choices (Gaydos et al., 2009 as cited in Gaydos et al., 2010). Thando's non-belief in ancestors may stem from her strong religious beliefs that provide a safety net from which traditional beliefs and practices can be questioned. Tayla speaks of the solace she receives in following God's path, which she believes is the right one for her and her baby. It seems that she feels blessed and protected in her identity as a Christian.

[8] In isiXhosa culture, the tradition of paying *lobola* (in cash or kind) for a wife by the prospective husband is common, with negotiations typically being undertaken by the heads of both families.

*"I've changed to my husband's Church…even before I fell pregnant it played a very big role in my life because I've realised that I have been living the way that they have explained as to how…Christians should live and I'm just going into it at this stage of being pregnant and having to do the **whole blessing thing** to make sure that my baby and I, on the road of, with God and that we are still fine and blessed you know throughout this journey that we are having."*
(Tayla, p. 33, l 1157-1164)

Ntombi

*"This is my place of where I sometimes worship. I enter this room so that I can be **cleaned**, so that I can be bathed. I recently went. I went on Monday so that my woollen holy girdle [intambo][9] could be cleaned, so that the baby can be protected and to rid me of any dirty substances that could be harmful…I only get bathed and I also receive holy water...I feel as though the weight of the baby is lighter."*
(Ntombi, p. 3, l 87- 106)

Both Tayla and Ntombi make reference to certain rituals such as *being blessed* or *being cleansed*, which are experienced as supportive. Institutions of faith (like churches) can be instrumental in communities, as they have the ability to directly influence community norms and reproductive health by providing services (Gaydos et al., 2010). The *intambo* that Ntombi refers to is symbolic of protection from the ancestors, and demonstrates how the involvement of her community (ancestors included) may become a form of intangible support in pregnancy. Unlike Thando, Ntombi combines Christian and traditional Xhosa practices with ease.

There was no description of any aspect of religion being a deterrent in one's pregnancy experience. The overall sense is that culture, family traditions and religious affiliation act as a buffer, and thereby enable pregnancy supportability.

5.12.4 Gender norms preventing supportability

The womxn in this study spoke matter-of-factly about norms and expectations that made their pregnancies harder, as these are typically embedded in a patriarchal

[9] cord

discourse but taken for granted by both the partners. Tayla, Kerry and Sandra reported increased fatigue during pregnancy, but did not expect frequent support from their partners to alleviate their tiredness, since their partners worked outside the house and would have their own fatigue and stress to deal with; they seemed to accept this fact, though perhaps with some underlying frustration. Thando, Linda, Ntombi and Anelisa did not refer to partner support in terms of help with house chores, perhaps because this is unheard of and culturally inappropriate. These perceptions are cited in Ganle and Dery's (2015) research around pregnancy and related aspects being within the female domain, while men only provide for the family. The authors' assertions are echoed in Tayla's extract below, in which she not only comments on the division of the chores around the house, but also states how it is expected of all womxn in general.

"If things were bothering me I would talk to her (Brother-in-law's girlfriend) about it because since we are womxn, we both have…the same…complaints yeah. And it would be most of the time, money, or things around the house or what should we do. We would all discuss, like ok it's my turn to do that or we would just do whatever we felt needed to be done <u>because we are womxn</u>. And since my brother-in-law is a man, men don't really [giggles] like wanna do things around the house. He would just chill back and relax and help around with the baby that's it. Yeah, my husband went to work every day on Saturdays as well. The only time he would get off was on a Sunday and I married into his church uh. I'm part of the (his) church now."
[Tayla, p. 13-14, l 446-462]

Such gendered perceptions (men not being responsible for household chores) are shaped by society, which have varying degrees of influence on the womxn's personal experience. Womxn's lower expectations of help leads to an increase in their chores, which further leads to fatigue. Gendered discourses such as 'because we are womxn… since he is a man" subtly justify their lack of involvement in the pregnancy process, when it seems like this is the type of tangible support that can lower womxn's distress and frustration. Visible yet again is the interplay of the three levels – macro-discourse influencing partner micro-interactions influencing the physical well-being of the womxn – that could create a supportable and supported pregnancy. This ties in with prior literature on social support related to individual beliefs, changing gender roles, conventional discourses on motherhood and financial resources (Guendelman et al., 2001). A quote from Anelisa nicely sums up the

pregnancy experience in terms of various interwoven aspects that contribute to its supportability.

"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…if you don't have none of those things (2) because if I don't have money to go to the doctor first of all [I go] to the public clinic n then I will get the [rude] 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 for yeah, then he has to do what he is supposed to do."
[Anelisa, p. 17, l 582-589]

5.13 CONCLUSION

The themes that emerged from this chapter shed light on the womxn's pregnancy journey right from the moment of finding out about the pregnancy, to negotiating the event with herself, her partner and family, to overcoming various challenges through various support structures. Remarkably, it become apparent that supportive spaces for one individual were, at times, stressors for another. A pregnant womxn's traits such as her levels of stress, age, ethnicity (Dunkel-Schetter et al., 1996) and support-accepting style (Park et al., 2013) impact the way in which she perceives support. Findings from this research support these prior claims. At relevant points in the chapter, I link certain findings from extracts to previous research that has been conducted. The narratives of each participant ended with acceptance of her situation, acknowledgement of the challenges and help available, and sharing of hopes for herself, her infant and her future family.

In my concluding chapter, I discuss the themes that panned across categories to underscore the utilisation of the intersectionality lens and the benefits of using the supportability model.

CHAPTER SIX: DISCUSSION AND CONCLUSION

6.1 INTRODUCTION

In this chapter, I summarise the analytical findings of the preceding chapter in the form of a table. In line with an intersectional thematic analysis, I highlight certain themes that cut across different categories under the three headings of the personal level, the micro-level and the macro-level. I reflect on the findings from this research and discuss their implications for enabling the supportability of pregnancies in the Eastern Cape Province of South Africa and, possibly, other regions. I also examine the strengths and limitations of the study, and provide recommendations for future research that can address the shortcomings identified in the present study. I situate my reflection by looking at the research question that steered this study, the theoretical framework that underpinned the research and the supportability model that enabled the entire process. Although it is conventional, in the concluding chapter, to cite convergences and divergences in relation to prior literature, I do not refer to these aspects here as I have highlighted them in the previous chapter, the analysis.

Through this study, I sought to explore womxn's narratives of their pregnancy by using an intracategorical intersectional framework that places 'supportability' at the centre of thinking about pregnancies. I formulated the following research question: What are the various themes that emerge from a womxn's narrative of her pregnancy that speak to the promotion or hindrance of its supportability? While global research on pregnancy has yielded information on how womxn generally experience pregnancy, the different facets have usually been examined individually. For example, research has focused on partner support or antenatal care or workplace policies. In addition, the majority of pregnancy support research has been quantitative in nature. Qualitative studies of pregnancy experiences that are enabled or constrained by micro-level interactions and macro-level structures and policies have not, to my knowledge, formed part of any main research studies. These gaps formed part of the rationale for this study.

6.2 TABLE SUMMARY OF FINDINGS

In the previous chapter, I examined the participants' narratives in relation to each aspect of Macleod's supportability model, as well as aspects that were left unspoken (such as a lack of mention of 'Momconnect'; and typically macro-structures affecting lived experiences). I now present a table with the highlights that emerged under each topic. They are demarcated under two columns, the first column containing aspects that promote the supportability of pregnancy, and the second containing those that hinder it. It should be noted that in a few cases, nothing appears under the headings. This is because the narratives did not reveal any data relevant to those headings.

TABLE 3: PERSONAL ASPECTS PROMOTING AND HINDERING SUPPORTABILITY

PROMOTING SUPPORTABILITY	HINDERING SUPPORTABILITY
PERSONAL LEVEL	
PHYSICAL/PHYSIOLOGICAL	
▪ Bodily changes leading to recognition of the pregnancy ▪ Acknowledgement of the pregnancy, leading to altered behaviour ▪ Adoption of healthy eating habits ▪ Avoidance of alcohol/cigarettes	▪ Negative experiences rising out of bodily changes – feeling fat, ugly, unable to fit into clothing. ▪ Discomfort from a range of physical symptoms ▪ Miscarriage ▪ Illness (for e.g., multiple sclerosis) ▪ Desire/cravings for 'bad' substances (alcohol, unhealthy food, cigarettes)
COGNITIVE	
▪ Positive thoughts about impending mothering	▪ Uncertainty due to unplanned pregnancy
EMOTIONAL	
▪ Feelings of connection with the foetus ▪ Desire to be a 'good mother'	▪ Stress caused due to finances and inter-personal conflict

Under the personal level, seven of the eight pregnancies were physically supportable primarily due to their lack of illnesses and behavioural changes adopted by the

womxn. In one of the seven cases, the possibility of a multiple sclerosis diagnosis had the potential to hinder supportability but was closely monitored and the situation did not progress into an ailment. Access to information played a key role for this womxn in promoting the supportability of her pregnancy. The only case of a physically unsupportable pregnancy in this research was one that ended in a miscarriage in the seventh month. The reason remained unknown during the course of the research due to a delay in receiving the report from the hospital. In relation to the emotional aspects, any negative emotions arose from financial strain and inter-personal conflict. Positive micro-level interactions and a cognitive meaning-making process (such as narrating their story) often led to the shift of a negative emotion into a positive one of acceptance. This is discussed further in section 6.3, where I explore the themes that cut across categories. Cognitively too, all pregnancies were perceived as positive, despite six of the eight being unplanned. Various forms of support enabled the shift from unplanned to wanted pregnancies. This is why, at a cognitive level, all pregnancies were identified as supportable. It also indicates the degree of influence asserted by micro-level and macro-level facets, which have the capacity to convert unsupportable pregnancies into supportable ones.

TABLE 4: MICRO-ASPECTS PROMOTING AND HINDERING SUPPORTABILITY

PROMOTING SUPPORTABILITY	HINDERING SUPPORTABILITY
MICRO-LEVEL	
PARTNER	
▪ Reassurance (for e.g., regarding body and future plans) ▪ Sharing experiences ▪ Frequent contact ▪ Interest in the pregnancy (what the womxn does/what she eats) ▪ Accompanying her to the clinic ▪ Small acts of love	▪ Negative comments (for e.g., regarding body) ▪ Lack of understanding regarding bodily and emotional changes ▪ Denial of paternity ▪ Conflicts/fights/IPV

FAMILY	
▪ Source of advice ▪ Source of material support ▪ Intervening with others (boyfriend/community members) ▪ Visits ▪ Domestic assistance	▪ Drunkenness
FRIENDS	
▪ Acceptance ▪ Altering behaviours to support pregnancy ▪ Encouragement ▪ Material support ▪ Listening	▪ 'Pressure' (as experienced by participant) from friends to continue studying
COMMUNITY MEMBERS	
▪ Active support groups ▪ Creation of a network of care ▪ Psychosocial support from researchers	▪ Gossiping or spreading rumours about the pregnant womxn
WORKPLACE/SCHOOL	
▪ Assistance from co-worker	▪ Insensitivity of and criticism from boss ▪ Harsh working conditions ▪ Challenging school demands – difficulty with time management
HEALTHCARE WORKERS	
▪ Expertise of nurses and doctors ▪ Reassurance	▪ Nurses being rude and judgemental ▪ Nurses making patients return at different times or days ▪ Clinic staff and doctors lacking sensitivity ▪ Delayed service
HEALTHCARE IT	
	▪ Messages on 'Momconnect' not relevant

MIDWIVES	
▪ Ease physical discomfort ▪ Caring and attentive manner provides reassurance ▪ Cheaper than private healthcare	

Under the micro-level, the number of interactions promoting supportability outweighed those that hindered it in most categories – partner, family, friends and community members. The role of a private midwife and womxn in the community who assist with alleviating physiological discomfort appear to only promote supportability. This reveals the importance of womxn-centred care, especially in the absence of quality antenatal care services and positive face-to-face healthcare interactions. It is significant that Healthcare IT did not feature in the womxn's discussion of what was beneficial to their pregnancies. In the one case where it was mentioned, it was only to indicate that it did not have relevance for her. It is a matter of concern that workplace and healthcare worker interactions were two categories where points hindering supportability overshadowed those promoting it. However, the general consensus in this study from micro-level interactions as a whole, points to supported pregnancies, since other categories often compensated for a lack of support in a particular category.

TABLE 5: MACRO-ASPECTS PROMOTING AND HINDERING SUPPORTABILITY

PROMOTING SUPPORTABILITY	HINDERING SUPPORTABILITY
MACRO-LEVEL	
SOCIO-ECONOMIC	
▪ Ability to pay for private care	▪ Lack of employment prospects ▪ Inability to pay for 'damages' ▪ Disparity in public and private healthcare services
WORKLACE/SCHOOL POLICIES	
	▪ Lack of policies that accommodate pregnancy and childcare adequately

CULTURAL	
▪ 'Damages'	▪ Lack of special treatment for pregnant womxn ▪ Drinking and smoking culture ▪ Clash of cultural values
RELIGION	
▪ Being blessed ▪ Being cleansed	
HEALTH SYSTEMS	
	▪ Waiting times and long queues ▪ Insufficient counselling and lack of emotional support ▪ Lack of equipment
GENDER NORMS	
	▪ Domestic duties as womxn's business

Under the macro-level, except for religion, all other categories examined – socio-economic structures, and cultural practices – have more points that hinder supportability than promote it. In fact, workplace and school policies, health systems and gender norms did not offer any aspects that promote supportability. Under the category of religion, no negative aspects emerged; in other words, religion seems to enable supportability.

6.3 THEMES ACROSS CATEGORIES

In the previous section, I described what emerged from the narratives under each heading separately, in order to gauge precisely which aspects are experienced as either enabling or hindering pregnancy support. My focus now moves onto intersectional themes that cut across several categories. During the course of their pregnancy journeys, all the womxn shared similar hopes and dreams of their post-partum life, which included imagining their life after the delivery, the kind of mother they would like to be and the type of life they envisioned for their child. This section

emphasises the novelty of using an intersectionality lens enabled by Macleod's supportability model.

6.3.1 Changes – moving from rejection to acknowledgement

All womxn in this study described a process of transition, thereby creating a theme of *moving from rejection to acknowledgement*. This was experienced at various levels: an initial physical rejection of one's changing body, an aversion to the gamut of emotions on discovering an unplanned pregnancy, and a cognitive discordance (especially when the pregnancy was initially experienced as unwanted). Other behavioural challenges included the avoidance of certain foods, cessation of smoking and adoption of healthy behaviours. Several shifts were influenced by actions from others, and support from the partner and family had a strong influence on the womxn's overall wellbeing. Acceptance from a mother and partner, especially, allowed for easier acceptance from the pregnant womxn. This, in turn, eased other stressors such as concerns around finances, childcare and negative responses from community members.

6.3.2 Conversations as sustenance during pregnancy

Conversations emerge as a theme in this pregnancy research because they are seen as comforting. This includes communication between the pregnant womxn and her partner, family members, nurses and doctors. It also includes conversations that do not include the pregnant womxn but are about her pregnancy. Hence, discussions between families to promote good relations while acknowledging the event, claiming 'damages' through negotiations, and showing support of the pregnant womxn by intervening when she felt attacked by rumours about her, were all experienced as support. Being able to discuss stressors and jointly make plans with a partner for the future lays the foundation for a supported environment. Open communication with nurses and doctors is also crucial for all pregnant womxn, so that they can clarify their concerns and receive information regarding their pregnancies.

6.3.3 Finances – to work or not to work

Irrespective of the womxn's background and employment status, financial stress affected all participants. The womxn made reference to it directly or indirectly while discussing expenses during the pregnancy and costs of providing for the unborn child's future. Although financial strain is typically linked to one's employment status, it is not always straightforward to ascertain the source. Whether the pregnant womxn or her partner was working, the pressure of providing for the child was always a cause for concern. The decision to study further or work was constrained by whether there would be sufficient childcare while the mother was away for work. Financial security becomes a relative term in that it is closely connected to the standard of living that the family is used to. The interconnectedness of different categories such as partner support, partner employment status, family support (in helping with childcare), access to information, work environment, work or school policies, and affordable healthcare are underscored, as when they are combined, they have the ability to ease financial strain and create a supported pregnancy.

6.3.4 Pregnant womxn – showing agency and being agents of support

All the womxn made reference to the importance of staying positive and accepting what life or God has planned for them in relation to their pregnancy. Some of them had waited for this defining moment, while others had reconciled themselves to the notion after much thought and discussion. Meditation, positive thoughts, healthy behaviour, faith in God, reading books and accessing support from others were some of the ways in which each pregnant womxn found strength. Their stories also revealed that, far from only being womxn in need of support, they provided support to others. This was in the form of listening and offering advice, planning to create a support group for other pregnant womxn and placing their own career plans on hold to support a partner and their own pregnancy. Through these acts they demonstrate wisdom, resilience and courage.

6.5 LIMITATIONS AND STRENGTHS OF THE RESEARCH

I identify the initial high levels of attrition of prospective participants as a limitation in this study. In the methodology chapter, the possible reasons for attrition in the research sample were discussed. The stories and experiences of those womxn who initially showed interest but did not participate, remain unknown, as well as their reasons for opting out. It is possible that a different sample of participating womxn may have led to different findings.

The representativeness of the research sample could be viewed as another limitation. Using antenatal clinics as a point of contact to recruit womxn for this study required sanctions and ethical clearances from the Department of Health. These ethical requirements could, in some way, have impeded access to a more representative group of womxn. While ethics must not be compromised, it does highlight the invisibility of womxn who are unable to access antenatal care and therefore fall outside the research process.

I identify the theoretical lens and supportability model as strengths in my study. Using the supportability model provides a complex, nuanced and comprehensive account of the experiences of pregnant womxn. While it is important to acknowledge that several authors in the past have studied pregnancy and social support, these studies have typically focused on selective variables to the exclusion of others. The intracategorical intersectionality lens, facilitated by the supportability model, has enabled a rich, vivid examination of the many ways in which social categories influence and shape each other. For example, it has been possible to show how micro-interactions are driven by the macro-structures and how they invariably influence day-to-day interactions.

6.6 RECOMMENDATIONS

The findings from this study reveal the importance of reassurance and perceived support in pregnant womxn's lives. Therefore, it could prove extremely beneficial to

normalise the physical and emotional aspects of the pregnancy experience right from the beginning. It would be comforting for pregnant womxn to receive information about the range of physiological and psychological changes they could expect to undergo during their pregnancy journey. The current information available to pregnant womxn appears to be insufficient, if not irrelevant. As an example, flyers could be distributed at ANC clinics, addressing issues that go beyond illness, disease and HIV-screening.

Apart from perceived support, tangible support appears as a strong component that promotes supportability. An important feature of tangible support is not only *what* is being offered, but also *who* is offering the support. The significance of the role of partner support is reiterated in my research findings. Partner support, both instrumental and emotional, is influenced by gendered perceptions, which impact pregnant womxn's physical, mental and emotional health. It is, therefore, important to formulate health education that addresses these perceptions. Firstly, partners need to be involved in the education process. Secondly, the role of partner support and the perception of gender norms should be emphasised during the education process. This type of education could be included in mobile health services that travel into communities in order to reach the target audience. This would impact the perceptions of participants in such information sessions, extended family members, partners, and the womxn themselves, thus creating a supportive community around the pregnant womxn and her unborn child.

6.6.1 Improvement of the healthcare system

Health Minister Aaron Motsoaledi admitted in an interview that four areas of the health sector in particular must be addressed in order to enhance the healthcare delivery system: human resources (HR); financial management; procurement and supply chain management; and the maintenance of infrastructure and equipment ("8 things you need to know about the National Health Insurance bills", 2018). In the current study, at least two of these areas have posed problems for the womxn. A shortage of human resources and inadequate maintenance of infrastructure and

equipment have led to delayed health services. The provision of more staff, and training for these staff, would benefit maternal health considerably. Employing more staff at clinics – particularly nurses, social workers and counselling psychologists – would relieve some of the pressure on current staff, thereby improving interactions between the pregnant womxn and their healthcare workers. Their current interactions include long waiting times and rude behaviour on the part of the employees, which leaves much to be desired in terms of healthcare delivery.

Mental health services must be prioritised in these clinics. My recommendation is that the Department of Health make a provision for the employment of counselling psychologists. This would improve the quality of care offered, by catering to the emotional and mental well-being of pregnant womxn. The presence of counselling psychologists would also create avenues for wellness training programmes for clinic staff themselves, as they are often overworked and underpaid.

The issues raised by the Health Minister fall under the overarching theme of Universal Health Coverage (under Goal 3 of the UN Sustainable Development Goals). He noted that the biggest challenges in achieving this goal are the lack of funds, and the consumer perception of public healthcare.

The sharing of information was typically a positive experience for the womxn in this study. There needs to be an improvement in healthcare communication, especially in public health spaces. Forums for communication may be created either in a formal setting with nurses and doctors (hence highlighting the value of staff communicating appropriately with patients), or in an informal setting through social workers and psychologists who can cover a range of pregnancy-related aspects, while considering the social context and individual needs.

No aspects of Health IT featured in Table 4 enables supportability. An increase in the quality and quantity of interaction and communication can help assess the cultural- and context-specific pregnancy needs. This can further equip clinic staff with

relevant information to feed into Health IT (such as 'Momconnect' and other pregnancy-related phone apps) in order to improve and expand Health IT.

6.6.2 Policies in work environments

Planning for childcare after maternity leave was an area of concern and stress for womxn during their pregnancy, especially if they were studying or working. The South Africa Labour Law mandates that pregnant womxn are eligible for four months of unpaid maternity leave. As companies are under no legal obligation to remunerate employees during this time, it creates financial pressure on pregnant womxn. At a macro-level, paid maternity leave should be an important consideration for the government.

The provision of childcare facilities would be advantageous both from the company's perspective (of not losing personpower) as well as the mother's perspective (continuing to work while the child is looked after).

6.6.3 For future research

One of the outcomes from this research is to utilise the findings for the development of a quantitative tool to access and assess the supportability experiences of pregnant womxn. One such tool could be a survey questionnaire to operationalise the supportability model and administer it across healthcare facilities in the Eastern Cape, as well as regions across SA. It might be useful to include a quantitative grading scale to assess certain aspects based on the supportability model, as well as a qualitative section where womxn can describe any additional information relevant to their pregnancy. It may also be worthwhile to add a section for pregnant womxn to ask questions and create avenues for further communication.

I would also recommend an assessment of the micro-interactions between clinic staff and pregnant womxn. Findings from this research have shown that the long waiting periods and lack of time during healthcare consultations result in certain topics being ignored. There needs to be a discussion about what is typically left out.

While the role of the immediate, extended and in-law's family are all potentially supportive during womxn's pregnancy experience, these areas may be further examined at the time of antenatal care interactions and thereby open up more avenues of support for womxn.

Finally, this research is, in itself, amongst the first few to utilise an intersectional approach that focuses on support at a personal, micro- and macro- level. Hence, it can serve as a template for future research that employs the supportability model to study other areas of maternal health, and even child and adolescent health.

This research underscores the truth in the African proverb that *it takes a village to raise a child,* which, if I may add, should commence at the beginning of the pregnancy.

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APPENDICES

APPENDIX 1: ETHICAL CLEARANCE

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 DOH

To the Department of Health

Subject: Permission to use premises for recruitment of participants (accessing antenatal care) for the purpose of research

Dear Madam,

We are from the Critical Studies in Sexualities and Reproduction unit, 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, health services and other macro situations within which their pregnancies occur.

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 six to ten participants. We wish to place flyers (in isiXhosa and English) at the reception desk at clinics. 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/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 [date]. Please find attached copies of all consent forms and the recruitment flyer. A report in the form of a policy brief will be posted to the Department of Health, regarding the findings of our research.

We would like to be present at the clinic on a few days wearing name tags, so that prospective participants can approach us should they be interested in taking part in the research project. 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.

Thanking you.

Kind regards,

Yamini Kalyanaraman

APPENDIX 3: CLEARANCE FROM DOH

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: PERMISSION REQUEST FROM CLINIC SUPERVISOR

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

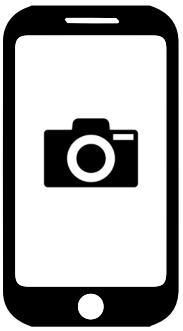
APPENDIX 5: FLYER

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.

APPENDIX 6: INFORMED CONSENT

RHODES UNIVERSITY
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: PHOTO CONSENT

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 analyze 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: AUDIO-RECORDING CONSENT

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 9: IMAGE-RELEASE FORM

RHODES UNIVERSITY
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 researches.
- 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 _____