'Choice' in women's abortion decision-making narratives: Introducing a supportability approach

Abstract

Liberal abortion legislation emphasises pregnant persons' autonomous choices in abortion decision-making. Within psychological theories, decision-making is understood as largely individual, rational and cognitive, with various factors affecting women's[1] abortion decision-making. In this study, purposively recruited from three sites in South Africa and three sites in Zimbabwe, 25 and 18 women, respectively, participated in narrative interviews which were analysed using thematic analysis and a supportability framework. Participants' narratives constructed continuation of the pregnancy as a 'non-option', abortion emerging as the only solution. Economic resources, gender norms and partnerships, and the undesirability of the pregnancy meant the pregnancy was unsupportable at micro- and macro-levels, and sometimes despite parenting being desired by the women. A supportability framework offers opportunities to understand reproductive decision-making as imbricated in the circumstances of the pregnancy which render it (un)supportable, therefore opening up or closing down particular decisions. This framework enables a necessary shift towards systemic understandings of decision-making, and a possible reduction in abortion-related stigma.

The debate on abortion largely revolves around reproductive autonomy: the right of a pregnant person to make decisions concerning their body. Liberal abortion

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Keywords

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[1] We use 'woma/en' to refer to *all* women-identifying people and 'ma/en' to refer to all men-identifying people. We do so cognisant of, *against*, and with a view to visibilise the problematic use (including within some feminist praxes) of 'woma/en' and 'ma/en' to narrowly define 'proper womanhood/manhood' in white supremacist, cisheteropatriachal, ableist, ageist and nativist ways, among others. Furthermore, we use 'pregnant persons/people' to refer to and acknowledge the gender diversity of all (potential) abortion service users.

law reinforces, to a greater extent than restrictive legislation, the right to bodily integrity by enshrining pregnant persons' right to choose the outcome of a pregnancy themselves. For example, the South African Choice on Termination of Pregnancy Act (No. 92 of 1996), which permits abortion on request in the first 12 weeks of gestation, outlines the following in its preamble: "Recognising that the Constitution protects the right of persons to make decisions concerning reproduction and to security in and control over their bodies; Recognising that both women and men have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice". In these statements, rights, decisions, personal control, access and choice are emphasised.

Contrastingly, in Zimbabwe, pregnant people may apply for an abortion based on serious threat to life or health or the pregnancy resulting from unlawful intercourse. Other reasons (e.g. not having the economic resources to look after a(nother) child) are not legally recognised (Chiweshe, 2016). The assumption of a pregnant person making autonomous choices regarding the outcome of a pregnancy (largely reflected in liberal legislation) overlaps, to some extent, with the general psychological literature on decision-making in which decision-making is viewed as intra-personal, cognitive and active. For example, decision-making has been defined as the process of making choices among possible alternatives based on given criteria or strategies (Schacter, Gilbert, & Wegner, 2011). Within the extensive theorisation on what decision-making entails (Wang, & Ruhe, 2007; Kenji, & Shadlen, 2012), psychological theories have largely understood it within the context of an individual's set of needs, preferences and values which influences their choices (Schacter et al., 2011). Various factors that influence decision-making have been outlined, including past experience (Juliusson, Karlsson, & Gärling, 2005), cognitive biases (Stanovich, & West, 2008), age and individual differences (De Bruin, Parker, & Fischhoff, 2007), and belief in personal relevance (Acevedo, & Krueger, 2004).

Similarly, research on abortion sees decision-making regarding the outcome of a pregnancy as largely individual/intrapersonal, cognitive and active. Pregnant people select a logical choice from the available options considering various factors and influences (Khan, & D'Costa, 2002; London, Orner, & Myer, 2007; Lie, Robson, & May, 2008; Harvey-Knowles, 2012). Within this, researchers are interested in women's reasons for wishing to terminate a pregnancy, i.e. the premises on which the decision is made. For example, in a study conducted in Ghana, the authors concluded that

> [W]omen of various profiles have different reasons for undergoing abortion. Women considered the circumstances surrounding onset of pregnancy, person responsible for the pregnancy, gestational age at decision to terminate, and social, economic and medical considerations. Pressures from partners, career progression and reproductive intentions of women reinforced these reasons (Gbagbo, Amo-Adjei, & Laar, 2015: 34).

The context within which decision-making occurs is increasingly being recognised. For example, Sereno and colleagues argue that "the decision is a meaningful experience that reflects personal characteristics, and is associated with relationships and social support, economic and educational circumstances, life contingencies and the social, cultural, and legal environment" (Sereno, Leal, & Maroco, 2013: 143).

In the search to outline the abortion decision-making process, and the factors related to the decision, however, three, related, issues are largely overlooked. The first is what an abortion decision reflects. Terminating a pregnancy is an active decision, whereas taking a pregnancy to term may be a passive one in which the pregnancy simply runs its course. In deciding to terminate a pregnancy, the pregnant person is clearly stating that the pregnancy, for whatever reason, is unsupportable. They can no longer continue with the pregnancy. The second is that decisions and choices are not necessarily the same thing, with choice often implying desire *and* a freedom from constraint or coercion. Pregnant persons must actively decide upon and put into motion the actions leading to an abortion. This does not mean that choices exist, or if they do, that these are equally valid or accessible. To be clear, we are not suggesting that choice is *not*, even to a limited extent, involved in abortion decision-making (that, too, would be problematic, albeit with different implications), merely that it cannot be *assumed* to be. The third is that relational and systemic issues or norms *cannot be separated* from the decision-making process, and as such enable or constrain specific decisions. Within the literature, women, as decision-makers, are often seen as being *influenced* by social context, rather than as deeply embedded in multiple micro- and macro-level power relations that have implications for the supportability of their pregnancy, and hence any decisions related to it (Sell, Santos, Velho, Erdmann, & Rodriguez, 2015).

Baylies (2001: 42) suggests why the assumption of choice and reproductive autonomy cannot (and should not) *necessarily* be made when it comes to understanding reproductive decision-making:

> If one considers societal norms about fertility, together with the agendas of family planning organisations and AIDS-protection campaigns, one can see the dilemmas of women very clearly. The language of choice, preference, planning, and decision-making, often used by health providers, emphasises the reproductive rights that all should enjoy. But these terms often misrepresent what actually occurs. Their use obscures the complexity of a process of negotiating – or failing to negotiate – the nature of sexual activity, which is grounded in power relations, convention, the heat of the moment, and, sometimes, gender violence.
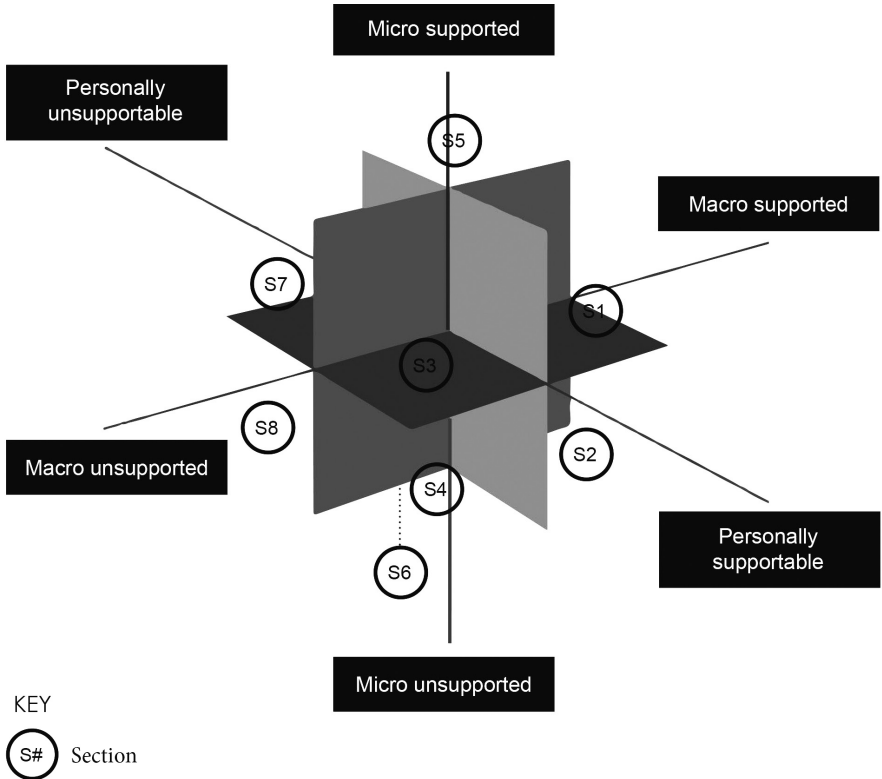
Indeed, the separation of the individual and society has long been criticised in feminist psychology, and calls have long been made for theories that highlight *how* social contexts and individuals are intertwined (Venn, 1984). To effect this in relation to abortion decision-making, we draw on a supportability framework where pregnancies are viewed as biologically, emotionally, cognitively and/or psychologically supportable or unsupportable (or unevenly supportable and unsupportable) (Macleod, 2016). As (un)supportability is inevitably intertwined with 'support', any analysis of unsupportable pregnancies (or decisions that a pregnancy is unsupportable) must be accompanied, according to this framework, with an analysis of micro- and macro-level relational, discursive and structural support.

Through discussion of extracts from narratives of South African and Zimbabwean women concerning their decision to terminate a pregnancy, we show how such a framework may be put to use, as well as the surprising commonalities across these women's stories of their decisions, despite the (lack of) support provided by very different legislative environments. This suggests, we argue, that the legal right to autonomous decision-making is but a small part of the picture.

The supportability model: a framework for understanding abortion decision-making

Barring physiologically unsupportable (e.g. ectopic) pregnancies or being forced by service providers (Li, 2012), partners or parents to abort, pregnant persons who terminate a pregnancy have actively decided that their pregnancy is personally unsupportable. For reasons ranging from not wanting the pregnancy to health- or economic-related hardships, the commonality is feeling unable to continue with the pregnancy. The conditions or types of support required to continue the pregnancy are simply not available, not accessible, and/or are insufficient. When 'support', which is a social term, is interlinked with 'supportable', which describes a state of being, the inseparability of an individual's abortion decision from the relational, discursive and structural power relations surrounding a pregnancy are highlighted. This model, thus, enables an integrative analysis of abortion decision-making processes. **Figure 1** on the opposite page illustrates the main tenets of the model.

Based on an intra-categorical intersectionality approach, the supportability model insists on analyses that integrate the personal supportability of a pregnancy, with micro-level support (interactions with partner, family etc.) and macro-level support (policies, social discourses etc.) – each of which need to be seen as a continuum rather than as discrete. These intersections suggest multiple possibilities in terms of pregnancies. For example, in Figure 1, Section 1 represents pregnancies that are supportable with good micro-level and macro-level support. Unsupportable

PERSONAL	MICRO - LEVEL	MACRO - LEVEL
1. Physiological	4. Partner interactions	8. Religious, social, gender and cultural discourses/practices
2. Emotional	5. Family / kin interactions	9. Social policies
3. Cognitive	6. Workplace/school interactions	10. Socio-economic policies/structures
	7. Healthcare interactions	11. Health care systems/policies

Micro supported

Personally unsupportable

S5

Macro supported

S7

S1

S3

S8

S2

Macro unsupported

S4

Personally supportable

S6

Micro unsupported

KEY

S# Section

Figure 1. Pregnancy Supportability

pregnancies are located in sections 5 to 8. In section 5, micro- and macro-level support is good, but the pregnancy is unsupportable on an individual physiological, emotional or cognitive level. Sections 6 to 8 represent various levels of lack of support – either at the micro- or macro-level or both.

Utilising this framework within abortion decision-making requires understanding the complexity of the decision-making process within interpersonal relationships, which, in turn are embedded within normative constructions around reproduction, sexuality and parenthood, and structural features, such as access to reproductive health services (including contraceptive services) and to material resources (e.g. through employment).

Abortion legislation in South Africa and Zimbabwe

The women whose narratives are analysed in this paper lived in either South Africa or Zimbabwe at the time of conducting our study on which this paper is based. The legal framework in which abortions take place differs in the two countries. In South Africa, the Choice on Termination of Pregnancy Act (hereafter CTOP Act) legalises abortion on request until 12 weeks of gestation and thereafter under specified, varying conditions which two health service providers must agree have been met. The CTOP Act employs a reproductive rights approach and positions women as reproductive citizens endowed with the "choice" to terminate pregnancies up to 12 weeks' gestation. Zimbabwean abortion legislation continues to be restrictive. A new constitution that was approved in 2013 only allows abortion in limited situations, which are still to be determined through legislative processes. The Termination of Pregnancy Act (Chapter 15:10, 1977), which is the current law in operation allows abortion on the grounds that continuation of the pregnancy threatens the life of the woman or poses a serious risk of permanent impairment to her physical health, and the pregnancy resulted from unlawful intercourse, including rape, incest or intercourse with a "mentally handicapped" woman. Legally obtaining an abortion is a long and troubled process.

Our research

In the following section we use data from our research to illustrate how the supportability framework may be used to understand abortion decision-making. In this research, we sought to explore women's stories of the abortion decision-making process. The data for our study were collected in South Africa and Zimbabwe between 2013 and 2015. In South Africa, participants were women who had requested an abortion at one of three termination of pregnancy clinics, chosen by the researchers, in the Eastern Cape province of South Africa. Clinic 1 is a non-governmental reproductive health service provider located in Nelson Mandela Bay. Clinics 2 and 3 are both within government hospitals. Clinic 2 is located in a hospital situated in a small town in a predominantly rural area of the former Ciskei

(the hospital services clinics in a former homeland[2] area). Clinic 3 is in a township[3] in Buffalo City and is close to both rural and urban environments. Women were interviewed at the clinics after receiving pre-abortion counselling but before the abortion procedure. In Zimbabwe, data were collected from three sites in the capital city, Harare. The restrictive legal environment meant that interviews were conducted with women who had already (illegally) terminated their pregnancies. Site A is a government hospital that services an urban population; women seeking post-abortion care were interviewed there. Site B is a working-class suburb in Harare; women were accessed through a nurse who provides post-abortion follow-up services and were interviewed in their homes or at the nurse's house. Site C is a very low-income suburb located just outside Harare; women who had terminated pregnancies were accessed through an existing University of Zimbabwe health programme and were interviewed at the house of a village health care worker. We chose three sites in the two contexts to allow for some diversity in the contextual conditions of women's lives regarding location and, to some extent, socio-economic status. In South Africa, Clinic 1 charges for services and is thus mostly (although not exclusively) used by pregnant people with varying access to economic resources whereas clinics 2 and 3 provide services that are free of charge and thus cater to pregnant people who do not have economic resources to pay for healthcare. Similarly, in Zimbabwe, the three suburbs were chosen to reflect different levels of income.

Participants

In our study we used purposive sampling as we required women who were about to terminate or had already terminated their pregnancy. Women were included in the study if they were 18 years or older (because of the ability to give consent to participate in the research) and were willing to narrate the decision-making process in a research interview. In South Africa, participants were recruited through the TOP healthcare providers. During pre-abortion counselling sessions, healthcare providers briefly informed women about the study and that if they wanted to know more or wanted to participate, they could proceed to a room that had been allocated for interviews. Once there, the first author explained the study in more detail, presenting women with the consent form, and ascertained whether the women wanted to be interviewed or not. Thus, participants were women who had already decided on an abortion and were interviewed at the facility, after receiving pre-abortion counselling but before the termination of pregnancy. In Zimbabwe participants had secretly and illegally terminated a pregnancy in the past year because in Zimbabwe, unlike

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[2]   Areas designated for Black African people during Apartheid.
[3]   Underdeveloped residential areas architectured for Black (i.e. 'non-white') peoples who were meant to serve as labour for surrounding white areas during Apartheid.

South Africa, accessing women who have decided, or are in the process of deciding, to have an abortion is difficult due to restrictive laws, thus constituting a hard-to-reach population. Participants were recruited from three separate locations, a public hospital, a working-class suburb and an informal settlement. At the hospital, the second author approached women in a separate room after post abortion care had been given and they had been cleared for discharge. Key informants who worked with women who had had abortions were used to approach women in the working-class suburb and informal settlement.

We are aware that interviewing women at different stages of terminating their pregnancies might present limitations regarding comparability; there may be differences in how they think and feel about and recall their experience. Nevertheless, we argue that as stories are culturally located, the ways in which people may construct narratives about particular events (Taylor, & Littleton, 2006), particularly abortion (Mavuso, 2015; Chiweshe, 2016), are limited. In addition, our interest in this article is to demonstrate how stories of decision-making are intricately imbricated in micro- and macro-level support, including differences in abortion legislation which enable/constrain possibilities in terms of obtaining an abortion.

A total of 25 Black women were recruited in South Africa at the above-mentioned clinics. Regarding employment status, three women were employed, 13 were unemployed, seven were studying, and two did not discuss this in their narratives. In terms of relationship status, one woman had separated from her husband and two were divorced. The remaining women were not married; they were either in a relationship at the time of the study or had a relationship that had ended due to the pregnancy. Regarding number of children, seventeen women had one or more children and eight had no children at the time of the study. The women ranged from 19 to 39 years of age with an average of 25.8 years.

In Zimbabwe, 18 Black women were recruited through contacts that the second author has with community health workers, service providers at the hospital and a pregnancy crisis clinic, and using snowball sampling. Regarding employment status, ten women were unemployed, two were studying, and six were employed (three worked as domestic workers, one as a sex worker, one as a church counsellor and one as a vendor). Participants' relationship status at the time of data collection varied: six were married, ten were single, one was divorced, and one was separated. Nine women had one or more children at the time of the abortion, and nine had none. Participants ranged in age from 19 to 43 years with an average of 26.7 years.

In both countries, data were collected through an adaptation of narrative interviewing.

Narrative interviewing allows the participant to narrate her story in her own way, using culturally and socially available understandings (Jovchelovitch, & Bauer, 2000). The narrative-inducing question was, "Please tell me the story of your decision to have an abortion and all the events and experiences that have been important to you personally; begin wherever you like, I won't interrupt, and I'll just take some notes for afterwards." After a short 15 minute to 30 minute break, a second interview was conducted, based on themes brought up by participants in their initial interview. Interviews were conducted in Shona and/or English and isiXhosa and/or English by the second author and a co-interviewer in Zimbabwe, and by the first author and a co-interviewer in South Africa, respectively, and according to participants' wishes. The initial and follow-up interviews combined, interviews lasted between 10 minutes and an hour, with most being around 45 minutes long. Data were transcribed and, where necessary, translated into English with back translation[4] being used to check linguistic and conceptual equivalence. Translations meant that minimal transcription conventions were used (pauses: (.); interruption and overlapping talk: =). During transcription, pseudonyms, which were chosen by the women and appear here in the extracts, were used in order to protect participants' anonymity.

The Rhodes University Ethics Standards Committee and the Zimbabwe Medical Research Council granted ethical approval. To counter any potential distress experienced by the women, the co-interviewer in South Africa and both interviewers in Zimbabwe are experienced counsellors with expertise in containing distress, and knowledge of referral procedures. In our study, counselling support was only required twice: an interview was stopped for one participant in South Africa and the co-interviewer worked to contain her emotions, and one participant in Zimbabwe was referred to a clinical psychologist for counselling.

English (translated) transcripts were analysed using thematic analysis (Braun, Clarke, Hayfield, & Terry, 2019) based on the supportability framework. Thematic analysis enables an understanding of patterns across a data set. The analysis was conducted reiteratively in the following stages:

    (i)   familiarization with the data: this involved repeated listening of audio data and reading of transcriptions;

    (ii)   initial coding: data were labelled and organized into succinct features based on the supportability framework;

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4   Back translation is the procedure according to which an independent person translates a document previously translated into another language back to the original language in order to ensure rigour in the translation process. For example, transcribed data which had been translated to English were translated back to Shona and the two versions compared.

(iii) generating themes from the codes: patterned responses were identified by revisiting the codes and searching for similarity and linkages; in particular for each theme the individual, micro-level and macro-level implications were highlighted;

(iv) reviewing potential themes: initial themes were checked against codes and data extracts

Findings

Participants consistently indicated that the circumstances of their lives precluded continuation of the pregnancy (i.e. the pregnancy was unsupportable). Despite this, the abortion decision was not desired, and hence complex. However, the lack of support in micro-level interactions, and by extension, macro-level systems necessitated the decision. We home in here on two major ones highlighted by the participants: (1) partner interactions (micro-level) and gender norms (macro-level); and (2) economic dependence (micro-level), and economic systems (macro-level).

Partners and gender norms
In the extracts below, women narrated the abortion decision as one they were forced to make owing to partner relationships. Thus, although made by them, the decision was not chosen from two equally viable alternatives:

Anele [South Africa]: "The other reason is that that my boyfriend said it it's (.) it's not his child so."

Tina [Zimbabwe]: "I told the owner that I was pregnant but he denied responsibility (.) and he said it might be someone else's pregnancy especially since he said that I used (.) to smile too much at the customers. He fired me from the job and he said he never wanted (.) to see me again. My life ended then"

In the extracts above, Anele and Tina both speak about how their partner's denial of paternity precluded continuation of the pregnancy from their field of possible options. Thus, at a personal level the pregnancy is emotionally and cognitively unsupportable owing to paternity denial (micro-level interaction). For Anele, abortion is occasioned by a refusal of paternal responsibility and an implied continued relationship with her boyfriend. For Tina, abortion is occasioned by a denial of paternity by a partner who, also her employer, terminates her employment and their relationship. As Tina describes, this micro-level interaction had substantial effects on her personally – "my life ended then".

These micro-level interactions are, however, located within macro-level dynamics. Socio-economic activity continues to be dominated by men, thereby enabling the situation where Tina is at the mercy of her boss who was also her partner. The lack of protection for women working in the informal sector exacerbates this. Thus, Tina can be fired from her job as a cashier in a bar with no avenue for recompense. Gender norms and inequitable power relations intersect with male dominance of economic activity; both women point to dynamics where male partner paternal support (economic and emotional) may not necessarily be relied upon and can be easily withdrawn. Significantly, neither of the women *explicitly* state that parenting is no longer an option but imply it. This points to a normative understanding of the kinds of support that *should* be provided by a conception partner, which at a basic level means accepting the pregnancy, and providing financially.

For some women in our study, the decision-making process was described as involving a decision between two undesirable alternatives.

Tanya [Zimbabwe]: "The guy was renting at the house he was staying in and he left (.) and I did not know where he went. He ran away. I had not seen his relatives and he changed his line and his old number was not available. I was at my wits' end (.) as I thought we were going to get (.) married and have a (.) family [sobbing]."

Andiswa [South Africa]*:* "I think he has blacklisted me, meaning that he does not want anything to do with me when I speak about the child and things. Understand? Because starting (.) before I started to talk about the child we were speaking nicely. Understand? But that week, he no longer wanted anything to do with me (.) by me and what I am talking to him about […] I think he does not want anything to do with me and the child […] I think, the best way is if I take it out [terminate the pregnancy]. Otherwise, it is not a decision that is (.) easy. It is hard [said in English]. It is very difficult, but it is a thing (that must be done) (.) that is all."

Idi [Zimbabwe]: "Should I do it or not? But you are forced to do it because of your situation. You will be in a tight corner and for you not to do it it's hard. You will be saying, 'whatever happens, happens'."

Tecla [Zimbabwe]: "The situation I was in whatever I chose to do was like dying for me. It was hard for me. I actually wanted to die as [then] I would find rest. My life was hard to live, it was (.) impossible. I did not want to have a child (.) with a killer. It would have meant I was tied to him all my life."

Above, Tanya, Andiswa, Idi and Tecla all describe the decision to terminate the pregnancy

as complex and emotionally difficult, as they are caught between two undesirable alternatives. While they want to continue with the pregnancy, doing so would have adverse consequences for them. Terminating the pregnancy is also undesirable precisely because they want to continue with the pregnancy. Tanya describes her emotional difficulty thus: "I was at my wits' end (.) as I thought we were going to get (.) married and have a (.) family [sobbing]". Similarly, Andiswa, explains: "I think, the best way is if I take it out [terminate the pregnancy]. Otherwise, it is not a decision that is (.) easy. It is hard [said in English]. It is very difficult, but it is a thing (that must be done) (.) that is all". Indeed, as Idi describes, a decision-making process that involves deciding between two undesirable options is akin to being "in a tight corner".

For Tanya and Andiswa, partner abandonment means that they must choose between two undesirable alternatives, with abortion emerging as the only possibility. Both women imply that they desire to continue with the pregnancy, thus, at a personal, emotional level, the pregnancy is supported. However, their own emotional support for the pregnancy cross cuts with their partners' lack of desire for the pregnancy, which culminates in an abrupt end to the relationship. Tanya describes her abandonment thus: "the guy was renting at the house he was staying in and he left (.) and I did not know where he went. He ran away. I had not seen his relatives and he changed his line and his old number was not available". Andiswa, in extract 8, constructs an almost identical narrative: "I think he has blacklisted me, meaning that he does not want anything to do with me when I speak about the child and things. Understand?" For Tecla, her own desire for the pregnancy intersects with her fears of the prospect of being married to a violent partner.

At a macro-level, Andiswa, Tanya and Tecla's pregnancies are rendered unsupportable because of inequitable gendered power relations. For Andiswa and Tanya, this takes the pattern of male partner abandonment where they have not only been abandoned in the relationship but have also been left with the responsibility to make a decision about the pregnancy. Implied is that, should they continue with the pregnancy, it may now, at the macro-level, be economically unsupportable as well. In Tecla's case, the decision to terminate the pregnancy is underpinned at a micro-level by the possibility of intimate partner violence (IPV), and at a macro-level by gender norms underpinning male dominance in heterosexual relationships, which mask and normalize IPV. Thus, even though she uses the language of choice, this choice is clearly understood as incredibly constrained.

What is particularly interesting about Tanya, Idi and Tecla's narratives, is that, owing to the unsupportability of the pregnancy, abortion emerges as the only option despite restrictive abortion legislation in Zimbabwe which means that abortion must be self-

induced clandestinely, carrying great risks to their health and life. The unsupportability of the pregnancy ultimately means that such risks must be accepted, as Idi explains: "for you not to do it it's hard. You will be saying, 'whatever happens, happens.'"

Dependence and economic resources
Below, Qaqamba and Rose speak to how a lack of sufficient economic resources precluded continuation of the pregnancy and thus necessitated abortion:

Qaqamba [South Africa]: "I am raising two children. I am being raised by my mother. So, again, I will be with another child, the third one. I do not want this third child, because (1) I do not (.) I do not have money to just do this again [have another child]. I am saying I (.) I was distressed a lot after raising my two children, so I do not (.) I do not think I will again on my own be able to raise another one. So I took this decision, I am removing (.) my stomach [terminating the pregnancy]."

Rose [Zimbabwe]: "I was afraid that I had nothing to give to the children. I already had four children and what would I give the fifth one? The ones that are there I am already struggling to feed them. These are children from my first marriage. The life is difficult especially when it comes to support. You would have seen that your problems are bigger than any risk that might come from terminating the pregnancy."

The women in these extracts emphasise their lack of access to economic resources ("I do not have money"; "I am already struggling to feed them"), and their reliance on others (micro-level interactions) for money. Qaqamba explains that her economic support comes from her mother who is unemployed but provides for her family through government grants (not shown in the extract). As she explains, her economic resources mean that she does "not have money to just do this again", with the word "just" underscoring the economic resources required and the implications that continuing the pregnancy would have. Rose is similarly constrained by a pregnancy that is not economically viable. She explains that her existing children were born when there was marital support (micro-level interaction), but that lack of current support necessitates the abortion, despite the risks. These interactions obviously take place within macro-level economic structures in which employment possibilities are limited, especially for marginalised women.

Gendered and generational access to resources
Both Qaqamba and Rose, above, already have children. Continuing the pregnancy would mean an additional child, and that the basic needs of the existing children and the additional child would be compromised by stretching already strained economic resources. As neither women receive economic support from the conception partner,

gendered power relations, where a terminated heterosexual relationship means a lack of economic support for parenting, thus render the pregnancy unsupportable.

Several women indicated that they were not ready to have a(nother) child. This readiness was couched in terms of generational and gendered norms and access to resources, and hence the power to make decisions. Qaqamba's extract above, and Sesethu and Zusakhe's responses, below, are examples:

Sesethu [South Africa]: "he was considering marrying me so (makes a sound to signal her disagreement with this) I'm still not ready 'cause (.) I don't wanna be a housewife. If I go to school then (.) if I get married now, he'll have to support me. If I go to school then my parents won't have to take out money, he'll have to take out money. Now, I don't want like (1) say maybe some time in the future we have fight or, maybe we gonna get divorced and then like he'll say, 'I took you to school' and all those other stuff so, if I get married I want to get married when I have everything, I've got my own job and everything else […] I don't have to depend on anyone 'cause at the moment I depend on my parents, so like (.) I think another child would be a disappointment to them. And like the things that they do for me would like (.) cut down, or maybe they'll stop doing anything for me (.) I might not go back to school next year you see?"

Zusakhe [South Africa]: "As soon as I saw that (2) I had missed my periods and I saw that (.) there is something wrong (1) I bought a pregnancy test. I tested myself. It came back positive. /ok/ Then I told myself that I will never (3) I do not want another child because I have two kids already. I got out of a marriage (.) all of that"

Sesethu describes how her partner's reaction to news of the pregnancy was to consider marriage, presumably to legitimate the pregnancy and make available the resources and support that are normatively associated with a marital relationship. However, this is untenable for Sesethu who wants to continue her education and does not want to "be a housewife" and have to depend on her husband to do so. Sesethu also fears that her marriage would mean being tied to her partner as he might use her economic dependency on him as leverage to prevent her from divorcing him later should she wish to.

Continuing with the pregnancy but not marrying her partner would also likely result in negative consequences. It would mean continuing her dependency on her parents, who already provide her with some support in raising her existing child; as Sesethu explains, her parents likely disappointment at another child would mean less economic support from them, including her schooling which would likely be in jeopardy. Thus, to continue the pregnancy would mean economic dependency whether through inequitable

gendered power relations or generational power relations (micro-level interactions) which intersect to render the pregnancy unsupportable. The gendered heterosexual norm within which men are seen as breadwinners and women as home-makers (macro-level dynamics), and generational norms where parents have decision-making authority are seen as immutable, with terminating the pregnancy as the only route out of such a quandary.

For Zusakhe, another child is undesirable because she is satisfied with the number of children she already has and because she is divorced. At a personal level, then, her pregnancy is unsupportable because she does not want to continue with the pregnancy. Nevertheless, gender norms in which having children only makes sense within the context of a marriage underpin her decision to terminate her pregnancy. Being divorced would also likely mean she would have to parent the potential child alone should she continue with the pregnancy. This would have financial implications. Indeed, during the interview Zusakhe explained that because she was working as a security guard, her two kids were staying with their father (her ex-husband) until she had secured a permanent, well-paying job.

Discussion

The narratives of abortion decision-making discussed here construct continuation of the pregnancy as a 'non-option'; abortion emerges as the only possibility. This may be due to abortion stigma which creates a spoiled identity for women who are understood as transgressing discourses around womanhood in which motherhood is expected of women (Kumar, Hessini & Mitchell, 2009), something Tamale (2011) refers to as the imperative of mothernormativity.

These normative ways of understanding abortion may, therefore, mean that there are limited ways of narrating an abortion decision whilst mitigating against a spoiled identity or recuperating a positive one (Chiweshe, Mavuso, & Macleod, 2017). The absence of 'choice' in these narratives may, we argue, also point to the need to understand abortion decision-making within the contexts of pregnant people's lives which close down or open up decision paths. A supportability framework enables an understanding of how different aspects of a pregnancy can contribute to its supportability or unsupportability. It allows us to view support *as* a resource, including: supportability at the individual level such as the emotional supportability/ desirability of the pregnancy or physiological supportability such as the pregnant person's health; support at the micro-level such as intimate partner interactions, or workplace arrangements (where these exist); and, at the macro-level, oppressive systems which construct gender norms, inequitable gender and generational power relations and which differentially grant access to economic resources. Applying these

to how people speak about their abortion decision enables an understanding of how reproductive decisions may or may not be made in the presence of choice and desire and how the ability to make reproductive decisions based on one's desires is necessarily enabled or hindered by access to various resources which create supportable or unsupportable pregnancies.

It is clear from these data that working towards supportable pregnancies means disrupting current patriarchal gender norms and reconfiguring patriarchal gendered power relations so that pregnant people have access to resources to continue with a pregnancy should they so desire. This supportability model (Macleod, 2016) may, however, be applied to understanding abortion, too, as requiring support for it to be an option. Thus, where pregnant people do want or need to terminate a pregnancy, conditions must be created so that they are able to access abortion safely.

Abortion stigma, in various ways and to various degrees, limits the support required for abortion to be an option in pregnant people's reproductive decision-making. In Zimbabwe, abortion stigma manifests in the government's concern with too-high levels of induced abortion, despite the lack of readily available and reliable figures (Maternowska, Mashu, Moyo, Withers, & Chipato, 2014), on the one hand, and in the fact that there are high levels of abortion-related mortality from unsafe abortion (Zimbabwe Women Lawyers Association, 2012) on the other. The restrictive nature of legislation and practice in Zimbabwe, often means that pregnant persons have no recourse but to self-induce abortion using various methods (Chiweshe, 2016) and do not seek post-abortion care due to fear of legal and social repercussions (Maternowska et al., 2014). Abortion is also stigmatised socially, culturally and religiously (Chikovore, Lindmark, Nystrom, Mbizvo, & Ahlberg, 2002; Chigudu, 2007). Indeed, Zimbabwean participants described how their pregnancy decision-making was complicated by fears of legal repercussions and/or the prospect of suffering ill-health or even death from an abortion that was legally restricted and dangerous, but nonetheless necessary because their pregnancy was unsupportable. Their narratives underscore the necessity of liberal abortion legislation and the provision of safe, free abortion services.

Even where abortion legislation is liberal, however, abortion stigma may obstruct access to abortion or undermine the provision of quality, non-directive abortion services. In South Africa, healthcare providers' refusal to provide abortion services and the fact that only 50% of designated facilities are providing abortion services have contributed to a reduction in the provision of safe, legal abortion services, particularly in the public health sector where abortion is free of charge and on which the majority of the population rely, and has meant that pregnant people are still relying on illegal and unsafe providers (Harries, Cooper, Strebel, & Colvin, 2014; Hodes, 2016; Moore, &

Ellis, 2013). In some cases, anti-abortion rhetoric has also permeated abortion service provision, including abortion counselling, resulting in abortion service provision which is directive and harmful in intent and/or effect (; Cullinan, Modjadji, & Nortier, 2020; Mavuso, 2018). Furthermore, popular discourses on abortion tend to negatively construct abortion as immoral, a violation of foetal rights and personhood, and against cultural and family values (Macleod & Hansjee, 2013; Macleod, Sigcau, & Luwaca, 2011). Attitude research suggests that where abortion is constructed as tolerable, this tends to be in situations where a woman can be seen as unaccountable for the pregnancy itself (such as rape), and/or unaccountable for the need to terminate the pregnancy (on grounds of ill health, foetal abnormality, and the pregnancy posing a threat to their life (Patel, & Myeni, 2008)). Thus, support for abortion also necessitates a discursive climate in which abortion is normalized, and decisions to terminate a pregnancy are placed in context.

Beyond understanding abortion decision-making in new ways, there are important implications to applying a supportability framework (Macleod, 2016) in relation to abortion decision-making, particularly if meaningful social transformation is to be achieved. Firstly, it enables a necessary shift from neoliberal and psychological models of decision-making which focus, for the most part, on individuals and attribute their decisions to choice and desire. Given the imperative to decolonize psychology in (Southern) Africa and debates about the form and content that a decolonized psychology will take, a supportability approach may enable psychological knowledge production around abortion decision-making that resists both over-provincialization and excessive universalism. Over-provincialization theorizes local realities and experiences in a way that invisibilizes commonalities across different contexts and in so doing, ironically perpetuates the othering that is synonymous with historical (and contemporary) racist applications of psychology to people of color; excessive universalism focuses on commonalities linking realities and experiences across different contexts, but invisibilizes the specificities of individual contexts (Makhubela, 2016). Using a supportability approach enables an understanding of the particular personal, interpersonal, and societal conditions that create supportable and unsupportable pregnancies and shape abortion decision-making, whilst allowing for the visibilisation of commonalities in the conditions of (un)supportability regarding the abortion decision-making of pregnant people from different countries, such as South Africa and Zimbabwe.

Secondly, as we have attempted to show here, the supportability framework visibilises the conditions necessary to make decisions based on choice and that are in line with one's reproductive desires, and therefore visibilises the collective (including and especially the state's) responsibility to ensure pregnant people's autonomy in their

reproductive lives. Thirdly, adopting a language of supportability with respect to abortion decision-making may reduce abortion stigma. Anti-abortion discourses normatively frame pregnant people's desire or choice to have an abortion as inherently problematic. Thus, perhaps a supportability framework may disrupt such discourses, and the stigma they produce, by understanding abortion decision-making to occur within and be shaped by the intersecting conditions of a pregnancy, *including* whether pregnancy/parenthood is desired which render a pregnancy (un)supportable.

Acknowledgements

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