Probing Sexual and Reproductive Health (SRH) services: experiences of women at Umkhambathini eNkanyezini, KZN-South Africa.

By

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of the requirement for the degree of

PhD in Anthropology

Supervisor:

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November 2024

DECLARATION

I **Philani Goodman Kuluse** declare that:

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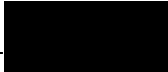
Signature: 

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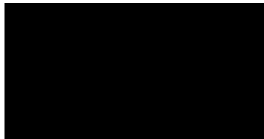

DEDICATION

I would like to dedicate this dissertation to my dedicated supervisor, my beloved Mbalenhle Mbatha, and all my siblings. I am deeply grateful for your presence in my life. You have been the light that brightens each of my days. I will always cherish you and continue striving to make you proud. May God bless you. To maZondi, my mother, this is for you. I have worked tirelessly every day since your passing, driven by your encouraging words and your dreams for us to pursue education. This doctorate is a fulfilment of those wishes, and though I wish you were here to see me reach this milestone, I pray that you are watching over me.

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SUPERVISOR'S STATEMENT

I **Dr Balungile Zondi** declare that this thesis has been submitted with my approval

………………………………..   ………………………….

Supervisor's signature   **Date**

ABSTRACT

This qualitative study contributes to feminist anthropology, specifically the anthropology of women, by exploring the sexual and reproductive health (SRH) experiences of rural women in uMkhambathini, eNkanyezini, KwaZulu-Natal, South Africa. The study problematizes the higher mortality rates of rural women compared to men in this village, highlighting significant health disparities. Feminist anthropology addresses the interconnected challenges women face in accessing healthcare and proposes meaningful solutions. The study is framed by three theoretical perspectives: Social Constructivism, Critical Medical Anthropology, and Gender Theory. Purposive and snowball sampling methods were used to select thirty (30) participants, with data collected through five focus groups, each comprising six women. The findings underscore the continued marginalisation of rural women in uMkhambathini, impeding the realisation of South Africa's National Development Plan Vision 2030. These women remain unable to fully access Basic Human Rights as enshrined in the South African Constitution (No. 108 of 1996) and international frameworks such as the Sustainable Development Goals (SDGs), which advocate for sexual and reproductive rights. Data analysis reveals that structural barriers, including education levels and family size, significantly hinder their ability to access and utilise SRH services. Furthermore, rural healthcare facilities in uMkhambathini are under-resourced and geographically isolated, exacerbating healthcare exclusion due to inadequate resources and limited government intervention. The study introduces the Framework for Localised Reproductive Health and Support Structures (FLRHSS), which aims to accelerate the provision of SRH services for the benefit of rural women in uMkhambathini. The findings also reveal inconsistencies and a lack of clarity regarding the age of consent for HIV and SRH services in high-burden areas like eNkanyezini, particularly concerning oral PrEP. The study recommends prioritising rural women in SRH programs and expediting the implementation of the National Health Insurance (NHI) system to address structural, economic, and geographic barriers. Ensuring the availability of essential medical technologies and products is crucial for enabling healthcare workers to deliver effective services. Additionally, community-based education programs targeting women and mothers are vital for dismantling systemic barriers to SRH access. This research underscores the need for a more inclusive and equitable approach to SRH services that addresses the unique challenges faced by rural women in South Africa. It also calls for future research to explore the SRH needs of women with disabilities, further advancing a comprehensive understanding of reproductive health disparities in rural contexts.

Keywords: *Sexual and Reproductive Health, Ethnomedicine, Biomedicine, Healthcare, Rural Community, Community Infrastructure, Social Constructs, Culture, Social Expectations. Framework for Localised Reproductive Health and Support Structures (FLRHSS).*

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ACRYONYMS

SRH - Sexual and Reproductive health

SRHR - Sexual and Reproductive health rights

HIV - Human Immunodeficiency Virus

AIDS - Acquired Immunodeficiency Syndrome

PrEP -Pre-Exposure Prophylaxis

PeP- Post-Exposure Prophylaxis

FLRHSS - Framework for Localised Reproductive Health and Support Structure

CMA - Critical Medical Anthropology

SDG - Sustainable Development Goals

MDG- Millennium Declaration Goals

NIH- National Health Insurance

BHR- Basic Human Right

HDI- Human Development Index

IDP- Integrated Development Plan

KZN-KwaZulu-Natal

STD- Sexual Transmitted Disease

TB-Tuberculosis

WHO- World Health Organization

CHAPTER ONE

Introduction to the study

1.1 Introduction

In recent years, access to sexual and reproductive health (SRH) services has remained a significant issue. Heads of state have taken substantial steps to improve the SRH status of women. African leaders play a crucial role in implementing SRH policies by shaping national health agendas, mobilizing resources, and advocating for gender-inclusive health programs. Their leadership influences the integration of SRH services into national healthcare systems and the prioritization of men's reproductive health. For instance, in Rwanda, President Paul Kagame has championed universal healthcare coverage, including access to family planning and SRH services for both men and women, contributing to increased contraceptive use and a reduction in maternal mortality (Bicchieri et al., 2022). Similarly, in Ethiopia, former Prime Minister Hailemariam Desalegn supported male involvement in family planning initiatives, encouraging men to accompany their partners to antenatal clinics (Cleland et al., 2018). In South Africa, President Cyril Ramaphosa has promoted HIV prevention strategies, including voluntary medical male circumcision, which has helped reduce HIV transmission rates among men (UNAIDS, 2021). Additionally, through regional bodies such as the African Union (AU), heads of state have endorsed continental frameworks like the Maputo Plan of Action, which calls for comprehensive SRH services and emphasizes male responsibility in reproductive health (African Union, 2016). While these efforts demonstrate progress, challenges persist as political will varies across countries, and traditional gender norms continue to hinder effective implementation. Strengthening political commitment and aligning policies with cultural realities remain essential for the success of SRH programs in Africa.

Despite these efforts to ensure equal access to medical information, care, and facilities, socio-political and socio-economic variations, such as poverty, illiteracy, and unemployment, have compromised the intended objectives of SRH services in many underdeveloped countries. Rural women, in particular, are often not prioritized in international health responses. These women typically have limited knowledge of SRH services. According to Azad, Charles, Ding, Trickey, and Wren (2020), women are disproportionately impacted by economic vulnerability, lower social

status, and limited access to education when compared to men. They also face significant barriers to healthcare facilities and the political economy of underdeveloped nations globally.

This study seeked to explore rural women's experiences regarding SRH services in the rural settlements of Umkhambathini, specifically in eNkanyezini. Several international documents address SRH services, including the Sustainable Development Goals (SDG, 2019). SDG 3 advocates for good health, underscoring the importance of women's health in broadening the conversation. Subsections 1 and 7 emphasize the reduction of maternal mortality ratios and general access to sexual and reproductive healthcare. The Constitution of South Africa (No. 108 of 1996), in Section 27, asserts that "each individual has the right to access healthcare services, including sexual and reproductive care." Several international documents set global standards for accessibility, gender equality, and public health regarding SRH. For example, the SDGs (2015) emphasize SRH through Goal 3 (Good Health and Well-being) and Goal 5 (Gender Equality), particularly Target 3.7, which calls for universal access to SRH services, and Target 5.6, which ensures reproductive rights as outlined in the Programme of Action of the International Conference on Population and Development (ICPD, 1994). The ICPD marked a shift from population control to reproductive autonomy, influencing national policies such as India’s expansion of contraceptive and maternal health services. Similarly, the Beijing Declaration and Platform for Action (1995) reinforced SRH as a fundamental human right, advocating for the elimination of gender-based violence and increased access to family planning, an approach reflected in South Africa’s National Adolescent and Youth Health Policy (2017). The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979), a legally binding treaty, further ensures women’s equal access to healthcare, including family planning, with countries like Rwanda aligning their policies to improve contraceptive and maternal healthcare services. Additionally, the WHO Global Reproductive Health Strategy (2004) promotes reproductive health through strengthened healthcare systems, influencing maternal care improvements in Nigeria. Collectively, these frameworks guide international, regional, and national policies, ensuring reproductive rights and access to essential SRH services.

Despite the extensive policy frameworks and goals set, reviews of these policy implementations indicate that the realization of such international and local commitments remains far from being fully achieved. This chapter argues for the unmet sexual and reproductive health rights of millions of African rural women. Consequently, higher rates of HIV/AIDS, maternal and newborn

mortality, unsafe abortion, and sexually transmitted infections are prevalent in many rural regions due to the lack of access to SRH care.

Although SRH services are regarded as a universal human right, structural, cultural, and environmental factors continue to hinder their effective delivery, as many medical anthropology studies have not fully addressed these barriers. The uMkhambathini community is one such rural area where women face significant structural health challenges. The originality of this study lies in its exploration of the localization of SRH services, aiming to develop practical solutions to address the structural and detrimental factors limiting the effective implementation of SRH services in the eNkanyezini area. Chandra-Mouli, Neal, and Moller (2021) argue that SRH and rights have been central topics in medical anthropology, particularly in the scope of Critical Medical Anthropology. To address women's health issues, prominent feminist anthropologists, such as Margaret Mead, Elsie Clews Parsons, Ruth Benedict, and Zora Neale Hurston, have focused their ethnographic research on understanding causative factors.

Critical Medical Anthropology scholars have questioned the structural barriers that hinder women's access to medical care and healthcare systems, as these should be universal rights. These studies examine medical systems, biocultural approaches, and the impact of medical pluralism (Ndlovu, 2022). African women have long been subjected to discriminatory practices, violence, and denial of their health-related rights for various reasons, including cultural, traditional, and economic factors (Witeska-Mlynarczyk, 2015). The political economy of marginalized rural women includes unique factors that shape their health situation, and many African policies have failed to address these, even within democratic frameworks that emphasize equality as a fundamental human right (Dadzie, Ebron, & Kipenda, 2021; WHO, 2019). Maiga (2014) suggested that the current situation of women's health in Africa demonstrates the limitations of policies that have not prioritized women's health needs. Barriers to the promotion of reproductive and sexual rights also limit women's ability to control their health, fertility, and autonomy, hindering their participation in social and economic life. The protection of sexual and reproductive rights remains a major human rights issue, exacerbated by neoliberal economics, fundamentalism, conflict, and ongoing poverty and illiteracy, especially in poorer and conflict-ridden African countries.

In Africa, when a woman expresses pain or frustration, she is often considered a lamenting person. Despite some improvements, the notion that African women are gradually occupying political roles

has not led to substantial change in decision-making positions. According to Tawiah and Ngmenkpieo (2018), South Africa is a middle-income nation with high rates of poverty, much of it concentrated in rural areas. Poverty and illiteracy rates in rural South African communities are currently at an all-time high of 67%. Rural women, with higher unemployment rates than men, are disproportionately affected by illiteracy and lack of access to transportation. Without these essential resources, rural women may struggle to invest in their own health and the local economy. This study aims to explore the structural limitations faced by rural women in uMkhambathini, which may impact their access to SRH services. It contributes to the anthropology of women by examining cultural perceptions in rural KwaZulu-Natal, which hinder women's understanding of SRH services. Additionally, the study will examine the demographic factors that influence SRH understanding, such as gender, age, and social standing.

In South Africa, health problems in rural areas disproportionately affect women, as shown by the South African health report (2022), which indicates poor maternal and neonatal outcomes, STDs, pregnancy termination, gender-based violence, and other unfavorable socio-demographic outcomes for women. Cooper et al. (2004) argue that the historical marginalization of black South Africans contributed to limited access to health services, particularly in rural areas. Racial and geographic disparities continue to affect the public health system, which remains fragmented. However, women in rural regions have not benefited significantly from changes in health legislation, policy, and service provision in South Africa over the past decade. Furthermore, corruption, fraud, and poor management continue to hinder progress, exacerbating the healthcare situation in peripheral areas. Gendered assumptions also prevent effective SRH evaluation in rural areas. According to Azad, Charles, Ding, Trickey, and Wren (2020), sociocultural factors, including autonomy, gender norms, and decision-making authority, are key barriers to access that disproportionately affect women. In the context of medical anthropology, additional study is needed to fully understand these consequences and their impact on SRH.

This study also seeked to examine how societal views on gender roles influence decision-making and how these perceptions could be harmful to women's health. By addressing the observable characteristics that rural women cannot control, as well as those they can potentially change, this study emphasizes the importance of addressing gender disparities in healthcare access. The contributions of medical anthropology will help improve SRH and influence public policy. Additionally, this research aims to shed light on the rural sociocultural and socio-economic factors

that hinder women from accessing SRH services, revealing grassroots perceptions that maintain the lack of SRH knowledge in these areas. The originality of this study lies in probing SRH services and women's experiences in uMkhambathini, a rural area in KwaZulu-Natal (KZN). While healthcare cannot be universally generalized, it must be categorized based on settlement types. Each region's unique healthcare needs, particularly in uMkhambathini, must be considered when addressing SRH challenges. The study raises the critical question: "Why are women dying more than men in uMkhambathini?" By situating this issue within the framework of SRH, the study aims to identify key health risk factors, which have long been influenced by the settlement's location. Given the lack of studies focused on this community, this research is essential to address these critical health concerns.

1.2 Problem Statement

This study focused on two key issues: the access to and availability of Sexual and Reproductive Health (SRH) services in uMkhambathini, as well as the cultural and social barriers to SRH service utilization. First, the study explores barriers such as long distances to health facilities, lack of transportation, staff shortages, and inadequate health infrastructure, and assesses how socio-economic factors (e.g., poverty, unemployment) limit access to these services. Second, the study examines how traditional beliefs, gender norms, and stigma surrounding sexuality impact women's willingness to seek SRH services, while also exploring the role of gender dynamics in decision-making related to reproductive health.

The problem area is centered around the numerous health issues that affect women in rural areas (Chimbindi, Ngema, Ngwenya, Gibbs, Groenewald, Harling, Mthiyane, Nkosi, Seeley, & Shahmanesh, 2022). This thesis highlights that rural women, including those in the uMkhambathini community, face barriers to receiving SRH services, underscoring a gap in current research on this topic. According to African feminist and marginalized theories, women's health is often hindered by a combination of traditional beliefs, religion, personal biology, socio-cultural factors, economic status, and environmental influences (Eddo-Lodge, 2020; Morindo, 2017). These factors contribute to the social marginalization of women. A recent study by Ouahid, Mansouri, and Sebbani (2023) reveals that women have a higher mortality rate than men, with 830 women dying daily from avoidable causes. In many African countries, women either lack access to SRH services or face significant structural barriers in obtaining these services. Additionally, societal norms tend to focus

reproductive and sexual health services primarily on married women, neglecting or marginalizing the needs of teenage girls and single women. This issue is situated within a broader context of privilege and marginalization, and future studies should examine SRH accessibility from the perspective of status and societal roles.

The existing literature reveals a notable gap in understanding the SRH experiences of rural women in uMkhambathini. While general studies address SRH issues across Africa, this thesis argues for more localized research to address specific contextual challenges, thereby contributing solutions tailored to the needs of these communities. This research aims to explore the SRH experiences of rural women through an anthropological lens, which can inform responsive health interventions such as the Integrated Development Planning (IDP), the Health District Model, and other strategic frameworks.

Many studies in medical anthropology and critical medical anthropology (CMA) emphasize the importance of ethnographic research to reveal the health challenges faced by people in their specific geographical contexts (Goodson & Vasar, 2011). Feminist anthropologists argue that it is crucial to study sociocultural norms and perceptions from both ethnomedical and biomedical perspectives. This qualitative study aims to uncover these perspectives, recognizing that each viewpoint offers a deeper understanding of the issues. The impact of South Africa's colonial political economy has been profound, as it systematically disenfranchised black people, limiting their access to medical knowledge, facilities, and care. Ethnomedicinal practices became a primary means of intervention, which influenced many rural women to prefer traditional medicine over biomedical services. This historical exclusion has created significant barriers for SRH services, undermining the potential benefits of biomedicine and contributing to lower life expectancy among women compared to men.

The colonial legacy has fostered a lack of confidence in the outcomes of SRH services, leading to reluctance in using these services even in the context of medical advancements in Africa. Socio-economic factors, educational levels, and more traditional decision-making roles within families, particularly by husbands and fathers, further influence women's health choices. Ouahid, Mansouri, and Sebbani (2023) highlight that the maternal mortality rate is significantly higher in rural areas (111.1 per 100,000 live births) compared to urban areas (44.4 per 100,000 live births). According to the World Health Organization's 2023 outlook on rural women, women in the African region are more likely to die from maternal and prenatal complications, nutritional deficiencies, and

communicable diseases such as HIV, TB, and malaria. In South Africa's democratic context, rural communities remain underdeveloped due to:

1. The failure of decentralized health services,
2. Budget constraints and corruption,
3. Geographical barriers to accessing health facilities,
4. A shortage of adequately trained health practitioners.

The key health issues affecting rural women in uMkhambathini include HIV/AIDS, lack of medical information, and limited access to healthcare facilities. The historical legacy of colonialism and apartheid continues to shape the healthcare system in rural areas, contributing to inequality between rural and urban healthcare systems (Oronje et al., 2011; Sabry, 2019). Rural healthcare facilities face numerous challenges, including poor infrastructure, inadequate trained personnel, scarcity of medications, and overcrowding, all of which exacerbate SRH issues. To address these constraints, increased efforts are necessary to improve access to SRH services (Sabry, 2019).

A study by Namasivayam, Osuorah, Syed, and Antai (2012), cited by Tesha, Fabian, Mkuwa, Misungwi, and Ngalesoni (2023), outlines several obstacles women in Africa face when accessing SRH services.

1.3 Key Objectives:

- To explore the experiences of rural women in accessing and utilizing SRH services.

1.3.1 Secondary Objectives:

- To examine the structural factors that inhibit women from accessing and utilizing SRH services in the uMkhambathini community.
- To document the negative impacts on women's experiences due to the lack of access to SRH services in the uMkhambathini community.
- To understand how rural women have navigated SRH challenges over time in the uMkhambathini community.
- To provide recommendations for improving access to and utilization of SRH services in the uMkhambathini community.

1.4 Key Research Questions:

- What are the experiences of rural women in accessing and using SRH services?

1.4.1 Secondary Questions:

- What are the structural factors that inhibit women from accessing and utilizing SRH services in the uMkhambathini community?
- What are the negative consequences for women due to lack of access to SRH services in the uMkhambathini community?
- How have rural women navigated SRH challenges over time in the uMkhambathini community?
- What recommendations can be made to improve access to and utilization of SRH services in the uMkhambathini community?

1.5 Research Area

Map: Umkhambathini

From the municipal IDP as well as the Rural Land Use Management Policy, the following rural settlements have been identified and mapped within the various wards:

Ward 1 | Table Mountain | Maqongqo | Villa Maria | Gcina

Ward 2 | Ntweka | Abebhuzi | Manyavu | Ophokweni A | Ophikweni B

Ward 3 | Masangweni | Imboyi Area

Ward 4 | Eston | Manderston | Ntimbankulu | Tala Valley

Ward 5 | KwaNyavu | Ngangezwe | Oqweqweni | KwaChitshane | Eqeleni

Ward 6 | Ismonth | Makholweni - Nungwane | Kwaluzizi | KwaSidingane Area | Esigodini | KwaThomi Senzakahle Road

Ward 7 | Mgwenya | Ngilanyoni | Gulube | Sgondini

(REVIEW OF THE SPATIAL DEVELOPMENT FRAMEWORK, 2018)

The uMkhambathini Local Municipality shares borders with the uMgungundlovu District Municipality to the southeast, Richmond and uMsunduzi municipalities to the west, uMshwathi to the north and the eThekwini Metropolitan Municipality to the east. The municipal offices are located in the town of Camperdown. Mkhambathini's proximity to Pietermaritzburg, Durban, and the industrial hub of Cato Ridge gives it several competitive advantages. The N3 highway passes through the heart of the municipal territory in an east-west direction. In the Spatial Growth and Development Strategy, this specific highway segment has been named a Provincial Corridor (uMgungundlovu District Municipality IDP 2012/13). The uMkhambathini Local Municipality is home to roughly 62,142 people and occupies 917 square kilometers. The community is primarily rural. The high percentages of poverty and poor employment negatively impact the municipality's ability to collect service fees. It is one of the seven local municipalities that make up the uMgungundlovu District Municipality in KwaZulu-Natal.

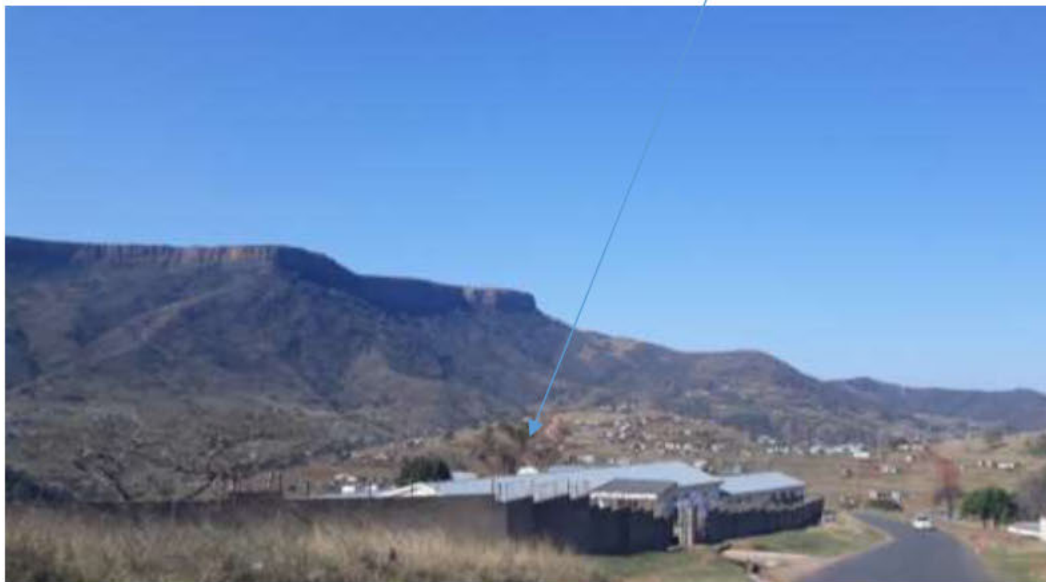


Image 1

The image represents the eNkanyezini area in uMkhambathini. This side shows the side of Unobhala High School. This is near the hall just next to the school, 1 minutes' walk from the Unobhala High School. The image shows the infrastructure and settlement organisation of the uMkhambathini rural areas. The image shows roads, schools, halls, and transport routes. The rural area of uMkhambathini is slowly developing as the population increases.

1.6 Rural setting

The rural area of uMkhambathini within the uMgungundlovu District in KwaZulu-Natal was selected as the study site due to its historical, socio-economic, and cultural significance in understanding the lived experiences of women, particularly in relation to sexual and reproductive health (SRH). Like many rural areas in South Africa, uMkhambathini is characterized by small towns and sparsely populated settlements, where livelihoods are primarily sustained through subsistence farming, government assistance, and migrant labor (Fay, 2015). These economic constraints often shape women's access to healthcare, family planning services, and sexual health education, limiting their autonomy over reproductive choices.

Additionally, uMkhambathini is situated within a region that was part of the former Zulu homeland during the Apartheid era, which continues to impact land tenure arrangements, governance structures, and cultural norms (National Treasury, 2011). Traditional communal land tenure systems and patriarchal leadership structures influence gendered access to resources, healthcare, and reproductive rights. Given that the majority of the population in the district is Zulu-speaking, cultural expectations regarding femininity, marriage, and motherhood play a significant role in shaping women's experiences of SRH. Norms around traditional masculinities, initiation practices, and perceptions of contraception further affect women's ability to make informed reproductive decisions.

Furthermore, rural healthcare infrastructure in areas like uMkhambathini often faces challenges such as inadequate facilities, a shortage of trained healthcare professionals, and limited access to SRH services, particularly for young women and unmarried individuals. The distance to healthcare centers, financial barriers, and stigma surrounding sexual health issues further contribute to the obstacles women face in seeking SRH services.

By selecting uMkhambathini as the study site, the research acknowledges the intersection of historical marginalization, traditional governance, and contemporary socio-economic challenges that shape women's SRH experiences. This location provides an opportunity to explore critical issues such as access to contraceptives, maternal health services, reproductive rights, and the impact of cultural beliefs on SRH decision-making. Additionally, the study will contribute to broader discussions on rural healthcare accessibility, gendered health inequalities, and the need for culturally sensitive interventions in South Africa’s rural communities.

1.7 uMkhambathini Clinic

Mkhambathini Local Municipality has a population of approximately **63,142** people, with an estimated **16,495** individuals (about **26.1%** of the population) attending a clinic at different times. In Nkanyezini, the presence of only **one clinic** significantly impacts health seekers by creating overcrowding and long waiting times, which can discourage regular health visits and delay treatment. The limited capacity of the clinic also means that specialised services, such as maternal health care and chronic disease management, may be unavailable, forcing patients to travel to distant facilities, which adds financial and logistical strain. Additionally, the high patient-to-healthcare worker ratio places pressure on staff, reducing the quality of care and increasing the likelihood of misdiagnosis. Geographic barriers, including poor road infrastructure and limited transport options, further complicate access to healthcare, particularly for vulnerable groups such as the elderly and pregnant women. As a result, some residents may delay seeking medical attention until their conditions worsen, leading to poor health outcomes. The lack of adequate healthcare services may also push some individuals to rely on traditional healers, which could delay the diagnosis and treatment of serious conditions. This highlights the urgent need to expand healthcare infrastructure, increase staffing levels, and improve transport networks to enhance healthcare access and outcomes for the Nkanyezini community.

Societal factors refer to the broader social, economic, and cultural influences that affect health-seeking behaviour and healthcare access at a community or population level. These include factors such as poverty, unemployment, education levels, cultural norms, and access to healthcare infrastructure. For example, if there is a general shortage of healthcare facilities in rural areas or widespread reliance on traditional medicine due to cultural beliefs, these would be societal factors influencing health-seeking patterns in uMkhambathini. Individual factors, on the other hand, are personal characteristics or circumstances that influence a person's health-seeking behaviour and health outcomes. These may include age, gender, and health status, personal beliefs about health, financial situation, and access to transport. For instance, a person’s decision to visit the uMkhambathini Clinic might be influenced by their ability to afford transportation or their trust in Western medicine versus traditional healing practices.

The framework is presented under the subtitle “uMkhambathini Clinic” to contextualise the

discussion within the specific healthcare challenges faced by the local community. Focusing on the uMkhambathini Clinic allows the analysis to reflect the real-life dynamics of healthcare access and utilisation in the area, highlighting how both societal and individual factors interact to shape health outcomes. This approach helps to ground theoretical insights in a concrete setting, making it easier to identify practical solutions and policy recommendations.

Local Clinic	Name of Clinic
1	Njabulo Clinic

The study will be focused on women from uMkhambathini. Their age cohort is between 18 to 55 years and beyond.

Explanation of figure 1: SRH Conceptual Framework (Namasivayam et al: 2012)

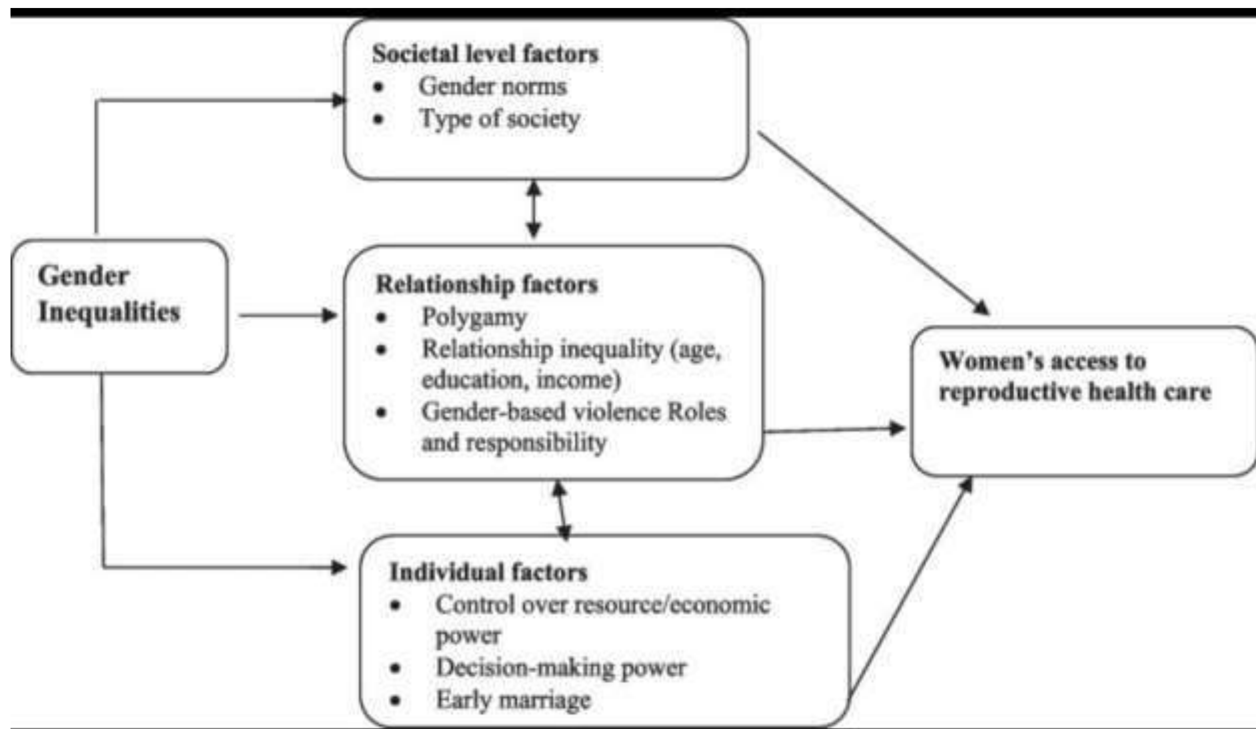


Figure 1 illustrate intersecting issues that are affecting rural women from accessing sexual reproductive health. The figure is placed to problematize societal and individual issues of rural women at Umkhambathini. Umkhambathini is a sub-location known as eNkanyezini, a deep rural community under uMsunduzi Local Municipality, KZN-South Africa. Demographics of many rural communities confirm that it has more women who have incurred many health illnesses (Aruleba and Jere, 2022). Women in uMkhambathini confront a variety of health problems, with age, disability, geography, and other factors influencing their conditions and prospects towards sexual reproductive health or holistic, comprehensive health care. Furthermore, these rural female residents face more obstacles than female city dwellers. Their daily experiences involve fewer job prospects, a greater distance and poor infrastructure such as clinics and hospitals, which influence their seeking of sexual reproductive health (SRH) services. This research endeavours to understand the socio-structural limitations of SRH in rural areas for women. These limitations subject women to all forms of social and health detriments. Socio-structural limitations in sexual and reproductive health (SRH) for rural women are deeply rooted in both systemic healthcare barriers and cultural constructs that restrict access to essential services. Limited healthcare infrastructure, economic constraints, and geographical inaccessibility often force women to forgo critical SRH care, exacerbating health inequalities. Additionally, patriarchal norms, religious beliefs, and cultural taboos surrounding reproductive health decisions further marginalize women, limiting their autonomy and access to contraceptives, maternal healthcare, and STI prevention. The interplay of these structural and cultural barriers not only increases the risk of maternal mortality and unplanned pregnancies but also perpetuates gender-based violence and psychological distress. Addressing these challenges requires a holistic approach that integrates improved healthcare policies, culturally sensitive interventions, and enhanced rural healthcare accessibility to ensure that women in rural communities receive equitable and dignified SRH services. The structural constraints involve cultural limitations, and the functional summarizing of the resource hinders in the rural uMkhambathini. The exploration of SRH rests on devising measures to expand its availability in rural areas. The thesis's contribution will highlight structural conditions that have excluded rural women of uMkhambathini to develop practical recommendations in the context of SRH.

1.8 The Relevance of Medical Anthropology Research in This Study

- Health Consequences of Adaptation and Maladaptation: This includes both positive and negative outcomes from adapting or failing to adapt to sexual and reproductive health (SRH) services.
- Domestic Health Care Practices and Popular Health Culture: Examining how local cultural practices and beliefs influence the access and use of SRH services.
- Rural Perspectives on Health Risk and Responsibility: Discussing how communities in uMkhambathini perceive risk, susceptibility, and accountability for disease and medical treatment, especially in the absence of SRH services.
- Rural Preventative Health and Harm Reduction: Investigating how rural populations use SRH services for prevention and harm reduction.
- Cultural Norms and Social Institutions: Exploring how social institutions, cultural norms, and risk and protective factors influence the access to and use of SRH services in the uMkhambathini rural region.
- Social Relationships and Illness: Analyzing how social relationships impact rural women's experiences with illness, health care, and SRH services. This includes examining how health, nutrition, and medical care transitions are intertwined with SRH services.

Medical anthropology is specialized in studying the health experiences of people through various approaches, such as the Biomedical, Ethnomedicine, Ecological, Critical Medical Anthropology (CMA), and Applied Anthropology approaches. According to the World Health Organization (2020), various factors influence the health of individuals and communities, such as environmental conditions, genetics, income, education, and relationships. These factors have a more significant impact on health than access to medical treatment. Therefore, anthropologists examining health and illness must consider both biology and culture for a comprehensive understanding.

1.8.1 Approaches in Medical Anthropology

1. Biomedical Approach: This method attributes illness to specific agents such as pathogens (viruses, bacteria), physiological problems (organ failure), or biochemical malfunctions (cancer).
2. Ethnomedicine: The comparative study of health, sickness, and healing across cultures. It involves examining how various cultures use natural resources and spiritual beliefs in healing practices, such as acupuncture or herbal remedies. Ethnomedicine is essential for understanding cultural explanations (ethno-etiology) of health problems, especially in developing regions where alternative health theories persist.
3. The Relevance of Anthropology of Women and Critical Medical Anthropology (CMA): This branch of anthropology focuses on how power, politics, medical systems, and biocultural approaches affect women's health. CMA emphasizes the role of socio-economic inequality, particularly how race, ethnicity, gender, and class can influence health outcomes and access to medical care. CMA investigates how structural factors at the macro level (e.g., politics and economy) affect women's health experiences at the micro level.

- CMA's Focus: It explores how structural inequalities shape the lived experience of SRH services, particularly for rural women, and attempts to connect macro-level political and economic factors with the access and utilization of SRH services.

1.9 Understanding Health Disparities in Rural Areas

The study aims to highlight the challenges women face in rural KwaZulu-Natal, focusing on the structural disparities in healthcare availability. Poverty, which perpetuates poor health outcomes across generations, significantly impacts health, especially in rural areas. As medical care and public health services continue to be under-resourced, this shared vision of healthcare becomes more critical.The study also seeks solutions for these issues in rural South Africa, with a particular focus on advancing women's sexual and reproductive health rights. Managing diseases like HIV/AIDS, often transmitted through sexual contact, remains a pressing issue, especially since women frequently have limited control over their sexual relations within or outside family structures.

1.9.1 The Role of Ethnomedicine in the Study

Ethnomedicine is vital in understanding the healthcare practices in rural settings. Quinlan (2022) describes ethnomedicine as the cultural knowledge related to illness, disease management, and healing practices. This encompasses belief systems, religious practices, and natural remedies tied to the environment, with ethnomedical healers like herbalists and midwives offering alternative health solutions. The study will explore how these systems interact with biomedicine in rural areas, especially regarding SRH services, and whether ethnomedicine serves as a substitute for biomedical approaches. In uMkhambathini, ethnomedicine significantly influences how rural women perceive healthcare, including SRH services. The study will examine how these perceptions shape healthcare-seeking behaviors and whether culturally ingrained beliefs present barriers to accessing biomedicine.

1.9.2 Social and Cultural Dimensions of Health

Cultural influences, including societal norms and values, significantly affect healthcare access. In rural areas, these cultural norms often limit women's ability to seek medical help. Previous studies have shown that rural women are less likely to seek medical attention than their urban counterparts, even for similar illnesses. The study aims to address these issues, focusing on how socio-cultural and socio-economic limitations impact SRH experiences for rural women. Therefore, by investigating the structural, cultural, and socio-economic factors, this study hopes to contribute to a broader understanding of rural health challenges and inform policy changes to improve SRH access for women in rural KwaZulu-Natal.

1.10 Key Concept

1.10.1 Ethnomedicine

Ethnomedicine refers to the cultural practices and knowledge systems regarding health, illness, and healing within a society. It involves understanding how cultures define symptoms, diseases, and healing methods. This includes natural remedies and rituals that are culturally relevant, often linked to spiritual beliefs. Examples of ethnomedical practitioners include herbalists, midwives, and shamans, whose knowledge is passed down through apprenticeships or cultural traditions. Ethnomedicine plays a crucial role in rural healthcare, where it coexists with biomedicine, offering alternative or complementary healing practices. The study will examine how ethnomedicine shapes

SRH perceptions and access to services in uMkhambathini, highlighting the interaction between cultural beliefs and medical practices.

1.10.2 Biomedicine

Biomedicine, while seemingly straightforward, represents more than just the intersection of biology and medicine. It is deeply embedded in Western cultural and power dynamics and serves as both a framework and a collection of intellectual commitments (Valles, 2010). As the dominant theoretical framework, biomedicine influences much of the health science and medical research conducted in academic and governmental institutions. Most global health organizations and medical practices are built around this biomedical approach. International medical aid and health interventions are often rooted in biomedical principles.

In essence, biomedicine describes how the leading international health organizations perceive the relationship between biology and medicine. Valles (2010) asserts that the best method for evaluating health-related issues is through experimental methods, treating the human body as a collection of interrelated parts and processes. This approach aligns with how SRH services are generally structured in contemporary medical systems, particularly in clinics and hospitals within eNkanyezini. It also highlights the socio-political limitations that affect healthcare delivery in rural areas like eNkanyezini.

1.10.3 Healthcare

Healthcare refers to the provision of medical services to individuals, ensuring access to resources that maintain or improve health (Habib, Khan, and Hamadneh, 2022). However, "access" is a complex concept, involving multiple factors. Access is not solely determined by the availability of services but also by financial, organizational, social, and cultural barriers that may limit utilization (Habib, Khan, and Hamadneh, 2022). These constraints, such as the expense, physical accessibility, and acceptability of services, must be considered when evaluating healthcare access (Xiong, Huang, and Huo, 2022).

Thus, true access to healthcare involves more than just having enough services in place; it requires that these services be relevant, useful, and culturally appropriate to the needs of the community. This concept is vital for understanding the healthcare landscape in rural areas, particularly in

eNkanyezini. The availability and accessibility of healthcare resources directly impact women's utilization of SRH services, and this will be a central focus of the study.

1.10.4 Health Access and Availability

"Access to healthcare is central in the performance of healthcare systems worldwide" (Levesque, Harris, and Russell, 2013). The ability of individuals to utilize healthcare services is often defined as the convenience and appropriateness of services provided to meet the community's needs. There are varying perspectives on what constitutes "access," with some emphasizing the characteristics of healthcare providers and others focusing on the entire process of care, including the initial point of contact (Levesque, Harris, and Russell, 2013).

Access can also be understood in terms of the need for care and the associated costs. This study will examine how healthcare access in eNkanyezini influences women's utilization of SRH services. Availability and accessibility of local healthcare facilities are crucial indicators of the quality of healthcare services provided, and these factors will be explored in relation to SRH service usage among rural women.

1.10.5 Health Facility

Health facilities are essential in maintaining healthcare services, especially in times of crisis or high demand. Disasters, whether natural or otherwise, can strain the capacity of hospitals, clinics, and other healthcare institutions, affecting both the structural elements (buildings) and non-structural elements (e.g., water, power, medical equipment) of healthcare facilities (Otten, 2016). In addition to physical damage, healthcare workers may face injury or illness, further complicating the delivery of services during such times.

In rural areas like eNkanyezini and uMkhambathini, the availability and quality of healthcare facilities are key to ensuring access to SRH services. The infrastructure of these healthcare facilities is integral to disseminating knowledge and providing services related to sexual and reproductive health. This concept is vital for understanding how healthcare facilities support and influence SRH service delivery in rural communities.

1.10.6 Rural Community

Rural areas are characterized by low population density and limited infrastructure compared to urban settings. People in rural areas typically live in dispersed settlements, with agriculture often being the primary industry (Bennett, Borders, Holmes, Kozhimannil, and Ziller, 2019). Rural communities are often viewed as peaceful and remote, yet they face complex issues such as limited access to specialized medical care, housing discrimination, lack of work opportunities, and inadequate education campaigns.

As Bono et al. (2022) highlight, resilience in rural areas arises from the dynamic interactions between individuals, families, society, and culture. The chosen study area in KwaZulu-Natal, although rural, has developed infrastructure and features that impact the access and availability of SRH services. Understanding the challenges faced by rural populations is key to addressing gaps in SRH service provision in these areas.

1.10.7 Rural Women

Rural women are vital economic contributors, playing a central role in the progress of their communities and the financial well-being of their families (ILO, 2012). They engage in various types of work, such as paid employment, self-employment, family businesses, farm and non-farm labor, and entrepreneurship. However, they also bear a disproportionate burden of unpaid labor at home, such as gathering fuel and water, caring for children and the sick, and preparing meals (ILO, 2012). Despite their contributions, rural women's participation in the economy and other sectors is often limited by persistent discrimination, restrictive gender norms, and unequal access to resources (ILO, 2012). Rural women typically devote more time to reproductive and domestic tasks than their urban counterparts, largely due to culturally imposed roles and inadequate rural infrastructure and services (UN Women Watch, 2012). For instance, the lack of infrastructure in rural areas forces women to gather fuel and water, tasks that are time-consuming and limit their opportunities for other work (UN Women Watch, 2012). In the context of uMkhambathini and eNkanyezini, this term helps to highlight the specific reproductive health challenges faced by rural women. It connects these challenges to the socio-economic and cultural circumstances in which they live. The socio-cultural constraints in rural areas significantly impact women's sexual and reproductive health (SRH) and influence the types of SRH services they access.

1.10.8 Urban Women

Urban women generally have better access to infrastructure, services, paid employment, and fewer socio-cultural constraints than rural women. However, men in urban areas also face certain disadvantages in terms of income, property, time, and authority (Pozarny, 2016). Despite these advantages, urban women encounter significant challenges, including social injustices, fear, and obstacles in various aspects of life (Reichlin and Shaw, 2015; Pozarny, 2016). This concept has been useful in understanding the differences in SRH experiences between urban and rural women. While urban women have better access to healthcare, their circumstances differ from rural women in terms of healthcare choices and outcomes. The unique characteristics of urban environments influence healthcare decisions and SRH outcomes, highlighting the need for tailored approaches to address the distinct needs of urban and rural women.

1.10.9 Community Infrastructure

Community infrastructure refers to small-scale, essential facilities and systems built within a community to support its survival and livelihood (GFDRR, no date). These infrastructures are typically community-led projects designed to meet local needs and goals, providing basic services crucial to the community's survival. They are integral to community life, connecting directly to the livelihoods and well-being of local residents (GFDRR, no date). However, community infrastructures are vulnerable to damage, especially from natural disasters, due to their weaker design compared to larger facilities. This makes rural communities more susceptible to the negative impacts of disasters (GFDRR, no date). The condition of rural community facilities, including those in informal settlements and slums, is often poor, further exacerbating vulnerabilities.

The concept of community infrastructure is key in understanding access to healthcare in rural areas. Community infrastructure is fundamental in facilitating healthcare access, and its condition can greatly influence the availability and utilization of SRH services. This concept will help measure and define the role of rural infrastructure in determining access to essential SRH services in areas like eNkanyezini.

1.10.10 Social Constructs

In anthropology, a social construct refers to the meaning, concept, or interpretation that a society attributes to an object, event, or phenomenon based on collective perception and agreement (White,

2021). These constructs arise from human interactions rather than from objective reality, and they exist because society collectively accepts them as valid. Examples of social constructs include nations and money, which are given meaning by the collective belief in their existence (White, 2021). Social constructs shape social structures, as seen in the way race is defined by observable physical characteristics (e.g., skin color) (Drew, 2023). These constructs are not inherent truths but are widely accepted by society. The social constructivism and relativism perspectives emphasize that these meanings are created through collective social acceptance (Drew, 2023). In this study, the concept of social constructs is used to understand how rural women in eNkanyezini are perceived by their communities. The shared beliefs and values of the community shape how women are viewed, which in turn influences their health-seeking behaviors. Misconceptions and societal views about SRH services, shaped by social constructs, can affect how these services are perceived and accessed by rural women.

1.10.11 Culture

Culture is the collective body of a society's material and spiritual values. It includes the intellectual, emotional, spiritual, and material characteristics, ideals, beliefs, practices, and knowledge that evolve as part of a social system (Bennett et al., 2019; Bullough et al., 2022). Culture is continuously shaped by the society's responses to challenges and interactions with its environment, forming a pattern of responses passed down through generations (Bullough et al., 2022). In a community, culture encompasses shared philosophies, ideologies, values, beliefs, expectations, attitudes, and norms. These cultural elements, along with learned behaviors, are transmitted from one generation to the next (Bullough et al., 2022). In the context of this study, the concept of culture helps explain how cultural beliefs influence women's access to and use of SRH services. These beliefs, formed from a young age, shape their healthcare choices, particularly regarding SRH. Understanding cultural views and practices is crucial in identifying barriers to SRH access and improving service delivery for women in eNkanyezini.

1.10.12 Social expectations

According to Rummel (no date), events influence how we behave toward others and the psychological distance we feel. Our actions are shaped by both the occasion and the distance between individuals. However, one might not act in a certain way because the outcome might be unfavorable for various reasons. When given the opportunity to act, we often regulate our behavior

by anticipating the consequences of our actions (Rummel, no date). Humans are surrounded by social expectations, beliefs, awareness, and a fear of how others will respond to our actions. We play our parts in this social "theatre" and react based on how others behave toward us. Therefore, when we act in a particular way toward others, we not only perceive them as different from ourselves but also consider how our actions will affect them and what we might expect in return. These expectations influence the dynamics of relationships and social behavior. This framework outlines the common expectations within the rural community of UMkhambathini. The cultural norms and values upheld by local households in UMkhambathini may give rise to these social expectations. As a result, social constructs shape the societal standards that residents must adhere to, which are influenced by rural values and norms. These factors also impact how people seek healthcare in rural areas, particularly in the context of the sexual and reproductive health (SRH) services that women in eNkanyezini prefer.

1.11 Brief introduction of the research design and methods of data collection

The study was a qualitative research. By definition, qualitative research relies on studies that provide descriptive data rather than numerical measurements. In anthropology, qualitative research acknowledges people's experiences or emic viewpoints (Greckhamer and Cilesiz, 2022). The focus group interview strategy was employed for data collection, incorporating the interpretivist paradigm. Thematic analysis was also utilized as a technique for processing data and visualizing the narratives that were analyzed. The chosen sample aligns with the context of qualitative research (Alvi, 2016). Purposive and snowball sampling techniques were employed to obtain the sample for the study. As a result, the sample consisted of 30 rural women from uMkhambathini eNkanyazini, aged 18 to 49. These sampling methods are particularly relevant in qualitative research designs, as they allow the researcher to purposefully include or exclude participants (Robinson, 2014). Snowball sampling was implemented through referrals, with participants introducing one another. Unstructured, open-ended interviews were carried out during the focus group intereview. The five main objectives of this study on the SRH experiences of women in the uMkhambathini rural area of KZN formed the foundation for these focus groups. Each focus group consisted of no more than six study participants. According to Correa de Oliveira (2011), focus groups are particularly useful for researching topics that affect women because they give them a forum to talk about their everyday lives. Their interpreted narratives are useful to the researcher.

According to Guest, Namey, Taylor, Eley and McKenna (2017), focus group interviews create a relaxed and welcoming environment, which allows participants with common interest to share their views.

1.12 Justification of the Study's Epidemiological Direction and Response to the Sensitivity of the Study

Wilson, Kenny and Dickson-Swift (2015) opine that qualitative research is usually emotional; consequently, the topic's sensitivity and the participants' safety remain critical. They further assert that the topic's sensitivity does not imply that the study is not doable. These academics acknowledge the important contributions made by health and social science researchers to the literature on delicate subjects like birth, death, cancer, bereavement, sexual abuse, violence, drugs, homelessness, and many other delicate or emotional subjects. Studying these areas requires different research techniques, therefore employing participants' safety. These scholars further allude that many sensitive types of research have the potential to impact the studied population as they are ground-breaking, exposing concealed experiences to come up with responsive interventions. Researchers are encouraged to examine potential harm and comfort their participants while being careful of their positionality in the study. Mohajan (2018) expands the discussion by acknowledging that qualitative research is deemed sensitive because it is inductive, but this does not mean such studies should not be explored. The sensitivity of qualitative research lies in its goal, which is a deep understanding of the particular.

I understood that the study carries sensitivity. The sensitivity comes in two folds. I am a male student studying sexual reproductive health issues of women. Secondly, sexual reproductive health is a sensitive topic on its own. However, I believe such studies must be conducted from the affected party's perspective to contribute to responsive interventions that will be celebrated in the future. To create a conducive environment and a level of comfort, I have contracted a female research assistant who has assisted in asking specific questions to the targeted population to create a level of comfort. The criteria for a suitable research female assistant were that she possesses a Master's Degree in Anthropology, is familiar with ethical considerations in Social Sciences, and has experience researching female-related topics. I have trained the assistant on the data collection instrument. I have also trained the assistant on the study's ethical considerations, and where participants were comfortable with having me as a male during the research questioning phase, I

would continue without the involvement of the female assistant. The introduction of the research assistant was part of the informed consent that the participants will be asked to sign voluntarily. The research assistant was also asked to sign a confidentiality clause with me as the principal investigator.

1.13 Summary of Ethical Considerations

Ethical considerations were prioritized throughout the study. Participants were encouraged to sign a consent form that clearly outlined the research objectives and key questions. Prior to data collection, participants were informed of their rights within the study. To ensure confidentiality, pseudonyms were used, and participants' identities were protected. Data was securely stored to prevent unauthorized access, both for unprocessed and processed data. All data was recorded exclusively on the data collection instruments, and participants were informed that their voices would be recorded, with prior consent obtained. Focus group interviews were held at locations selected by the participants to ensure their comfort. Additionally, the first draft of the study will be presented to participants for their approval before final submission.1.14 Structure of the Thesis

CHAPTER ONE – Introduction

- Introduction to the study
- Problem statement and rationale for the study
- Key objectives and research questions
- Definition of key concepts
- A brief introduction to theoretical frameworks and research design used in the study
- Chapter summary

CHAPTER TWO: Literature Review

The chapter will discuss the following themes:

- Introduction to the chapter
- Contextualizing the history of anthropology and health
- Development of Sexual and Reproductive Health and Rights (SRHR) in local and international human rights law

- Global and national health issues for women in rural areas
- South Africa's commitment to SRHR
- Conceptualizing SRH
- Health issues of women in rural South Africa
- International commitments to SRHR, including policies and programs
- South Africa's constitutional commitment to SRH
- Challenges in the successful implementation of SRHR
- Stigma and discrimination in healthcare
- Misconceptions about healthcare in rural communities, both internationally and regionally
- Forms of stratification in health
- The implications of health literacy and illiteracy
- Understanding health literacy
- Chapter summary

CHAPTER THREE- Theoretical Framework

This chapter will discuss the following theoretical frameworks:

- Introduction to the chapter
- Gender theory
- Critical Medical Anthropology theory
- Social Constructivism theory
- Chapter summary

CHAPTER FOUR- Research Methodology

CHAPTER FOUR – Research Methodology

This chapter will outline the research methodology:

- Introduction to the chapter
- Explanation of the research methods, including research designs and methodologies
- Discussion of the sampling technique used to recruit participants

- Ethical considerations guiding the study
- Data analysis procedures
- Chapter summary

CHAPTER FIVE- Data Presentation and Analysis.

The chapter will present and analyze the following:

- Introduction to the chapter
- Experiences of rural women in accessing and using SRH services
- Structural factors inhibiting access to SRH services
- Detrimental factors experienced by women due to lack of access to SRH services
- How rural women have navigated these SRH challenges over time
- Chapter summary

CHAPTER SIX – Data Presentation and Analysis: Thematic Analysis

This chapter will present themes emerging from the data analysis in a qualitative format. Participants will share their experiences related to SRH:

- Demographic characteristics of research participants:
    - Age categories
    - Family structures
    - Marital statuses
    - Education levels
    - Socio-economic status, including employment and financial brackets
- Mapping of health facilities and their accessibility
- Chapter conclusion

CHAPTER SEVEN: Contributions and Findings

This chapter will summarize the research findings and highlight the researcher's contributions to the study.

CHAPTER EIGHT: Summary, Recommendations, and Conclusion

This chapter will provide a summary of the study, offer recommendations related to improving access to SRH services, and present the final conclusions of the study.

1.14 Chapter Conclusion

This chapter has highlighted the SRH experiences of rural communities in Umkhambathini eNkanyezini, KZN, South Africa, focusing on the challenges related to the localization of SRH knowledge and services in these areas. It summarized the key objectives and research questions, with an emphasis on critical concepts such as healthcare and biomedicine. Additionally, the chapter outlined the qualitative research design, data collection methods (focus groups), and data analysis techniques (thematic analysis) used in the study. The next chapter will provide a comprehensive literature review to further contextualize the research findings and discussions.

CHAPTER TWO

Literature review

2.1 Introduction

Medical anthropology has emerged as one of the most influential sub-disciplines within anthropology, focusing on the health vulnerabilities of populations. Its relevance and application in both national and international health development programs have solidified its credibility among social scientists and policymakers in public health institutions (Massé, 2001: 41). According to Massé (2001), medical anthropology plays a pivotal role in diagnosing structural factors that hinder the implementation of health-related policies. The 1980s marked a shift in industrialized nations, where issues surrounding social and cultural determinants of health gained attention. This shift encompassed epidemiological concerns such as AIDS, tuberculosis, and issues like drug addiction, adolescent pregnancy, and eating disorders. These changes also reflected growing skepticism about biomedicine. The involvement of anthropologists in interdisciplinary public health teams became particularly critical during the twin epidemics of AIDS and drug misuse in the 1980s (Massé, 2001; Singer, 2009). This chapter delves into the ongoing debates surrounding sexual and reproductive health.

2.2 Broader Evaluation of Sexual and Reproductive Health in Developing Regions

Africa accounts for 20% of the world's births and 18.1% of its population, yet it experiences nearly half of the global maternal deaths during pregnancy and childbirth. According to the World Health Organization (WHO), poor reproductive health is responsible for up to 18% of the global disease burden and 32% of the illness burden among women of reproductive age. A significant factor contributing to this issue is the lack of access to essential reproductive health services, such as family planning (WHO, 2023). There is considerable variation in sexual and reproductive health (SRH) structures and systems between developing and developed regions, with the Human Development Index (HDI) predicting several factors for this disparity (Deb, 2015). The HDI, which measures a nation's performance across three core areas—standard of living, knowledge, and health—indicates that many African countries still face significant challenges in reducing poverty and addressing the socio-economic factors impacting health (Deb, 2015).

Veras de Oliveira (2021) emphasizes the importance of development in overcoming social and economic barriers that hinder health policy implementation. Development goods encompass the expansion, improvement, and inclusion of various economic, environmental, social, demographic, and physical elements (SID, 2021). The goal of development is not only to raise living standards but also to protect environmental resources while creating job opportunities and increasing local and regional income (SID, 2021). African nations have made notable strides in improving healthcare, particularly for women. However, there is still much work to be done in promoting health policies that cater to women's rights and needs. The disparities between developed and developing regions in SRH are evident in resource management, planning, and service outcomes (Izugbara et al., 2020). While many African countries have made progress in healthcare, significant gaps remain, particularly between urban and rural areas. Overcoming the barriers to SRH care requires moving beyond cultural and affordability issues and promoting policies that support SRH services.

2.3 Relevance of This Study in Medical Anthropology and Critical Medical Anthropology

This study aimed to explore the factors that affect health and well-being, broadly defined, including the distribution and experience of illness, prevention and treatment, healing processes, and the social relations involved in therapy management. The cultural significance of pluralistic medical systems is central to medical anthropology, a subfield that integrates social, cultural, biological, and linguistic anthropology (Singer & Baer, 2018). Medical anthropology compares healthcare systems and human health, considering numerous bio-cultural dynamics that influence population health. The discipline examines the underlying theories of illness causation and the strategies communities use to address health issues. Through a comparative approach and cultural relativism, medical anthropologists study how social and cultural factors shape views on health, illness, and the body.

Medical anthropology embraces a variety of theoretical perspectives, acknowledging the political dimensions of science, the social construction of knowledge, and popular health culture (Singer & Baer, 2018). It studies how human interactions, cultural norms, social structures, and global forces impact local communities, social formations, and individual health. Critical Medical Anthropology (CMA), a subfield of medical anthropology, applies critical theory and ethnographic methods to examine the political economy of health and the impact of social inequality on health outcomes

(Rocha, 2021). CMA emphasizes the importance of social structures over purely biomedical factors when analyzing health, recognizing human health as a political-ecological and biosocial product (Rocher, 2021). By integrating anthropological perspectives with conventional critical methodologies, CMA highlights the importance of emic views—allowing individuals to describe their everyday health experiences. CMA explores the interaction between personal experiences, social organization, and macro-level social structures.

2.4 Contextualizing Anthropology's History and Health

Globally, anthropologists have been instrumental in designing and assessing public health initiatives addressing issues like AIDS, tropical diseases, and diarrheal illnesses. Much of the debate in medical anthropology has centered on its contributions to public health and the socio-cultural understanding of infectious diseases (Massé, 2001). Medical anthropology's holistic, systemic approach has been pivotal in understanding the integration of healthcare institutions within the cultural and social fabric of societies (Massé, 2001). Since its inception, medical anthropology has focused on the social structures, power dynamics, and politics underlying health systems (Closser et al., 2022). Ethnographic work has provided critical insights into the power dynamics that shape global health policies and systems.

Ethnographic research in medical anthropology offers a unique perspective on the functions and meanings behind global health policies, helping to understand the complex systems influencing health outcomes (Closser et al., 2022). Health systems have long been a key area of study in global public health. Since the 1960s, the WHO has organized international conferences on health planning, and anthropologists have contributed valuable insights into the governance, economics, and politics of health systems (Pfeiffer & Nichter, 2008; Closser et al., 2022). Ethnographic research challenges mechanistic health system standards, providing a more nuanced, historical, and social understanding of these systems.

Understanding medical anthropology's relationship to the broader field of anthropology is crucial. Plessy (no date) suggests that anthropology explores what makes humans unique, and its contemporary theories continue to address fundamental questions about human beings that have been present since the discipline's inception. The paradigm of medical anthropology evolved in

the 1950s and 1960s, particularly as practitioners began integrating biomedical practices into their cultural health repertoires in Latin America, Asia, and Africa (Plessy, no date).

Medical pluralism has become a key feature of African health systems due to the continent's cultural diversity (Tchouaffi & Kitchener, 2020). Anthropologists have long studied how individuals relate to illness and treatment, examining the diverse ways people understand and address health issues (Tchouaffi & Kitchener, 2020). Anthropology has highlighted the culturally specific nature of medical practices and illness perceptions, shaping the way health and treatment approaches are studied and understood.

2.5 Development of Sexual and Reproductive Health and Rights in Local and International Human Rights Law

Sexual and reproductive health (SRH) rights and services have become central to global public health discourse. The WHO defines sexual health as a state of physical, mental, and social well-being concerning sexuality, highlighting its significance in public health (Association of Directors of Public Health, 2023). Health outcomes, particularly for women, are significantly influenced by socioeconomic conditions. Those in extreme poverty, living in substandard conditions, often without access to birth control, suffer from higher rates of illness and infant mortality. Throughout the early 1900s, medical professionals, influenced by societal norms, strongly opposed birth control, viewing it as immoral and contrary to traditional values.

The shift towards recognizing birth control as a legitimate medical practice marked the beginning of the modern sexual health services movement. By the 1920s, the establishment of clinics such as the National Birth Control Council (NBCC) in the UK began offering family planning services, although access was still limited for working-class and single women. The Family Planning Association (FPA), established in 1939, continued the fight for accessible reproductive health services (Association of Directors of Public Health, 2023).

Maternal mortality remains a critical concern. Despite a global decline in maternal deaths, the SDG target of reducing maternal deaths to 70 per 100,000 live births by 2030 remains a significant challenge, particularly in Sub-Saharan Africa, where maternal mortality rates are still among the highest in the world (World Health Organization, 2023). Unsafe abortions, infections, and

complications like eclampsia and hemorrhage continue to account for most maternal deaths, exacerbated by indirect causes such as HIV/AIDS and malaria (Ketsela, no date).

The concept of reproductive justice, first introduced in the United States, has gained prominence globally. In South Africa, the 1997 Choice on Termination of Pregnancy Act allowed women to exercise autonomy over their bodies and reproductive choices, a significant step towards reproductive justice (Stevens, 2019). This law laid the foundation for continued advocacy in SRHR, promoting justice and equality in reproductive health access for all individuals (Stevens, 2019).

2.6 Global and National Health Issues of Women in Rural Areas

Rural development remains a significant barrier to healthcare, particularly in terms of Sexual and Reproductive Health (SRH) in rural communities. Research by Galappaththi, Zulu, Kleppa, Lilebo, Qvigstad, Ndhlovu, Vennervald, Gundersen, and Susuma (2018) as well as Kjetland and Taylor (2018) highlights that a large number of rural women remain unaware of their SRHR. Consequently, they are burdened with health issues such as STIs, HIV, unintended pregnancies, and other health complications. These women face structural barriers to accessing SRH services, including long travel times to health facilities, expensive services, inefficient or untrained medical staff, privacy concerns, long waiting times, domestic responsibilities, and the constant fear of stigma.

In countries like South Africa, efforts have been made to address these disparities, yet the issues persist. According to Morrison (2013), women's mortality rates remain high due to lack of knowledge and difficulty accessing medical care, particularly in rural areas where socio-economic inequality exacerbates the problem. There is a stark contrast between rural and urban health institutions, with rural facilities often under-resourced compared to their urban counterparts, which meet international standards. This inequality disproportionately affects black women and young women in rural communities, resulting in higher mortality rates due to limited access to SRHR services (Gaede & Versteeg, 2011).

Blas and Kurup (2010), Pizzarossa (2018), and Samuel, Birukand Lire (2020) discuss how SRHR is often not a health priority in many countries, particularly in rural areas. Susuman (2018) points out that in South Africa, the failure to address SRH issues is primarily due to poorly implemented policies, often tainted by corruption. Waldman and Steven (2015) echo this, noting that although

South Africa has some of the most advanced and comprehensive health policies, their implementation is either compromised or ineffective, leading to dismal outcomes in the healthcare sector. Gerntholtz, Gibbs, and Willan (2011) argue that SRHR research in Africa is still in its early stages, as women in rural areas continue to be denied access to necessary services.

South Africa's healthcare inequality is deeply rooted in its history of socio-economic and cultural barriers, which have shaped the healthcare available to rural communities. This inequality dates back to the colonial and apartheid eras (Heleta, 2020). The legacy of slavery and colonization created a profound system of inequality, where race and socio-economic status were key determinants of access to healthcare. Despite more than 20 years of democracy, South Africa continues to grapple with an inequality gap in its healthcare system (Mhlanga & Garidzirai, 2020). During the apartheid era (1948–1993), racial discrimination heavily influenced healthcare access, and these inequalities persist today (Mhlanga & Garidzirai, 2020).

Inequality in healthcare has been exacerbated by historical divisions, particularly along racial, gender, age, and socio-economic lines. "Race and socio-economic status were crucial factors in healthcare access and utilization during apartheid, and despite more than 25 years of democracy, inequality remains entrenched in many sectors, including healthcare" (Mhlanga & Garidirai, 2020:1). According to Newsroom Africa (2022), most healthcare facilities in South Africa are located in urban areas, leaving rural populations underserved. In rural areas, only about 5% of people have medical aid, which creates significant barriers to accessing SRHR and other critical healthcare services. Glaeser (2005) and Makgekla (2020) argue that inequality in healthcare is multidimensional, with disparities arising from political, social, and economic factors.

Umkhambathini, a rural area near Pietermaritzburg, exemplifies these challenges. Rural areas often face barriers such as limited anonymity, social stigma, and privacy concerns, which hinder access to healthcare (Rural Information Hub, 2023; Ros & Smith, 1993). These barriers are particularly significant in the context of sensitive healthcare services like sexual health, mental health, and substance abuse treatment, where privacy concerns and fear of judgment can prevent people from seeking care (Ros, Smith, & Taylor, 1993; Rural Information Hub, 2023).

Additionally, cultural factors in rural communities also play a major role in healthcare utilization. Socio-economic disparities, institutional barriers, and lack of transportation continue to impede

access to healthcare in many rural regions. This issue is not unique to South Africa. In Ghana, for example, only 47% of rural residents have access to healthcare within 5 km, compared to 95% in urban areas (Adjei, 2023). Institutional, social, cultural, and economic barriers hinder healthcare utilization in rural Ghana, with long commutes, lack of transportation, shortage of medical staff, and inability to afford care being key obstacles (Lu et al., 2010; Adam, 2004).

In rural areas, gender disparities also increase vulnerability to health risks, including HIV and AIDS. Women in rural areas are more likely to face gender-based violence, economic dependence, and lack of power in negotiating safe sex, all of which contribute to higher HIV risk (Sajadipour et al., 2022). Gender, as a major socioeconomic determinant of health, influences women's access to healthcare and overall health outcomes (WHO, 2017). SRH services are often the first point of contact for many women and girls, making access to these services crucial for HIV prevention and care. WHO (2017) underscores the importance of integrating SRH and HIV services, as access to quality SRH care enables healthcare providers to identify individuals at high risk of HIV, improving prevention and treatment outcomes.

Despite advancements in global healthcare, many countries still face significant healthcare challenges. This is particularly evident in Africa, where traditional beliefs often dominate over biomedical practices. The lack of adequate healthcare systems in some countries exacerbates the impact of these challenges (WHO, 2018). Socio-economic factors, such as education, employment status, income, gender, and ethnicity, play a significant role in determining an individual's health outcomes (WHO, 2018). Health inequities, which are systematic differences in health outcomes between different demographic groups, have far-reaching social and economic consequences for individuals and societies.

These inequities are particularly evident in rural communities, where healthcare services are often intangible and difficult to measure. The quality of healthcare services is shaped by the interactions between healthcare providers and patients, making it harder to assess consistency and effectiveness (Mosadeghrad, 2013). In South Africa, the public healthcare system serves approximately 80% of the population, with the remaining 20% relying on the private sector (PWC, 2022). In an effort to address healthcare inequalities, the South African government introduced the National Health Insurance (NHI) Bill in 2018, which aims to provide more equitable access to healthcare services across the country (PWC, 2022).

2.7 South Africa's Commitment to Sexual and Reproductive Health and Rights

Ensuring women's reproductive autonomy requires meaningful access to sexual and reproductive healthcare. This includes services such as contraception, abortion, prenatal and postnatal care, treatment for reproductive health conditions, and HIV prevention. South Africa has made significant strides in providing comprehensive and rights-based SRH services. The National Contraception and Fertility Planning Policy and Service Delivery Guidelines, as well as commitments made under the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs), reflect the country's dedication to SRH and women's rights (Lince-Derochei et al., 2016).

Key legal frameworks supporting SRH rights in South Africa include the Constitution and Bill of Rights (1996), the National Population Policy (1998), the Choice on Termination of Pregnancy Act (1996), and the National Contraception and Fertility Planning Policy and Service Delivery Guidelines (2012). These frameworks promote access to SRH services for vulnerable groups, including immigrant women, and align with international strategies such as those developed at the 1994 International Conference on Population and the 1995 Beijing Fourth Conference on Women (National Adolescent Sexual and Reproductive Health and Rights Framework Strategy, 2014-2019).

While South Africa's laws and policies provide a robust foundation for SRH services, socio-economic factors still pose challenges to access. Issues such as inadequate information, healthcare service delivery inequalities, and the public-private healthcare divide continue to affect women's ability to make informed reproductive choices (Morrison, 2013). Furthermore, immigrant women face additional obstacles in accessing healthcare, particularly when their immigration status complicates their ability to seek treatment (Hiralal, 2017). The WHO's involvement in sexual health since 1974 has shaped global attitudes towards sexual health and reproductive rights. A positive and respectful attitude toward sexuality and safe sex is crucial for ensuring that people can make informed and autonomous decisions about their health and well-being (Thomas, 2024).

2.8 Conceptualizing Sexual and Reproductive Health

Sexual Reproductive Health adopts that human beings have the freedom to access a healthy, harmless, communal and pleasurable sex life, take care of their bodies and gain reliable material that guarantees access to health care services at the time of their need. Healthiness is a critical universal right endorsed in the International Declaration of Human Rights and conventions, assertions, and consensus treaties. These statutory rights are delineated to be celebrated by all human beings. These civil rights thresholds encourage state leaders to accelerate and achieve SRH for their people. The state must institutionalize spaces allowing people to actively have a voice in tailoring healthcare policies. SRH guarantees admittance to healthcare and related information, ensuring their privacy. These rights are worldwide, blended and undeniable. They are embedded in indispensable human rights, which include access to health, (i) not being discriminated against, (ii) being allowed privacy, and (iii) being free from harm or maltreatment. Mishra, Cooper and Kuh, 2010 andStarrs, Ezeh, Barker, Basu, Bertrand, Blum, Coll-Seck, Grover, Laski, Roa, Sathar, Say, Serour, Singh, Stenberg, Temmerman, Biddlecom, Popinchalk, Summers and Ashford, 2018) argues that being a direct beneficiary of SRH implies that one is informed about one's health rights and women have access to affordable contraceptives. It links the guarante of access to knowledge on preventative measures to inhibit STIs including HIV and AIDS and many dreadful illnesses and diseases. The realization of full human rights and health for all individuals is closely tied to sexual and reproductive health and rights (SRHR). Issues such as sexually transmitted infections, sexual assault, unintended pregnancies, and childbearing can significantly impact a young person's life, healthcare needs, educational outcomes, economic opportunities, and social participation (ICPD, 1995). The well-being of women in all their diversity is significantly impacted by intimate relationship abuse, including sexual violence. Therefore, efforts must be made to ensure that everyone has access to justice, information, and services so they can enjoy their SRHR. Furthermore, laws, policies, and strategic plans should guide the attainment of SRHR for all. Internationally, and particularly in South Africa, the goal of improving everyone's SRHR has been given top priority. Therefore, both gender equality (SDG 5), which aims to eradicate gender-based violence (GBV), and health, particularly sexual and reproductive health (SDG 3), are given top priority in the sustainable development objectives. Such service delivery promises should also include or be directed by rural women of uMkhambathini community, a village that stands out to be patriarchal and not fully rendering sexual reproductive right services to women.

Cooper, Mantell, Moodley, and Mall (2015:2) suggest that public sector health policymakers and civil society leaders in South Africa are expected to strongly support the development, integration, and prioritization of sexual and reproductive health (SRH)-HIV policies, including the inclusion of safer conception and contraception in HIV services. These parties have an impact on HIV and SRH policies, guidelines, provider training, and care provision. There are strong reasons to integrate SRH and HIV policies, programs, and services because both HIV and SRH emphasize human sexuality and the associated risks of STIs and unintended pregnancy. Closer linkages between HIV and SRH can eliminate missed chances for SRH care and enable a greater choice of services. Black women in rural South Africa often face a series of interconnected structural barriers that limit their ability to fully exercise their rights (Khuliso, Andrea-Joy, and Charlene, 2022).

Khuliso, Andrea-Joy, and Charlene (2022) highlight that unfairness and discrimination based on gender, geography, and economic status are the causes of these barriers. Black women in rural areas face severe poverty, limited access to economic opportunities, lack of education, and little to no access to information, all of which violate their rights. In areas governed by traditional leaders and customs, which often include sexism and discrimination against women's agency and their freedom to select their sexual and reproductive health and rights, their vulnerability is heightened. These social obstacles have a significant detrimental impact on rural Black women's overall health and well-being, as well as their capacity to exercise their right to free will. Due to restricted geographic access to high-quality education—particularly comprehensive sex education and information on where and how to obtain abortion services—rural Black women have a hollow right to choose. Due to the complexity and diversity of the discrimination faced by black women there are various identities and social contexts that inhabit rural women, it is crucial to examine these obstacles women are faced with when trying to access abortion care from an intersectional perspective. Additionally, black women have limited access to abortion facilities due to their geography, economic situation, and race.

Kekler (2001) and Neely and Ponshunmugam (2019) explain why rural South Africa is the poorest of the poor, how they differ from men regarding poverty and inequality, and how socio-economic status affect them differently. African rural women are not only denied access to

resources and vital healthcare services, but they also have unequal rights within households and unequal access to resources such as land and animals (Kekler, 2001; Neely and Ponshunmugam, 2019). This explains why African rural women are poorer in their families and in society at large and why their experiences of poverty differ and are more intense than those of men. As a result, African rural women face discrimination and oppression both within and outside of their homes, in addition to being overburdened with a range of tasks encompassing reproductive and productive responsibilities (Kekler, 2001; Neely and Ponshunmugam, 2019).

2.9 South African context of health issues of women in rural areas

2.9.1 Development and Political economy of women/unemployment

Bryant and Rhodes (2023) argue that development continues to produce variations in healthcare, and it is important to link women's struggles with poverty within the context of political economy and development. Differences in resources, opportunities, and infrastructure arise due to factors such as infrastructural availability and economic activities. These disparities are also evident on a smaller scale, such as in rural and urban development. Developed nations that have historically influenced developing countries have impacted how those nations address healthcare issues. For example, although there have been modifications to meet local demands, the educational and healthcare systems in former British colonies in Africa and Asia largely follow British models. Similarly, countries influenced by France, the Netherlands, and Belgium may experience comparable outcomes. While some less-developed nations display unique trends in healthcare system organization, others show significant differences and gaps in administration and resources.Some of the factors that concentrate poverty and inequality among women in South Africa include labour market rigidities that maintain differences between what men and women earn for the same work, limited participation in informal sectors, lack of economic access and opportunities, and exclusion from productive primary and secondary sectors (Moleko, 2021).

Men are 12% more likely than women to get employment, and once they do, they enjoy benefits like paid time off, greater base salary, health insurance and retirement fund contributions, and other financial incentives and rewards. On average, men earn 30.3% more than women when paid monthly and 28.8% more when paid on an hourly basis, according to Moleko (2021). Women are concentrated in the lowest-paying occupations: 97% of domestic workers, who are predominantly

African, are female, but just 32% of managers in all occupations are female. Young women are even more impoverished as a result of obstacles to obtaining land and capital as well as a decline in their participation in the informal sector, which frequently thrives when women are involved.

Only 30% of the workforce works in industries with low employment rates for women, such as communications, mining, transportation, and construction. Subsequently, several variables (including political or social instability) can make health care administration more difficult and sometimes even entirely disrupted; these disparities and inequities are more noticeable in less developed nations than in developed ones (Bryant and Rhodes, 2023). Countries with such weak healthcare systems frequently depend on foreign organizations for assistance. According to the Society of International Development (2021), development is a process that leads to growth, progress, positive change, or the inclusion of demographic, social, economic, environmental, and physical components. Raising the level of living for the populace while preserving the resources of the environment is the aim of development. Additionally, it seeks to boost employment and local income. Although not often immediately apparent, the development includes a quality change component and the establishment of conditions for the continuation of that change (SID, 2021). Ruger (2003) asserts that these essential components are a component of a different perspective on growth and health, and that a number of considerations are pertinent to this perspective. This is because economic development depends on health, and health, in turn, depends on economic growth—there is a reciprocal relationship between the two.

Ruger (2003) suggests that income can influence health and demographics by improving access to food, housing, education, and sanitation, as well as providing incentives to reduce family size. However, disparities in social standing and income can also negatively impact the health of marginalized populations. Therefore, rather than assuming a one-way relationship between health and rising wealth, it is crucial to incorporate efforts to enhance both economic opportunities and health. Ruger (2003) further emphasizes that opportunities for people to express their agency and engage in social and political decision-making are closely linked to both economic development and health improvement. Making informed decisions depends on political and civic rights, including free speech and dissent. A very small range of disorders threatens good health and its associated benefits for development. The majority of diseases that impoverished people in

developing nations suffer from, such as HIV/AIDS, malaria, tuberculosis, paediatric illnesses, and diarrhea diseases, are often connected to nutritional inadequacies (Fasaulis, 2023).

2.9.2 Inaccessible health care and facilities

It is critical to recognize the connection between aspects of inequality and healthcare inaccessibility. This is because inequality leads to disparities in social opportunities and access to appropriate medical treatment. In isolated, rural populations, this is particularly bad. Lack of access to healthcare in African impoverished communities has been an ongoing issue for many years (Ransburg, 2021). The situation was made worse in the last quarter of the 20th century by a combination of structural change, the economic crisis, and the adoption of healthcare cost recovery. However, they have also spurred several suggestions for compensatory policies (Ransburg, 2021). The South African healthcare system is currently working on the difficult project of establishing universal health coverage, which will guarantee the system's ability to provide comprehensive care that is accessible, affordable, and acceptable to patients and families, despite the system's significant pressures (de Villiers, 2021). The growing prevalence of chronic illnesses, systemic and structural problems in service delivery, and societal problems with unemployment and poverty are the three primary factors that affect South Africa's healthcare system (de Villiers, 2021).

According to de Villiers (2021), South Africa's quadruple burden of diseases consists of HIV and AIDS, communicable and non-communicable diseases, violence, and injuries. This is one of the largest problems, which the overburdened public health system is no longer able to manage. These conflicting epidemics have a high death and morbidity rate, according to de Villiers (2021). South Africa has more HIV-positive persons than any other country in the world, at 7.1 million. Additionally, the nation has one of the highest incidences of TB, which is resistant to many drugs. Chronic non-communicable diseases are affecting an increasing number of South Africans. The state is still responsible for delivering healthcare because of the high unemployment and poverty rates, and the persistent access gap between public and private healthcare systems has left the public sector overworked in comparison to the private sector. Even though the public sector provides healthcare to around 84% of the population without private health insurance, the government only pays for less than half of all healthcare expenses (de Villiers, 2021).

2.9.3 Traditional customs that expose women to risky health issues

A greater burden of illness is linked to socio-economic and cultural problems, frequently as a result of the various economic and cultural disadvantages that exist in communities such as uMkhambathini. According to Euromedinfo, poverty and unequal access to social and health services among communities from various socio-economic strata are the results of South Africa's disproportionate living and working conditions within communities. According to the EU (2013), all cultures have health belief systems that describe the causes of illness, how to treat or cure it, and who should be involved. How well-received and helpful patients find patient education can be strongly influenced by their perception of its cultural relevance (Euromedinfo, 2013). They see illness as the outcome of natural scientific processes, Western industrialised societies like the United States favour medical therapies that fight microorganisms or use state-of-the-art technology to diagnose and treat disease. Some cultures, like those in Africa, believe that illness is caused by supernatural events and advocate for spiritual intervention, such as prayer, to counteract the perceived animosity of powerful powers (Euromedinfo, 2013).

Cultural differences significantly influence patient compliance. In this context, rural communities' culture has a way of influencing people's healthcare choices including the use of SRH services for women and girls. For example, the use of pregnancy prevention methods may also be determined by the partner or criticized by the in-laws. Univer (2013) asserts that culture is made up of ingrained thought, emotion, and behaviour patterns that are mainly learned and passed down through symbols. Culture also manifests itself in artefacts. The fundamental building blocks of culture are traditional (i.e., historically derived and selected) notions and their relationships (Spencer-Oatey and Franklin, 2012; Univer, 2013). Culture is intertwined with beliefs and values. Culture creates a sense of identity and belonging by influencing the behaviours we share with members of that culture. As a result, every culture has unique customs and values that shape how individuals perceive and react to different life circumstances.

The notion above summons the debate of biomedicine and ethnomedicine, especially within SRH and healthcare in the rural uMkhambathini. The two medical specialties of traditional medicine and biomedicine have different traits. Traditional medicine is based on shared knowledge about using medical materials that have been gathered through experiments and experiences of human groups (Sousa, Albuquerque and Araujo, 2022). It also represents a particular population's cultural traditions, religious convictions, and socio-economic characteristics (Sousa, Albuquerqe and Araujo, 2022). Biomedicine, on the other hand, includes prescription drugs, laboratory testing, and medical consultations, and is characterized by experimental and clinical research. Sousa, Albuquerque, and Araujo (2022) explain that these elements help define the scientifically proven approaches to illness treatment. Traditional medicine is more common in rural areas because medicinal plants are more readily available there than in urban areas and because traditional medicine is more physically and financially accessible to rural populations (compared to biomedical services). Additionally, biomedicine is more likely to be practiced in urban areas.

The study by Paulos et al. (2016) illustrates that many socio-cultural and economic factors impact how people seek health across the globe. In particular, people in Ethiopia's rural communities are renowned for using medicinal plants as a significant element of their access to healthcare. The survey found that the Hamer ethnic group uses traditional medicine fairly frequently. More women than men preferred conventional medicine. Effectiveness, affordability, and accessibility are the key drivers of this desire. Farmer et al. (2012) recognize that understanding one’s own culture is essential for comprehending cultural variations and their impact on health and healthcare delivery. However, this understanding is often constrained by the unquestionable dominance of certain cultures in society, which highlights the need to examine cultural diversity and perceptions. Such an examination would reveal how the effectiveness of existing health interventions, health outcomes, and healthcare usage might be impacted by a failure to recognize and respect cultural differences. In addition to biological traits, cultural and societal factors significantly affect women’s health. Rezaee, Salar, Ghaljaei, Seyedfatem, and Rezaei (2017) further emphasize that cultural and societal concerns have a greater impact on how we perceive health issues than the biological differences between men and women. In reality, the societal structure of gender dictates the roles that are prescribed for both men and women. Gender influences women's life, needs, opportunities, and health resource access.

The above factor sparks some concerns regarding gender equity in healthcare for women. Alemayehu and Meskele (2017) state that women who benefit from gender equality enjoy greater autonomy in decision-making and improved health outcomes, including a decline in fertility rates, an increase in family planning use, and a drop in unmet contraceptive needs. According to the evidence, age and family structure are clearly related to women's decision-making autonomy (Alemayehu and Maskele, 2017). Women in nuclear families and older women are more likely to have more decision-making autonomy. In addition, Alemayehu and Maskele (2017) also mention that studies show that women who play a significant part in their reproductive health care are more likely to be literate, engaged in income-generating activities, and married later. Additional research has revealed that people experiencing poverty are typically sicker than their peers are and use healthcare services less frequently. Moreover, working and literate spouses are more likely to participate in decision-making even though women from sub-Saharan African nations are frequently thought to have less control over resources and participation in decisions around reproductive health.

According to Ariff and Beng (2006), understanding the sociocultural elements behind a patient's health beliefs, attitudes, and behaviors requires a successful clinical engagement. These include differences in how patients view their health and illnesses, their understanding of the management strategy, their expectations for care, their adherence to medications and preventative measures, their ability to identify symptoms, their threshold for seeking care, and their ability to communicate their symptoms to a provider. Physicians can identify the cultural influences on the disease experience by comparing illness and disease. Akazili, Kanmiki, Anaseba, Govender, Danhoundo, and Koduah (2020) state that one of the main goals of the Sustainable Development Goals is to increase access to sexual and reproductive health (SRH) services. Akazili et al. (2020) state that the effectiveness of those programs' integration of sexual and reproductive health and rights (SRHRs) will be the primary determinant of the extent to which SRHR targets are met. Effective SRH service delivery can be facilitated by a number of factors, including stakeholder cooperation and support, a health system structure that supports a continuum of care, data availability for tracking advancement and setting priorities, and an effective method for sharing lessons and accountability through regular review meetings.

The successful outcome of MCH services is a healthy child (Bundy, 2004; Matsuoka et al., 2010). Mothers, due to their significant investment in the reproductive process, are highly concerned with this outcome. However, this focus has often overshadowed attention to the health risks that mothers face during pregnancy and childbirth, as well as the establishment of necessary obstetric functions and facilities to address these risks. Therefore, the tragedy of maternal mortality in emerging nations can no longer be overlooked. Family planning programs have improved women's quality of life, but they have also left some women with unfulfilled needs and real concerns. Women are deeply invested in fertility control, as the purpose of contraceptives is to empower them by maximizing their options and managing their sexuality, fertility, health, and ultimately their life (Fathalla, 1994; Bangrats, 2014). Demographics have played a significant role in the family planning movement. Fathalla (1994) and Bangrats (2014) further argue that women were often viewed as objects rather than subjects by policymakers, and some governments failed to recognize that when women are given the freedom to choose, along with the necessary knowledge and resources, they are best positioned to make decisions for themselves, their communities, and the world.

The reproductive process has left many women’s health needs unmet. While infertility may not pose a significant risk to physical health, it can lead to substantial mental and social health challenges (Cantwell, 2021). It is inequitable for society to prioritize the care of fertile women while ignoring the struggles faced by infertile individuals. Women who engage in sexual activity are at risk of unintended pregnancies (WHO, 2020). Additionally, many women are at a significantly higher risk of contracting HIV and other serious sexually transmitted infections as a result. Programs that focus solely on demographic factors fail to acknowledge this critical need for women (WHO, 2020). While Maternal and Child Health (MCH) initiatives emphasize reproductive health to ensure a healthy child for society, they often overlook other essential reproductive health needs (Jasienska, 2020). Women’s reproductive health concerns extend beyond their reproductive years. The reproductive functions of young girls, adolescent girls, and adult and elderly women are closely linked to their broader health needs (Jasienska, 2020). Even more widespread is the cultural mindset that views women as means rather than ends (Foley, Oxenbridge, Cooper, and Baird, 2022). There is frequently a veterinary element to the services provided to women. Advocates for girls' education point to the benefits of education for children's health and survival as well as its potential to lower birth rates (Ara, Maqbool, and Gani, 2022).

The necessities of the developing fetus and nursing baby justify women's nutrition. The argument for investing in keeping women alive, despite the tragedy of maternal mortality, is that their existence is essential to the survival of their offspring. The dispersion of the current services and their focus has led to the recent emergence of the notion of reproductive health. A thorough, integrated approach to the health requirements of reproduction is provided by the more general "reproductive health" concept. As subjects rather than objects, as ends rather than means, it places women at the centre of the process.

2.10 International Commitment to Sexual Reproductive Health and Rights

In both affluent and developing countries, disparities in sexual and reproductive health and rights (SRHR) continue to mark significant milestones in development. Recognizing these differences is crucial as it helps global stakeholders identify and address SRHR limitations. This, in turn, assists various governments in tackling SRHR deficiencies. Matthews et al. (2010) emphasize that the most basic healthcare services should be simple, efficient, and rooted in practical scientific methods and traditional approaches, utilizing available resources and personnel while being integrated into the broader health system. There are many options available under this framework. However, to meet the healthcare and development needs of disadvantaged populations, many developing countries have created basic-level healthcare programs (Matthews et al., 2010). Each approach has its unique strategy. For example, China provides primary healthcare through widespread educational initiatives.

Despite its rapid healthcare advancements, China's evolving health system still faces both new and persistent challenges. Rural-to-urban migrants, mostly of reproductive age and not registered as urban residents, face significant barriers to accessing SRH services, even though the gap between rural and urban SRH access is narrowing (Fang, 2015). Due to both supply-side and demand-side factors, China's caesarean section rate exceeds 46%, significantly higher than the WHO's recommendation. Additionally, adolescents and unmarried young people have unmet SRH needs, including contraception, leading to high and recurring abortion rates. The male-to-female sex ratio imbalance at birth remains a significant issue, with 118 male births for every 100 female births in 2012, despite government efforts to address it (Li, 2012). Many of China's SRH successes have come from top-down initiatives, which, while effective in mobilizing resources for specific issues, may overlook problems not currently prioritized (Fang, 2015). The integration of the health and

family planning systems in 2013 remains ongoing at the municipal level, with uncertain implications for SRH. This reform could provide more integrated SRH services and reduce population management pressures.

In Canada, access to SRH services is not as challenging as in developing nations. SRH healthcare is legally accessible, and in some cases, provincial or territorial health insurance plans cover it (Nelson, 2016). Although we have reason to believe that access issues are not severe, there is a need to further explore the scope of these challenges. Very little data is available on the accessibility of reproductive health services in Canada. For most Canadian women living in or near major urban centers, access to education and healthcare is not a significant barrier. However, respecting reproductive autonomy is more complex than merely offering people numerous choices and letting them make decisions on their own. When transitioning from the MDGs to the SDGs, world leaders reaffirmed their commitment. Progress toward the MDGs has been modest and inconsistent across nations. Fehling, Nelson, and Venkatapuram (2013) estimate that 15.5% of the global population remains undernourished, with many countries, especially those in Africa, unlikely to meet the goal of reducing child mortality by two-thirds by 2015. Maternal mortality rates have seen little improvement. In sub-Saharan Africa and Southern Asia, regions where 80% of the world's poorest populations live, progress toward the MDGs has been exceptionally slow. The SDGs, established at the 2012 UN conference, aim to guide global sustainable development post-2015 (Tazinya, Hajjar, and Yaya, 2022). With 17 goals and 169 targets, the SDGs replace the more limited MDGs. These goals emphasize universality, applying to all countries and populations, and ensuring that no one is left behind. Both developed and developing countries face different obstacles in meeting these targets, with the scale of these challenges varying based on national circumstances and resources (Tazinya, Hajjar, and Yaya, 2022).

2.10.1 International Commitments (Policies and Programs)

International efforts to address healthcare challenges for women are gradually gaining momentum. However, various factors may limit or slow the process of implementing SRHR commitments in policy and legislation.

2.10.1.1 Vietnam Case Study

Vietnam has shown a strong commitment to addressing adolescent and youth SRH issues, as evidenced by its ratification of several international human rights treaties and declarations, such as the 1990 Convention on the Rights of the Child, the 2000 Millennium Development Goals, the 1994 International Conference on Population and Development (ICPD) Program of Action, and the 2015 Sustainable Development Goals (Khanh Chi et al., 2021). The country has established numerous legal frameworks to address SRH issues among adolescents and youth, including the Vietnamese Youth Development Strategy (2011-2020) and the National Population and Reproductive Health Strategy (2011-2020). Despite these efforts, SRH education and service availability for adolescents and youth remain inadequate, particularly in rural and remote areas. The country's policies must be reassessed and improved to better align with its Sustainable Development Goals and the 2030 Agenda.

2.10.1.2 India Case Study

India's Ministry of Health and Family Welfare has set six strategic priorities for adolescent health, including nutrition, sexual and reproductive health, substance abuse, non-communicable diseases, violence (including gender-based violence), and mental health (Sahadevan, Dar Lang, and Dureab, 2023). The 2005 Adolescent Reproductive and Sexual Health Strategy laid the foundation for improving services for youth. In 2014, the Rashtriya Kishor Swasthya Karyakram (RKSK) program expanded the scope to address broader health concerns, including non-communicable diseases, nutrition, mental health, and violence, in addition to sexual and reproductive health (Sahadevan, Dar Lang, and Dureab, 2023). Although RKSK has achieved greater coordination between federal and state governments, challenges remain, including infrastructure issues and lack of involvement from NGOs. A significant cultural barrier persists, as many parents are uncomfortable with the idea of their children, particularly daughters, receiving sexual and reproductive health education. Since 2020, India has made strides in promoting adolescent health through school programs that reach a large number of students nationwide, though stronger oversight is still necessary, especially in religious schools.

2.10.1.3 USA Case Study

USAID runs FP/RH projects in over 30 countries, focusing on 24 priority nations in Africa and Southern Asia. The agency's goal is to support countries in meeting their FP/RH needs (Global Health Policy, 2016). In addition to its independent programs, USAID coordinates with international organizations like the UNFPA and Family Planning 2030 (FP2030) to improve access to family planning services (Global Health Policy, 2024). U.S. funding for FP/RH has fluctuated but remained consistent at around $600 million in recent years. Coordination with global HIV initiatives, such as the President's Emergency Plan for AIDS Relief (PEPFAR), has also grown stronger, aiming to integrate SRH services with HIV prevention and treatment efforts (Global Health Policy, 2016).

2.11 South Africa's Constitutional Commitment to SRH

South Africa has made strides in adopting SRH programs and initiatives in legislation, though there has been limited progress in implementation. Sexual and reproductive rights have gained global recognition, particularly since the 1993 World Conference on Human Rights, where participating countries agreed that violations of women's rights constitute violations of human rights (Bracke, 2023). South Africa has implemented several SRH laws and regulations since the 2000 MDGs, but the primary challenge lies in their effective execution (Ramkissoon et al., 2010). Barriers to policy implementation include political factors, resource availability, and health system challenges.

In 2009, South Africa created the Ministry of Women, Children, and Persons with Disabilities, signalling commitment to addressing gender-specific needs. However, concerns have been raised about the ministry's ability to effectively plan and execute programs for women's health, particularly given its broad focus on multiple vulnerable groups (Masango and Mfene, 2015). The South African Constitution guarantees the right to sexual and reproductive health, including the right to make personal decisions regarding one's body and health (Starrs et al., 2018). Despite significant strides in addressing issues like HIV/AIDS, maternal and infant health, and contraception, certain SRH topics such as access to safe abortion, menstrual health, gender-based violence, and sexuality remain under-addressed (Starrs et al., 2018).

2.12 Challenges in the successful implementation of SRHR

Kim, Park, and Tukeren (2020) highlight the interconnectedness of healthcare and welfare, noting that women often face fragmentation in the healthcare system when trying to meet their reproductive and general healthcare needs. Women also tend to visit medical professionals more frequently than men. Thompson et al. (2016) emphasize that women are particularly engaged with healthcare issues and possess significant knowledge in this area. Despite this, access to reliable healthcare information remains limited. Numerous studies have pointed to a shortage of medical personnel, pharmaceuticals, essential supplies, and healthcare infrastructure. Surprisingly, these material shortages do not always correlate with better health outcomes (Tauiwalo, Robalino, and Frenk, 2004). While technological improvements or more comfortable healthcare settings may enhance the quality of care, some research suggests that the relationship between such structural elements and improved health outcomes is tenuous at best (Tauiwalo, Robalino, and Frenk, 2004).

Healthcare delivery involves multiple organizational units, such as hospitals, doctors' offices, and specialized clinics, which must align with the parameters where value is created (Porter, 2010). All services and activities that collectively determine whether patient needs are met should be included in the measurement of value. Teklehaimanot and Paola Mejia (2008) argue that the poor have less access to healthcare compared to wealthier populations, with significant disparities even within countries. South Africa, in particular, faces significant political and socioeconomic barriers to healthcare access. Moreover, the relationship between poverty and healthcare access is bidirectional: a lack of resources and expertise makes it difficult for individuals to access services, and in turn, delaying or avoiding necessary medical care leads to worsened health, lost wages, and higher medical costs, which exacerbate poverty, especially in rural areas like uMkhambathini. Poor women in developing countries face particular risks due to these deprivations, impacting their sexual and reproductive health and rights (SRHR).

Healthcare and sexual and reproductive health services are closely related. In comparing the healthcare systems of South Africa's rural and urban areas, a clear disparity emerges. The legacy of colonialism and apartheid continues to shape healthcare, creating disparities in resources and service locations. Even in the post-apartheid era, enduring inequalities persist, with continued stratification of society (Robert, 2005). These injustices contribute to social stratification, with lower socioeconomic status linked to limited access to healthcare and health vulnerabilities. Even

wealthy countries face stratification, as some citizens cannot afford private healthcare, a situation particularly evident in South Africa.

Before 1994, South Africa's healthcare system was racially divided, with a well-resourced system benefiting the white minority, and an underfunded system serving the black majority (Koch and Omotoso, 2018:2). This led to a fragmented and racially segregated health system, with 14 distinct health departments. Omotoso and Koch (2018) note that primary healthcare for the black population was neglected, while most healthcare resources were focused on private hospitals. Since 1994, South Africa's health system has evolved into a two-tiered, unified system, but it still faces significant challenges. Public healthcare, funded by the government, offers free care, including prescription drugs and home care visits. However, it suffers from long wait times, low-quality care compared to the private sector, outdated facilities, and inadequate disease control strategies. Despite these issues, a study found that poor South Africans often prefer private healthcare when financial constraints allow (Govender et al., 2021). South Africa's private healthcare sector offers modern facilities, short wait times, and a more comfortable experience, attracting top medical professionals who are offered better pay and benefits than those in public hospitals (Harris et al., 2011).

The healthcare system faces numerous limitations that hinder the integration of sexual and reproductive health (SRH) and HIV services. The South African National Strategic Plan, 2017–2022 (Department of Health, 2017) and other national policies support integration, but slow adoption of these policies in the public sector limits their effectiveness. Despite evidence that integrating SRH and HIV care is both feasible and beneficial, low-income settings struggle with implementation due to infrastructure limitations and the lack of trained healthcare providers. Integrated services have been promoted but not effectively implemented, with care often divided along social categories. Training healthcare workers on new methods of service delivery has been shown to support integration (Chege et al., 2005; Church et al., 2017). Milford et al. (2019) argue that training must address healthcare workers' attitudes and build on previous training to be effective. High staff turnover in South Africa, due to both migration and relocation, complicates integration efforts. To address this, training modules should incorporate staff supervision, task shifting, and ongoing support (Milford et al., 2019). Furthermore, the evaluation of integration processes remains complex and understudied, with most literature focusing on perceived benefits rather than actual outcomes.

2.13 Stigma and Discrimination in Healthcare

Stigma is a significant barrier to healthcare access, particularly for those seeking disease prevention, treatment, or support for maintaining a healthy quality of life (Nyblade et al., 2019). Stigmatized conditions hinder access to diagnosis, treatment, and positive health outcomes, and stigma also affects healthcare workers, who may be reluctant to seek care or disclose their health conditions. Stigma reduction is not consistently incorporated into healthcare delivery or worker training. Discrimination in healthcare leads to a loss of confidence in the system and causes various stress-related complications, including anxiety, depression, and hypertension, which further exacerbate health problems (Hosseinabadi-Farahani et al., 2021). While strategies to address discrimination, such as ongoing training and policy reviews, have been implemented by organizations like the WHO, discrimination remains a persistent issue in healthcare. Discrimination may stem from societal perceptions of certain groups based on their ethnicity, gender, disability, social class, or other factors (Togioka, Duvivier, and Young, 2021).

2.14 Misconceptions in Healthcare for Rural Communities

Misconceptions about health can hinder the dissemination of knowledge and the improvement of health practices. These misconceptions are deeply ingrained beliefs that are not supported by current scientific understanding (Badenhorst et al., 2015). Culture plays a significant role in shaping health perspectives, with varying cultural interpretations of disease (Rosen, 2015). Misunderstandings of health and illness are particularly prevalent in rural communities. In Australia, for example, while a large portion of the Aboriginal and Torres Strait Islander population lives in urban centers, those in rural and isolated areas often face barriers to healthcare access, exacerbated by a legacy of colonization (Glenister et al., no date). Misconceptions about mental illness in Zambia and other African countries also contribute to stigma and discrimination, making it difficult for those affected to seek help (Mwambwa-Johnson, 2021).

2.15 Forms of Stratification in Health

Health stratification, particularly as it affects women, is a key issue in medical anthropology. Social stratification refers to the hierarchical classification of individuals based on specific criteria, leading to inequalities in access to resources, opportunities, and healthcare. This type of stratification restricts healthcare access for marginalized groups, including rural residents and those

living in poverty. Women, especially in rural areas, often bear the brunt of these disparities. In stratified societies, wealthier individuals can afford better healthcare, while those in lower socioeconomic classes experience poorer health outcomes (Oyekola and Oyeyipo, 2020). Women's health is disproportionately impacted by these stratifications, as they are often excluded from healthcare services due to both economic and social factors.

2.16 Implications of Health Literacy and Illiteracy

Health literacy is crucial for understanding health needs and accessing appropriate care. However, women with low health literacy often face challenges in navigating the healthcare system, seeking medical help, and communicating with healthcare providers. This issue is exacerbated by patriarchal cultural structures that have historically limited women's access to education. Low health literacy contributes to poor health outcomes, increased hospitalizations, and deaths. According to Deliktas (2016: 22), health literacy is defined as the ability to obtain, process, and understand health information necessary to make informed health decisions. Conversely, health illiteracy results in worsened health outcomes and greater ignorance of medical conditions and treatments.

2.16.1 Table 1: Conceptual understanding of health literacy

Holistically, health literacy implies the following.

Health literacy	**Access or obtain information relevant to health**	**Understand information relevant to health**	**Appraise, judge or evaluate information relevant to health**	**Apply or use information relevant to health**
Health care	1. Ability to access information on medical or clinical services.	2. Ability to understand medical information and derive meaning.	3. Ability to interpret and evaluate medical information.	4. Ability to make informed decisions on medical issues.

Diseases prevention	5. Ability to access information on risk factors.	6. Ability to understand information on risk factors and derive meaning.	7. Ability to interpret and evaluate information on risk factors.	8. Ability to judge the relevance of the information on risk factors.
Health promotion	9. Ability to update oneself on health issues.	10. Ability to understand health-related information and derive meaning.	11. Ability to interpret and evaluate information on health related issues.	12. Ability to form a reflected opinion on health issues.

Source: World Health Organisation (WHO). 2016. Health literacy. The solid facts. World.

Deliktas (2016) suggests that individuals with high health literacy are more likely to seek medical care in a timely manner, comprehend their health conditions, and follow the advice provided by healthcare professionals. This contributes to improved life expectancy and overall well-being, which is celebrated by many. Shieh and Halstead (2009) emphasize the significant impact of health literacy on women's health. A woman's ability to engage in health promotion and prevention is directly influenced by her health literacy, both for herself and her children. A lack of understanding of healthcare information leads to poorly informed decisions, which, in turn, results in lower satisfaction with healthcare outcomes for the woman and her family. Low health literacy can contribute to difficulties in managing diseases, increased complications, decreased quality of life, dissatisfaction with healthcare services, and a reduction in participation in screening programs. Furthermore, individuals with lower health literacy are less likely to utilize preventive health services, leading to an increase in health issues and the need for more intensive treatments.

2.17 Chapter conclusion

The chapter also discussed the conceptualization of sexual and reproductive health, emphasizing the importance of access to healthcare and related information while ensuring privacy. In the South African context, it explored women's health issues in rural areas, addressing subthemes such as unemployment, limited access to healthcare, and inadequate facilities. A global perspective was incorporated, particularly concerning China's evolving health system, which continues to face both

persistent and emerging challenges. While gaps in SRH services between rural and urban areas are narrowing, rural-to-urban migrants—particularly those of reproductive age—often struggle with limited access due to their non-registration as urban residents.

The review further explored international commitments to SRHR, including a case study on Vietnam, which has ratified numerous international human rights treaties and declarations, demonstrating the government's dedication to addressing the needs of adolescents and youth (A&Y). Additionally, the chapter discussed South Africa’s constitutional commitment to protecting sexual and reproductive rights, positioning the country as a global leader in this regard. Despite these advancements, the chapter identified ongoing challenges in the effective implementation of SRHR policies and programs. The next chapter will introduce the theoretical framework for the study, incorporating Gender Theory, Social Constructivism, and Critical Medical Anthropology.

CHAPTER THREE

Theoretical Framework

3.1 Introduction

The previous chapter provided a comprehensive literature review for this study, while this chapter focuses on the theoretical frameworks that guide the investigation. Theoretical frameworks are essential in shaping the exploration of sexual and reproductive health (SRH) services, particularly in rural areas, and are central to understanding the experiences of women in relation to SRH. By utilizing these frameworks, the study aims to position the targeted population at the heart of knowledge construction on SRH. This chapter discusses the role of theory within qualitative research and explores the theoretical triangulation applied in the study. The theoretical lenses employed include Gender Theory, Critical Medical Anthropology Theory, and Social Constructivism Theory. Through these frameworks, the study gathers emic perspectives from rural women in uMkhambathini eNkanyezini, providing a deeper understanding of their SRH experiences and the factors that contribute to their vulnerability to various health challenges.

Neuma (2014)

3.2 Theoretical Triangulation

Securing objectivity in qualitative research requires enhancing both validity and dependability. One of the 24 techniques identified by Onwuegbuzie and Leech (2007) for ensuring the credibility of qualitative research is triangulation. Triangulation involves using multiple methods, investigators, sources, and theories to gather corroborating evidence (Van Drie and Dekker, 2013), drawing on descriptions from various scholars. The purpose of triangulation is typically to confirm findings by demonstrating that other measures align with or do not contradict them (Van Drie and Dekker, 2013). Various types of triangulation can be applied in qualitative research, including triangulation by data type, researcher, method, source, and theory. Theory plays a crucial role in guiding research, not only by providing structure but also by supporting the creation of the study. Theoretically, theory helps to construct the research framework, akin to constructing a building where theory provides the structural components, such as bricks and mortar (Wampold, 2019). Thus, research can only be meaningfully conducted through the lens of theory. The research process unveils the theories that form the backbone of the study, illustrating how theory and research work together in practice (Wampold, 2019). In qualitative research, theories help us understand complex phenomena by offering interpretive frameworks. However, when relying on multiple hypotheses, the comprehensiveness and robustness of the research findings can be limited. To overcome this, researchers employ theory triangulation, integrating multiple theoretical perspectives to explain a particular phenomenon or study context (Bans-Akutey and Tiimub, 2021).

This study applies three theoretical frameworks—Gender Theory, Critical Medical Anthropology Theory, and Social Constructivism Theory—providing a multifaceted approach to examining women’s experiences with sexual and reproductive health (SRH) services in uMkhambathini eNkanyezini. Gender Theory explores how gender norms and power dynamics influence access to SRH services, focusing on how patriarchal systems affect women’s autonomy and decision-making. Critical Medical Anthropology Theory examines the intersection of socio-political and economic structures with local health systems, revealing how systemic inequalities, medical authority, and cultural barriers impact SRH service delivery and women's health outcomes. Social Constructivism Theory contributes further by analyzing how women’s perceptions and experiences of SRH services are shaped by social constructs, cultural norms, and interactions within their

communities. Together, these theories offer a nuanced understanding of how gender expectations, structural inequalities, and individual agency intersect to shape SRH experiences.

3.3 Defining Theory in Qualitative Research

Theory is adaptable and can be applied across diverse contexts in qualitative research (Tavallaei and Abu Talib, 2010; Bradbury-Jones, Taylor, and Herber, 2014). According to Collins and Stockton (2018), theory condenses data into conclusions about social life that can be applied across different contexts, communities, locations, and even time periods. These theories are supported by explanatory narratives, characterized by four "big truths": (1) they employ an if-then logic to predict and guide action, (2) they account for variation, (3) they use causality to explain occurrences, and (4) they offer solutions for improving social interactions (Collins and Stockton, 2018). In qualitative research, theory serves at least three primary purposes:

- As a framework guiding the study
- As a tool for developing theories from data collection
- As a foundation for research paradigms and procedures

Improving the utility of theory in research requires a clearer understanding of its different applications. This section provides an overview of techniques found in general qualitative research literature (Collins and Stockton, 2018). Collins and Stockton (2018) argue that theory considerations help researchers select the appropriate research study design, such as phenomenology, ethnography, or narrative research. Understanding the theories that inform methodological and epistemological choices is crucial, though the relationship between methodological theories and theoretical frameworks often requires further clarification. Tsindos (2023) proposes that theory can be divided into three levels: macro-level, intermediate-range, and micro-level. Grand theories are broad and universal, applicable to various topics and disciplines. Examples include theories from theorists such as Karl Marx, Friedrich Engels, Max Weber, Emile Durkheim, and Michel Foucault. For instance, Sylvia IV applied Foucault's theory of biopolitics to analyze how governments controlled populations during the COVID-19 pandemic. Middle-range theories are more localized and focus on narrower scopes, such as Normalization Process Theory, which explains how practices become embedded in settings, or Diffusion of Innovations Theory, which describes how ideas spread within systems (Tsindos, 2023). Micro-level theories

focus on individual-level relationships and interactions. Phenomenology, for example, explores the unique experiences of individuals, while symbolic interactionism examines social interactions that reveal broader societal meanings (Tsindos, 2023). In their research, Basic (2022) applied symbolic interactionism to analyze power dynamics and identity formation in young people, particularly through stigmatization and social comparison with other groups.

The function of theory in research can be assessed in three ways: first, as a paradigm that influences the research design; second, as a "lens" that provides insight into the subject of research; and third, as knowledge resulting from the research itself (Mngadi, 2018). A paradigm encompasses the philosophical assumptions regarding social reality, or ontology, epistemology (what constitutes knowledge), and methodology (the methods of data collection). These frameworks guide researchers in understanding social worlds and their relationships with individuals (Chilisa and Kuliwa, 2015).

Characterizing Theory (Kivunja, 2018)

A theory should possess several defining characteristics (Kivunja, 2018):

- It should propose claims that can be tested, validated, and evaluated.
- It must be clear and concise.
- Its predictions should improve upon existing theories in explaining phenomena.
- Its predictions should be broad enough to apply across various contexts.
- Its claims or predictions, when implemented, should lead to the anticipated effect.
- Social scientists use theory to explain real-world phenomena, making its claims subject to refinement and revision.
- Its principles and propositions should clarify why things occur and help predict future events.

3.4 Theoretical Framework of the Study

Qualitative research follows the naturalistic paradigm, which assumes that people construct reality based on their experiences (Garvey and Jones, 2021). In this approach, researchers act as instruments for data collection, inductively building findings from the ground up toward a more conceptual understanding (Garvey and Jones, 2021). A theoretical framework provides essential

structure for research, offering a set of related definitions and concepts that explain the connections between variables and phenomena (Sreenkumar, 2023). It serves as a roadmap, guiding the researcher in compiling data and drawing conclusions. Theoretical frameworks are particularly valuable in qualitative research, as they help define the concepts and relationships within the phenomenon under study (Miles, Huberman, and Saldana, 2020). These frameworks may emerge inductively from previous research or existing theories, and they are crucial when abundant data must be analyzed, ensuring that the focus remains on the most relevant aspects (Miles, Huberman, and Saldana, 2020).

3.5 Importance of Theoretical Framework

The theoretical framework plays a critical role in guiding the study of Sexual and Reproductive Health (SRH) experiences among women at uMkhambathini eNkanyezini, KZN, South Africa, by:

- Providing an overarching structure for the entire research process.
- Offering formal ideas as a guide for the research.
- Keeping the study focused through a general guideline.
- Directing the choice of research methods, data collection, and analysis.
- Assisting in developing research questions and hypotheses while clarifying connections between different topics.
- Filling gaps in existing research literature.
- Analyzing collected data, drawing meaningful conclusions, and extending the applicability of the findings.

3.6 Gender Theory

Gender theory, primarily grounded in feminist perspectives, seeks to understand how patriarchal structures at local, national, and global levels disadvantage women in rural African settings. This theory highlights the sexual division of labor, power, and emotional attachment, which frame gendered relationships. It argues that women's health issues must be examined within the context of power, culture, economic agency, and access to healthcare and information.

Gender theory addresses how societies define and organize sexual differences, often reinforcing patriarchal systems that favor men. Political institutions, laws, and language uphold these systems,

which have been widely studied in feminist movements since the 19th century. Contemporary gender theory continues to challenge these norms, often questioning how masculine and feminine behaviors are socially constructed (Gerish, 2005).

3.6.1 Feminism and Gender

Linking feminism and gender is crucial to understanding gender theory in the context of women's experiences in uMkhambathini. Women's health challenges are shaped by various factors, often acting as barriers to accessing SRH services. Gender inequality in South Africa is rooted in socio-economic and cultural factors that perpetuate gender disparities across multiple social, economic, and environmental domains. Understanding gender theory in this study is key as it highlights the gender-based challenges that influence women's health-seeking behavior. According to Bangani (2019), addressing gender inequality requires promoting a more equitable division of labor and ensuring equal access to employment opportunities for women.

The integration of gender and women's issues into all societal structures, institutions, policies, procedures, practices, programs, and government projects is foundational for achieving gender equality (Bangani, 2019). As Bangani (2019) points out, a key focus is enhancing women's participation in decision-making and meeting the Public Service employment equity target of 50% female representation at all Senior Management Service (SMS) levels. Addressing women's empowerment and leadership development requires coordinated efforts from all levels of government—federal, provincial, and municipal. The gender perspective explores how an individual's gender influences their social roles, relationships, and opportunities (Lindsey, 2020). Gender directly impacts the successful implementation of policies, programs, and projects, affecting the overall social development process (Lindsey, 2020). Gender influences every aspect of an individual's life—economic, social, and private—and shapes the roles assigned to men and women within society. As Dhaswadikar (2021) asserts, gender inequalities are social constructs rooted in preconceived ideas about men's and women's physical traits, presumed preferences, dispositions, and abilities. These distinctions are fluid, changing over time and across cultures, in contrast to the fixed nature of biological sex (Dhaswadikar, 2021).

To fully understand the context of Sexual and Reproductive Health and Rights (SRHR), it is important to incorporate feminism into gender theory. Feminism plays a crucial role in addressing

the challenges women face, acting as a catalyst for constitutional evaluation and administrative prioritization of women's healthcare needs, especially in rural KwaZulu-Natal. Malinowska (2020) notes that feminism is a broad term encompassing various cultural movements linked to the worsening conditions of women within patriarchal systems. Charles Fournier (1772–1837) first used the term in 1837 in response to organized efforts advocating for women's suffrage. Over time, feminism has evolved through four waves, each with complementary or vicarious movements (Malinowska, 2020).

A core aspect of feminist work is intersectionality, a concept that has recently dominated much feminist research and theorizing (Kiguwa, 2019). Feminists are increasingly moving away from a narrow focus on what affects women, shifting toward a more comprehensive understanding of the various intersections that must be considered in achieving gender equality. Rooted in black feminist critique, intersectionality also highlights marginalized feminisms, such as African and Black feminism, aiming to elevate the experiences and voices of women of colour. This approach addresses gender disparities not only as a critique of Western feminism but also as a means of developing new perspectives on gender and engaging with patriarchal structures to spark resistance (Gqola, 2011; Kiguwa, 2019). Intersectionality remains a vital tool in feminist politics, offering a critical examination of the tensions and conflicts that arise between different groups (Kiguwa, 2019). By doing so, it challenges theoretical analyses that often promote homogeneous gender conceptions.

3.6.2 Theoretical Contribution

Gender theory plays a vital role in explaining the gendered identities of rural women within the context of this study. It enables women to socially construct their daily experiences, particularly their access to and the responsiveness of SRH services. This theory goes beyond micro-level analyses of power dynamics involved in accessing and utilizing SRH services, suggesting that comparative and empirical research should test and expand upon its application. The theory's current work expands into understanding gendered challenges in healthcare, particularly those related to sexism and gender hierarchies. These challenges include healthcare worker behavior and the stigmas associated with using specific healthcare services in rural areas.

Rural women, such as mothers, wives, and sisters, encounter gendered barriers that differ from those faced by men in uMkhambathini. However, as noted by some participants, healthcare workers often treat women differently, reinforcing these gendered obstacles. This different treatment might be connected to gender stratification embedded within the healthcare system in rural areas. The gender stratification observed in the uMkhambathini community highlights the social constructs that influence women's choices. These choices may empower women to decide whether to engage in contraceptive use or seek an abortion. Several factors drive gendered views, such as women's occupation and marital status, which impact their healthcare decisions, thus affecting the quality of their treatment.

Many women work on temporary contracts for companies, further limiting their healthcare options. Many women are regular clinic visitors, underscoring the priority placed on SRHR among rural women. On average, women in this area have three children and often lack medical aid or stable employment. Regarding occupation, the sexual division of labour is evident, with women identifying themselves as domestic workers, restaurant workers, caregivers, among others. Therefore, the sexual and reproductive health experiences of women in uMkhambathini link directly to Gender Theory, which helps locate gender concerns that challenge the implementation of SRHR in the area. Gender norms serve as a limiting factor for rural women in uMkhambathini, eNkanyezini, hindering their full engagement with SRH services of their choice.

Gender also influences the kind of healthcare-seeking behavior women in uMkhambathini exhibit. Devaluing attitudes and discriminatory actions extend to families, further undermining the likelihood of utilizing SRH services. Rural women, especially those with health needs like abortion, often suffer from feelings of stigmatization. The theory aids in understanding that some partners and healthcare workers still hold stigmatising attitudes towards women using contraceptives. This negatively impacts the quality of healthcare received by many rural women, undermining their gender identity as females in a rural community.

3.7 Critical Medical Anthropology Theory

Critical Medical Anthropology (CMA), a term coined by anthropologists Merrill Singer and Hans Baer in the 1980s, emerged as a critique of traditional medical anthropology (Newnham, Pincombe, and McKellar, 2016). Initially, medical anthropology, a branch of anthropology, tended to take

Western medicine (biomedicine) at face value. It served as a cultural mediator, translating biomedicine to improve understanding of medical encounters, encourage adherence to medical advice, or increase the likelihood of following health recommendations (Newnham, Pincombe, and McKellar, 2016).

Medical anthropology, although useful, was not necessarily reflexive or critical in its understanding of biomedicine, primarily working within the framework of medical authoritative knowledge. There was growing concern to examine biomedicine as another cultural system, similarly situating its belief systems, rituals, and values in the context of broader cultural domains (Newnham, Pincombe, and McKellar, 2016). CMA takes a critical stance in studying biomedical culture, questioning medicine's portrayal as an objective and unbiased adjudicator of truth, free from cultural influences (Newnham, Pincombe, and McKellar, 2016). It also examines how power relationships in medicine contribute to the global capitalist economy, ensuring that medical anthropology does not inadvertently become an agent of capitalist hegemony (Newnham, Pincombe, and McKellar, 2016).

CMA explores how economics and politics shape the overall health status of individuals, addressing disparities in healthcare quality in the presence of social inequalities. It investigates social divisions based on race, ethnicity, gender, and class, and how these divisions influence access to healthcare and disease susceptibility. As Witeska-Młynarczyk (2015) notes, CMA centers its argument on health inequalities, including concerns about gender inequality, gender-based discrimination, and the intersectionality of structural issues.

3.7.1 Medical Anthropology and Healthcare

Critical Medical Anthropology theory is instrumental in examining women's experiences with Sexual and Reproductive Health services. Medical anthropologists study health and illness as biosocial phenomena within the life worlds of different populations. They focus on the links and flows between macro- and microenvironments, paying particular attention to the distribution (and maldistribution) of diseases and health resources (McMahan and Nichter, 2011).

Medical anthropologists engage in several lines of research, of which five are particularly significant. The first involves a biocultural examination of health and illness across the lifespan, considering how changing social, cultural, material, and environmental conditions affect biological

processes (McMahan and Nichter, 2011). The second examines how cultural values, social institutions, and power relations inform how illness and health risks are experienced, represented, and responded to by different groups and ethno-medical systems (McMahan and Nichter, 2011).

The third line of research explores healthcare provision and exclusion, disease surveillance, and control, focusing on the politics of responsibility at local, national, and global levels (McMahan and Nichter, 2011). The fourth involves critically assessing health interventions, particularly how they are implemented, monitored, and evaluated. The fifth line of research centers on the production of knowledge about health, questioning how health problems are framed and by whom, and how such framing shapes approaches to solving these problems (McMahan and Nichter, 2011).

Hans Baer defines CMA as an approach that "aspires to merge theory and praxis in a desire to promote experiential health, as opposed to the functional health associated with contemporary political economics around the world" (Campbell, 2011). Since the emergence of CMA, several anthropologists have applied this approach to public health policy. This is not to say that medical anthropology has only recently engaged with public health, as anthropologists have long played a role in public health. However, prior to CMA, many medical anthropologists served as "cultural brokers." CMA, however, focuses on critically appraising the work of policymakers and their unintended negative effects on target populations (Campbell, 2011).

Campbell (2011) describes the anthropology of public health as being passionately concerned with ill health and deprivation, while remaining committed to a rigorous and critical analytical perspective. Anthropology contributes significantly to health policy development through its new critical and reflexive perspectives. Public health, and more generally, policy development, benefits from research contributions from various disciplines. This multidisciplinary approach addresses the public health needs of populations, with epidemiology being one of the most influential disciplines in health policy due to its methodical sampling and ability to extrapolate conclusions about the health of entire populations.

3.7.2 Theoretical Contribution

The theory provides valuable insight into how women access sexual and reproductive health (SRH) services, as outlined in the Millennium Development Goals (2019) and various health policies governing South Africa and the broader African context. The Critical Medical Anthropology

(CMA) approach to health and illness is particularly effective in analyzing the national contexts of countries undergoing political and social transitions, such as South Africa. It enables a deeper understanding of the micro-level challenges contributing to health inequalities.

South Africa's recent health reforms have led to a shift from an apartheid-era healthcare system to a more equitable, though resource-limited, socialist model, eventually moving toward the commercialization of healthcare. This transition has resulted in disparities in healthcare access, creating a growing divide between the quality of care received by the wealthy and the poor, alongside the expansion of medical technologies. CMA has helped contextualize and compare the healthcare system in uMkhambathini, examining how the evolving political regime has shaped health provision in rural communities.

As health increasingly becomes framed as a key driver of economic growth and an untapped source of revenue for the private sector, CMA offers a critical lens to address local health inequalities and their consequences. It helps map these disparities and underscores the urgent need for local governments to take decisive steps to protect both citizens and the physical environment. The social justice vision inherent in CMA calls for prioritizing collective action to build a just and equitable healthcare system that works toward alleviating poverty in uMkhambathini.

CMA emphasizes the lived experiences of women and focuses on macro-social processes influencing access to and use of SRH services. The underlying assumption is that how individuals experience illness is shaped by socially constructed meanings and the political and economic forces that influence their daily lives. In this research, CMA theory is applied to improve the health and well-being of women in uMkhambathini, with particular attention to poverty, deprivation, social exclusion, and inequalities.

3.8 Social Constructivism Theory

Social constructionism theory posits that there is more than one objective reality. This theory places emphasis on daily interactions between people, their daily experiences, and the use of language to construct their reality (Galbin, 2014). It recognizes social constructs that outline communal norms and values, which influence women's and young women's behaviors in accessing their immediate health rights.

Galbin (2014) outlines several characteristics of social constructionism:

- While traditional positivistic approaches to knowledge are essentially non-reflexive, social constructionists reject them.
- Social constructionists challenge widely held beliefs about social reality, asserting that certain social constructs serve to further the interests of prevailing social groups.
- Proponents of social constructionism argue that our perception of reality results from past interactions and compromises between social groupings.
- Social constructionism is aimed at broadening one's understanding of what is possible, rather than providing knowledge that is definitive and universally applicable.
- Social constructionism seeks to redefine psychological concepts like "mind," "self," and "emotion" as socially manufactured processes, rather than innate qualities of the individual.

Andrews (2012) distinguishes between moderate (or contextual) constructionism and stringent (or extreme) constructionism. According to Andrews, the former maintains that social constructs are created by human interactions but still acknowledges the existence of a physical reality. Critics of extreme constructionism argue that it fails to account for the empirical reality of the world. In contrast, moderate constructionism asserts that while reality exists, its meaning is socially constructed (Andrews, 2012).

3.8.1 Social Constructs and Culture

Social constructs are inherently linked to culture, which plays a significant role in shaping rural men's and women's health-seeking behavior. This is due to the strong influence culture has on people's beliefs and behaviors regarding health, both in biomedical and ethnomedical contexts. The concept of social constructs speaks to specific ideas, norms, and values that rural women hold, particularly in the context of SRH services.

Culture is often described as a combination of a body of knowledge, beliefs, and behaviors (Eagleton, 2016). It involves various elements specific to ethnic, racial, religious, geographic, or social groups, including personal identification, language, thoughts, communication, actions, customs, beliefs, values, and institutions (Eagleton, 2016).

Andrews (2012) suggests that constructionists view knowledge and truth as created, not discovered, by the mind. However, he also maintains that one can be a constructionist and still believe that concepts have a correspondence to something real. According to Andrews, most research on social constructionism employs a moderate or contextual analysis, which maintains a distinction between participants' beliefs or claims about the social environment and what is known empirically as reality. He argues that extreme constructionism, which denies the existence of an objective reality, is largely incompatible with empirical research (Andrews, 2012).

3.8.2 Theoretical Contribution

This theory provides an opportunity to explore how social constructs shape women's choices regarding sexual and reproductive health (SRH) services. The theoretical lenses applied in this study are crucial for understanding the social construction of health and illness, which refers to how our social world influences the assessment, treatment, and collective understanding of various diseases and health conditions. Health-related organizations must view health as a social construct because how diseases are treated and understood largely depends on their social context.

In the case of SRH services, this theory highlights persistent health-related challenges faced by many women, including pregnant women and underage girls. The theory also offers insight into the concept of medical pluralism, where people use a variety of therapeutic modalities, combining both biomedical and alternative treatments, especially in low-resource settings like uMkhambathini, eNkanyezini, where traditional healers offer alternative healthcare options outside the formal biomedical system. Traditional healers, who are recognized by the community for their healing abilities, are an integral part of the local healthcare landscape, offering accessible and affordable services in rural areas. These healers maintain strong patient relationships and are often viewed as more approachable than biomedical professionals, especially in rural settings.

In the context of medical anthropology, traditional healers are often the first point of contact in medically pluralistic settings. Their accessibility and affordability contribute to their popularity, not only in rural areas but also in urban settings, where reliance on traditional healers persists despite the availability of numerous biomedical facilities. This challenges the simplistic view that traditional healers are only popular due to convenience. The theory also emphasizes the significance of the social and cultural dimensions of illness, recognizing that certain health

conditions may carry specific social or cultural meanings. For SRH, illnesses like HIV/AIDS and sexually transmitted diseases (STDs) are often stigmatized. The theory helps to understand the social dynamics surrounding stigma, how it is managed, and how it evolves over time. Understanding illness stigma is critical for understanding the choices women make regarding healthcare resources. The impact of social constructs is evident in SRH service utilization rates, with both biomedicine and traditional healing offering distinct forms of healthcare.

3.9 Chapter conclusion

The chapter has outlined the theoretical foundation of the study, providing a comprehensive understanding of the key frameworks utilized in the research. It aimed to define the role of theory within qualitative research and explored the application of Gender theory, Critical Medical Anthropology (CMA) theory, and Social Constructivism theory in the context of this PhD dissertation. These frameworks were examined for their unique contributions to the study's objectives. The chapter also introduced the concept of theoretical triangulation, which involves integrating multiple methods, investigators, sources, and theories to strengthen and validate findings.

Gender theory, rooted in feminist perspectives, emphasizes how patriarchal structures, community power dynamics, national political systems, and global hierarchies collectively disadvantage women, particularly in rural African settings. The Critical Medical Anthropology (CMA) theory, developed by Merrill Singer and Hans Baer in the 1980s, critiques traditional medical anthropology by examining the intersections between health, culture, and socio-economic inequalities. Social constructivism theory, in turn, highlights the role of social constructs in shaping communal norms and values that directly impact women's access to their health rights. The next chapter will focus on the research methodology, offering insight into the methods used to collect and analyze data. The following chapters will apply the theoretical perspectives outlined in this chapter to critically examine and interpret the data, thereby enriching the study's conclusions and implications. This theoretical framework will guide the analysis of the research findings, helping to contextualize the complex relationships between gender, health, and socio-cultural dynamics in the study.

CHAPTER FOUR

Research Methodology

4.1 Introduction

The previous chapter explored the theoretical framework of the study, examining the history, origins, and key contributions of the selected theories: Gender Theory, Critical Medical Anthropology, and Social Constructivism. Building upon this foundation, Chapter 4 shifts focus to the study's methodology, specifically investigating the sexual and reproductive health (SRH) services and experiences of women in Umkhambathini eNkanyezini, located in KwaZulu-Natal, South Africa. This qualitative research utilizes various methods, including focus group interviews with 30 women participants. The chapter begins by sharing the insights gleaned from the research, offering a reflective overview of the study. Additionally, the chapter provides a map and detailed description of uMkhambathini as the rural study area, situated in the KwaZulu-Natal province. The discussion highlights the rural context of eNkanyezini and the relevance of this setting to the research objectives. It further elaborates on the qualitative research design and defines the phenomenological approach applied in the study. The chapter also outlines the participant recruitment process, providing an in-depth explanation of the data collection tools used. Special attention is given to the importance of these instruments in gathering reliable data. The methodology section includes a thorough description of the sampling methods, including purposive and snowball sampling techniques. Furthermore, it addresses the data collection and analysis procedures, as well as the chosen interpretivism paradigm, which guides the study's interpretation of findings. Ethical considerations, including the approval process and participant access, are also discussed, with a particular emphasis on ensuring data protection and ethical standards throughout the research process.

4.2 Context of research

In anthropology, empirical research is centred on people's experiences, and this informs what is valid and reliable. Anthropological research findings lead to conceptualizing societal problems to solve practical problems. Research is an intrinsic part of more diverse anthropological knowledge generation. The focus on the most vulnerable spaces and communities is essential to track social,

political and environmental factors and their impact on access to healthcare and social needs. The study then focuses on localized healthcare challenges pertaining to SRH services. According to Lawal (2019), social science research is a process of enquiry into social issues and social problems. Therefore, new knowledge is being derived using this social science research, and new information is obtained through a systematic and scientific procedure. Social science research is the systematic manner of deriving new data on any social subject that affects man in society (Lawal, 2019). Social research gives insight into social occurrence(s), making researchers understand why, when, where, what, and how social life is constructed and reconstructed daily. Nonetheless, through social science research, the complex nature of society is observed. Hence, this is because social science research provides insight into the sustenance or displacement of preconceived realities (Lawal, 2019).

4.3 Relevance of qualitative research in the study

Greenhalgh, Annandale and Ashcroft (2016) explain that qualitative studies help us understand why promising clinical interventions do not always work in the real world, how patients experience care, and how practitioners think. They also explore and explain the complex relations between the healthcare system and the outside world, such as the socio-political context in which healthcare is regulated, funded, and provided. Qualitative research methods recognize that human beings are the source of knowledge and that their voices/ perspectives on matters are worth being recorded (Greenhalgh, Annandale and Ashcroft, 2016). People's voices are recognized as narratives, emic perspectives and thick descriptions through which explanations are recognized. In medical anthropology, explanatory models carry thick descriptions. The researcher can critically sense even unspoken words and provide deeper for more insights. Contextually, qualitative research allows the interpretative approach to data collection and analysis, which is concerned with the meanings people attach to their experiences of the social world and how people make sense of that world. Qualitative research comprises both qualitative methods of data collection and qualitative methods of analysis; it gathers words or visual, descriptive forms of data and explicates these using text-based, interpretative, and analytical methods. Qualitative research tries to interpret social phenomena such as interactions, behaviours, and communications regarding the meanings people bring to them. The use of qualitative methods can independently to uncover social processes or access areas of social life that are not open or amenable to quantitative research. Qualitative research can also provide rich details about life and behaviours in healthcare settings. Qualitative

methods are often used in studies of health service organizations and policies to considerably affect the evaluation of organizational reforms and changes to health service provision. This means that qualitative research is inductive and allows the social construction of knowledge from the subject's viewpoint.

Qualitative research accommodates emic and etic perspectives, with the emic being defined as analyzing participants' internal behaviour within the system. The etic perspective examines behaviour from an external perspective of a given system (Xia, 2011). Linguistic anthropologists can also get a deeper understanding of the epistemologies of the phenomenon. The study gathered emic and etic perspectives through the data collection methods, which led to the recording of rural women and young women of uMkhambathini on SRH services. The data collection methods led to the collection of empirical data representing narratives of rural women and young women of Umkhambathini. The flexibility of the qualitative method is an interesting fact. This flexibility allows qualitative social researchers to probe for clarity from the subject until saturation is reached: "The subject has nothing new to add or clarify" (Kuluse, 2021). Kuluse (2021) agree that qualitative research demands an extended and even intensive involvement in some social world. The method results in insider knowledge by the researcher and the discovery of social actors' cultures and worldviews through probing and verifying data accuracy (Denzin and Ryan, 2007). The above associations of qualitative techniques have been very applicable in my research. In anthropology, qualitative research provides valuable context as participants can express themselves in their vernaculars. During data collection, I was particularly interested in conducting an overt exploration to observe how AmaZulu women take pride in sharing their experiences, particularly when narrating their daily encounters with accessing sexual and reproductive health (SRH) services in uMkhambathini, eNkanyezini. This approach allowed the study to celebrate the detailed stories of women in their own geographical context, uMkhambathini. Thus, the descriptions above highlight the qualitative researcher's ability to take comprehensive notes while posing essential questions.

4.4 Strengths of qualitative research in the study

The strength of qualitative research depends on the open-ended questions through which the studied population is placed at the centre of knowledge generation. This gave the subjects more freedom to explain themselves and clarify any points they felt were unclear because they were not

limited to a predetermined list of questions about SRH services. Based on the results, the qualitative method provides a significant degree of freedom in conducting inductive studies. The study clearly shows that the methodology facilitated the collection of additional data, which, in certain cases, may have influenced the quality of the results. Researchers can gain further insights relevant to the study and opt for flexibility, as interpretivism suggests that research should remain impartial and have a narrow scope. This perspective aligns with interpretivism, allowing researchers to draw conclusions based on the evidence collected. Given that individual interpretations can vary, this approach was adopted in my study.

This study conducted in the rural area of eNkanyezini shows that during data collection, some questions were modified during the research proposal stage to be more culturally appropriate for the respondents (rural women) since they might not be comfortable with how they were framed in the first place. Focus groups yield detailed information through in-depth interviews. Therefore, the qualitative approach allowed the researcher to collect more data and information while better understanding the research problem's details. Qualitative methods such as focus group interviews allowed the researcher to acquired detailed information for this study. As a result, a researcher may end up with detailed information for his or her study. This may help the study result to achieve data adequacy and, therefore, effectively answer research questions.

4.5 Relevance of the Qualitative Research Design in Anthropological Research and the Research Topic

Anthropology is a discipline that prioritizes the collection of primary data. In the context of this study, which focuses on the experiences of rural women and young women in uMkhambathini, qualitative research plays a crucial role in achieving the following:

1. Phenomenology enables researchers to explore how individuals create and assign meaning to their world, offering an empirical approach to understanding their lived experiences. Phenomenologists typically use interviews to capture these subjective experiences in detail. The study aligns with Interpretive Phenomenological Analysis (IPA), which seeks to understand how participants interpret their personal experiences. This approach facilitates a deeper exploration of the participants' perspectives.

2. The study also integrates interactionism, which examines the relationships, interactions, and exchanges between individuals and groups. This approach particularly emphasizes the role of symbols, with a focus on the language used during these interactions. By employing interactionism, the study delves into how social dynamics and communication influence the experiences of women in this rural context.

By employing qualitative research methods in the study, symbolic interactionism/constructionism was accomplished. Constructionism adopts the relativist stance that "reality" is socially constructed and focuses on research questions about how this "construction" happens and who makes and sustains particular versions of reality. This was observed when the studied population socially constructed meanings through social interactions and relationships. To reveal various interpretations of reality and their creation, this theoretical method frequently employs open-ended interviews, sometimes doing several interviews with the same individuals.

4.6 Relevance of qualitative research design concerning the theoretical frameworks

The Gender theory, Critical medical anthropology and Constructivism theory were used for this dissertation, and they have elevated my qualitative research and analysis. Qualitative researchers also depend on theories drawn from the social sciences and humanities to guide their research process and illuminate their findings, which I have achieved. The relevance of qualitative research design to the theoretical framework is that this research method permitted the collection of experiences, and the theoretical framework explained what could be affecting people about the title of this statement. Theoretical frameworks shaped that qualitative data; hence, the design best fitted the study.

4.7 Research Design

This study employed a phenomenological qualitative research design. Qualitative approaches have garnered significant attention in recent discussions on social science research methodologies, with some authors considering qualitative methods as novel and revolutionary. During the 19th century, as contemporary empirical behavioral science began to take shape, qualitative methods were widely used, both before and alongside quantitative approaches. Introspection, for instance, is a technique where academics examine their subjective experiences to understand how people interpret their environment and themselves (Cropley, 2019). By the turn of the 20th century, a

substantial body of literature had developed around this technique. The qualitative approach has had a profound influence on contemporary thinking in anthropology and sociology, fields that dominated early modern discussions about qualitative methodology.

Qualitative research provides a deeper understanding and exploration of real-world issues. In addition to generating hypotheses, qualitative research aids in the analysis and investigation of quantitative data (Tenny, Brannan, and Brannan, 2017). It focuses on collecting people's views, behaviors, and experiences, addressing not the "how many" or "how much," but the "how" and "why." Qualitative research can be designed as a standalone study using only qualitative data or as part of a mixed-methods study, integrating both qualitative and quantitative data (Tenny, Brannan, and Brannan, 2017). According to Tenny, Brannan, and Brannan (2017), qualitative research design is often nonlinear in contrast to quantitative research, due to the open-ended nature of research topics. One of the key advantages of qualitative research is its ability to elucidate human behavior patterns and processes, which can be difficult to quantify. Experiences, attitudes, and actions are often challenging to measure precisely, while a qualitative method enables participants to describe how, why, or what they were thinking, feeling, and experiencing at a particular moment or during an event of interest. Although it is possible to quantify qualitative data, its primary aim is to identify themes and patterns, which can be difficult to measure. It is essential to preserve the context and narrative of qualitative work, avoiding inappropriate attempts to quantify data that doesn't lend itself to such analysis.

The data retrieval method in qualitative research is distinct and in-depth. Additionally, qualitative research emphasizes the researcher acting as an instrument to collect non-numerical primary data, such as words and images. This approach is well-suited for providing factual and descriptive information (Eyisi, 2016). The significance of the phenomenological qualitative research approach lies in its ability to fully understand and appreciate human behavior and cognition in a social setting by examining a broad range of events. Through phenomenological qualitative research designs, human behaviors, such as interaction, cognition, reasoning, composition, and norms, are studied holistically due to the comprehensive examination of phenomena (Eyisi, 2016). This research design fosters close engagement between researchers and participants, facilitating the participation of individuals and enabling them to share their everyday experiences. Consequently, phenomenological qualitative research accounts for a significant portion of knowledge about human experiences.

According to Ugwu and Eze Val (2023), qualitative research focuses on the nature of phenomena, rather than their range, frequency, or position within an objectively determined causal chain. It explores the quality of phenomena, their various manifestations, the contexts in which they occur, and the perspectives from which they can be perceived. Typically, qualitative research uses verbal data instead of numerical data. As noted by Ugwu and Eze Val (2023), qualitative research involves obtaining and analyzing non-numerical data to gain a better understanding of concepts, viewpoints, or experiences. In contrast, quantitative research collects and processes numerical data for statistical analysis (Ugwu and Eze Val, 2023). Qualitative research is widely employed in the humanities and social sciences, including history, anthropology, sociology, education, and health sciences. Rather than relying on logical and statistical methods, qualitative researchers use various inquiry systems, such as ethnography, grounded theory, historical analysis, phenomenology, biography, and case studies.

Berg and Howard (2012) characterize qualitative research as encompassing meanings, concepts, definitions, metaphors, symbols, and descriptions of things. This definition demonstrates that qualitative research contains all the necessary tools to trigger recall, which aids in the problem-solving methods employed to collect data and offer a thorough description of the study's subjects. The use of concentrated group settings and participant observations, combined with the qualitative research approach, provides a deeper understanding of behavior. Consequently, qualitative research generates a wealth of data about real people and situations (Leedy and Ormrod, 2014). The emergent theory derived from the data allows the researcher to construct and reconstruct theories as needed, based on the data they generate, as opposed to evaluating data generated by other researchers. Researchers analyze participants' expressions and emotions, even when limited or no prior information is available about the individuals (Leedy and Ormrod, 2014).

4.8 Paradigm

The Interpretivism paradigm is commonly used in qualitative research within the social sciences. It is based on the belief in multiple realities rather than a single, objective reality (Thanh and Thanh, 2015; Abbadia, 2022). According to interpretivists, human behavior is complex and cannot be predicted by predefined probabilities. Human behavior is not a scientific variable that can be easily controlled. Interpretivism focuses on methods of gaining knowledge about the world that rely on interpreting or understanding the meanings that humans attach to their behaviors.

In contrast, the Postpositivism paradigm is concerned with the subjectivity of reality and deviates from the objective perspective of logical positivism. Postpositivism seeks objective answers by striving to recognize and address the biases in the ideas and knowledge developed by researchers (Panhwar, Ansari, and Shah, 2017; Abbadia, 2022). For this study, the interpretivist paradigm was chosen. This paradigm aligns with the shift in qualitative research and is particularly suited to exploring the complexities of human behavior, which is central to this research.

4.8.1 Interpretivist paradigm

An interpretivist paradigm is applied to the study. The interpretivist paradigm is a way of understanding the world that emphasizes the role of interpretation in understanding reality. The interpretive paradigm has been increasingly influential in the social sciences, as it provides a way to understand human behaviour that is not limited by the conventional positivist approach. This paradigm shift has been fundamental in sociology, anthropology, education, and psychology, where the interpretivist approach has allowed for a more nuanced understanding of human behaviour (Omodan, 2022). The interpretivist paradigm is not without its critics. However, some argue that this approach leads to a relativistic view of reality, where anything goes, and there is no objective truth (Omodan, 2022). Others contend that the interpretivist approach is too subjective and fails to capture the complexity of social phenomena. Nonetheless, the paradigm provides a valuable perspective for understanding the social world from varying life perspectives. It provides a valuable understanding of the social world from multiple women's perspectives. It often uses qualitative methods, such as interviews and observations, to understand how people make sense of their social experiences. This approach can be constructive in understanding how people experience and make meaning of complex or sensitive topics.

4.9 Phenomenology

According to Marshall and Rossman (2014), early 20th-century philosophers like Husserl, Sartre, and Merleau-Ponty are credited with developing phenomenology, the study of conscious experience. Moreover, several of the concepts presented in the writings of these early phenomenologists were later used by eminent academics in the behavioural and social sciences, including social scientist Alfred Schütz (1967) and psychologist Amedeo Giorgi (1970). A variety of theoretical stances and analytical techniques can guide the collection of qualitative data in a mixed methods study (Marshall and Rossman, 2014). Researchers must know how, when, and why

they plan to integrate qualitative and quantitative datasets. For example, the idea of conversational inquiry and open-ended questions, which are common in qualitative research, frees research participants from the limitations of fixed-response questions, which are typically found in quantitative studies, and allows them to discuss a topic in their own words (Marshall and Rossman, 2014). Sometimes, as in ethnographic research, the subject of the study is cultural processes or social structures larger than any one person's experience. Nonetheless, information on these subjects is frequently gathered.

Phenomenological studies investigate human experiences using participant accounts. We refer to these encounters as lived experiences. Phenomenological research aims to characterize the significance of experiences for each individual. Studies in fields with limited information are conducted using this kind of research (Flick, 2022). Respondents are invited to characterize their experiences as they see them in phenomenological research. Although they might write about their experiences, interviews are typically used to gather information. The researcher must consider her or his thoughts and feelings to comprehend the lived experience from the subject's point of view (Flick, 2022). The procedure known as bracketing requires the researcher first to state what they hope to learn and then set these expectations aside consciously. It is only feasible to view the event through the eyes of the individual who has lived it when the researcher sets aside her or his theories about the phenomenon. It would be necessary to recognize these emotions and then set them aside to hear the individual explain how she copes with the situation.

4.10 Recruitment of Participants

As an anthropology researcher in the field, I had to navigate several processes, starting with the gatekeeper letter request. This step was crucial because it allowed me to gain access to the uMkhambathini rural area, introducing me to key local figures and ensuring appropriate access to the study site. After obtaining the gatekeeper's approval, I submitted the RIG application, which marked the official start of my fieldwork.

The next step was meeting my gatekeeper, who, being familiar with the area, played a critical role in connecting me to participants within the uMkhambathini community. I initially asked my gatekeeper, Nontokozo, to introduce me to the first eight participants, who would then refer me to additional participants—typically one or two—who met the study's criteria. Although the process faced some initial challenges, such as unavailability, I ultimately secured all the participants I

needed, thanks to the assistance of my gatekeeper. These referrals began in the first week of November 2023, just before the data collection phase began.

The intended inclusion criteria for this study were women aged 18-49 residing in the uMkhambathini, eNkanyezini area. This focus is justified, as this demographic represents the reproductive age group, making them the primary users of sexual and reproductive health (SRH) services. Women within this age range are more likely to encounter reproductive health challenges, including family planning, maternal health, and access to contraception and prenatal care. Socio-cultural and structural barriers that affect access to SRH services are often most pronounced among women of reproductive age, significantly influencing their health outcomes and overall well-being. Furthermore, the rural context of uMkhambathini, eNkanyezini presents unique challenges, such as limited healthcare infrastructure, traditional gender norms, and economic constraints, which complicate access to essential SRH services.

Therefore, examining the experiences of women in this specific age group offers valuable insights into the gaps and opportunities for improving SRH service delivery in rural KwaZulu-Natal. These women were highly engaged in the study. However, before the focus group interviews, I needed to clarify the study's aims, as some participants initially confused me with a health worker. The questions were answered in isiZulu. This clarification was essential to eliminate confusion and ensure the continued participation of my subjects.

The exclusion criteria for the study included underage girls, women over 50, and men. A designated meeting point, the community hall in eNkanyezini, was selected, and no home visits were conducted for potential participants. Satisfaction was achieved once all participants understood the study's details, including the date, venue, and meeting time. This information was communicated following the ethical clearance from the RIG. All participants volunteered to be part of the study and provided written informed consent. Data collection continued until all participants who met the criteria were assessed. A key research questions were asked to screen participants for eligibility.

4.11 Justification of duration

A 10-month duration for the study in uMkhambathini is justified, as it provides ample time to conduct a thorough investigation into the experiences of women accessing sexual and reproductive health (SRH) services. This period allows the researcher to account for variations in service access

and utilization across different seasons, which may impact healthcare availability and health-seeking behaviors. It also offers sufficient time for participant recruitment, data collection through interviews, data analysis, and the validation of findings.

Additionally, engaging with the community over an extended period helps build trust and ensures a more accurate understanding of the socio-cultural factors influencing SRH access. The 10-month timeframe guarantees that the study is comprehensive and allows for follow-up interactions to clarify data, thereby enhancing the reliability and depth of the research outcomes.

4.12 Eligibility criteria

This study sample included amaZulu women with SRH knowledge and experience who:

- were at least 18 years old at the time of recruitment
- presented with typical experiences from the clinic (on observation)
- had suffered challenges in accessing and using Sexual and Reproductive health services
- had been in uMkhambathini for the past 10 years before recruitment
- Understand the local healthcare challenges and limitations that impact getting SRH

The second and third criteria sought to ensure a reasonable similarity in the SRH experience of participants.

4.13 Research Assistant

The isiZulu-speaking female research assistant assisted with data collection and translation of research tools, data collection, interview transcription and transcriptions. Employing a female research assistant ensured the active participation of participants in the study because it was foreign to have a male student taking an interest in issues of women's SRH services. The researcher trained the research assistant on the background of the study, ethical aspects and the various instruments to be used. Specific aspects covered in the training included:

- the type of study
- aims and objectives of the study

- ethical principles and documentation, specifically completion of written informed consent
- procedural protocol for the study
- the qualitative interview schedule, and how to facilitate semi-structured interviews.

The female research assistant played a key role in conducting semi-structured interviews and collecting data on specific questions to ensure the comfort of rural women participating in the study. Constructive feedback was provided to her, recognizing her strengths in facilitating and translating the interviews. The researcher was consistently present during the data collection process, addressing any questions or concerns raised by the research assistant and engaging in collaborative problem-solving. This experience greatly benefited the research assistant, enhancing her understanding of the complexities involved in data collection for PhD research, especially since she had recently completed her Master's degree in anthropology. Additionally, she gained a deeper appreciation for the ethical considerations inherent in qualitative research. As a resident of uMkhambathini, eNkanyezini, she was well-acquainted with the local context.

4.14 PILOT STUDY

A pilot study was conducted to pre-test every step of the technique that would be used before the actual study began. This was to ensure that the study achieved its intended goals. In qualitative studies, pre-testing plays enormous in ensuring that the researcher asks relevant questions and detects ethical hindrances that need to be addressed before more data is collected. The objective was to identify any areas that needed improvement. The three pilot participants were also invited to participate later in the data collection to the sample size of 30 used in the pilot study. The 30 member subjects participated in the study after identifying the pilot study's errors and omissions and making the necessary modifications. The pilot was performed on very few of the women from eNkanyezini as an initial step to testing the feasibility of questions. The aim was to determine the feasibility of your research tools. This was a preliminary phase. A small-scale "rehearsal" in which researchers tested the methods deemed to befitting the study. This included using a data collection instrument, which entailed open-ended questions with a few questions that probed for demographical data. The pre-testing confirmed the correctness of the data collection instrument used in the study.

4.15 Data collection tools

The study has employed focus group interviews. Focus groups typically are conducted with 6 groups of 5 people, some of whom have been pre-screened, ensuring they are qualified to speak on the topic of interest. Hayman and Sierra (2010) state that although people recruited for one of several sessions may, by design, differ markedly from each other socio-demographically, behaviorally, and attitudinally, people within a given session should be as similar to one another as possible. Hayman and Sierra (2010) consider the difficulty of managing substantive conversations between people with little in common or who use different words to describe the same things. A successful focus group requires participants to converse meaningfully with each other as guided by the researcher (Hayman and Sierra, 2010). This is because focus group participants within a given session should have similar lifestyles and experiences. The pre-screening needs to be undertaken accordingly. Many factors encourage or discourage people from participating in focus groups. The positive factors include ego enhancement, personal validations, catharsis, personal growth, socialisation, and extrinsic rewards for participating. In contrast, the negative factors include ego threats, political correctness, memory decay, inarticulateness, reticence, and time constraints. These negative factors tend to inhibit participation, either to attend a session or to speak during it.

The guiding principle for the focus groups was the five key questions discussed in this thesis. The use of the five key questions was to screen participants to feature in the focus groups and to ensure that each focus group had enough participants with relevant experiences in the context of the study. Correa de Oliveira (2011) asserts that focus groups are most relevant in studying women-sensitive issues because they create a space for women to discuss their daily experiences. The researcher benefits from their interpreted narratives. Nonetheless, while women benefit from each other's coping tactics, the research gains thick descriptions of the subject matter. According to Guest et al. (2017), focus group interviews create a relaxed and welcoming environment, which allows participants with a common interest to share their views. The focus group study approach enabled women to respond more freely. In the focus group interview, the researcher is responsible for ensuring that all participants are protected and free to express their views regarding the phenomenon of the study (Guest et al., 2017).

Each group had six participants, which is the rule of thumb when conducting focus groups in anthropology. I held five different focus group interviews to complete the sample of 30. This

confirms the participation and inclusion of all research participants in the study. Each group member was asked to remain in the same group until the data collection process was completed. Each group had two subsequent sessions to accelerate more discussions. The responses were rich and detailed, which demonstrated their commitment to sharing the SRH experiences. My gatekeeper, a community member, arranged these focus group interviews at the local community hall. The focus group interviews took ten months. This period was spaced up; five months were for data collection, while the other five months were mainly for confirming and validating the data set that was gathered. I used the focus group interview session, which lasted 60 minutes of discussions. Therefore, the participants were given time to stretch for minutes between the sessions and reconvene again. As part of being an empathetic researcher, there was an offering of refreshments to participants. This was to create a more comfortable environment. The refreshment provision was categorised as a token of participation but came from the space of uBuntu, which recognises that people get hungry. Each member of the focus group interview was given the opportunity to express their views, ensuring that no single participant dominated the conversation. The atmosphere was kept casual to foster a more inclusive and relaxed environment, especially for shy participants. A female research assistant assisted by asking questions on my behalf, as the study focuses on women, and some participants might have felt uncomfortable answering certain questions from a male researcher. I used the same set of interview questions across all focus groups to ensure the validity and reliability of the data.

I designed the focus group in-depth interview questions to gather information relating to participants' demographic characteristics, relevant SRH-related information and socio-cultural factors. A panel of academics within the School of Social Science at UKZN reviewed the research proposal and the focus group interview questions. The questions were designed in isiZulu (Appendix B) and English (Appendix C) including the informed consent (Appendix E & D). Minor changes were made to the phrasing of a few questions to facilitate clarity before their attachments to the RIG ethics process application online. It also important to highlight that the researcher reviewed the translation. They also decided that no changes to the original translation were necessary. The questions were pre-tested on two isiZulu-speaking women in uMkhambathini, eNkanyezini. The focus group interviews sought to describe how participants perceived their life roles, obtain descriptions of the activity requirements to fulfil these perceived roles within their

context and capture the SRH contextual barriers experienced whilst living in Umkhambathini. The focus group interview questions were semi-structured.

The pre-test was conducted on four participants. These people met the inclusion criteria. During pre-testing, these participants had difficulty in answering the original opening question, which was phrased as "What is your knowledge about the Sexual and Reproductive Health services?". The question seemed too broad, as participants needed help in understanding and interpreting it. To enhance participants' understanding, the main research question was translated into isiZulu. Follow-up questions were then asked to explore their perceptions of healthcare, limitations in health-related activities, and the contextual barriers to sexual and reproductive health (SRH). Participants provided detailed responses, offering valuable insights into these restrictions and challenges. The focus group interviews were conducted in isiZulu by a trained research assistant fluent in both English and isiZulu, under the researcher's supervision.

The anonymity of all study participants was assured by allocating a number to each study participant. Follow-up questions were carried out verbally throughout the focus group interviews to ensure that the researcher and research assistant correctly understood the descriptions and experiences expressed by participants. The researcher and research assistant collaboratively viewed the data after being transcribed from the focus group interview discussions. By doing so, the researcher could compare understandings and check meanings with the research assistant, a critical informant of AmaZulu culture.

4.16 Sampling

The sampled population is the uMkhambathini women. The sample is 30 women aged between 18-49 years. Sampling methods are probability or non-probability (Berndt, 2020). Probability sampling methods incorporate random selection, which ensures that each case in the population has an equal likelihood of being selected (Berndt, 2020). Common types of probability methods include random sampling, systematic sampling, stratified sampling, and cluster sampling. Non-probability sampling methods use an approach in which the sample is selected based on the subjective judgment of the researcher instead of using random selection (Berndt, 2020). Common non-probability sampling methods include quota, purposive, self-selection, and snowball. A sample of 30 women was recruited using purposive- snowballing sampling techniques. The non-probability sample fits in the context of qualitative research. Purposive and snowballing will be

used to recruit women between 18-55 years from the eMkhambathini community. These sampling methods are relevant in qualitative research designs, allowing the researcher to include or exclude purposefully (Robinson, 2014).

In this study, a sample size of 30 is justified as it allows for an in-depth exploration of the experiences of women accessing sexual and reproductive health (SRH) services in uMkhambathini, eNkanyezini, while remaining manageable within the study's timeframe and available resources. In qualitative studies, a sample of 30 participants is sufficient to achieve data saturation, where no new information or themes are likely to emerge, ensuring that the findings are comprehensive and reflective of the target population. This sample size also allows for diversity in participants' backgrounds, including variations in age, socio-economic status, and health-seeking behaviors, which enhances the validity and generalizability of the findings. Furthermore, a sample of 30 strikes a balance between capturing detailed qualitative insights and maintaining the feasibility of data collection and analysis within the study's scope.

4.17 Contextualizing non-probability sampling in the study.

4.17.1 Non-probability Sampling Technique

With the use of non-probability sampling in the qualitative investigation there is no likelihood that any unit of the study population will be included in the study sample size (claims Kothari (2004: 59). Taherdoost (2016:22) gave examples of non-probability sampling, including quota, snowball, convenience, and purposeful sampling. According to Taherdoost (2016:22), the sample of participants need not be random. However, there must be a valid justification for choosing some products above others:

- Quota sampling is chosen per a present set of criteria for the sample to have the same dispersed characteristics as the entire population.
- Snowball sampling involves a technique that increases the sample size by recruiting more participants and using a small number of participants as an example. This strategy is helpful when the population is small and difficult to reach.
- Convenience sampling works by choosing participants who are conveniently and easily accessible; convenience sampling helps research overcome its financial and accessibility

constraints.

- Purposive sampling is employed when a specific participant is chosen on purpose to give data that is not otherwise available from other sources.

4.17.2 Purposive sampling

Purposive sampling strategies move away from any random form of sampling. They are strategies to ensure that specific kinds of cases that could be included are part of the final sample in the research study (Campbell et al., 2020). The reasons for adopting a purposive strategy assumes that, given the aims and objectives of the study, specific kinds of people may hold different and important views about the ideas and issues in question and, therefore, need to be included in the sample (Campbell et al., 2020). Purposeful sampling is a technique widely used in qualitative research to identify and select information-rich cases. In addition, to also effectively use limited resources (Palinkas, Horwitz, Green, Wisdom, Duan, and Hoagwood, 2015). This involves identifying and selecting individuals or groups who are incredibly knowledgeable about or experienced with a phenomenon of interest (Palinkas et al., 2015). In addition to knowledge and experience, availability, willingness to participate, and the ability to communicate experiences and opinions in an articulate, expressive, and reflective manner (Palinkas et al., 2015).

Purposive sampling was deemed appropriate for the scope of this study, as it allows for the intentional selection of participants who are directly affected by sexual and reproductive health (SRH) services in uMkhambathini, eNkanyezini. Given the study’s focus on women's experiences, this method ensures the inclusion of individuals with relevant insights, thereby enhancing the depth and richness of the data collected. In a rural context where access to healthcare services may be limited and influenced by cultural and socio-economic factors, purposive sampling helps identify information-rich cases that offer nuanced perspectives on both the challenges and benefits of SRH services. Additionally, this approach aligns with qualitative research methodologies, which prioritize in-depth exploration of lived experiences over generalizability. By selecting participants based on their direct engagement with SRH services, the study generates meaningful findings that contribute to a deeper understanding of women’s healthcare experiences in this specific setting.

4.17.3 Snowballing sampling

Snowball sampling can be utilised by seeking information from various lists to identify primary research reports frequently referred to by stakeholders interested in the phenomenon (Suri, 2011). Even though snowball sampling can introduce an 'expert bias (e.g. preferences for large samples or frequently cited studies)'. It is beneficial to capitalise on expert wisdom, identify studies highly valued by different stakeholders, and identify studies outside the academic mainstream (Suri, 2011). Another way snowball sampling may be utilised in a research synthesis assumes that the most cited primary research reports are the most information-rich cases. Snowball sampling is a network sampling design that preserves the information of the network structure (Kolaczyk, 2009). It is an iterative procedure of collecting vertices information linked with vertices collected in the previous iteration. Snowball sampling is a cost-efficient sample collection method (Chan, 2015). For example, researchers can collect data from neighbours, friends, or family in the initial samples.

Snowball sampling was deemed a suitable method for this study as it allows for the recruitment of participants through referrals, ensuring access to women who have engaged with sexual and reproductive health (SRH) services in uMkhambathini, eNkanyezini. Given the potential stigma, privacy concerns, and cultural sensitivities surrounding SRH topics, women may be hesitant to participate in formal research. Snowball sampling helps to overcome these barriers by leveraging trust networks, where initial participants recommend others who have relevant experiences. This method is especially effective in rural settings, where social ties and community connections are key to information-sharing. Additionally, snowball sampling enables the study to reach hidden or hard-to-reach populations, such as young women, those with limited healthcare access, or individuals who may not openly discuss their SRH experiences. By using this approach, the study was able to gather rich, diverse, and contextually relevant insights while ensuring participants' comfort and their willingness to share their daily challenges without hesitation.

4.18 Importance of data collection instrument

Data collection implies the systematically gathering data on variables of interest that enables one to answer stated research questions. Paradis, O'Brien, Nimmon, Bandiera and Martimianakis (2016) argue that the data collection component of research is common to all fields of study,

including physical and social sciences, humanities and so on. While methods vary by discipline, the emphasis on ensuring accurate and honest collection remains the same. The goal for all data collection is to capture quality evidence that then translates to rich data analysis and allows the building of a convincing and credible answer to questions posed (Paradis et al., 2016). Planning your research is essential to obtain desirable results. In research, there must be a prioritisation of data relevance. It plays a pivotal role in laying a foundation for your study. Improper data can introduce bias and question the validity of your findings. Therefore, data collection is a critical step of any research project. It involves strategising the process of gathering data to ensure its accuracy and reliability. With a thoughtful and systematic approach to data collection, researchers can maintain the integrity and validity of their findings. By understanding the principles and strategies behind planning data collection, researchers and academicians can enhance the quality and impact of their research endeavours. Some questions featured in the data collection instrument exploring aspects of SRH services along the lines of gendered limitations and socially constructed ideas about SRH services. These gendered limitations could be cultural and structural, thus producing healthcare marginality that might slow the process of accessing the much-needed SRH services for women of eNkanyezini in uMkhambathini. The three theoretical approaches were also functional in arguing for the context of Critical Medical Anthropology, Gender and Social constructivist theory.

4.19 Data analysis

McLeod (2024) states that researchers may adopt elements from different thematic analysis approaches depending on their research questions, goals, and epistemological stance. According to McLeod (2024), the choice of approach should be guided by the research aims, the nature of the data, and the philosophical assumptions underpinning the study. TA as a method was first developed by Gerald Holton, a physicist and historian of science, in the 1970s (Clarke and Braun, 2014). TA has been extensively used in the social sciences to analyse qualitative data.

- **Data analysis method**

The study applied the reflexive thematic analysis method. TA is a method for systematically identifying, organising, and offering insight into patterns of meaning (themes) across a dataset. In anthropological research, the thematic analysis allows the researcher to see and make sense of collective or shared meanings and experiences by focusing on meaning across a dataset.). As discussed by, McLeod (2024) the thematic analysis approach emphasizes the role of the researcher in the analysis

process. It acknowledges that the researcher's subjectivity, theoretical assumptions, and interpretative framework shape the identification and interpretation of themes. In reflexive TA, the analysis starts with coding after data familiarization. Unlike other TA approaches, there is no codebook or coding frame. Instead, researchers develop codes as they work through the data (McLeod 2024). As their understanding grows, codes can change to reflect new insights; for instance, they might be renamed, combined with other codes, split into multiple codes, or redrawn boundaries (McLeod, 2024). If multiple researchers are involved, differences in coding are explored to enhance understanding, not to reach a consensus. The finalized coding is always open to new insights and coding.

The reflexive approach to TA highlights the researcher's active role in knowledge production (Byrne, 2022). Codes represent the researcher's interpretations of patterns of meaning across the dataset. Reflexive thematic analysis is considered a reflection of the researcher's interpretive analysis of the data conducted at the intersection of (1) the dataset, (2) the theoretical assumptions of the analysis, and (3) the analytical skills/resources of the researcher (Byrne, 2022). In the study, I attempted to follow the method's guidelines, which helped produce evidence from the data already collected; the method created simplicity in the raw data and helped identify important data patterns. According to Braun and Clarke (2012), thematic analysis is a flexible method that allows the researcher to focus on the data in numerous ways. With TA, you can legitimately focus on analysing meaning across the entire dataset or examine one particular aspect of a phenomenon in depth. The two main reasons for using TA are its accessibility and flexibility. For people new to qualitative research, TA provides an entry into a way of doing research that otherwise can seem vague, mystifying, conceptually challenging and overly complex. Thematic analysis (TA) and all its steps have been used for data analysis. Braun and Clark (2012) confirm that thematic analysis presents and analyses qualitative data. It will help develop central themes and patterns, which were generated from participant responses.

Thus, thematic analysis can be descriptive, explanatory, and/or critical. The thematic analysis enables scholars to define and describe a participant's reality using their written or spoken accounts (Lochmiller, 2021). Moreover, this orientation summarises participants' reports and aggregates these understandings into identifiable patterns. As an explanatory tool, thematic analysis can be used to infer meaning about experiences, perspectives, or belief systems through the lens of a

particular conceptual or theoretical framework (Lochmiller, 2021). This approach involves considering how the patterns found within data depict particular conceptual or theoretical ideas. This approach requires the analyst to match patterns to a specific theoretical or conceptual explanation.

4.19.1 THEMATIC ANALYSIS STEPS:

- ***Familiarising***

According to Maguire and Delahunt (2017), this step involves the researcher taking a broad, high-level view of the data, examining it as a whole, and noting their initial impressions. This typically includes reading through written survey responses and other texts, transcribing audio, and recording any patterns that emerge. It is important to review the data in its entirety several times during this stage to develop a comprehensive understanding of all the information.

- ***Generating Initial Codes***

Maguire and Delahunt (2017) state that after familiarising yourself with your data, the next step is coding notable features of the data methodically. This often means highlighting portions of the text and applying labels, aka codes, to them that describe the nature of their content.

- ***Generating themes***

Castleberry and Nolen (2018) explain that after creating the codes, it is necessary to examine them, identify patterns, and generate themes. They emphasize that themes are broader than codes and that multiple codes can be grouped together to form a single theme. This is the stage where researchers check that the themes generated accurately and relevantly represent the data they are based on. Once again, it is beneficial to take a thorough, back-and-forth approach that includes review, assessment, comparison, and inquiry. With the guidance of the thematic analysis, it was possible to identity key themes for data analysis which will be table in the subsequence chapter.

4.20 ETHICAL PROCESS APPROVAL AND GATEKEEPER CLEARANCE

The study received clearance from the Humanities and Social Sciences Research Ethics Committee (HSSREC) designated at the University of KwaZulu-Natal.

4.21 Ethical consideration: Data collection phase

- ***Informed consent***

When someone gives their informed permission, it indicates that participants have been informed about the nature of the investigation (Arifin, 2018). The study's goal, the person or organisation sponsoring it, the intended use of the results, any possible negative effects of their involvement, and who will have access to the results must all be explained to participants. Informed consent is primarily intended to enable the participant to decide whether to engage in the evaluation. Additional information was provided to my participants where isiZulu (**Appendix D**) and English (**Appendix E**) consent forms were distributed. The participants were informed about the study before signing the consent form.

- ***Voluntary participation***

In Social Science research, voluntary participation implies that recruited participants are informed about the nature of their participation. This means that research participants were informed that the decision to participate is free and not wired on tokens of appreciation either before the start or at the end of data collection (Arifin, 2018). Upon recruitment, sampled participants for the study were informed that they were being asked to voluntarily participate in the study without expecting any token of appreciation. I informed them about protecting their identities and their right to withdraw if they wish to be removed from the study. Research participants were also informed about the study's intentions and that their original names would be protected in the study.

- ***Do no harm***

Harm can be both physical and psychological and, therefore, can be in the form of stress, pain, anxiety, diminishing self-esteem or an invasion of privacy (Hernández, Nguyen, Casanova, Suárez-Orozco, Saetermoe, 2013). The evaluation process must not harm (unintended or otherwise) participants. I assured my participants that no harm would be inflicted on them during this study. The wording of the research questions did not invoke sad emotions. I also ensured that the focus groups were conducted in a secure space with no harm.

- ***Confidentiality***

Confidentiality refers to the practice of ensuring that any identifying information is not disclosed to anyone other than the researcher and supervisor (Bender, Jarmin, Kreuter, & Lane, 2020). It involves excluding identifying details, such as names, from any reports or publications. In this study, maintaining confidentiality was essential to prevent any potential link between the information provided and individual participants, even in the absence of names.

- ***Anonymity***

Anonymity is a stricter form of privacy than confidentiality, as the participant's identity remains unknown to the research reader (Novak, 2014). This is more difficult to achieve than confidentiality, as the researcher usually knows participants in the context of social research. The original names of the participants were not used. This was done to protect their identity. The use of pseudonyms is vital for ethical considerations. These ethical considerations reflect respect for women participants who contributed to the focus group interviews.

- ***Confirmability***

Confirmability is the last criterion of Trustworthiness that a qualitative researcher must establish (Cacciattolo, 2015). This criterion concerns the confidence level that the study's findings are based on the participants' narratives and words rather than potential researcher biases. The data is original, and all responses come from the participant women. The information is confirmable by the raw data collected. This data was collected using focus group interviews.

- ***Generalisability***

Generalisability refers to the extent to which the results of a study can be applied to a broader group of people or situations (Cacciattolo, 2015). In qualitative studies, generalisability is often limited due to the smaller sample sizes. Nonetheless, qualitative researchers recognize that generalisability is difficult to determine. Instead, the focus is on the reliability and validity of the data, which is ensured by representing participants who share similar experiences within the study's specific context. In this study, the SRH experiences of rural women in uMkhambathini are not intended to be generalized to the experiences of women in other rural areas. The findings provide a framework

for other rural women to draw insights from, particularly those that resonate with the context of rural women in uMkhambathini.

- ***Reliability and validity***

In qualitative research, both reliability and validity refer to the consistency and trustworthiness of the findings. These concepts ensure that the results are stable and could be replicated—meaning that if the study were conducted again under similar conditions, comparable outcomes would emerge. Unlike in quantitative research, where reliability and validity are typically assessed using statistical methods, qualitative reliability and validity are maintained through strategies like transparency in data collection, thorough documentation of research processes, and researcher reflexivity. According to Hajjar (2018), reliability in qualitative research is assessed by selecting participants who have directly experienced the phenomenon being studied, which also supports the *validity* of the findings by ensuring that the data accurately reflect the perspectives of those with lived experience. He further emphasizes that including irrelevant participants may divert the researcher's focus, thus compromising both the reliability and the validity of the study's core objectives. In this study, the reliability and validity of the data were reinforced by including rural women from uMkhambathini, who were eager to share their authentic experiences with sexual and reproductive health (SRH) services.

4.22 Data protection

4.22.1 Focus Group Interview Stage

Data analysis took place several weeks after the data collection phase was completed. I transcribed and analyzed the data independently, ensuring that it was not shared with anyone. The data were securely stored on encrypted devices and protected by passwords. To cross-check during data analysis, the transcripts were stored in a password-protected email. Information was kept on my personal desktop computer, laptop, hard disk, and memory sticks, all of which were also password-protected. Any hard copies or written materials were stored in a secure cabinet within a locked room, with restricted access to ensure compliance with ethical data protection requirements. Both the written and electronic data will be stored for five years. However, interview written responses will be disposed of once they are no longer necessary. The study's results will be shared with the

UKZN library and other search engines, and a written feedback report in isiZulu will be provided to the research participants or relevant community members in the uMkhambathini rural area.

4.22.2 Data Collection Experiences

Anthropological researchers often engage in reflective practice. This reflection allows them to consider the challenges they encountered, which can provide valuable insights for future researchers. Such reflection helps to better prepare future researchers and can contribute to avoiding delays during data collection.

4.22.3 Cultural and Linguistic Barriers

Researchers must be fully aware of the challenges within their study and proactively plan for potential obstacles, as these can influence the timing and overall flow of the research. From the onset of this study, I was conscious of the fact that, in AmaZulu culture, women may need permission from their husbands or partners to participate in the research. Consequently, I allowed sufficient time for eligible participants to discuss their participation with their husbands or partners. In this context, women had the option to contact me, or I would reach out to them only with their consent. As a result, there was a situation where one woman chose not to participate, citing personal reasons.

I was also mindful of the importance of using the participants' mother tongue during the interview sessions to ensure that they could express their experiences in the most comfortable and accurate way possible. This approach improved communication between the researcher and participants. However, one case arose where a woman who spoke isiXhosa was screened for eligibility based on her ability to understand isiZulu. It was later found that she did not meet the residency criteria for uMkhambathini, eNkanyezini, as required by the study. As a result, she was excluded from participation.

Women in uMkhambathini, eNkanyezini, KwaZulu-Natal, often encounter significant cultural and linguistic barriers when accessing sexual and reproductive health (SRH) services. Deeply ingrained traditional beliefs about gender roles and sexuality frequently discourage open conversations about reproductive health, leading to misinformation and stigma. Many women fear judgment from healthcare providers and community members, especially in rural areas where patriarchal norms

prevail. Additionally, language barriers exacerbate the problem, as medical terminology is typically presented in English or formal isiZulu, making it difficult for some women to fully grasp their health options. The lack of culturally sensitive communication further alienates them, limiting their ability to make informed decisions about contraception, maternal care, and sexual health screenings. Addressing these barriers necessitates the integration of culturally appropriate health education and ensuring that healthcare providers are trained to engage with women in ways that respect their linguistic and cultural contexts.

4.22.4 Handling and Managing Distress During Focus Group Interviews

The face-to-face focus group interviews involved in-depth questioning, requiring the research team to listen carefully and respond thoughtfully to participants' answers. While listening is crucial in qualitative research, it can unintentionally cause harm, particularly in sensitive settings. It was anticipated that some women might feel challenged, shy, or stressed when expressing their emotions during the interview. To mitigate potential distress, arrangements were made with available clinic counselors before the data collection phase, in case any participants required emotional support due to past trauma. These arrangements were facilitated through local dignitaries, and a letter of assistance from the municipality was obtained to ensure support.

Additionally, the presence of a research assistant helped create a comfortable environment, encouraging participants to openly discuss women's issues. All participants were informed that they could withdraw from the interview at any time if they felt uncomfortable or if answering the questions affected their mental well-being. Throughout the five focus group interview sessions, all 30 participants remained comfortable and were given the option to pause the session if needed, resuming once they felt ready. During these breaks, the research team focused on lighter topics unrelated to the study, such as discussing participants' children's names or personal interests, to divert attention and provide emotional relief.

Interrupting the interview and offering support when participants showed signs of distress highlighted the research team’s awareness of their vulnerability and their right to a respectful, supportive, and safe research environment.

4.23 Experience of focus group interviews

4.23.1 Successes:

- **Positive Cultural Behavior and Community Support:**

  The Umkhambathini area demonstrated positive cultural behavior, with strong respect for elders, and the presence of a monarchy that helped maintain tradition.

  The involvement of municipal leaders and Induna (local chiefs) facilitated substantial support and cooperation from the people of uMkhambathini.

  Cordial interactions between the researcher, gatekeeper, and municipal dignitaries contributed to establishing trust and comfort in the field.

- **Data Collection and Trust Building:**

  The first round of focus group interviews, conducted in August 2023, set the tone for a positive and encouraging start to the fieldwork.

  Natural social interactions were a significant achievement during the data collection process.

  Trust was successfully built with the community, resulting in smooth cooperation during the fieldwork.

- **Focus Group Interviews:**

  The researcher conducted multiple rounds of focus group interviews between August 2023 and July 2024, collecting valuable insights into women's sexual and reproductive health (SRH) experiences.

  Purposive and snowball sampling techniques were effectively employed, resulting in a thorough selection of participants.

- **Exploration of Cultural Contexts:**

  The qualitative research uncovered cultural beliefs and practices, such as the differences between Shembe followers and Christians, and how these impacted women's experiences with SRH services.

- **Research Site Selection:**

Choosing the uMkhambathini area for the study proved to be a unique and valuable decision, offering significant potential outcomes. The study was conducted where sexual reproductive health issues had not be explored through research.

4.23.2 Failures/Limitations:

- **Delays in Gatekeeper and Ethical Clearance:**

  One major limitation was the delay in obtaining gatekeeper clearance from local dignitaries, which postponed the data collection phase.

  The researcher had to establish relationships with local dignitaries, which further delayed the approval process.

  Waiting for ethical clearance from the University of KwaZulu-Natal caused additional delays, hindering the commencement of the research for several months.

- **Geographical Distance:**

  The physical distance between the researcher's residence (Oribi Pietermaritzburg) and the research site (Umkhambathini) posed logistical challenges.

  The researcher had to spend a full day in the eNkanyezini area to gain a deeper understanding, which further complicated the research process.

- **Gender Stratification and Healthcare Limitations:**

  Women in the uMkhambathini area experienced gendered limitations in accessing healthcare, as most women are primarily mothers and wives.

  These traditional roles affected women's ability to fully engage with healthcare services, leading to social and age stratification within the community.

- **Shembe Religion as a Limitation:**

  The strong presence of the Shembe religion in the area created a limitation for research participation, as their religious observance on Saturdays conflicted with the availability of participants.

  As a result, the researcher had to seek alternative participants who were not part of the Shembe community. This led the researcher to spend more time during data collection.

- **Geographical Landscape:**

  The geographical layout of the research site created additional challenges, as the researcher had to travel long distances to engage with participants and collect data.

  The selected research location was far from the gatekeeper's residence, making logistical coordination for data collection more complicated.

4.24 Additional Insights:

- **Gendered and Social Stratification:** The research highlighted deep insights into gender, social, and age stratification, which significantly impacted women's access to sexual and reproductive health services.

4.25 Methodology-Based Findings

Conducting focus groups proved to be a valuable method for exploring women's experiences, providing valuable insights and feedback from my target audience. However, I encountered several common challenges and pitfalls during the process. Recognizing these obstacles beforehand helped me navigate them effectively, ensuring the success of my five focus groups, each consisting of six members.

4.25.1 Group Dynamics

Managing group dynamics was one of the most challenging aspects of conducting focus groups. The debate often became unbalanced due to participants' varying personalities, levels of involvement, and communication styles. Some individuals were reluctant to speak up, while others dominated the discussion. To overcome this, it was essential to set clear ground rules, promote equal participation, and skillfully moderate the conversation to ensure that everyone’s opinion was heard.

4.25.2 Lack of Diversity

Another challenge was the lack of diversity among the participants. It is crucial that the sample reflects the target audience. In my case, the participants in the focus groups had different demographics and viewpoints, which may not have provided a well-rounded perspective. To address this, I made a conscious effort to include a range of age groups, genders, ethnicities, socioeconomic backgrounds, and other relevant characteristics to obtain more comprehensive insights.

4.25.3 Groupthink and Bias

Focus groups can sometimes be susceptible to groupthink, where participants adopt the dominant perspective or social norms. This can lead to biased remarks that do not reflect the full range of viewpoints. To minimize this challenge, I encouraged opposing views, fostered a judgment-free atmosphere, and probed deeper to uncover participants’ genuine ideas and feelings.

4.25.4 Limited Sample Size

While focus groups can yield valuable qualitative data, it is important to keep in mind that they only represent a small sample size. As a result, the findings may not be statistically significant or fully representative of the larger population. To compensate for this limitation, I supplemented focus group findings with additional research methods, such as interviews, to triangulate and validate the data, offering a more comprehensive understanding.

4.25.5 Controlling the Discussion

Moderators must strike a delicate balance between guiding the conversation and allowing it to flow naturally. It was essential to maintain the discussion's focus on the study's goals while encouraging free expression of participants' thoughts. To ensure I gathered the necessary information, I needed to be vigilant about digressions and skillfully steer the conversation back to the main topics when needed.

4.26.6 Time Management

Time management was another challenge, as focus groups often have a set time limit. It can be difficult to cover all the targeted subjects within this constraint. To address this, I carefully organized the discussion guide, prioritized the most important questions, and kept the session on track to avoid time wastage. Being prepared to adjust and make quick decisions in response to the flow of conversation helped make the most of the limited time.

4.25.7 Analysis and Interpretation

The analysis and interpretation of the data commenced immediately after the conclusion of the focus group sessions. Unlike quantitative research approaches, which rely on numerical data and statistical analysis, analyzing focus group data is inherently more subjective and time-intensive due to its qualitative nature. The process involved meticulously identifying patterns and recurring themes within the responses, followed by systematic coding and transcription of the material. Recognizing these typical challenges allowed me to adopt a more organized and strategic approach to conducting and analyzing the focus groups. To navigate these complexities effectively, I adapted my strategy to align with the specific context and objectives of the research. This included refining the moderation style, ensuring a conducive environment for open dialogue, and actively listening

to participant feedback to identify nuanced insights. When thoughtfully designed and carefully moderated, focus groups can generate rich and valuable information, offering profound insights into experiences with sexual and reproductive health services.

4.26 Demographic data

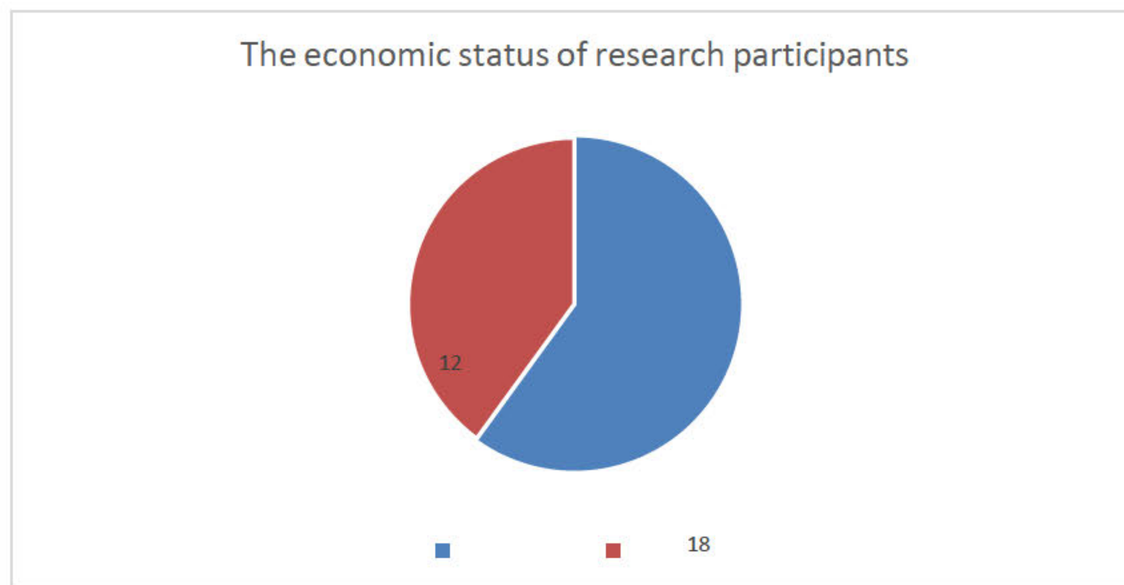
In qualitative research, presenting demographic data helps the reader understand the characteristics of the sampled population. This is essential for ensuring the reliability and validity of the study, as demographic information provides evidence that the research is grounded in the experiences of real people. In the context of Critical Medical Anthropology (CMA), the presentation of demographic data is particularly important because it enables researchers to identify variables that either facilitate or hinder access to, and utilization of, health-related services. The data presented here includes information from 30 participants, all aged between 18 and 49 years. A more detailed discussion of this data will be provided in the next chapter. The table below presents macro-level data on age, marital status, sexual and reproductive health (SRH) service use, SRH knowledge, number of children, level of education, religion, and employment status.

Parti No.	Age	Marital status	SRH service use	SRH knowledge	Number of children	Level of education	Religion	Employment status
1.	18	Single	No	No	None	Grade 12	Shembe	Unemployed
2.	19	Single	No	No	1	Grade 12	Shembe	Unemployed
3.	25	Married	Yes	No	2	Grade 12	Shembe	Employed
4.	20	Married	No	No	2	Grade 12	Shembe	Employed
5.	22	Married	No	No	3	Grade 12	Shembe	Unemployed
6.	19	Married	No	No	1	Grade 12	Shembe	Unemployed
7.	30	Single	Yes	Yes	4	Grade 12	Christianity	Unemployed
8.	28	Single	No	No	2	Grade 12	Christianity	Unemployed
9.	22	Married	Yes	Yes	2	Grade 11	Traditional	Employed
10.	24	Married	Yes	Yes	2	Grade 12	Shembe	Employed

11.	24	Married	No	No	2	Grade 12	Shembe	Employed
12.	30	Single	No	No	2	Grade 12	Christianity	Unemployed
13.	34	Married	No	No	3	Grade 11	Christianity	Employed
14.	31	Married	No	No	2	Grade 10	Christianity	Unemployed
15.	33	Married	No	No	4	Grade 11	Shembe	Employed
16.	40	Married	No	No	6	Grade 9	Shembe	Unemployed
17.	38	Married	No	No	5	Grade 11	Shembe	Employed
18.	47	Widowed	No	No	6	Grade 7	Shembe	Employed
19.	37	Widowed	No	No	1	Grade 12	Shembe	Employed
20.	48	Widowed	No	No	2	Grade 12	Christianity	Unemployed
21.	35	Widowed	No	No	2	Grade 12	Christianity	Unemployed
22.	28	Single	Yes	No	1	Grade 12	Traditional	Employed
23	21	Married	Yes	No	1	Grade 12	Traditional	Unemployed
24.	22	Widowed	Yes	Yes	1	Grade 9	Traditional	Unemployed
25.	19	Married	No	Yes	1	Grade 12	Christianity	Unemployed
26.	23	Married	No	No	2	Grade 11	Shembe	Unemployed
27.	27	Single	Yes	No	2	Grade 10	Shembe	Unemployed
28.	29	Single	Yes	No	2	Grade 12	Christianity	Unemployed
29.	42	Married	No	Yes	3	Grade 7	Traditional	Unemployed
30.	39	Married	Yes	Yes	2	Grade 12	Traditional	Employed

The table above highlights the determinants that either facilitate or hinder the realization of sexual and reproductive health (SRH) in the study context. It is noteworthy that the data collection attracted rural women from diverse social categories. Data was gathered from married, widowed, and single women, with the lowest level of education being Grade 7. The majority of rural women in uMkhambathini lack a proper understanding of SRH, which reflects the health illiteracy referenced by scholars in Chapters 1 and 2 (see Mwambwa-Johnson, 2021; Deliktas, 2016; World Health Organization [WHO], 2016; and Shieh & Halstead, 2009). These dynamics are impacting the SRH experiences of women in the rural uMkhambathini context.

4.26.1: The economic status of research participants



Ndlovu (2022) explained in her study that the economic status of rural areas plays a significant role in determining how women access health information and facilities. In South Africa, unemployment is defined as the proportion of the economically inactive population (Brynard, 2011). The pie chart above shows that the majority of women in rural areas were unemployed during the study. According to Gender Theory, the experiences of rural women are often more challenging than those of their urban counterparts. Rural women face significant barriers when it comes to accessing sexual and reproductive health (SRH) services and health facilities.

4.27 Chapter conclusion

This chapter focused on the methodology used in the study. It provided an overview of the research area, describing how the uMkhambathini Local Municipality borders the uMgungundlovu District Municipality to the southeast. The chapter also included an assessment of the study setting, which was conducted in a rural area of KwaZulu-Natal, specifically eNkanyezini, near the city of Pietermaritzburg, where the majority of the amaZulu population resides in South Africa. It highlighted the context of rural settings, noting that rural areas in South Africa are typically characterized by sparsely populated land with small villages or towns.

The chapter explained the research design, emphasizing the qualitative approach, which has gained significant attention in recent social science research. It also discussed the phenomenological and interpretivist paradigms. The data collection and analysis methods used in the study were outlined, focusing on the contextual barriers that affect women's access to and use of sexual and reproductive health (SRH) services in uMkhambathini, eNkanyezini.

The chapter further detailed the fieldwork recruitment strategy for the study participants, which involved focus group interviews. These interviews were conducted with groups of six pre-screened participants to ensure they were qualified to speak on the topic of interest. Purposive and snowball sampling techniques were employed to recruit a sample of 30 women. The chapter also explained the use of thematic analysis in the study and its role in interpreting the data. Finally, it addressed the research limitations, successes, and experiences encountered throughout the study, providing insights into the uMkhambathini eNkanyezini fieldwork. Chapter 5 will focus on data presentation and analysis.

CHAPTER FIVE

Setting the context: Demographic data analysis

5.1 Introduction

This chapter presents the demographic data of the participants for analysis. The previous chapter outlined the study's methodology. The aim of this research is to understand how women in the rural settlements of uMkhambathini describe their experiences with sexual and reproductive health (SRH) services. Therefore, this chapter provides the context for analyzing the demographic data and situates SRH services within the rural setting of uMkhambathini. Chapter one of this thesis emphasized that the reproductive and sexual health rights of millions of African women remain unmet. Rural communities continue to suffer from inadequate SRH services, contributing to the high prevalence of HIV/AIDS, elevated maternal and infant mortality rates, unsafe abortions, and increased rates of sexually transmitted infections. By presenting the demographic data of the research participants, this chapter lays the foundation for the study's analysis.5.2 Participant age representation.

In medical anthropology, age is crucial for understanding access to healthcare services, particularly sexual and reproductive health (SRH). The diagram below shows the ages of the 30 women from uMkhambathini, eNkanyezini, who participated in the study through focus group interviews. The accompanying table presents the age distribution of the participants. This distribution is key to assessing how age influences access to and use of SRH services. Understanding these age differences is essential for identifying potential barriers or unique needs within different age groups. The study highlights the impact of age on healthcare accessibility, offering insights into the challenge's women face in accessing SRH services in this community. By examining these patterns, the research aims to inform policies and interventions tailored to the specific needs of women at different life stages. It also emphasizes the importance of considering demographic factors when designing programs that address the health disparities faced by various age groups. This approach is crucial in improving overall health outcomes and reducing inequities in SRH access.

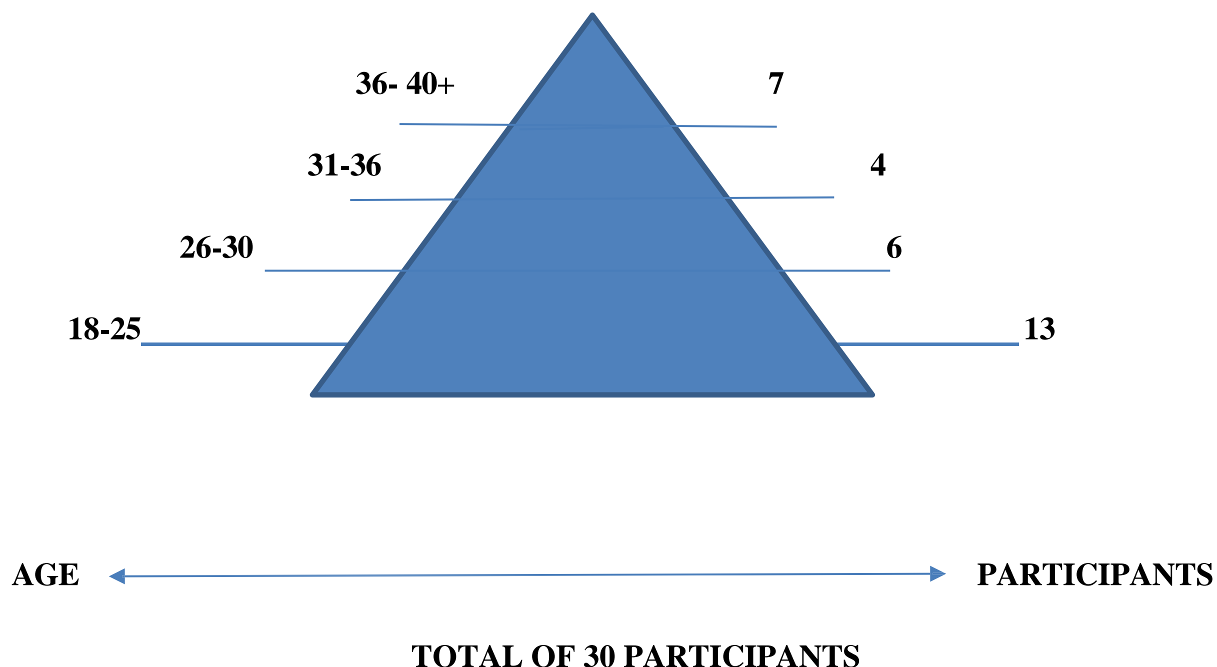


Diagram 5.2 The diagram represents the ages of women who participated in the study, which focused on their experiences with sexual and reproductive health (SRH) services in uMkhambathini, eNkanyezini. Their willingness to participate contributed to the diversity of the study, as the women are at various life stages. This diversity provides valuable insights into the SRH service challenges faced by both young and middle-aged women, who share different experiences with SRH services. The participants' ages range from 18 to 49 years.

Singh, Jogee, and Chareka (2018) report that currently, 10.5 million children in Eastern and Southern Africa have lost one or both parents to AIDS. The study required participants to be at least 18 years old, as this is the prescribed age for consent. Excluding underage participants helped manage time and avoid delays, as obtaining consent from parents of participants under 18 would have posed significant challenges. Additionally, involving minors would raise various ethical concerns and limitations due to the sensitive nature of the questions in the data collection instrument. The process of assembling all parents in a timely manner could have further complicated the study.

Furthermore, the data indicates that participants were primarily under 50 years old. It is important to note that uMkhambathini is a rural area, where older individuals may be more conventional, meaning they could be highly traditional. This could present limitations on what questions can be asked and answered. Since the study focuses on sexual and reproductive health (SRH) services, it may provoke mixed reactions from older participants due to the sensitive nature of the questions. These services might be uncomfortable for the older generation of rural women, who may need clarification on such topics. Consequently, the data suggests that many younger women from rural uMkhambathini were more willing to participate in the study. The diagram shows 13 participants between the ages of 18 and 25, which is a positive indication, as these individuals are in their childbearing years. Therefore, it is essential to assess their knowledge and experiences with SRH services, as they are a high-risk group for illness and disease.

According to Singh, Jogee, and Chareka (2018), the risk of contracting HIV is higher among girls and young women. The prevalence of HIV among young women aged 15 to 24 is currently 4.8%, which is 2.5 times higher than in men in the same age group. In Swaziland, the HIV prevalence among young women is 15.6%, compared to 6.5% in young men. Singh, Jogee, and Chareka (2018) argue that the global agenda offers opportunities to ensure the effective implementation of both new and existing HIV prevention, treatment, and care policies and programs to benefit youth. These include key population policy briefs (WHO, 2012; Singh, Jogee, and Chareka, 2018), the 2013 guidelines for HIV care and treatment for adolescents living with HIV, and the 2012 guidelines on Pre-exposure oral prophylaxis (PrEP) for men, transgender women, and high-risk couples. These groups are of childbearing age.

The diagram shows that some participants feel psychologically prepared to have a child in their 20s, while others do not. Childbirth can bring emotional and psychological challenges, requiring patience, flexibility, planning, a willingness to seek help when needed, and empathy (McLaren, 2020). Six of the 30 participants were between the ages of 26 and 30. It is important to note that they gained valuable insights into SRH services during their participation. They expressed that more young people in rural areas and other groups need access to SRH information. This could help minimize teenage pregnancies and school dropouts—issues that many of these women identified as significant challenges. The increase in teenage pregnancies has various consequences,

including financial and psychological limitations, which can make childbirth more stressful, exhausting, or less rewarding.

The diagram also shows that 4 participants out of 30 were between the ages of 31 and 36. These more mature mothers face distinct SRH limitations and challenges. Recent global guidelines have explicitly urged countries to review their existing policies and consider revisions to address age-related barriers to access and uptake of SRH services, including HIV Counselling and Testing (HCT), as well as linking prevention, treatment, and care services. HIV remains a significant issue in the Southern Africa sub-region, which includes Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe, with each country having an adult HIV prevalence rate of over 10% (Singh, Jogee, and Chareka, 2018). A study titled "Barriers and Enablers to Young People Accessing Sexual and Reproductive Health Services in Pacific Island Countries and Territories" highlights the belief that premarital sex is taboo. The study argues that teaching young men and women about sex would encourage them to engage in premarital sex (Baigry et al., 2023). This belief is why parents, elder relatives, and community members often feel uncomfortable discussing sexual matters with young, unmarried individuals. Additionally, both young people and medical professionals may be unwilling to talk about SRH issues (Baigry et al., 2023). It is also evident from my study that many married women agreed to participate, which could suggest a promising outcome for the research.

5.3 Participant marital status representation

Marriage is a social engagement that plays a significant role in shaping sexual and reproductive health (SRH) services. As a result, marital status continues to influence the choices of rural women. The table presents the marital statuses of the women who participated in the study from uMkhambathini, eNkanyezini. These 30 women, who took part in the focus group interviews, helped generate the data shown in the diagram. The table categorizes the participants into three groups: single, widowed, and married.

Marital status	category
Married	16
Widdowed	7
Single	7

The **table 5.3** above represents the marital status of 30 women from uMkhambathini, eNkanyezini. Marriage in rural areas is seen as a significant social engagement, contributing to a woman's social status and acceptance within the community. However, it also imposes socio-cultural restrictions, especially in the context of sexual and reproductive health (SRH). In such settings, married women are often expected to seek approval from their husbands and show obedience and respect, which is deeply rooted in cultural norms. This cultural context influences the way SRH services are perceived and accessed.

In this study, the role of married women provided a unique perspective on childbearing, as well as the challenges they face when using SRH services. These challenges are often linked to patriarchal traditions, where women are considered secondary to men in marriage. As a result, marriage can be both a positive and negative force in the lives of rural women. This dynamic is particularly evident in uMkhambathini, where marriage plays a complex role in determining access to SRH services.

The data reveals that 17 out of the 30 participants were married. Many of these women shared narratives highlighting how marriage often limits their autonomy, particularly when it comes to healthcare decisions. Once married, they feel bound by responsibilities and expectations that leave little room for personal agency, including in the realm of healthcare. This aligns with broader societal beliefs that marriage brings social respect and status, which sometimes overshadows individual needs, including access to healthcare. Sociologically, marriage is seen as a critical achievement for women, as discussed by Waters and Waters (2016), and often holds a significant place in rural communities like eNkanyezini.

Many of the married women in this study are young, which can further complicate their ability to navigate emerging reproductive challenges. As observed in regions like West and Central Africa,

where polygamous marriages are common, adolescent brides often struggle to make informed sexual decisions, placing them at higher risk for sexually transmitted diseases (Lowe, Joof, and Rojas, 2019). These findings emphasize how cultural expectations and marital status intersect to shape health-seeking behaviors, often limiting access to SRH services and putting women at risk.

This situation may also explain the higher rates of early motherhood in the sub-Saharan African region. In many rural communities, there is immense pressure on women to conceive shortly after marriage, resulting in early pregnancies, short intervals between births, and larger family sizes. For example, in 2009, over 13.4% of women between the ages of 20 and 24 gave birth before the age of 16, and about 31% gave birth before they turned eighteen. The institutional value placed on marriage in rural areas may contribute to the devaluation of women's reproductive choices and restrict their ability to negotiate safer sex and other critical decisions.

Cultural and religious practices, combined with a lack of SRH knowledge, contribute to these issues. Misconceptions about SRH services and the restrictive nature of intergenerational dialogue in rural communities also hinder young people's ability to access accurate sexual health information. The study by Nkonde, Mukanga, and Daka (2023) explores similar challenges in Zambia, where male partners often influence women's decisions regarding family planning, sometimes restricting access to contraception due to fears of abuse, infidelity, or concerns about side effects. These gendered power dynamics limit women's ability to make informed decisions about their reproductive health.

Furthermore, the World Health Organization (2009) has noted that early pregnancies increase health risks for both mothers and babies. Biological, behavioral, social, and economic factors, along with limited access to healthcare services, exacerbate these risks. In this study, 7 out of 30 participants were single. While these women may not be married, they are still engaged in sexual relationships, and their experiences with SRH services are just as critical.

The study illustrates that both single and married women face distinct health challenges, and both groups are exposed to life-threatening issues. It is essential to recognize that, while single women might experience unique risks associated with sexual activity, married women are not immune to these challenges either. In rural settings like uMkhambathini, single women often face

marginalization when seeking SRH services, as they may be stereotyped as promiscuous or assumed to have multiple sexual partners. Despite these challenges, the inclusion of single women in the study highlights the importance of SRH services for all women, regardless of their relationship status. The data underscores that SRH services are essential for improving the health and well-being of women in rural communities, especially considering the social and health-related vulnerabilities they face.

Participant 8 *explained that being older and single in our community is categorised as "ukushima" someone who does not attract men "amadoda".*

Participant 12 joined the conversation by narrating that when you are known to be single in our community, you are categorised as someone who is spreading infections. There is a lack of knowledge including that it is an individual choice to be single. Women who are in a marriage institution think they are safer from sexually transmitted illnesses than us women, but on the contrary, the community has laid to rest many married women than us single women. "Kanti babulawa yini abafazi emshadweni"? This has become an ongoing debate in our community. Abangaphakathi bafuna ukuphuma in the rate of deaths that the community has recorded. At first we thought women were dying because of COVID-19, not they get skinny and die. It's painful that women die more than men in our community.

The stigma associated with being widowed in rural communities often leads to the perception that widows are engaging in risky sexual behaviour. This societal pressure magnifies the reproductive challenges that women face, as their decisions regarding sexual and reproductive health are closely scrutinized by the community. Such stigma can impede women's efforts to maintain healthy sexual and reproductive lives. According to Shisana et al. (2004), unmarried and divorced women were more likely to use condoms or abstain from sex as preventive measures, in comparison to married women. The survey found that married women felt 45% more likely to contract HIV than divorced or separated women (53%), while single women felt 25% more likely to contract the virus. Cultural practices like polygyny can influence a married person's likelihood of contracting HIV, either increasing or decreasing the risk. Additionally, cultural expectations around extramarital affairs, where it is deemed acceptable for men to engage in such behavior but not for women, also play a significant role in these dynamics. The table above also highlights that 5 out of the 30 participants

were widowed. Among the married participants, 8 out of 30 were under 25 years old, revealing concerns about young rural women in communities like eNkanyezini, who are expected to assume the roles of wives, mothers, and sisters. The participation of widowed women in the study provided valuable insights into their unique experiences outside of marriage. These women, who have transitioned from being single to married and later widowed, shared their narratives, contributing to a broader understanding of SRH experiences. There is a possibility that these widowed women remain sexually active and have expressed interest in using SRH services. Some also demonstrated prior knowledge of SRH services. Their inclusion in the study offers a more complete view of women's reproductive and healthcare experiences within rural communities. However, cultural beliefs surrounding widowhood in rural areas, such as uMkhambathini, may act as additional barriers for widowed women seeking to lead independent sexual and reproductive lives. The traditional marriage structures established within family unions often persist long after a husband has passed, which may prevent widowed women from engaging in sexual activities freely. In some cases, widowed women may even remarry within the same family, a practice that may not guarantee their safety in sexual practices with a new partner. In Kenya, Agot et al. (2010) examined how traditional practices, such as widow inheritance (WI), sexual cleansing, and male non-circumcision, have contributed to disproportionately high HIV prevalence. In 2007, 1.4 million people aged 15-49 in Kenya were estimated to be HIV positive, with a prevalence of 7.4%. Widow inheritance, a longstanding cultural practice where a male relative assumes responsibility for a widow’s financial and social needs after her husband's death, has been identified as a major contributing factor to the high HIV rates among the Kenyan Luo population.

5.4 Participants' Use of SRH Services

As discussed in Chapters One and Two, the contributions of Critical Medical Anthropologists and the Anthropology of Women have highlighted that rural women are often excluded from accessing knowledge about SRH (Deliktas, 2016). These scholars have played a significant role in emphasizing the importance of improving SRH health literacy for rural women, with the goal of increasing their life expectancy. Understanding how SRH services are used is crucial to grasping their context in uMkhambathini and eNkanyezini. The table below represents the use of SRH services by the women who participated in this study from uMkhambathini, eNkanyezini. The age

of the participants is particularly important in assessing access to and use of SRH services. A total of 30 women participated in the focus group interviews, providing valuable insights into their experiences.

Use of SRH (Yes/No)	Sum of participants
No	20
Yes	10

Table 5.4 shows that 20 out of 30 participants were using some SRH services, such as contraceptives, PrEP, and ARVs. This indicates that less than half of the participants reported not using SRH services, which is concerning given the low response rate. Several factors could have contributed to this situation, including clinic staff discrimination, poor doctor-patient confidentiality, community misinformation, and limited clinic resources. Notably, there is only one clinic operating in the area, which may contribute to high HIV transmission rates and teenage pregnancies. These factors emerge as structural and functional barriers for women in eNkanyezini.

One critical component of intervention efforts is the use of contemporary family planning techniques, especially following childbirth (Demissie et al., 2022). Under the broader objectives of population health and well-being and gender equality, the 2030 Agenda for Sustainable Development Goals (SDGs) includes specific targets for increasing the use of contraceptives (Demissie et al., 2022). Family planning services are essential for improving living standards, as they reduce the risk of unintended pregnancies and the associated negative effects, such as HIV/AIDS, abortion, and maternal and child morbidity and mortality (Demissie et al., 2022). Data from 51 surveys conducted between 2006 and 2013 revealed that 41% of women in Sub-Saharan Africa who intended to use modern contraceptives were not doing so, despite the fact that preventing unintended pregnancies could prevent 30% of maternal fatalities and 10% of infant deaths. In 2010, only 17% of married women in Sub-Saharan Africa used contraceptives,

a significantly lower rate than in North Africa (50%), the Middle East (39%), East Asia (76%), and Latin America (68%) (Demissie et al., 2022).

This low utilization of SRH services could present various health concerns for women in the rural area of uMkhambathini, including increased pressure on both local and national healthcare systems. This pressure on local healthcare may result in overworked clinic staff and poor service delivery. The relationship between low SRH service use and healthcare-related challenges for rural women is likely rooted in knowledge gaps. Many South Africans in rural areas still lack access to affordable, high-quality, universal healthcare, despite significant government investment in strengthening the healthcare system (Gumede, Taylor, and Kvalsvig, 2021). There is also evidence of a shortage of health professionals in rural areas, which share characteristics similar to many other sub-Saharan African countries, including high sickness rates, high unemployment, and subpar healthcare services in public health facilities.

The data above may reflect a microcosm of SRH service use, highlighting the reproductive health limitations women face in rural settings. These limitations may stem from rural social constructs, including patriarchal and stereotypical ideas that influence women's reproductive choices. Patriarchy often manifests in the control exerted by male partners in making reproductive decisions for women.

Drawing from the Critical Medical Anthropology, this study revealed the following narratives: A contextual response from research participants revealed that:

Participant 3 *"As a young woman living in uMkhambathini, I've always felt that accessing healthcare, especially sexual and reproductive health services, has been a major challenge. The nearest clinic is quite far from my home, and transportation is not always reliable. On one occasion, when I needed contraception, I had to wait for the mobile clinic to visit, which only came once a month. This delay made me feel anxious, and I realized how difficult it is for women in rural areas to access regular SRH services. It made me more aware of the barriers that come with living in such a remote area, where healthcare resources are limited."*

Participant 10 *"As a woman in uMkhambathini, I've always been aware of the cultural beliefs*

around sexual health. Talking about contraception or HIV testing is seen as taboo in my community. I remember the first time I tried to seek out information on sexual health, I was afraid of being judged by my peers and elders. When I eventually found a health worker who was understanding and confidential, I felt relieved, but I noticed that many women here feel too ashamed to even ask for help. It's clear to me that the stigma around SRH issues is a huge barrier to accessing services in our area, even when they are available."

Participant 15 *"I was fortunate to hear about a youth-friendly SRH clinic in a nearby town. I went there with my friend, and it was a very positive experience. The clinic staff were understanding, and I felt comfortable asking questions about contraception and sexually transmitted infections. What stood out to me was that they respected my privacy and gave me information that was relevant to my age and life stage. This experience made me realize that when SRH services are tailored to young people and are provided in a non-judgmental environment, it can make a huge difference in empowering us to take control of our sexual health."*

Participant 20 *"Growing up in uMkhambathini, I didn't have access to proper sexual education. My knowledge of SRH was limited, and I had to rely on word of mouth from friends and family, which wasn't always reliable. When I finally went to a local clinic, I found that there wasn't enough information on contraceptives or sexual health services in languages that were easy to understand. I felt that there should be more educational outreach in rural areas, especially for young women like me, who may not have the support or resources to learn about SRH in schools or from healthcare providers."*

Participant 25 *"In my community in uMkhambathini, women are often expected to fulfill traditional roles, which can make it difficult to prioritize our own health. I remember when I went to the clinic to seek advice about family planning, my partner was not supportive. He didn't understand why I wanted to take control of my reproductive health, and I felt pressured by his views. Many women in uMkhambathini face similar pressures, where traditional gender roles restrict our ability to make decisions about our bodies. It made me realize that promoting SRH services also requires addressing the cultural and societal expectations that limit women's autonomy."*

In examining the narratives of women in uMkhambathini, a critical medical anthropology lens uncovers the complex intersection of healthcare access, cultural norms, and gender roles that shape

sexual and reproductive health (SRH) experiences in rural settings. Participants in this study highlighted significant barriers to healthcare access, including long distances to clinics, unreliable transportation, and infrequent mobile clinic visits, which delay the ability to obtain essential services like contraception. These logistical challenges contribute to anxiety and a sense of isolation, particularly for women in remote areas. Furthermore, cultural taboos surrounding discussions of sexual health, as seen in Participant 10's account, reinforce stigma and create a climate of silence around SRH issues. Despite the availability of services, the fear of judgment often prevents women from seeking help, underscoring the need for more inclusive, culturally sensitive healthcare approaches. In contrast, when SRH services were tailored to the needs of young people in a non-judgmental setting, as described by Participant 15, it empowered them to make informed choices about their sexual health. However, knowledge gaps persist, as evidenced by Participant 20's reliance on unreliable sources for sexual education, further exacerbating the challenges faced by rural women. Finally, Participant 25's narrative highlights how traditional gender expectations restrict women's autonomy over their reproductive health, illustrating that SRH interventions must go beyond healthcare access and address broader cultural and societal norms that shape women's decision-making power. This study emphasizes the need for a multi-faceted approach to improving SRH services in rural areas, integrating healthcare accessibility with cultural sensitivity and gender empowerment.

A total of 10 out of 30 participants reported using any SRH services at the clinic. This could be seen as a negative indicator of healthy sexual and reproductive life, as more than half of the women do not utilize SRH services. Despite the benefits of SRH services, these figures suggest that the services are possibly less popular or even taboo among these rural women. According to Pliskin, Welti, and Manlove (2022), family planning clinics in rural locations are more likely to be understaffed, under-resourced, and staffed with doctors who have less training, particularly in the provision of contraceptives. In addition, rural patients face limited appointment availability, long travel distances, and challenges related to privacy and confidentiality. Hurdles to care for patients in rural areas are often related to cost, lack of health insurance, and poverty. Pliskin, Welti, and Manlove (2022) also emphasize that these restrictions disproportionately affect immigrants and rural residents of color. Notable differences in SRH service outcomes between rural and urban women can be attributed to care-related barriers, such as lower rates of pap tests in rural areas, higher rates

of unplanned pregnancies, and worse maternal and infant health outcomes. Women of colour in rural areas frequently experience disproportionately lower outcomes.

5.5 Participants' Response to SRH Service Knowledge

The triangulation of SRH service knowledge is essential in identifying misconceptions and misinformation. These misunderstandings can shape participants' perceptions of the available SRH services in uMkhambathini and eNkanyezini. A lack of understanding about SRH may be attributed to various factors, including cultural influences. Participants' level of SRH service knowledge is a crucial measure of health access and the utilization of necessary reproductive information. A total of 30 women participated in the focus group interviews.

Prior knowledge of SRH (Yes/No)	Sum of participants
No	23
Yes	7

Table 5.5 shows the number of participants who had prior knowledge of SRH before the study. The data reveals that 23 out of 30 participants reported having no prior understanding of Sexual and Reproductive Health (SRH) services. Many factors contribute to this gap in SRH service knowledge, including traditional cultural ties that shape perceptions of SRH. The table highlights that over half of the participants lacked prior SRH service knowledge, which is likely due to the rural nature of the area and the limited availability of SRH services. This lack of knowledge may also lead to misconceptions about the effects of some SRH services; for instance, there are beliefs that contraceptives can cause infertility. As a result, many women fear using these services due to social constructs, with unmarried women particularly concerned about not finding husbands.

Moreover, marriage in eNkanyezini is often seen as a priority, despite the limitations it places on sexual and reproductive freedom. In such a context, women may compromise their health needs to avoid the social stigma of being unmarried in the community. Sexual and reproductive health are sensitive topics, and in many parts of the world, discussions about sex face significant limitations.

This makes it difficult to obtain services and information about SRH, particularly in areas where access to contraception and abortion is constrained by cultural or religious views (HPA, 2018). Good sexual and reproductive health is largely dependent on having a fulfilling and safe sexual life, as well as the freedom to decide when and if to have children (HPA, 2018). Clear sexual health advice and information, along with the flexibility to choose from a range of contraception options without facing stigma or discrimination, are critical. Inadequate SRH services can contribute to the spread of HIV and other STDs, which can have serious consequences for health, livelihoods, and overall well-being, especially if those affected do not have access to diagnosis or treatment. Furthermore, only a small percentage of people in West and Central Africa use modern contraceptives, and some subregions of Africa have the lowest global prevalence rates of contraception. Consequently, there is a tendency to prioritize large families in certain areas, while family planning is rejected by some religious and societal beliefs (Davis and Moore, 2010). Mozambique, Niger, and much of Central Africa report some of the highest total fertility rates (TFR) in the world, with Niger having the highest overall fertility rate in the study. In contrast, South Africa has a substantially lower TFR than most other sub-Saharan African nations (Davis and Moore, 2010). East and Southern African nations reported the highest rates of contraceptive use during this time. Southern Africa also has higher rates of modernization, urbanization, school-based education, and male involvement compared to other sub-Saharan African regions.

A total of 7 out of 30 participants had some prior knowledge of SRH services. This indicates that SRH service knowledge remains limited, with concerns about the conservative nature of people, especially parents and clinic staff. Participants expressed that they felt their children should not be taught about sexual and reproductive health, believing it would protect them from engaging in sexual activity. This reflects the hesitation and fear surrounding sexual conversations in rural families, creating limitations on accessing SRH information and services. As a result, many individuals may turn to indigenous medicines and engage in delayed or inadequate health-seeking behavior. This creates further complications and risks for reproductive health. Additionally, many women associated illness caused by reproductive health issues with witchcraft. The strong belief systems, which include church and traditional views, create more barriers for women seeking SRH services. It is possible that the women of eNkanyezini knew about SRH services but did not fully understand the full range of available services. Localized health structural and functional limitations

may hinder the dissemination of SRH service knowledge. The social structures, rooted in conventional family dynamics and gender roles, heavily influence women's choices regarding SRH. Many perceptions and expectations about women in rural areas are central to shaping their decisions. Furthermore, discussions about SRH are often considered inappropriate for young women and girls to engage in with their parents, which may hinder the distribution of valid SRH service knowledge. Functional limitations, such as the clinic staff's approach to SRH services, also play a role. The capacity of the clinic and available resources further impacts the accessibility and effectiveness of SRH services. The utilization of health services significantly influences health outcomes. According to Yao, Murray, and Agadjanian (2013), an individual's ability to access health services is a key determinant in how effectively they use those services.

5.6 Participants' Response on Number of Children

The number of children among participants is an important demographic detail. It is essential to consider this information when analyzing the intake of SRH services and understanding the barriers to family planning and SRH service use. The limitations surrounding women's access to SRH services are linked to various factors, including the resources available at the clinic and the capacity of the clinic staff. A total of 30 women participated in the focus group interviews.

No of children	Sum of participants
5-8	2
2-4	20
0-1	8

Table 5.6 discusses access to maternal health services during pregnancy and childbirth to ensure safe pregnancies for both mother and child. The data shows that only 8 out of 30 participants had between 0 and 1 children. This low number might signal that many women in the community had children at an early age. Several factors could contribute to this, including a lack of sexual and reproductive health (SRH) knowledge and limited SRH service use, as previously discussed in the diagrams. The low SRH knowledge may hinder young people's preparedness for sexual life, as many

rural youth reported never having sex education talks with their parents. This lack of communication may contribute to early pregnancies, unwanted pregnancies, and school dropouts. Consequently, there may be existing barriers to improving early SRH education in rural areas. Providing SRH knowledge is crucial for women to protect their health and make informed decisions about their reproductive lives. The absence of this knowledge deprives rural women of the sexual and reproductive choices they could make regarding their bodies.

Nevertheless, African fertility offers remarkable diversity, which is evident in the rising fertility rates in some regions, spanning from pre-transitional to replacement fertility. Although fertility rates have generally declined worldwide, the reasons for this decline remain largely unresolved (Ariho & Nzabona, 2019). A 2023 study by Tesfa et al. revealed varying fertility rates across sub-regions of Sub-Saharan Africa (SSA). The total fertility rate (TFR) for Eastern Africa was 4.74, for Southern Africa 3.18, for Central Africa 5.59, and for Western Africa 5.38. These variations reflect the unique socio-demographic, socio-political, economic, and cultural developments that shape fertility trends across different SSA countries (Tesfa et al., 2023).

The table also highlights that 20 out of 30 women participants had between 2 and 4 children. This demonstrates that many women in eNkanyezini have relatively small families compared to other rural areas. Gender roles play a significant part in shaping fertility choices, as early-age marriages often give men more control over decisions in the relationship. These dynamics are reflected in participants' narratives. Furthermore, there is a cultural belief that men prefer women who can bear children and take care of the family, which impacts women's decisions on SRH service use, especially in terms of family planning. Many individual participants expressed the view that men are more likely to stay with a woman who can bear children. These cultural beliefs create challenges for the utilization of SRH services, particularly in rural communities.

In comparison to other developing regions, Africa has experienced higher fertility rates in recent decades. This persistently high fertility has been linked to the region's lower level of socioeconomic development (Ariho & Nzabona, 2019). The TFR in Central and Western Africa exceeds the global average, with more than 50% of women in these regions marrying early, having their first sexual encounter, and giving birth by the age of 20. In contrast, countries like China have much lower rates of teenage motherhood, with only 2% of babies born to teenage mothers (Tesfa, 2023).

The table also indicates that 2 out of 30 women participants had between 5 and 8 children. This suggests that few participants have more than five children, which could be attributed to changing social arrangements and family values over time. The increasing trend of labor migration is reshaping family structures in areas like uMkhambathini and eNkanyezini. Families are striving for greater financial security, often resulting in fewer children. Gender theory suggests that unmarried women tend to hold more gender-egalitarian beliefs, while married women with children generally adhere to more traditional family structures (Davis & Moore, 2010). Little research has been done to determine whether having a first child, regardless of marital status, leads to a more conservative gender ideology for women, but parenthood is often associated with more traditional gender roles in many societies (Davis & Moore, 2010).

5.7 Participants' Response on Level of Education

Education plays a crucial role in disseminating SRH service knowledge. The level of education among women can range from primary to secondary to tertiary levels. Understanding the relationship between education and SRH knowledge is important for identifying misconceptions and misinformation that may hinder the use of SRH services in rural areas like uMkhambathini. The table below illustrates the education levels of the women who participated in the study from uMkhambathini and eNkanyezini. These 30 women, who took part in the focus group interviews, provided the data used in the table.

Grade	Sum of Participants
Grade 7	**2**
Grade 9	**2**
Grade 10	**2**
Grade 11	**5**
Grade 12	**19**

Table 5.7 shows that 19 out of 30 participants had Grade 12 as their highest level of education. This data also indicates that many rural women in eNkanyezini complete their secondary education, which is a positive sign as it provides a pathway to employment opportunities. However, this information suggests that while some women may receive adequate platforms to understand SRH

services, these services still remain a barrier for many. The diagram highlights that high school dropouts among women are present, though not widespread in eNkanyezini; still, a large percentage of women face economic marginalization. Factors such as early teenage pregnancies and challenging socio-economic conditions may play a significant role in these challenges. In addition, issues like limited healthcare resources and community values rooted in religious beliefs also act as structural barriers to accessing and utilizing SRH services. Collaboration between women who have completed Grade 12 and those who have not finished their studies could help foster a better understanding of SRH services. However, for those who dropped out of school, sexual education may be limited, further hindering their comprehension of reproductive health and SRH services. Lee and Yeo (2022) argue that early adolescence is a crucial period to introduce educational initiatives that lay the foundation for positive SRH outcomes. Implementing sexuality education in schools allows for reaching a significant number of young adolescents, and teaching them about sexuality at this formative stage—when their attitudes and behaviors are still developing—can have both immediate benefits, such as reducing risky sexual behavior and adolescent pregnancy, as well as long-term advantages that can enhance their overall well-being (Lee and Yeo, 2022).

Through the Critical Medical Anthropology as a theory, this study revealed the following narratives: A contextual response from research participants revealed that:

"I was in Grade 7, and I noticed that many of my friends were struggling with school. Some didn't show up regularly, and it seemed like they had lost interest. There was a lot of pressure, especially around puberty, and many of us were starting to get curious about relationships and sex. Some of my classmates talked about getting pregnant, and others were worried about STI risks, but we didn't really know enough to handle these situations. It was hard to focus on school when those issues were weighing on us." (Participant 7)

Grade 9:

"I was in Grade 9, and it was getting more difficult to keep up with school. I had friends who dropped out that year, mostly because they couldn't handle the stress of school, family expectations, or just didn't feel supported. A big challenge I noticed was the lack of proper sexual health education. Some of my peers made decisions based on rumors, which led to unwanted

pregnancies or contracting diseases. It was frustrating because there wasn't enough real talk in school about how to protect ourselves, and a lot of us were left to figure it out on our own." (Participant 23)

Grade 11:

"As a former Grade 11 student dropout, I saw so many people leave school early, mainly due to personal struggles or because they felt they weren't going anywhere. The biggest issue seemed to be how we were handling our sexuality. There was still so much stigma surrounding sex and relationships. A lot of us didn't have the support to deal with sexual health problems, and as a result, many ended up with unplanned pregnancies or STI scares. Our school did have some education programs, but it wasn't always enough to tackle the real-life issues we faced." (Participant 27)

"Grade 12 was a rollercoaster, and one of the things that stood out was how many of my peers were facing challenges related to sexual health. I heard of people who didn't even know how to properly use protection or how to access support when they needed it. The lack of comprehensive sexual education in school was a big issue. It wasn't just about avoiding pregnancy, but understanding how to take care of your health and well-being, and unfortunately, not all students got that chance before making risky choices." (Participant 17)

The narratives shared by the participants reveal the multifaceted challenges they faced regarding sexual health and education during their school years. These accounts can be interpreted through the lens of Critical Medical Anthropology, which emphasizes how socio-cultural and structural factors influence health outcomes. The participants' experiences highlight how the lack of comprehensive sexual education, societal stigma surrounding sexuality, and the absence of adequate support systems created an environment of confusion and risk for many students. For example, in Grade 7, the pressure of puberty and curiosity about relationships and sex led to an environment where students struggled to navigate these complex issues, as noted by Participant 7. Similarly, in Grade 9, Participant 23's account underscores how the absence of proper sexual health education left peers vulnerable to making decisions based on rumours, contributing to unintended pregnancies and STI risks. These

issues persisted into Grade 11, where stigma surrounding sexuality and a lack of real support further exacerbated the problem, as shared by Participant 27. In Grade 12, the gap in education and awareness continued to manifest in risky health behaviors, as demonstrated by Participant 17's reflection on the lack of practical, accessible sexual health knowledge. Overall, these responses highlight the need for a more comprehensive, culturally sensitive approach to sexual health education—one that recognizes the social determinants of health and addresses the structural barriers that young people face in accessing necessary information and support. Through the lens of Critical Medical Anthropology, it is clear that sexual health outcomes are deeply influenced by the interplay of cultural norms, educational systems, and societal expectations, all of which must be reconsidered in order to improve health and well-being for future generations.

The table shows that 5 out of 19 participants dropped out in Grade 11. This may be another consequence of lower SRH service knowledge. Women shared that being pregnant while in high school carries significant stigma from both teachers and students. This stigma, combined with health complications during pregnancy, may contribute to high dropout rates. Furthermore, the number and percentage of people between 18 and 64 without health insurance have increased, partly due to the historically high unemployment rates (Driscoll and Bernstein, 2012). The issue of unemployment and inadequate healthcare access reveals a significant disparity in the health decisions these rural women face regarding SRH services. It is important to note that many of these women lack viable alternatives when it comes to using SRH services, which ultimately affects their choices and the types of services they utilize.

The table also shows that four women participants dropped out in Grades 9 and 10. This suggests that getting pregnant in the early years of high school can be a collective disappointment, especially in eNkanyezini, a rural area where respect, behavior, and cultural traditions are highly valued. In such rural areas, some SRH services are criticized, while others are more commonly used, influenced by the socialization of specific cultural norms. According to the definition above, stigma refers to the negative judgment placed on a person due to a quality that others perceive as severely discrediting and devaluing them, reducing them from a whole and normal person to someone who is marginalized and disregarded. In many rural areas, such as eNkanyezini in uMkhambathini, stigma is pervasive. This is partly because relationships within small communities are often interconnected, and stigma

plays a unique role in rural healthcare settings. In South Africa, unplanned pregnancies among youth pose a significant public health concern, as they expose young women and their newborns to various health and social risks (Mbelle, Mabaso, Setswe, and Sifunda, 2018). These risks include unsafe abortions, maternal depression and anxiety, premature birth, and low birth weight. Additionally, unplanned pregnancies disrupt social stability, negatively impacting educational progress and future career prospects. Women with unintended pregnancies are more likely to have lower educational attainment and poorer financial outcomes compared to women who do not experience unintended pregnancies (Mbelle et al., 2018).

The table also highlights the issue of primary school dropout. In a traditional community like eNkanyezini, children engaging in sexual behaviors at a young age are strongly discouraged. However, despite this discouragement, participants expressed that they had never had sex-related conversations with their parents. Primary school education offers less sexual education than secondary education, which places young girls at a disadvantage in learning about SRH services early in life. Unplanned pregnancies often result from contraceptive failure and inconsistent or non-use of contraceptives, including inconsistent condom use (Mbelle et al., 2018). Several factors contribute to unplanned pregnancies among youth, including socio-economic, demographic, and behavioral factors such as low socio-economic status, age, living arrangements, peer pressure, sexual coercion, sex socialization, unprotected sex, ignorance, and negative attitudes towards contraception.

5.8 Participants Response on Religion

The concept of culture encompasses religious beliefs, norms, and values, which play a significant role in shaping social expectations. These norms and values may influence the choices of women in eNkanyezini when it comes to accessing and utilizing SRH services at their local clinic. The table presents the religious affiliations of the women who participated in the study from uMkhambathini, eNkanyezini. The data for this diagram was generated from the responses of the 30 female participants who took part in the focus group interviews.

Religion	Sum of Participants
Shembe	**15**
Traditional	**6**
Christianity	**9**

Table 5.8 illustrates the religious affiliations of the participants. Out of the 30 participants, 15 were from the Shembe religion, 9 were from the Christian faith, and 6 identified as traditional believers. This data highlights the significance of religion within the uMkhambathini (eNkanyezini) community. The coexistence of various religious beliefs fosters strong social solidarity, shaped by the diversity in cultural values. This religious diversity may also influence access to and use of SRH services. According to Hall, Moreau, and Trussell (2012), even religious young women engage in sexual relationships, with their sexual behaviors influenced by religious factors such as denominational affiliation, attendance at religious services, and the importance of religion in their daily lives. Research has explored how these religious elements act as both risk and protective factors for various SRH outcomes, including sexual education, unintended pregnancies, abortion, and sexual initiation (Hall, Moreau, and Trussell, 2012).

Through the Gender Theory, this study revealed the following narratives: A contextual response from research participants revealed that:

"As a member of the Shembe Church, I understand that our faith has a significant influence on how we approach issues like sexual and reproductive health. In Shembe teachings, purity and respect for one's body are emphasized, and this extends to our sexual health. However, there are often conflicting views in the church regarding sexual education. Some elders believe that the topic should be avoided because of its sensitive nature, whereas others feel that addressing SRH issues more openly is crucial for the younger generation. Despite this tension, our faith encourages strong family structures, and reproductive health is sometimes discussed in the context of traditional marriage, which is highly valued. In my experience, there is a need for more open dialogue within the church to balance tradition with the evolving SRH needs of our community." (Participant 3)

"From a traditional Zulu perspective, sexuality and reproduction are deeply tied to cultural norms and ancestral practices. The elders in my community often emphasize the importance of respecting traditional values, which include maintaining strong family ties and ensuring that sexual health is kept within the confines of marriage. While there is a certain respect for traditional medicine and practices around fertility and conception, SRH education is not widely discussed in public. The taboo surrounding sexual health means that many younger people struggle with understanding how to navigate issues like contraception or sexually transmitted infections (STIs). I believe there is a

disconnect between our cultural beliefs and the modern-day needs for sexual health education, especially as young people increasingly seek more information outside of traditional sources." (Participant 12)

"As a Christian, my faith has always emphasized the sanctity of marriage and the importance of abstinence until marriage. Growing up, I was taught that sexual relations are a sacred act meant to occur within the context of marriage. However, this strict perspective often creates confusion, especially in situations where individuals face health issues like STIs or unintended pregnancies. Many Christians, particularly younger people, struggle with the teachings because they don't always align with real-world challenges. I feel that the church should play a more active role in providing SRH education in a way that upholds Christian values but also addresses modern needs. For instance, there is a growing need for discussions around contraception, HIV prevention, and sexual consent in a way that respects both faith and health." (Participant 15)

The responses reveal the complex intersection of gender, culture, and religion in shaping sexual and reproductive health (SRH) education. Through the lens of gender theory, the narratives emphasize how traditional beliefs and religious teachings shape SRH, particularly in communities like the Shembe Church and within Zulu culture, where purity, abstinence, and respect for cultural values are central. The tension between preserving traditional gender norms and addressing modern SRH needs creates a generational divide: younger people seek more open discussions, while elders often favour silence or avoidance. This gendered silence, especially around issues like contraception and STIs, highlights how women are often excluded from crucial SRH education. There is a clear need for gender-responsive and culturally sensitive SRH interventions that balance respect for traditional values with the evolving health needs of communities, promoting open dialogue and empowering both men and women to better navigate sexual health.

Some participants noted that young women who identify with specific religious denominations or have strong religious beliefs may be more vulnerable to unfavourable SRH outcomes. This is because they are less likely to use contraception even after becoming sexually active and less likely to receive comprehensive sex education (Hall, Moreau, & Trussell, 2012). The participants demonstrated strong

cultural ties, which could mean that, although some of them might be aware of SRH services, they may still feel hesitant or skeptical about engaging with these services. They may fear that using SRH services could expose their sexual choices, which would contradict their belief system and social values. For instance, contraceptives may imply that the user is sexually active. Cultural attitudes that hinder the advancement of SRHR not only limit access to material resources but also impact those providing support for SRHR, including physicians, legislators, and health professionals (Bylund, Målqvist, Peter & Herzig van Wees, 2020). Moreover, in eNkanyezini, hesitation may prevent young women, especially teenagers, from speaking to medical professionals or other trusted figures about matters related to sex and reproduction.

The table illustrates the diversity of belief systems. It shows that religion is a dominant social force with the ability to influence community conditions and social dynamics. Regardless of the religion, adherents generally hold certain values that may exclude SRH services, as these services might contradict their religious beliefs. Religion, therefore, presents healthcare limitations for women and influences their control over their bodies. For instance, criticism of abortion is a prevalent value in many religious communities. Rural areas like eNkanyezini are significantly different from urban centers. The data suggests that a unique relationship exists between belief systems and health-seeking behaviors in rural communities. The majority of participants in this study belong to either the Shembe Church, the Christian Church, or follow traditional beliefs. Religion plays a significant role in shaping societal structures, as it governs social behaviors and community norms (Sarbini, Suharso, & Surnarsono, 2018). In uMkhambathini, eNkanyezini, religion serves both as a motivator and a regulatory force for its followers, influencing the social dynamics and governing the choices surrounding SRH services. This influence can lead to particular social health hesitations. The presence of religion is particularly evident through religious ceremonies performed by religious leaders, which are then followed by the community. These ceremonies serve as visible manifestations of religion and reinforce its functions within the community. Religion thus maintains balance and harmony in society, dictating behaviors and health choices.

5.9 Participants response on employment status

Socio-economic indicators are among the factors that medical anthropologists use to detect social inequality. For this study, the quest to capture employment status is a means to highlight the realities of South Africa's healthcare system, which has limitations and successes. The table represents the employment status of women from uMkhambathini and eNkanyezini who participated in the study.

Occupation status	Sum of Participan ts
Employed	12
Unemployed	18

Table 5.9 shows that 18 out of 30 participants were unemployed. In rural areas, women are often seen as wives, mothers, and caregivers, while men are typically seen as breadwinners and employees. Marriage has long been criticized as an institution that disadvantages women. The comparison between women with a Grade 12 education and unemployed women highlights a significant contrast. The data suggests that limited access to SRH services may stem from the inability to afford private healthcare. Participants also reported experiencing stigma and discrimination when making SRH service choices. Private healthcare could provide a wider range of options that encourage women to seek care earlier, minimizing the impact of illness and disease. According to Giatti, Barreto, and Cesar (2010), unemployment is associated with a higher risk of dying from various causes, including heart disease, neoplasms, premature death from external causes like suicide, and incapacitating diseases. It is also linked to common mental health disorders, physical health issues, and poor self-rated health. With 18 out of 30 women participants being unemployed, this data can serve as a microcosm for the broader community of eNkanyezini, highlighting unemployment as a significant challenge. This underscores the importance of examining the relationship between public health care and access to private healthcare. However, given the nature of rural communities like eNkanyezini, there may be additional limitations in discussing reproductive health issues and illnesses, often influenced by concerns about stigma in healthcare.

This study revealed the following narratives through application of the Critical Medical Anthropology Theory: A contextual response from research participants revealed that:

As a cleaner, I don't make much money, but I do have some healthcare coverage. I've been able to get regular check-ups, but I feel embarrassed to bring up sexual health concerns with my doctor. I don't think they understand the stress of my job or how it affects my personal life." Participant 10

"Working in retail, I often don't have time to look after my health, including my sexual health. I've had some issues with contraception and haven't had the time or resources to address them properly. It's difficult, especially with the pressure from my work schedule." – Participant 20

"Being out of work has really affected my sexual health. Without a stable income, I can't afford to see a specialist about my recurring infections. I'm also stressed about finding a job, which doesn't help my overall well-being." Participant 15

"I used to work in a factory, and I had good health coverage. Since I became unemployed, I've had issues with sexual health that I just can't seem to address. The lack of resources is the hardest part, and it's affecting my relationships." Participant 12

The Critical Medical Anthropology (CMA) theory emphasizes the intersection of social, economic, and political factors in shaping health outcomes, particularly how inequalities influence individuals' access to healthcare and their overall well-being. The narratives shared by participants in this study reveal how unemployment and employment status significantly impact sexual and reproductive health (SRH). Participant 10, a cleaner, highlights the challenge of limited financial resources and the emotional burden of feeling misunderstood by healthcare providers, illustrating the class-based stigma and stress that shape healthcare experiences. Similarly, Participant 20's experience in retail underscores the time constraints and work-related pressures that prevent individuals from seeking appropriate care, reflecting how low-wage, high-demand jobs contribute to health neglect. In contrast, Participant 15's story of being unemployed emphasizes how a lack of financial security hinders access to necessary healthcare services, thus exacerbating the cycle of ill-health. Lastly, Participant 12's account of losing job-related health coverage further underscores the critical role of employment in facilitating access to healthcare, and how the absence of such coverage leads to compounded health issues, particularly sexual health. These narratives align with CMA's focus on how structural factors,

such as job insecurity and socioeconomic disparities, influence health outcomes, revealing the deep connections between employment status, access to healthcare, and overall well-being.

Stigma, often rooted in perceptions, can impact the behavior of healthcare staff, creating certain social constructs that affect healthcare delivery. In healthcare settings, stigma impedes diagnosis, treatment, and positive health outcomes. To achieve good health and provide high-quality healthcare, stigma must be eradicated (Nyblade et al., 2019). Certain analysts argue that apartheid's distinct features, including laws promoting segregation, have significantly contributed to South Africa's healthcare problems (Hlayisi, 2022). Health insurance, or the lack thereof, may make it more challenging to receive essential medical care. Those without jobs are less likely than those with employment to obtain health insurance. There is also an increase in unhealthy behaviors, such as drug use, smoking, and alcohol consumption, linked to unemployment. Studies on health inequalities in South Africa tend to be one-dimensional, focusing on a small number of outcomes rather than the broad spectrum of healthcare access issues (Gordon, Booysen, and Mbonigaba, 2020). Research often focuses on specific aspects of the healthcare access pathway, such as healthcare outcomes, multimorbidity, disability, lifestyle diseases, maternal and child health, and healthcare utilization. Subgroups of people are affected by unemployment in different ways, and the association between unemployment and health is expected to vary depending on factors such as age, gender, and occupation (Giatti, Barreto, and Cesar, 2010). Unemployment is a stressful occurrence with two main effects on health: limited ability to meet daily needs and financial deprivation, and the psychological strain caused by uncertainty, loss of identity, and diminished self-worth. Psychosocial, behavioral, and physiological factors regulate the relationship between unemployment and health (Giatti, Barreto, and Cesar, 2010).

Table 5.9 indicates that 12 out of 30 participants were employed, highlighting the relatively low employment rate among women in rural areas of eNkanyezini. This indicator is crucial in establishing the relationship between socio-economic status and healthcare access, particularly for sexual and reproductive health services. However, employment status does not automatically equate to the ability to afford private healthcare. Employed women may experience less stigma due to greater financial independence and social standing, empowering them to seek SRH services more openly. In contrast, unemployed women or those in unstable jobs may face heightened discrimination, as their dependence on partners or family members can reinforce societal judgments about their sexual

activity and reproductive health choices. This stigma may arise from assumptions that unemployed women seeking SRH services are promiscuous or irresponsible, while employed women may be viewed as more autonomous and responsible. Employment status, therefore, shapes how women navigate SRH services, influencing both their confidence in accessing care and how healthcare providers and communities perceive their choices.

To demonstrate how unemployment, political unrest, and HIV/AIDS affect women differently due to their gender, it is essential to highlight the gendered dimensions of these issues. Unemployment tends to affect women more severely because of gender-based discrimination in hiring, wage gaps, and limited access to economic opportunities, particularly in rural areas where patriarchal norms dominate. Political instability often exposes women to gender-based violence, including sexual violence, displacement, and exploitation, which disproportionately affect them compared to men. Similarly, the HIV/AIDS epidemic disproportionately impacts women due to biological vulnerability, unequal power dynamics in sexual relationships, and barriers to accessing preventive and treatment services. Women are also more likely to bear the caregiving burden for affected family members, further limiting their economic and personal autonomy. Thus, while these issues affect communities broadly, women experience specific vulnerabilities rooted in gender inequalities, making their experiences distinct from those of men.

Social and economic conditions impact both physical and mental health. Employed women may have a different experience regarding healthcare and SRH services due to their financial power. Financial independence can lead to different lifestyles and better health-seeking behaviors. For instance, employed women may work longer hours, which could limit their social interactions, including their sexual life. This busy lifestyle might contribute to less frequent sexual activity, potentially influencing their decision to seek SRH services. However, this does not mean that these women do not face reproductive health challenges or do not need SRH services such as PrEP or contraceptives. Employed participants shared experiences where financial power allowed them to make more autonomous reproductive and health choices. Some of these women, particularly mothers, expressed concerns about the impact of another pregnancy on their health and financial security. Evidence has shown that the prevalence and incidence of health issues, illness, disease, and death are inversely

correlated with socio-economic status (SES). The strength of this correlation between self-rated health (SRH) and SES varies between countries (Alvarez-Galvez et al., 2013).

5.10 Participants response on type of employment

Employment is a significant gateway for proper healthcare in South Africa. The table below shows the employment of women participants from eNkanyezini. The table represents the employment status of 30 from uMkhambathini, eNkanyezini.

Categories of employment	Sum of Participants
Stay home	**18**
Cleaner	**4**
Retail worker	**5**
Factory workers	**1**
Chef/Cook	**1**
Creche worker	**1**

As indicated in **Table 5.10,** fewer women participants in eNkanyezini are employed, with many taking on roles traditionally associated with domestic duties or informal jobs. **Table 5.10** highlights the specific job types of the women participants and illustrates how these jobs are often contextualized within the gendered division of labour. In rural areas like eNkanyezini, women typically engage in roles that revolve around care work, such as cleaning, washing, and child-rearing, reflecting a broader patriarchal structure that governs both household dynamics and societal expectations. This gendered division of labor often results in women's financial dependence on their husbands or male partners, further limiting their autonomy and decision-making power, particularly regarding their sexual and reproductive health (SRH).

This gendered structure, reinforced by patriarchy, shapes women's decisions about their bodies and healthcare choices. In many households, husbands or male partners hold the authority to make

decisions about family planning, including the number of children to have. Despite the health impacts of such decisions, it is often framed as a woman's duty to comply with these choices. Some participants in the study shared that their husbands directly influenced or even made decisions regarding their SRH service use, such as contraception and healthcare-seeking behavior. This patriarchal control over women's bodies and healthcare is a critical issue that underscores the limitations women face in accessing SRH services, particularly in rural communities.

From a feminist theoretical perspective, the gendered division of labor and decision-making power within households highlights how women's choices are often constrained by social, economic, and political structures. Feminist theory, especially the concept of the "feminist economy of rupture," challenges the traditional androcentric discourse by advocating for a more nuanced understanding of women's roles in society. This theoretical approach calls for recognizing women as unique historical, social, and cultural subjects, rather than reducing them to mere caretakers or passive recipients of decisions made by men (Diaz-Jiménez, Herrera Gutiérrez, and Yerga Míguez, 2023). The data also shows that a significant number of women in eNkanyezini are stay-at-home mothers, with 18 out of 30 participants in this category. This financial dependence on their male partners further exacerbates their limited access to SRH services. The role of financial dependence in decision-making around SRH becomes evident, as those who are economically reliant on others are less likely to make independent decisions about their sexual health. This dynamic is compounded by the broader patriarchal structure that dictates women's roles and limits their choices.

The gendered division of labour in eNkanyezini not only affects women's autonomy over their bodies but also impacts their health and healthcare choices. Despite women being more likely to require healthcare due to the greater incidence of long-term illnesses and mental health conditions, their financial dependence can create barriers to accessing necessary services. Women's higher rates of depression, as well as the physical health issues they face, often necessitate regular medical attention, but the rising costs of healthcare further challenge their ability to seek treatment. Additionally, the societal expectation that women prioritize family and caregiving responsibilities often overrides their own health needs, leading to delayed or avoided healthcare-seeking behavior.

Thus, the intersection of gender, economic dependence, and patriarchal control creates a complex set of challenges for women in rural areas like eNkanyezini, affecting their access to sexual and

reproductive health services. The need for gender-responsive and culturally sensitive SRH interventions is clear, as these interventions must address not only the financial and structural barriers women face but also the social norms and cultural practices that influence their healthcare choices.

This study revealed the following narratives through the Gender Theory: A contextual response from research participants revealed that:

"*Angisebenzi kahle ubunzima buhlangene nokuba umama wekhaya ube unomsebenzi, lokhu kuye kube nzima kuwo wonke owesifazane onomntwana" (Participant 2)*

Participant 1 (Stay-at-Home Mother, Female, 38 years old)

"As a stay-at-home mom, my day revolves around taking care of the children and household chores. I don't have the time or resources to go for regular checkups. I struggle to get contraceptives because I don't have the money to go to a private doctor, and the public clinics are always so crowded. Sometimes I feel that my health isn't prioritized because everyone assumes I'm just focused on my family."

Participant 2

"I clean offices and homes, and my work hours are long. It's hard to find time for healthcare services, especially when I can't afford to take a day off. Sometimes, I feel embarrassed to ask for help because there is a lot of stigma in my community around women's sexual health. I also struggle with irregular periods, but I don't know where to go for advice. I can't afford to go to a private doctor, and I feel like I'm left to just deal with it."

Participant 3

"My job in a retail store is very demanding, and I'm always on my feet. I can't take time off to visit a doctor, and I often find it difficult to get contraceptives because the nearest pharmacy is not in a convenient location. Sometimes I experience pelvic pain and discomfort, but I don't have the time to seek medical attention. My employer doesn't provide any support for women's health issues, and that makes me feel like my needs are not considered."

Participant 4

"*I work in a factory, and the hours are tough. We work on shifts, and it's hard to schedule anything, especially health appointments. Contraceptives are hard to come by, and when I did ask for advice at a clinic, I was made to feel uncomfortable, like they thought I was being irresponsible. I also experience a lot of stress from the work environment, and it affects my menstrual cycle, but I don't have the time*

or energy to go to a doctor."

Participant 5

"Being a chef means working long hours in a hot, stressful environment. There is little time for self-care, and I often find it difficult to make appointments for sexual and reproductive health services. I also struggle with my weight, which affects my confidence and sexual health. I've tried asking for advice from colleagues, but it's hard to talk about these things at work, especially in a male-dominated kitchen."

The responses from the female participants in this study reveal a complex web of gendered labor expectations, social stigma, and systemic barriers that hinder women's access to sexual and reproductive health (SRH) services. Through the lens of Gender Theory, these challenges become evident in the ways societal expectations shape women's roles and experiences. Traditional gender norms often prioritize caregiving and domestic work for women, leaving their own health needs overlooked. Participants' narratives emphasize the burden of long working hours, financial constraints, and a lack of support from both employers and healthcare providers, which prevent them from prioritizing their health or seeking care when needed. The stigma surrounding women's sexual health choices—such as using contraception or engaging in sexual activity outside of marriage—further exacerbates these barriers. This creates a situation where women feel uncomfortable discussing or seeking care for their sexual and reproductive health, reinforcing the cycle of health neglect and perpetuating the underutilization of healthcare services.

The data from **Table 5.10**, which outlines the employment categories of women in eNkanyezini, further contextualizes these struggles. Many women in this community work in low-paying jobs, such as cleaning, retail, factory work, and caregiving, which often do not provide sufficient financial security or access to private healthcare services. As a result, these women face affordability challenges when it comes to seeking necessary medical care. The high levels of stigma and discrimination they encounter, particularly when engaging in sexual activity outside of marriage or using SRH services deemed "unethical," create an environment where these women feel socially ostracized and hesitant to pursue healthcare services.

The social and economic inequalities faced by women, particularly in rural settings like eNkanyezini, also have broader implications. Studies have shown that women, especially those living in poverty or in financially precarious situations, are more likely to bear a disproportionate burden of healthcare expenses. They are also more likely to live in poverty compared to men, primarily due to pay disparities and the high prevalence of single-parent households led by women. According to Borchelt (2024), women's out-of-pocket medical expenses often account for a greater portion of their income, making it more difficult for them to access the care they need. This economic disadvantage, coupled with the stigma and discrimination they face, means that many rural women struggle to seek SRH services even when they recognize their need for them.

5.11 Contextualizing Rural Women's Experiences

The findings presented in this chapter provide a detailed context of the sexual and reproductive health (SRH) challenges faced by rural women in uMkhambathini. Drawing on empirical data and guided by the theoretical frameworks of Social Constructivism, Critical Medical Anthropology, and Gender Theory, this chapter highlights the intersection of social, cultural, and economic factors that shape women’s health experiences. These theoretical lenses offer insight into why rural women are particularly vulnerable to health-related challenges compared to their urban counterparts.

Social Constructivism provides a valuable framework for understanding how societal norms, cultural beliefs, and shared values influence health behaviors and the use of SRH services. In rural communities like uMkhambathini, deeply ingrained cultural and religious norms play a significant role in shaping women’s health choices. These norms often prioritize traditional gender roles, such as caregiving and motherhood, and impose expectations on sexual behavior, which can create barriers to seeking SRH services. The social constructivist perspective emphasizes that health and illness are not solely biological phenomena but are shaped by societal perceptions and constructions. This approach highlights how health education and healthcare access are influenced by the social environment, impacting how illnesses, particularly reproductive health issues, are understood and treated (Wilson, 2023).

Additionally, Critical Medical Anthropology emphasizes the role of structural factors—such as poverty, gender inequality, and limited access to healthcare resources—in shaping health outcomes.

The experiences shared by women in this study reflect how these structural determinants intersect with cultural beliefs and practices, creating a complex set of challenges that limit their access to SRH services. Rural women often face compounded barriers, including financial constraints, social stigma, and a lack of support from both healthcare providers and employers, which further marginalizes their health needs.

Finally, Gender Theory underscores the gendered nature of healthcare access and the ways patriarchal structures limit women's autonomy over their bodies and health decisions. In many rural communities, traditional gender roles place women in subordinate positions, where decisions about their health are often made by male partners or family members. This dynamic can prevent women from accessing SRH services, as their choices are subject to approval from male figures in their lives. By examining these issues through a gendered lens, this study reveals how structural inequality and patriarchal norms affect women's ability to exercise agency in their health-related decisions.

Together, these theoretical frameworks offer a comprehensive understanding of the challenges rural women face in accessing SRH services. Social, cultural, and economic factors intersect to create barriers that hinder women from seeking care and prioritizing their health. Addressing these challenges requires a multi-dimensional approach that not only ensures access to healthcare services but also promotes cultural change, gender equality, and financial security. By recognizing the interconnected nature of these factors, effective interventions can be developed to empower rural women and improve their sexual and reproductive health outcomes.

Through the Social Constructivism Theory, this study revealed the following narratives:

A contextual response from research participants revealed that:

Participant 10 Indodana[5] *(referring to me as the primary researcher) and Indodakazi*[6] *(referring to my research female assistant). We are what has been defined by our community. Majority of us are born and bred in this community. This community has experienced many sad things, we have witnessed people dying from political wars. We have also seen people dying from many health issues.*

From 1990-till to date, majority of us are still dying from HIV/AIDs related infections. Others dying not knowing their statuses, while others dying while knowing. Others die because of the stigma that continues to be attached to people living with this virus.

Participant 3 also explained that, in this community which is deep rural have observed people dying from Tuberculosis and many other respiratory infections.

Participant 6 my son, some people have died from this community because of crime and warefares.

Narratives from participant 21 and participant 30 explained that majority of women at uMkhambathini are unemployed and have died because of hunger and poverty related health Challenges. Those that are still alive are solemnly depend on social grants and provisions that are made by their partners.

Participant 16.further narrative by saying, eyi,[making a sigh], kunzima ukungasebenzi ngoba uswela ngishoni. Ukungasebenzi kukwenza udansele isiginci sendoda nje ngoba iyona phela ekondlayo. [translation, being unemployed is really a challenge; you end up conforming to everything that is detected by your partner because he is the breadwinner]. Times are hard these days, it is not that we are not seeking employment, awekho amathuba omsebenzi. Those that do not have employed partners find it really hard. They don't have food choices, they sometimes go to bed on empty stomachs. Their children are also affected because, in most cases the social grant is not enough to cater all the needs to the household.

Participant 10 joined the conversation by alluding that the majority of people here at uMkhambathini have died because they defaulted on their chronic medication because, how can you take medication on an ampty stomach? Kuyenzeka ukuthi kube khona imingcwabo[7] edlule wemihlanu in our community sigcine sidideka ukuthi sizoyaphi singamalunga omphakathi[8].

Participant 19 Majority of us in this community are living below the poverty line. We are stay home moms. Poverty and hunger knows our names and home address. Lapho siyagula[9]. Some of the meds that we are taking requires us to eat first before taking them. The South African economy is really

affecting our health. Uwathatha kanjani amaphilisi[10] ungadlile.

Participant 12 alluded, the state of our unemployment as rural women of uMkhambathini also affects our health and this is a factor of many deaths in the community. In most cases rural health facilities are underresourced, this warrants that we to in the Pietermaritzburg CBD to access the East Street Clinic, how do we go there because we don't afford transportation money.

Participant 2 said, we grew up being told that "alikho ithuna lendlala[1]". These days I can safely confirm that majority of women that have died in our community have died because they were hungry and could not adhere on the requirements of their meds. In-fact sisazofa kulendawo if our government does not put economic/employment plants in place. What is concerning us as parents is that, our children will suffer like how we are suffering. When will the poverty cycle end? Indlala[11] isiphenduke ithuna impela.

Participant 13 said, thina la eMkhambathini we don't have food choices, amazinga obubha[2] enza sidle ukudla okukodwa isikhathi eside. The food that that we mostly eat in our household is not nutritious. This is because we don't afford health food. Our children mostly eat noodles and maas. We as adults sometimes eat uphuthu with water because asikho isishebo, sekwabiza nekabishi, isipinashi kanye namazambane. Inyama sekwaba eya basemzini. Inyama sesiyidla uma kuhlatshiwe emzini yabantu.

In light of the Gender Theory and Critical Medical Anthropology, the narratives presented above provide a clear understanding of how access to resources like food, money, and healthcare facilities is crucial to one's health, particularly for rural women. The intertwined relationship between poverty and unemployment significantly influences health outcomes, making them key determinants of health vulnerability in this study. Poverty and lack of employment lead to limited access to both physical and financial resources, which in turn negatively impacts the health of women, especially

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[1]*alikho ithuna lendlala: Regardless of the situation a child is born into, they will still grow up*

[22] *Amazinga obubha: Poverty levels*

in rural settings. If these women could attain stable financial well-being, it could foster better health behaviors, which, in turn, could significantly improve their quality of life and health outcomes.

These narratives align with the theoretical foundations of Critical Medical Anthropology, which emphasizes how structural inequalities such as poverty, unemployment, and limited access to healthcare shape health outcomes. Critical Medical Anthropology argues that health is deeply influenced by the broader political, economic, and social contexts in which individuals live. As the study reveals, unequal relations of access to resources, particularly health services, perpetuate disparities in health outcomes. These disparities are more pronounced in rural communities, where women are often marginalized and excluded from both economic and healthcare opportunities, thus hindering their ability to achieve and maintain good health.

In the context of Gender Theory, the narratives emphasize the ways in which gendered expectations and social roles place rural women at a disadvantage when it comes to health and healthcare access. The patriarchal structures that dominate these rural settings often restrict women's autonomy, leading to a lack of control over their health decisions. Women's roles as caregivers, combined with limited economic opportunities and low social standing, make them more susceptible to health vulnerabilities. The unequal political and economic systems in these rural areas further exacerbate these issues, creating a cycle of deprivation and limited access to essential health services, including sexual and reproductive health services.

The combination of Gender Theory and Critical Medical Anthropology provides a lens through which we can understand the compounded social, economic, and political factors that contribute to health disparities. As the study reveals, these factors—economic status, education level, public administration, and political systems—are key barriers to achieving global health outcomes, particularly for marginalized groups like rural women. The findings suggest that these women are often excluded from the benefits of health interventions and services that are more easily accessed by women in urban settings or women of different racial backgrounds. This exclusion is a result of entrenched inequalities that shape healthcare access and outcomes on both a local and global scale.

Thus, the study underscores the need for policymakers and scholars to critically analyze the political economy of inequality and its impact on health, particularly in marginalized communities.

Addressing these systemic issues is crucial for achieving global health goals and ensuring that interventions, such as sexual and reproductive health initiatives, are accessible and effective for all populations. The intersection of gender, poverty, unemployment, and health inequities calls for a holistic approach that considers the broader structural determinants of health and works toward dismantling the systemic barriers that perpetuate health disparities.

Participant 11 some things I regret to have been born and bred in rural areas. Yazi, izindawo zasemakhaya[3] *aziphucezi. Uma ziphucuzeka, intuthuko iyagqoza nje. Thina sihlezi sishiyeka nje*[4]*. Futhi kwezempilo sisele kakhulu. In urban areas, local clinics everyday of the week and they have all the services that community members need. You go then, you only spend few hours. In our rural settings, you have to wake up at 4am. You get there, practitioners treat you as if they are doing you a favour. You spend the whole day, when it is your turn, you are told that you need to come back tomorrow because there is a certain number of patients that the doctor or the senior health practitioner is allowed to see a day. In our rural clinics, we are treated as numbers not has humans who have rights to access health care. This is one reason we don't know about sexual reproductive health. Secondly, these are some of the reasons that have discouraged used from investing in our own health.*

Participant 15 Ndodakazi (referring to my research assistant) mina, I thought that our democratic dispensation was going to bring change. During the apartheid era, history tell us were told that race was use excluded black people from accessing advance health care hence many black people died from untreated infections and diseases. Now that we have voted in the democratic dispensation, there is no change. The only change is that we have clinics but those clinics are not meeting national standards because health practitioners are not informed about illnesses that are prevalent in our area. Our rural clinics are under resourced.

Participant 24 another thing to add in this conversation bantwana bami is that, if you access our local clinic, you should now that the person after you will know about why you had consulted. This means that, there is no confidentiality. This is another factor that compromised our health hence

[3] *izindawo zasemakhaya: Rural areas*
[4] *Thina sihlezi sishiyeka nje: We are always left behind*

majority of people die from untreated health issues.

Ji and Cheng (2021) assert that Africa has experienced structural violence which came from excluding people of other races from accessing health care services; hence, existing international treaties such as the Millenium Development Goals and provisions of sexual reproductive health were put in place to redress injustices of the past. The stagnant realization of this international health commitment is delayed by factors such as racism, sexism, political violence, and poverty. Rural communities, particularly women, experience the brutality of these factors. This section also highlights age, marital status, use of SRH services, prior SRH service knowledge, number of children, the level of education and religion of women in eNkanyezini. Therefore, although CMA explores many aspects, many relate to structural and functional concerns about health care in eNkanyezini. This relates to the presence of unequal economic status and structural violence. For instance, abusive, controlling and patriarchal relationships may be some structural violence. Alternately, the economic status may relate to unemployment, In terms of health, that may shape the women's position in using and accessing SRH services when looking at the selected rural area of uMkhambathini, eNkanyezini.

Participant 18 one of the discouraging factor to access our local clinic is that, you are judged by age as well as by the level of education. When you get to the first administrator, they ask you confidential questions that should not be known by other people. You are asked to disclose your health condition in front of other patients that are waiting in the que. Medical practitioners would ask "uzengani la emtholampilo[5]" what they expect us to respond to this question. When you lower your voice, they become rude "uze wasuthi angeke ukhulume, kubuhlungu amazinyo yini". Another question is that of your age, "being asked ukuthi unemyaka emingakanani infront of other patients after having being asked million questions kwehlisana isithunzi". How we are received in our local clinics needs to be improved. We don't want to access local health treatment because of the matter in which we are received and treated as we attempt to access sexual reproductive health information.

Participant 1 it is discouraging that when we get to the consultating room, health practitioners

[5] *uzengani la emtholampilo: why are you at the clinic*

laugh at us. Uzelangempela ngoba ungaziboni ukuthi uphethwe (esho edalula isifo sakho, lapho uyahleka). In that moment, isithunzi sivele sinyamalale same time. Uma unezinkinga esithweni sakho sangasese ugcina ukusaba nokumvezela umhlengikazi ngoba uzokuhleka futhi akwenze uzibone ukuthi angeke usakwazi nokusinda. Ingakhoke iningi lethu lingayi emtholampilo. What is also common is that, there is an expectation that we don't want to read about our health. Health practitioners in our rural clinics don't give us enough information. Mina have never seen then conducting community awareness or even encouraging our partners to come for their medical checkups. They always say that, they are understaffed, that's why they are not able to service our communities.

The narrative plotted above is aligned with the perspectives of the gender theory. The Gender theory, coupled with the anthropology of women, gives an expression that women are affected mainly by health-related challenges because of their age, marital status, use of SRH, prior SRH knowledge, number of children, level of education and religion. When health practitioners at the time of rendering health services do not conform to established gender norms, relations or roles, they often lead to stigma and discriminatory practices. These factors marginalised and socially excluded healthcare beneficiaries from celebrating a healthy life. This also inhibits their health literacy. African Health Organization (no date) states that gender norms influence access and control over resources needed to attain optimal health, including economic (income, credit); social (social networks); information and education (health literacy, academic); time (access to health services); and internal (self-confidence/esteem). Gender norms, roles and relations result in differences between men and women (African Health Organization, no date).

I am beginning to understand why women are dying in this community. Into ithi, sinemisebenzi eminingi esenza sibambe siyeke emakhaya, noma ugula, you end up prioritizing your family over your health. Thina abantu besifazane sigula size siphole singalubekanga emtholampilo. Ngamhla usuthi uya emtholampilo uhlangabezane nesigaxa sento engasalapheki. Okwesibili, life is difficult if you are unemployed, uphuma uthi uyaphi nje ngoba wena uphuma uma kuhole indonda. Nakhona lapho uphuma wazi ukuthi uyothenga i-grosa, unexhala lokuphuma kwezinga zesikole ngoba kumele zithi zibuya ube nawe usasekhaya. Kusanjalo, nomthengi wokudla kumele abuye ewasheliwe futhi usuphekile ngoba kuzo yimi uma efika ungakapheki. Siganile nje but kuningi okungcindezi esibheke

nayo lapho we are not allowed to talk about gender-based violence. When you are express your views, ubuzwa ukuthi uhlakaniphiswe ngubani………noma usukopele imithetho yakumuphi umuzi. Konke loku kulimaza isithunzi sakho njengomuntu wesifazane [participant 7]

Son, expression from participant 23 as I told you before, majority of women in this area are employed and they depend on their employed partners. It saddens me to share that, when a men puts food on the table, the women that consumes that food loses her voice and her identity. Patriarchy has socialized our husbands and partners to use money and many forms of provisions to control us as women. We find ourselves in a lot of risks. If your men is a provider in the family, you end up tolerating many things, uyaqonywa ngisho ikwamakhelwane noma aqonywe izinga ezincane, your voice is muted because he reminds you that he is responsible for your stomach. Even when you want to protect yourself from sexual transmitted infections, there is no room for negotiating such because your voice is silenced by poverty and unemployment.

Participant 29 majority of women that have died in this community have not only died because they were sick, they died because of depression. Their voices were silenced by women who did not allow them to express how they feel. Rural women do not have a voice because even in the clinics, medical practitioners want to lead the conversation as if they know what you are going through. At the end of the day, we are reminded by the religion ukuthi kumele sibekezele, nase clinic ufike utshelwe umhlengikazi ukuthi kumele ubekezele. Why is our life about a struggle?

Participant 4 when you happen to know your status, it becomes another thing because everything will be pinned on you as a woman. You will have to be silent because your husband/partner provides for the food that that you eat. Impiloni le esiyiphilayo singabantu besifazane basemakhaya, kuningi abantu abazi.

Participant 27 you go to church, we get told that our silence as women builds/sustains our houses, we destroy our houses by being vocal. This is extremely worse when you are not financially independent.

Participant 23 the life of rural women is cycle of misery. We were born in this situation. The same situation has now become the first-hand experience for our daughters. Who is coming to rescure us

as rural women of uMkhambathini? What worries me is that, our daughters die younger than our sons. This is because they are caged in similar health challenges that we are facing as their mothers.

5.12 Chapter conclusion

This chapter provided valuable insights into the experiences of women from eNkanyezini regarding their access to and utilization of sexual and reproductive health (SRH) services. The data gathered from the female participants helped to achieve the study's aims and objectives, shedding light on various social, cultural, and demographic factors that influence their ability to access SRH services. Key factors such as age, marital status, SRH knowledge, number of children, education level, religion, and employment status emerged as significant barriers to accessing these services.

Furthermore, the study highlighted the intersection of gender, socio-economic status, and cultural norms, which compound the challenges women face in rural areas. Structural barriers, such as the type of employment and the lack of financial resources, were identified as primary obstacles preventing women from seeking or accessing necessary healthcare services. Cultural and religious beliefs also emerged as powerful influencers, often shaping women's health choices. Additionally, negative attitudes of healthcare workers were identified as a major factor contributing to the hostile environment women face when trying to access SRH services, exacerbating the challenges they already encounter.

These narratives are crucial for understanding the lived experiences of rural women in uMkhambathini, particularly in the context of SRH. The chapter explored how women navigate the barriers surrounding SRH services, often contending with stigmatization, economic constraints, and gendered expectations within their communities. The data captured here will not only contribute to a deeper understanding of the barriers rural women face in accessing SRH services but also inform the study's recommendations for improving service delivery and support. The next chapter will further explore these lived experiences, providing a more detailed analysis of how rural women in uMkhambathini engage with SRH services and the specific challenges they encounter in doing so.

CHAPTER SIX

Lived Experiences of Rural Women of uMkhambithi in the context of Sexual Reproductive Health

6.1 Introduction

The previous chapter provided an overview of the demographic data analysis, setting the context for the study. The current chapter shifts focus to the data collected from five focus groups, each comprising six participants. This approach of gathering and analyzing data from multiple sources allows for a comprehensive assessment of results, identification of trends, and the development of potential solutions to the research questions (Simplilearn, 2023). Ensuring accurate data collection was critical to maintaining research integrity, ensuring quality control, and making informed decisions to achieve the study's aims and objectives. This chapter presents the themes that emerged from the data collected from women in the uMkhambathini area. By thematizing the data, we aim to make sense of the raw information and draw meaningful insights. The discussion integrates relevant literature to contextualize the findings and further support the achievement of the study's goals. The themes and subthemes are categorized based on patterns observed in the responses, providing a structured approach to understanding the data.

6.2 THEMES AND SUBTHEMES

Objectives	Themes	Subthemes
5.4.1 To understand structural factors that inhibit women from accessing and utilizing the SRH services.	5.4.1.1 Socio-cultural factors	5.4.1.1.1 The Impact of Religion on Rural Women in uMkhambathini
		5.4.1.1.3 Individualised attitude
5.4.2 To record detrimental factors that have been women's experiences because of not having access to SRH.	5.4.1.2 Hindering factors	5.4.1.2.1 Worker attitude
		5.4.1.2.2 Marital limitations
5.4.3 To establish how rural women have navigated these Inhibiting SRH conditions.	5.4.1.3 Health seeking access	5.4.1.3.1 Coping-mechanism
		5.4.1.3.2 Support system

5.4.4	To contribute recommendations to the issue of accessing and using SRH services.	5.4.1.4 Mitigating actions	5.4.1.4.1 Knowledge generation

6.4 Outline of Thematic Analysis

This section presents the themes derived from the focus group interviews. A total of 30 participants were divided into five groups, each consisting of six individuals. During these focus groups, questions were asked, and discussions were facilitated to generate data, which was then thematized. The responses were transcribed into English, although the questions were initially posed in IsiZulu. The thematic analysis is organized around four primary themes and seven sub-themes. The main themes include socio-cultural factors, hindering factors, health-seeking access, and mitigating actions. The sub-themes include individual mindset, individual attitude, worker attitude, marital limitations, coping mechanisms, support systems, and knowledge generation. Each theme is aligned with a specific objective of the study.

OBJECTIVE ONE: To understand structural factors that inhibit women from accessing and utilizing SRH services.

6.5 Socio-Economic Factors

This section delves into the socio-cultural dimensions that shape rural women's access to sexual and reproductive health (SRH) services, framed within Social Constructivism Theory, which emphasizes how experiences are influenced by everyday interactions and social realities. Grounded in Gender Theory and Critical Medical Anthropology, this study seeks to capture the emic perspectives of rural women in uMkhambathini, shedding light on their lived experiences with SRH services. Understanding the structural factors that hinder access to and utilization of these services is essential in medical anthropology, as it uncovers socio-cultural barriers that influence health-seeking behavior and can guide the development of context-specific interventions.

Rural women in uMkhambathini face a range of socio-cultural barriers that impact their health-seeking behavior when it comes to SRH services. These barriers include gendered social norms, religious and cultural perceptions, healthcare provider attitudes, and social categorization. The intersection of social and cultural factors significantly shapes women's access to healthcare and their willingness to engage with SRH services. Health and illness behaviors are often interpreted through the lens of cultural values and social norms. While health issues may sometimes be attributed to cultural practices or the inadequacy of healthcare services, culture can also serve as a source of resilience and coping. Rosén (2015) asserts that cultural factors profoundly influence health behaviors and perceptions. For example, what constitutes illness or health varies across cultural contexts—what one community considers normal may be perceived as an illness in another.

Social determinants of health, such as socioeconomic status, education, employment, social support networks, and healthcare access, are shaped by broader political and economic structures. According to the World Health Organization (WHO, 2013), these determinants are key drivers of health inequities, referring to the unjust and avoidable differences in health outcomes both within and between countries. Public policies, resource distribution, and political frameworks play a central role in either exacerbating or mitigating these health disparities (Rosén, 2015).

Participant 1, 4, 6 and 8

"We are unemployed, the clinic is the only option for us although at most times we return home without help. Sometimes, we stay very far to walk with kids." (*Participant 1)*

"Mmm, I think we are not used to private clinics and hospitals because of money for transport and medicine." (*Participant 4)*

"Ok, I work long hours, seeing a private doctor is also costly given I am not paid a lot." (Participant 6)

"My husband is the only person working, and he does not believe in private health care. He always sends me to the local clinic." (Participant 8)

The responses highlight the deep-rooted structural barriers that limit rural women's access to sexual and reproductive health (SRH) services in uMkhambathini, reinforcing health inequities and social marginalization. Economic constraints, such as limited financial resources, prevent women from accessing private healthcare and affording transportation costs, thus restricting their healthcare choices. Gendered power dynamics within households, where male dominance in decision-making limits women's autonomy, further exacerbate these challenges. Additionally, issues related to healthcare availability and capacity such as overcrowded public clinics, long wait times, and inconsistent service provision create further obstacles that discourage women from seeking care. Furthermore, distance and mobility challenges, rooted in poor rural infrastructure and lack of reliable transportation, make it physically difficult for women to reach healthcare facilities. These barriers reflect the intersection of economic, social, and cultural factors that undermine rural women's access to essential SRH services. Addressing these challenges requires dismantling systemic gender norms, enhancing healthcare infrastructure, and providing targeted financial and social support to empower rural women and improve health outcomes.

6.1 The Impact of Religion on Rural Women in uMkhambathini

Traditional healing and alternative religious-based healing practices play a significant role in the health and well-being of rural women, alongside biomedicine. In the context of this study, this theme is particularly relevant to the religious systems in uMkhambathini, which incorporate beliefs from various religious traditions, including traditional Christianity and the Nazareth faith. Van Niekerk (2018) emphasizes that religious authorities and institutions are central to this discussion, as they must be understood as distinct entities. Religious institutions, such as mosques and churches, serve as vital community resources that offer not only spiritual guidance but also social and medical care. Historically, in the 1960s and 1970s, the understanding of religion evolved beyond merely focusing on beliefs and practices, to recognizing religion as a comprehensive cultural system that influences all aspects of life (Van Niekerk, 2018). This expanded interpretation underscores the important role of religious and traditional healing practices in shaping healthcare decisions, with communities often relying on prayer, faith healing, and traditional medicine as complementary or alternative sources of care. The responses in this study will reflect how religious and traditional healing practices influence healthcare choices, demonstrating the critical role of religious institutions

in providing holistic support. The interaction within religion, particularly medical pluralism, shapes health-seeking behavior, with individuals holding contrasting views on biomedicine and ethnomedicine. This dynamic plays a significant role in determining women's SRH choices in the region.

Participants 2, 6, 8 and 10

"Well eh, for me, I have tried to bring up the conversation with my partner, but it hard because he is a traditional man and a Nazareth man, so this would be very religious and proud" (Participant 2)

"weh, hhai for me as a Jehovah's Witness, we do not engage in many of the SRH services you mentioned my sister worse, I did not know much about it hence, we believe that hospitals and clinics can help, but up to a certain degree we reject many services" (Participant 6)

Lord, for me as a Nazareth married women, it not something welcomed in the religion especially as I am a married woman" (Participant 8)

"Well, my child, we come from another generation where we do not engage in certain things and practices as a Nazareth woman, I believe in my religion, especially in health-seeking parties I go to the clinic but for things like SRH to be taken seriously it would take a lot convincing" (Participant 10)

The response above highlights that culture and religion are key drivers of social beliefs about SRH services, although there is a lack of complete understanding of these services among participants. Despite the fact that certain cultural perspectives may challenge women's healthcare choices, these perspectives still form an integral part of their worldview and belief systems. Culture, as Spencer-Oatey and Franklin (2012) and Univer (2013) argue, is a complex network of values and beliefs. It shapes our shared actions within a specific cultural context, providing a sense of belonging. Every culture has its own customs and moral values, which influence how people perceive and respond to different life situations. According to Social Constructivism theory, these cultural constructs guide specific ideas that can either encourage or discourage health-seeking behaviors. In the case of SRH services, it is evident from the responses that cultural norms, alongside gendered power dynamics, influence how women from uMkhambathini make healthcare decisions. These

power dynamics are particularly noticeable in the need for approval from close relatives, partners, or friends, highlighting the social pressures that women experience.

Gender, as a social construct, plays a key role in these dynamics. According to Social Constructionism, gender is internalized and becomes an essential part of an individual's identity. It is shaped by interactions with society and the expectations it imposes, creating either masculine or feminine identities. For social constructionists, gender is not just an individual characteristic but a social relation, defined and reinforced through social interactions. This view is evident in the responses from uMkhambathini women, where gender norms are deeply entrenched and influence their decision-making and health-seeking behaviors.

6.1.2 Individual Mindset

The theme of "Individual Mindset" revolves around how family belief systems shape personal attitudes toward available SRH services. This theme is considered a structural barrier because individual attitudes and beliefs are often influenced by broader social, cultural, and institutional factors. Although an individual's mindset may seem like a personal issue, it is frequently shaped by larger structures, such as patriarchal norms, traditional gender roles, religious teachings, and societal expectations. For example, if a woman hesitates to seek SRH services due to internalized shame or fear of judgment, this mindset reflects the influence of structural barriers like societal stigma surrounding female sexuality or restrictive cultural norms. Thus, the individual mindset is not merely a personal matter but a reflection of deeper societal structures that limit women's access to SRH services and their ability to make independent health decisions. These mindsets are shaped by both religious and traditional systems, which often provide explicit or implicit guidance on health-related behaviors. This can include instructions from healthcare workers about medical processes, such as completing TB treatment or following up on specific dates for further care. Such guidance may also influence women's decisions about SRH services, including their choices about contraceptives or abortion.

The individual mindset, therefore, becomes a significant barrier when discussing SRH access. This mindset shapes the ability of rural women to seek and receive necessary help.

Ribeiro, Havik, and Craveiro (2021) note that healthcare-seeking behavior is not uniform, and this can delay diagnoses. Behavioral patterns should be carefully considered when developing strategies to improve healthcare delivery. Healthcare personnel must receive ongoing training and become more attuned to their patients' needs to address them effectively (Ribeiro, Havik, and Craveiro, 2021). Delayed or inhibited healthcare-seeking behaviors can significantly impact the timeliness of diagnoses. Recognizing and correcting these behaviors is crucial for improving health outcomes. This is particularly relevant in the context of uMkhambathini, where similar barriers may delay women's access to the care they need.

Participants 1, 3, 5, 7 and 11

"Hello, how are you, I have never tried SRH services, but I have thought about it. I just got married I heard a lot of stories about it, including contraceptives ending fertility for women" (Participant 1)

"*What I say, we do not engage in SRH such contraceptives, and I think I never knew about it until I had to ask, but my community discourages women, especially young women, who get injections or visit clinic*s *or need to do abortion in cases of rape" (Participant 3)*

"Ehmn, well, personally, contraceptives, as you explained, are part of this, so there are some complications for me when I use these, and that has led to my family and my husband thinking that this is not for black people" (Participant 5)

"Eiy shame, I had not decided against the SRH you see, getting married early and also not knowing about such information, you can deduct peoples' ideas, maybe it me but I have not been saddened by not using the services as I lost my partner" (Participant 7)

"For me, I am a Christian, and since I am willing to have kids and I have no partner, I see no need to seek such services as a woman of God; my rightful partner will come eventually. I now know what this service entails as a rural woman judgements can shower your life if you use one or more of these SRH services you mentioned, especially as I do not believe in abortion" (Participant 11)

The response above highlights another structural factor influencing the use of sexual and reproductive health (SRH) services. It reflects differing individual perceptions regarding the use, importance, and understanding of SRH services in uMkhambathini and eNkanyezini.

Critical Medical Anthropology (CMA) posits that individual and group decision-making, as well as actions, are shaped by the intersection of socially constructed categories of meaning and the political-economic forces that influence daily life (Panter-Brick & Eggerman, 2018). In simpler terms, people form their own personal and societal meanings and reactions to sickness and health risks, but they do so within a world marked by disparities in healthcare access, productive resources (e.g., land, clean water, and air), and social status, which significantly impact their daily choices.

In the context of the responses, participants displayed a pattern of individualized solidarity. The focus on contraceptives in the responses raises questions about whether this reflects the participants' broader understanding of SRH or if it was influenced by the way the questions were framed during data collection. If the questioning was predominantly centered on contraceptive use, it could have influenced participants to focus on contraceptives as the primary SRH concern. However, if participants independently prioritized contraceptives without specific prompting, it suggests that contraceptive access and use may indeed be the most pressing SRH issue for women in the community. A broader exploration of other SRH dimensions, such as maternal health, STI prevention, and access to gynaecological care, could clarify whether contraceptives are truly the dominant concern, or if other essential SRH needs are being overlooked.

The phrase "limited SRH services" in paragraph 3, line 1, likely refers to the inadequate or insufficient sexual and reproductive health (SRH) services available within the community. This could encompass poor-quality care, limited service options, or restricted access due to structural barriers, such as inadequate healthcare infrastructure, staff shortages, or inconsistent availability of essential medications and supplies. Clarifying this term would help specify the nature and extent of the limitations being discussed. A study by Chekol, Sheehy, and Siraneh (2023) on "Sexual and Reproductive Health Experiences, Access to Services, and Sources of Information Among University Students in Ethiopia" found several unmet SRH needs among Ethiopian youth. It was estimated that 16% of women aged 15 to 49 did not receive family planning services, with this percentage being higher among young and teenage women. In 2016, many young individuals engaged in sex before the age of 18, with the median age for first sexual experience being 16. Research conducted among rural

adolescents in the East Gojjam zone revealed that 67% were knowledgeable about reproductive health topics, such as HIV, contraception, and fertility, but only 21.5% had utilized reproductive health services (Abajobir & Seme, 2014). This information indicates that while Ethiopian youth are aware of SRH issues, their utilization of SRH services remains low. Abajobir and Seme (2014) also noted that young people often live away from home and their social support networks for the first time when they start university, which may impact their access to SRH services.

OBJECTIVE TWO: To Record Detrimental Factors That Have Been Women's Experiences Due to Not Having Access to SRH

6.2 Hindering Factors

Stigma, discrimination, and judgment are significant contributors to healthcare pressures within society, often presenting a level of prejudice that negatively affects specific health needs. In many rural areas, individuals and communities experience these pressures, which, when combined with limitations in health-seeking behaviors, help explain why women face barriers in accessing SRH services. Stigma exacerbates various processes, such as social interactions, resource availability, stress, and psychological and behavioral responses, all of which contribute to poor health outcomes and impact the population's overall well-being (Stangl et al., 2019). The process of stigmatization, particularly in the health context, can vary across the socio-ecological spectrum of low-, middle-, and high-income countries. This process is outlined by the Health Stigma and Discrimination Framework, which defines stigma "marking," drivers, facilitators, and stigma manifestations as key elements influencing health outcomes within affected populations, organizations, and institutions (Stangl et al., 2019).

The scarcity of resources within healthcare systems, especially in rural areas, is often a driving force behind the lack of essential SRH services for women. However, it is equally crucial to consider how healthcare workers' attitudes—shaped by stigma, discrimination, and judgment—significantly contribute to the barrier's women face when attempting to access SRH services. These attitudes often reflect deeper societal prejudices, creating an environment that discourages women from seeking care. In many rural communities, the intersection of resource scarcity and negative attitudes toward certain health needs worsens the challenges women experience in trying to access SRH services. The

stigma attached to health-seeking behavior often limits women's willingness to seek care, while simultaneously discouraging health professionals from providing the necessary support. Not only does stigma affect social interactions, but it also undermines resource availability, increases stress and psychological distress, and ultimately impedes public health outcomes (Stangl et al., 2019).

Participants 6,8,10 and 14

"*Personally, people, especially nurses ask a lot of questions if you want to have contraceptives, they can even share the news with relatives, we are from uMkhambathini, we know each other" (Participant 6)*

"Well, I feel we do not have privacy and peace people gossip, they talk including spreading news about what one came for in the clinic and sometimes they do not have certain medication" (Participant 8)

" I personally feel the clinic is always full, which causes me to hesitate, I mean I work and it hard balancing holding long lines in the clinic, so I do not always use SRH service, the nurses are slow and rude" (Participant 10)

" Currently, I feel many of us feel having a single clinic compromises women especially mothers, kids have to be at the clinic for injection but it a job shame worse nurses are not nice" (Participant 14)

Other hindering factors included having domestic chores that don't permit us to go health facilities. Remember that being a housewife comes with a lot of challenges. Your chores are prescribed. You have to do domestic chores because you are not a breadwinner. Yours is to make sure that the house is clean and there is food for the entire family. These chores on their own take up time, even when you are feeling sick, our minds have been trained to dismiss that thinking because no one pays attention on your health needs. We basically don't have time to go local clinics, let alone being stigmatized when we get there. The first stigma experience is from health practitioners that are supposed to render professional services. As they service us, they make sighs of judgements such as "ubungaziboni yini ukuthi uyagula, njengaba ufika lesifo sakho sesibhebhethekile ucabanga ukuthi uzophila kanjani, why nidembesela, uthembeni ngempela, why are you not taking your health serious". Such judgment comments are strip us our dignity. This cuts deep if it is uttered by female health professionals.

The narratives shared by rural women above highlight the complex relationship between stigma and resource availability in healthcare settings. Participants noted that stigma often stems from healthcare workers' behavior and attitudes, which can be a significant barrier for health-seekers. The limited availability of resources, such as insufficient medical supplies and understaffed clinics, could further exacerbate the absence of essential SRH services, negatively impacting patients. This dynamic, where healthcare workers engage in gossip about patients' health needs or illnesses, coupled with resource constraints such as long working hours, low medical stocks, and the lack of necessary SRH services, creates additional obstacles for women seeking care.

6.2.1 Worker Attitude

This subtheme explores healthcare workers' conduct and its impact on women's experiences with SRH services. Different narratives from participants may provide insight into how each woman perceives and experiences the use of SRH services. According to Dapaah (2016), attitude plays a critical role in employee retention in the healthcare sector. Positive and encouraging attitudes among staff can significantly improve their well-being and job satisfaction, especially in high-stress, demanding work environments. When healthcare professionals demonstrate strong commitment, compassion, and teamwork, it fosters a supportive and collaborative work environment. This, in turn, reduces burnout and increases job satisfaction (Dapaah, 2016). A positive work culture can also decrease employee turnover and increase retention rates.

On the other hand, a negative or indifferent attitude from healthcare workers can have the opposite effect. A single staff member's poor attitude can negatively affect morale and create a toxic atmosphere, undermining teamwork and collaboration (Dapaah, 2016). In environments where healthcare professionals work closely together, lack of support can exacerbate the emotional and mental toll of the job. A hostile or disengaged workplace may eventually drive workers to leave in search of more supportive and rewarding environments. Poor staff-patient interactions, in particular, can lead to heightened frustration and, in some cases, even violence (Dapaah, 2016). This underlines the importance of improving healthcare worker attitudes and creating positive work environments to ensure the delivery of high-quality SRH services.

Participants 11, 13, 15, 17 and 19

"*Well, despite the kind of help we require but tjo our clinic staff are very judgemental, we wouldn't*

even ask about SRH services in detail, it hard shame" (Participant 11)

" Weh, I have 2 kids, even if I was not married I would never ask our uMkhambathini clinic staff anything, there is no client-patient confidentiality there; shame, as you explained SRH as it seems it is a sensitive matter and mostly are things we go for to the clinic" (Participant 13)

"You know for me, it has always been about confidentiality, and those ladies do not know what is that, the services you spoke about we need theme but we end up not engaging, the same people required to help us negatively talk about us or discuss us, even if you direct kids to avoid pregnancy they get judged" (Participant 15)

"Well, clinics where we need to get this information of SRH they judge us, women on women judging, here no one talks of aborting even if you got raped, no one expects a married woman to inject contraceptives, even worse clinic people stay around they talk about our illnesses and assistance we seek to neighbours" (Participant 17)

"For me I would use SRH as I previously did when I was staying in Xopo but here things are very different, yes, nurses in the public health system are not the friendliest people but here it has been hard, some services are not rendered at all some you feel shame and the staff will judge you" (Participant 19)

This social stigma may negatively impact the expected use of SRH services in uMkhambathini and eNkanyezini. However, denial of medical services is not the only form of discrimination within the healthcare system. Other examples of discrimination include providing false information, requiring third-party consent before offering services, violating privacy, and breaching confidentiality (UNAIDS, 2022). HIV-related discrimination, in particular, can take many forms, such as forced or coerced sterilization of women living with HIV, mandatory HIV testing without consent or adequate counseling, healthcare providers minimizing contact with or care for patients living with HIV, and delays or denials of treatment (UNAIDS, 2022). The responses above indicate the detrimental factors that continuously limit women's access to SRH services. Participants' accounts highlight the stereotypes, stigma, and discrimination exhibited by clinic staff. Stereotypes are generalized ideas about the traits and behaviors of members of specific social groups, often based on factors such as race, ethnicity, sex, age, financial status, or sexual orientation (Marx & Ko, 2019). These rural stereotypes and attitudes are inhibiting women's access to SRH services, and it remains a policy concern that healthcare practitioners may perpetuate such social stereotypes, stigma, and discrimination against rural women in uMkhambathini.

Furthermore, in the context of healthcare, social stigma refers to the negative association between individuals or groups possessing particular traits and specific illnesses (WHO, 2020). This study suggests that these intersecting barriers should be addressed to benefit rural women in uMkhambathini and eNkanyezini. The ongoing support for healthcare practitioners should emphasize that their primary duty is to ensure access to healthcare services, including sexual and reproductive health, and to save lives. Healthcare beneficiaries should not experience harm when seeking care.

6.2.2 Marital Limitations

Within the context of Gender Theory, marital status significantly influences gender-based violence, particularly by limiting women's access to sexual and reproductive health knowledge. In the African context, Gender Theory suggests that when a rural woman enters marriage, she often experiences a loss of personal identity and is objectified, as her value is determined by the lobola negotiations. These negotiations not only silence women's voices but also treat their bodies as property owned by their husbands. While unmarried women may not face the full extent of this dynamic, they, too, experience objectification within their intimate relationships. The following narratives highlight the lived experiences of rural women in uMkhambathini, exposing a deeply rooted gender hierarchy that marginalizes their voices.

Marriage, as a social institution, exists across various societies and is interpreted in different cultural contexts (Baloyi, 2022). While its significance may vary, marriage is universally considered crucial for societal continuity and preservation. Baloyi (2022) argues that marriage plays a vital role in sustaining human life across generations. However, within African Indigenous cultural systems, marriage is profoundly gendered, shaping the health experiences of rural women in ways that reinforce systemic marginalization. These cultural systems encompass a wide range of socio-cultural elements, including customary greetings, dress codes, social norms, food traditions, music and dance practices, occupational roles, religious beliefs, and prescribed behavioral patterns. Collectively, these factors contribute to the oppression of rural women, inhibiting their liberation and empowerment.

Participants1, 3, 4, 5, 9, 17, 23, 25 and 26

Ndodana, like we have shared earlier on that umshado has not brought joy to many of us. I

remember saying, while abanye befuna ukungena, abanye bafuna ukuphuma. Those of us that are within this instition have not had best moments. One we are unemployed that on its own makes us to be finally dependent on our husbands. These people objectify us. You don't have a voice because he did you a favour by marrying you. He did you a favour because wena ubuzogugela ekhaya ungathathwa ngumuntu. He did you a favour ngoba wakukhetha ezintombini eziningi owawubanga nazo. He did you a favour ngoba wakuthatha ekhaya lakho elalihlubeka. He did you a favour ngoba wakushintsha isibongo. All these labels are deeming and dropping your confidence as a women to zero percent. These are our daily circumstances as rural women. We also have the pressure to expand the family yet there is no support that is made available. We do not only navigate through these challenges but there are health risks which comes from accepted infedility behaviours that have been normalized in our community. By the time to fall sick either having depression, there is no form of support because ungubani ongathi une-depression, kuyaqala yini ngawe ukuhlushwa indoda. If it happens that you are medical sick, you don't have anyone to support you ngoba as a wife to someone implies that umfazi kumele uyibambe ishisa. This implies that you are on your own as umfazi. Those that test HIV positive or find themselves having sexual transmitted infections are not able to convey how they feel because they are always judged by their partners, their families both nuclear and extended families and worse by the community at large. Umfazi akanalo izwi enkonzweni yethu yamaNazareth, futhi angicabangi ukuthi nakwamanye amahlelo ezinkolo ukuthi umuntu wesifazane unalo izwi" (Participant 1).

Marriage is not easy as people think. What I am trying to tell you is that, we are not allowed to talk about menstruation or many other health related issues with our husbands. One, we are made to believe that sharing health problems with our husbans implies ukuthi sibaphuca isithunzi. As sishadile, awukwazi ukukhuluma about period pains. Ukuba on your period is associated nokugcola. Angiphathike uma kwenzeka waba ne heavy flow is associated with having a miscourage. Even if you are having a miscourage, no one is there to openly support you. Noone encourages you to seek medical help. Our socialisation as the AmaZulu nation has discouraged us to shy away from discussing health problems. Noma ngabe kumnandi kanjani emshadweni, awulokothi nje ukhulume ngokuthi unezinkinga zesinye or segazi as umuntu wesifazane. None encourages you to go for the examination of your health such as pepsmear. When you talk about pepsmear, ubukwa njengomuntu okhumulela amanye amadoda nomuntu ongasihloniphi isitho sakhe sangasese, mind you esakhokhelwa izinkomo. To add, ubudoda (Participant 3).

"Heh, Lord, I think it has to do with religion. In my religion, we do not believe in contraceptives. Also, my family has never supported it, or maybe I can say they have never been worried about SRH; in rural areas, it's all about what you believe. Many of us are having unplanned children because we have been raised to believe that having children is essential for expanding the family. Those that are not married they are socialized to believe that, if ufuna ukugcina indoda kumele uyizalele. Ifungazali izokushiya indoda. We have also been discouraged from using contraceptives we want to ensure that there is reproduction. Secondly, asiwasebenzi amaphilisi okuhlela ngoba siyasaba ukushiywa ngamadoda ngoba kuthi uyabanda uma usenbenzisa amaphilisi okuhlela umndeni. These social constructs are now part of the conversation that our young girls have inherited. This comfirms that the cycle of women misery does not shrink but it gets broader and broader each day. Kwesinye isikhathi ngifikelwa ukuthi kuyisiqalekiso ukuba umuntu wesifazane especially thina kakhulukazi esikhulele emakhaya futhi sashadela emakhaya." *(Participant 4)*

"For me, it is a shame that no one cared to talk about SRH services; it is one of those things parents never think is important, and worse, my father is a traditional man. He does not believe we should consider them; rather, he wants behaviour on us. Hence, today, as a married woman, I did not know what services come with SRH. What concerns me is that, I have nothing constructive that will save their health. We are a generation that is lacking health empowerment hence our lives are shaped by health-related risks." (Participant 5)

Jehova, umuntu usentweni, if it happens that you get married. Our church does not allow us to even go for medical check-up before kushadwe. Ungena ungaguli emshadweni, uzithole ugula usune HIV and other infectious illness because asihloli igazi ngamphambi komshado. When this happens, uvele uphathwe i-depression yokuthi ufike wazigcina wena wase uhlangana nekhehla noma nendoda edulayo. Even if you divulge your status to your husband, abakholelwa to advance for their own sexual health information. Bona they don't take their ARVs, kuba ithina kuphela esithatha imishanguzo. When you ask for their reasons, one amongst many is that, uzoya kanjani e-clinic ayotshelwa ukuthi unegciwane lesandulela ngculazi ebe eyinduna noma ebe engumsuyeli ebandleni. (Participant 17)

Amadoda ethu ayaba nezifo zocansi that are not treated, nathi sitheleleke bese siba nokuthi angeke

sikwazi ukuya ema-clinic because uma uveza lesimo, usuke uveza ihlazo lomkhwenyana kwakho. Into eyenzakalayo ukuthi, umkhwenyana uvele ahambe ayofunda ibhodlela lesintu (ethnomedicinal herbs) siliphuze ngaleyondlela asuke elulekwe ngalo umelaphi wendabuko. Indima edlalwa ngamakhambi esintu esimweni sokugula kwethu kusenza sigcine singasayanga emtholampilo ukuyothola ngisho ama antibiotics. Uthole ukuthi lesosifo siyabuya futhi. Uma sesibuya okwesibili, kuvele kuthiwe nguwe wena muntu wesifazane osilethile. (Participant 23)

"Personally, using SRH has never been my choice because, most of us in Nazareth church get married early, kuthiwa sizokhulela emendweni. Siya emendweni being told to serve the needs of our husbands not be proactive in talking care of our health. To be quite honest, as a young married woman, I am clueless about health choices that I should take or begin to discuss with my husband even if there is a room to do so. Understanding that we have been raised to conceal our emotions and our husbands have been socialized not to listen to us, I don't see if there will ever be a time where I openly speak about sexual reproductive health not only my benefit as a women but as a benefit of the entire family." (Participant 25)

"Mina I know briefly about sexual reproductive health, having access to contraceptives is one of the initatives but asivunyelwe ukuhlela umndeni. It has become common knowledge that kuyisono ukuhlela umndeni in my church. Ours as women is fall pregnancy/reproduce ingakho izingane zethu zingashiyani kakhulu ngeminyaka. Ingane ikhiswa enye ebeleni. Secondly, the use of contraceptives in my church has been downplayed misconceptions such as aqeda inzalo. It is public knowledge that those that are using or have used contraceptives will be diagnosed with cancer because government is trying to depopulate us" (Participant 26)

Narratives of rural women from uMkhambathini display that marriage comes with related challenges. According to Ekane (2013), polygamy, kinship networks, patriarchy and hierarchy, rural majority status, and a strong emphasis on lineage continuation are the main characteristics of African households that inhibit rural women from accessing sexual reproductive health interventions such as contraceptives or the holistic examination of their health. In rural areas of uMkhambathini, there is empirical evidence that rural women are subjugated by the following intersectionalities that discourage them from accessing sexual reproductive health.

Qualitative data analysis has revealed that patriarchy has introduced power and dominance, which silences women, particularly rural women of uMkhambathini. Additionally, although the uMkhambathini l maintains a stronghold in society, male supremacy inhibits women from sharing their sexual reproductive health concerns within the context of their marriages. Strong patriarchal customs, a high prevalence of polygamy, and fertility and lineage continuation are all given significant cultural weight, which subjugates rural women at the expense of their health. These are the salient factors that affect rural women. Rural women of uMkhambathini navigate under these factors daily. The intersectionality of factors clearly shows that rural women of uMkhambathini are less liberated than women in urban areas.

***OBJECTIVE THREE*:** The absence of ubuntu has significantly shaped how rural women navigate inhibiting sexual and reproductive health (SRH) conditions. Ubuntu, rooted in the African philosophy of interconnectedness and mutual care, emphasizes collective responsibility and support. When ubuntu is lacking, rural women often face isolation, stigma, and limited access to SRH services. Traditional gender norms and societal expectations may discourage open discussions about contraception, abortion, and HIV/AIDS, further marginalizing women seeking care. Structural barriers, such as inadequate healthcare infrastructure and discriminatory practices, are exacerbated by the breakdown of communal care and support. However, where elements of ubuntu persist, rural women often draw strength from community-based health networks, peer advocacy, and traditional healing practices. Support from women's groups, local healers, and cultural leaders fosters trust and empowers women to access SRH services without fear of judgment. Integrating both biomedical and indigenous knowledge systems through the lens of ubuntu can create more culturally responsive and supportive SRH interventions for rural women.

6.3 Health seeking access

Humans are inherently capable of navigating challenges and developing coping mechanisms. In medical anthropology and Critical Medical Anthropology (CMA), access to healthcare facilities is a critical variable used to assess the effectiveness of health services. Ndlovu’s (2022) recent contribution to medical anthropology highlights the difficulties people in rural areas face when attempting to access healthcare facilities, particularly during times of need. This observation, based on experiences during the COVID-19 pandemic, resonates with many people's recent encounters. In the context of this study, it was crucial to explore how rural women in uMkhambathini seek access to health services. The narratives of these women reflect common rural challenges related to

accessing SRH services. During the in-depth interviews, all thirty participants expressed that access to health facilities is influenced by multiple factors.

Access to healthcare in rural areas is far more challenging than in urban settings. Structural barriers significantly impact the ability of rural women in uMkhambathini to reach healthcare services. One of the major obstacles is the geographical distance to health facilities, which makes it difficult for users to access care. Factors such as inadequate transportation and poor road infrastructure further discourage women from seeking services. Additionally, rural health facilities are often under-resourced, making it difficult for them to provide comprehensive care. Other barriers include a lack of compassion, professionalism, and a sense of ubuntu (community spirit), all of which were consistently identified by the research participants as man-made obstacles that hinder their access to health services.

Accessing the best medical care in our community remains a huge challenge. The facility is not clean, you can't be sick and also be expecting medical care in the facility that is lacking cleanliness. Toilets are blocked, consultation rooms are not clean, the waiting are does not have enough chairs. If it happens that you eventually meet the health practitioner, you are told that the facility does not even have a panado to ease your pain (Participant 7).

Sengathi izinkinga zempilo yakho futhi lezi ezibucayi ungazikhuluma nomuntu ongamazi noma owolunye uhlanga ngoba usuke wazi nje ukuthi enikukhulumile kugcina phakathi kwenu nobabili. In our community, confidentiality does not exist, indaba yakho ixoxwa ungakaphumi nangesango (Particpant 10).

Mina ngisizwa ukuthi nginezihlobo kwezinye izindawo, ingakho sengakhetha ukuklinikha khona. La ungaziwa khona you get the best medical care (Participant 3, 15, 25, 30).

The responses highlight significant shortcomings in healthcare delivery within the community, exposing a lack of compassion, professionalism, and ubuntu in the healthcare system. Compassion, which involves recognizing and responding to the suffering of others with care and empathy, is noticeably absent in the poor state of healthcare facilities. Participant 7 describes how blocked

toilets, unclean consultation rooms, and a lack of chairs in the waiting area create an undignified and uncomfortable environment for patients. The absence of basic medication, such as Panado, further exacerbates the issue, leaving patients feeling neglected and uncared for. This reflects a failure to provide not only physical care but also emotional support, which is essential in building trust and encouraging patients to seek medical help.

Professionalism, which encompasses ethical standards, respect for patient dignity, and confidentiality, is also compromised. Participant 10's observation that patient information is frequently shared outside of the consultation room indicates a serious breach of confidentiality, undermining trust in the healthcare system. The perception that patients cannot speak openly about their health issues without fear of their privacy being violated reflects a lack of adherence to professional codes of conduct and patient care standards. Additionally, patients' preference to seek care in other communities where they feel more respected and cared for (Participants 3, 15, 25, 30) suggests a deep distrust in the competence and ethical conduct of local healthcare providers.

The absence of ubuntu has significantly shaped how rural women navigate inhibiting sexual and reproductive health (SRH) conditions. Ubuntu, rooted in the African philosophy of interconnectedness and mutual care, emphasizes collective responsibility and support. When ubuntu is lacking, rural women often face isolation, stigma, and limited access to SRH services. Traditional gender norms and societal expectations may discourage open discussions about contraception, abortion, and HIV/AIDS, further marginalizing women seeking care. Structural barriers, such as inadequate healthcare infrastructure and discriminatory practices, are exacerbated by the breakdown of communal care and support. However, where elements of ubuntu persist, rural women often draw strength from community-based health networks, peer advocacy, and traditional healing practices. Support from women's groups, local healers, and cultural leaders fosters trust and empowers women to access SRH services without fear of judgment. Integrating both biomedical and indigenous knowledge systems through the lens of ubuntu can create more culturally responsive and supportive SRH interventions for rural women. The African philosophy emphasizes human interconnectedness, collective care, and mutual respect is evident in this breakdown of trust and communal support. *Ubuntu* fosters a sense of belonging and shared responsibility for each other's well-being, which appears to be missing in the current healthcare setting.

The failure to provide compassionate and professional care reflects a broader disconnect from the values of *ubuntu*, where healthcare should be delivered with humanity and respect for the dignity of every individual. To operationalize these concepts, healthcare services must prioritize clean and well-equipped facilities, strengthen patient confidentiality measures, and foster a culture of empathy and mutual respect. Healthcare practitioners should receive training on ethical conduct and patient communication to restore trust and professionalism. Moreover, adopting a community-oriented approach that aligns with the principles of *ubuntu* where healthcare is viewed as a collective responsibility can help rebuild trust and improve overall health outcomes.

6.3.1 Coping Mechanism

The theme of coping mechanisms explores how rural women manage the challenges they encounter in accessing healthcare, particularly sexual and reproductive health (SRH) services. These challenges often serve as significant barriers to the effective utilization of such services. As noted by Algorani and Gupta (2023), coping mechanisms are enduring characteristics that shape an individual's responses and decisions when faced with stress. Coping strategies can be broadly divided into two categories: proactive coping, which seeks to prevent future stressors, and reactive coping, which addresses stressors after they arise. This distinction is particularly pertinent in understanding women's experiences with SRH services, especially within the roles of mothers and partners. The theme draws attention to the personal strategies that women employ during clinic visits to navigate access to SRH services.

These coping strategies frequently involve efforts to mitigate or avoid stigma within healthcare facilities, as stigma serves as a significant deterrent to seeking care, particularly for reproductive health issues. In many rural communities, women are exposed to stigma in various aspects of their lives, further compounding the challenges they face in accessing care. Coping mechanisms, therefore, refer to both the cognitive and behavioral strategies employed to address stress, whether internal or external. While defense mechanisms are often adaptive, unconscious reactions aimed at reducing or tolerating stress, coping mechanisms are conscious, voluntary actions taken to manage stress.

Rural women, particularly those who are mothers, wives, or daughters, are uniquely affected by these stressors. The socio-economic and cultural dynamics of rural life create a distinct set of

challenges for women in these areas (Chandra, Ross, & Agarwal, 2020). These include gender-based discrimination, poverty, poor health, and the burdens of agricultural labor. Vulnerability among rural women is further exacerbated by factors such as advanced age, widowhood, poverty, or residence in conflict-affected regions. These intersecting factors intensify the difficulties faced by rural women, making their coping mechanisms central to their ability to manage health-related stress and navigate access to SRH services.

Participants 7, 12, 14, 24 and 26

"Well, as much as some of us need to use SRH services, we just avoid using the local clinic, especially very sensitive things, even worse the sister at the clinic told my mother that my sister was pregnant before she even had a chance to tell the parents, she was furious, so we try to avoid" (Participant 7)

I am able to cope because of my economic agency. It is important to have your own money because you are not solemnly dependent on what is provided by your husband. Our husbands are bullies in case you don't know. When they help you or make provisions, you should know that you have traded your dignity and your voice. Mina my husband, knows that angimncengile kakhulu and when it comes to my health, I make sure that I access private medical care interventions because those health facilities don't gamble with our lives and they thoroughly take you through the importance maintaining a healthy life style. I truly feel it for unemployed women in my area because they stomach the bad treatment that their husbands toss around. (Participant 8).

You will hear majority of women in my area saying, sithwele singabantu besifazane. The social construct of sithwele singabantu besifazane[13] simply means that women go through a lot. They carry a burden of untold stories and they are hurting. We are constantly reminded to conceal what we go throught our expression only gets limited in saying sithwele singabantu besifazane. We also use the sithwele singabantu besibame as symbolic expression of copying. (Participant 11).

"Weh, heh, for me, I have to travel for serious matters; I have a clinic card from Hope-well, it is far but to avoid drama from the Clinic staff of uMkhambathini you need to be smart or else you will be the talk of the area" (Participant 12)

"em hah, mmh, we really try not to ask for any SRH services; my sister-in-law works at the clinic, imagine I cannot ask for any SRH services even my kids, I mean, what do we go for to the clinic is private but nothing ends up private" (Participant 14)
To be honest, mina I am coping because I use my child's social grant in order to travel to the East street clinic where my health is cared. This means that, I buy small quantities of grocesseries, mostly o-alishoni so that atleast there is food to last us for few days. Okunye okubalulekile, my kids don't get to eat three meals a day. They eat twice and, in those moments, they also eat small portions. Okunye futhi ukuthi, there is no rotation of food. When you are navigating in poverty like me, you don't have food choices. You train your children to eat what is put on the table. My children get to eat different food types only on Saturdays, nakhona uma bevakashe kubangani babo bagcina bephakeliwe. This communal support is another way of copying. (Participant 15)

Eyi, you won't believe that while abafazi bebukelana phansi but kulomphakathi waseMkhambathini eNkanyezini, siyathwalisana. Yazi in many instances sidla amaphilisi aphanayo, siyananelana ukuze sonke sigwinye ngesikhathi umuntu esazama imali yokugibela. Uma usubuya nawakho amaphilisi uyambuyisela obekade ekunanelile. (Participant 20)

Mina I cope by praying to Shembe. I have been raised to believe that whenever I pray to our mighty sheperd Shembe all our illnesses and takes care of our poverty. (Participant 21)

Like I said previously, I am able to cope simply because uma umuntu ehlabekile empilweni, umkhwenyana ami uvele azame amakhathakhatha esintu (ethnomedical herbs) siphuze sobabili, nakube kubalulekile ukuthi ngiveze ukuthi izifo zocansi azilapheki gelekeqe, ziyaphola okwesikhashana zibuye zibuye ngoba sisuke singawatholala ama antibiotics alesosifo. (Participant 23)

"There is simply nothing I can do, I go there as I really need help, even for SRH services. I do not have anywhere to go to this clinic with its issues I was born here, and I have never thought of joining other clinics" (Participant 24)

Min I am not issue if I am coping or note. It is a devastating feeling to know that you are sick but the person that brought the sickness in the home is not taking fully accountability of his wrong

behavior. What maybe keep me going is that, other women in the area have also confirmed that majority of use are cooked in the same pot. When we meet, we simply say, qina ntombazane sonke sasingazi ukuthi koba nje kodwa ngoba sekunje akusekho ukujikela emva kwendlu. This is our resilent copying mechanism. This also means that we cope because we know that you are not the only person who has been infected by her husband. Impiloni le esiyiphilayo? (Participant 30).

The responses above illustrate the diverse coping strategies employed by rural women to navigate the challenges they face in accessing sexual and reproductive health (SRH) services. These strategies encompass a wide range of economic, social, cultural, spiritual, and psychological approaches, reflecting how women manage not only SRH-related issues but also the broader socio-economic pressures they encounter.

- **Economic Coping Mechanisms** include financial independence and the strategic use of social grants. Women with their own financial resources, such as Participant 8, are able to access private healthcare services, which allows them to make independent health decisions. This reduces their reliance on male partners and the poor treatment often encountered at public clinics. For others, social grants are a crucial means of survival, enabling access to distant healthcare facilities and providing basic sustenance. However, as Participant 15 describes, this often results in food insecurity and limited dietary variety.
- **Social and Communal Coping Mechanisms** involve mutual support and resource-sharing within the community. Participant 20 highlights how women share medication and provide financial assistance to ensure that others can access transport and treatment. This collective effort fosters a sense of community resilience. Phrases such as "qina ntombazane" (stay strong, girl) and "sithwele singabantu besifazane" (women carry a burden) symbolize the shared understanding and emotional strength among these women.
- **Spiritual and Religious Coping Mechanisms** also play a significant role in offering emotional and psychological comfort. For example, Participant 21 finds strength through prayer to Shembe, believing that spiritual intervention helps manage both health and poverty. Similarly, Participant 23 relies on traditional healing practices, such as consuming ethnomedical herbs alongside modern treatments, to cope with health issues.
- **Psychological Coping Mechanisms** are evident in emotional resilience and acceptance of shared struggles. Participant 30 emphasizes that recognizing that other women face similar challenges

fosters emotional solidarity and reduces feelings of isolation. However, some responses also reflect emotional exhaustion and resignation, with women expressing feelings of helplessness in the face of ongoing systemic failures and male dominance. Despite these challenges, the collective reliance on communal support, spiritual faith, and economic resourcefulness illustrates a multi-layered coping system that highlights both the limitations and strengths within these women's social and economic contexts.

These coping strategies emerged during the focus group interviews and are closely linked to the participants' social experiences with SRH services, particularly their encounters with the uMkhambathini clinic. According to Bianca, Romona, and Loana (2022), coping mechanisms are complex processes that help individuals manage various stressful situations that seem overwhelming. Stressful circumstances often trigger adaptive responses, enabling individuals to develop new ways of handling unexpected or challenging events. If these coping strategies are effective, they help individuals gain control over, reduce, or tolerate stressful situations. These strategies are generally classified into two subtypes: active or problem-focused coping, which directly addresses the problem, and passive or emotion-focused coping, which involves managing the emotional response to the stressor (Bianca, Romona & Loana, 2022). Sambala and Ngoasong (2014) emphasize that empowering women is essential for improving their health and the health of their families.

6.3.2 Psychological Support

The theme of psychological support examines the role of communal psycho-social interventions, which often emerge from daily conversations with trusted individuals. The scope of SRH services extends beyond family planning to include issues such as gender-based violence (GBV). People choose whom they trust and confide in regarding sensitive matters, and this process is often viewed as a form of healing. Social networks and support are key components of social capital, a broader concept that encompasses both formal and informal support (Drageset, 2021). Social networks and social support can be described in various ways, often focusing on their structural and functional aspects. Individuals without close relationships may find formal support in healthcare settings, such as nursing care. The structure of a social network—defined by the number of relationships or social ties an individual has, as well as the nature of social exchanges (such as social support activities and

frequency of interactions)—is a crucial component of social support. Connections with friends and family are particularly important for providing emotional and psychological support.

By exploring these coping mechanisms and support systems, this study underscores the resilience of rural women in the face of systemic barriers to healthcare. It also highlights the essential role that social networks play in helping them navigate these challenges.

Participants 3, 5, 8, 10 and 14

"We talk as friends, me and my other friends discuss a lot; it helps, especially certain private things need to be shared although I won't be specific, we know how to get help though not all help, especially mental help" (Participant 3)

"Weh support structure, there is nothing like that, it either we use some SRH services or not, the support structure which is clinic staff and counsellor who are all people we distrust" (Participant 5)

"Hhai for me shame, I feel there is a lack of support from our local clinic, we try what we can, especially in cases of GBV, some move away from here eNkanyezini" (Participant 8)

"For us here, help is not available for many of the things you mentioned; we also keep many things to ourselves. It might not be impactful, but we are keeping our secrets, and no one is talking about us all over" (Participant 10)

"There is not much support when it comes to using SRH services. We give each other advice and attend traditional healers; at least they can keep things private. I have uGobela mina" (Participant 14)

Summary of coping machanisms employed by rural women of uMkhambathini when trying to access SRH.

The diagram above analyzes Sexual and Reproductive Health (SRH) and psycho-social support within the context of Shembe religious beliefs and broader socio-economic constructs. Here's how the elements in the diagram relate to each other:

- **Prayer to Shembe:** This suggests a reliance on faith-based healing rather than biomedical interventions. In the context of SRH, this could mean that individuals may turn to spiritual guidance, such as prayer to Shembe, instead of seeking medical treatment for reproductive health concerns, which might impact their access to SRH services like contraception, maternal care, or STI treatment.

- **Avoid Local Clinic:** This indicates a possible mistrust of formal healthcare services, which may stem from cultural beliefs, stigma, or negative past experiences. This avoidance could significantly limit access to essential SRH services, including contraception, maternal care, and STI treatment, which would further perpetuate health disparities.
- **Children's Social Grants:** This represents state-provided economic support, which can influence reproductive decisions. In some contexts, social grants may provide financial relief and encourage larger family sizes if they are perceived as a safety net. However, these grants could also contribute to financial stress if they are insufficient to meet all needs.
- **Social Constructs** (e.g., "sithwele singabantubesifazane"): This phrase, meaning "we carry the burden as women," reflects the societal gender roles that women are expected to uphold. In terms of SRH, it highlights how women bear the responsibility for reproductive decisions, childcare, and navigating healthcare systems, often without adequate support or resources. It also reinforces the concept of women's unequal burden within the context of SRH and healthcare decision-making.
- **Economic Agency:** Economic independence plays a significant role in reproductive choices and healthcare access. When women have financial autonomy, they are more likely to have control over their reproductive health, including decisions about family planning and healthcare choices. Economic agency enhances women's autonomy, empowering them to make informed decisions about SRH without excessive reliance on others.

These responses reflect the need for more comprehensive support regarding SRH service use. Innovative service models and technologies could help improve healthcare access, particularly in developing nations where large portions of the population live in rural areas (Barjis, Kolfschoten, and Maritz, 2023). Several factors contribute to the low quality of healthcare in remote locations, such as inadequate patient monitoring for those with severe or chronic conditions, low literacy, and poor infrastructure. In the context of SRH, individuals should have the right to inclusive and safe healthcare, accurate information, timely testing, and effective treatment and support (Bradfield et al., 2022). The importance of these resources cannot be overstated as they are vital for the maintenance of sexual and reproductive health.

Furthermore, good sexual and reproductive health also involves the freedom to make informed decisions about one's health, knowing the risks, and taking precautions to stay safe. It is essential

that everyone has access to the necessary information to make informed decisions about their SRH. Overcoming barriers to healthcare access, particularly SRH services, is paramount for ensuring equitable health outcomes.

OBJECTIVE FOUR: Recommendations to Improve Access and Use of SRH Services

6.4 Contextualizing SRH Action

This theme discusses the necessary actions to address the SRH service challenges in uMkhambathini and eNkanyezini. An essential part of mitigating these issues is the implementation of a productive plan. Kalua and Nyasulu (2007) emphasized that health education is critical in delivering health services. Health education is the process through which individuals and groups learn how to promote, maintain, or restore health (Kalua & Nyasulu, 2007). Unfortunately, many African healthcare systems are in dire conditions and produce poor health outcomes. Several studies have highlighted the challenges faced by African healthcare systems, with many aligning with earlier research (Oleribe et al., 2019). Survey participants identified limited human resources for health, inadequate healthcare funding, and poor leadership and management as the main challenges within the healthcare sector (Oleribe et al., 2019).

To address these issues and improve SRH services, the following recommendations could be implemented:

Strengthening Health Education: There is a need to implement widespread health education campaigns aimed at empowering individuals, particularly women, with knowledge about SRH, family planning, and available healthcare services.

Improving Healthcare Infrastructure: Investments in healthcare infrastructure, particularly in rural areas like uMkhambathini and eNkanyezini, are essential. This includes ensuring that clinics are equipped with the necessary facilities, medications, and trained staff to handle SRH needs. Increasing Healthcare Budget Allocations: Governments and international donors should prioritize increasing funding for healthcare, particularly for SRH services, to ensure that the needs of rural communities are met.

Enhancing Cultural Sensitivity in Healthcare Delivery: Healthcare providers should be trained to respect cultural beliefs, including religious practices like Shembe, and work to build trust with local communities, especially in areas where people may be reluctant to seek formal healthcare. Community-Based Healthcare Models: Establishing community-based healthcare models that integrate local knowledge, community support, and spiritual beliefs could help increase healthcare access and utilization. These models would ensure that care is both culturally sensitive and aligned with the needs of the population. Addressing Gender Inequality: Empowering women through education, economic opportunities, and policy changes can help reduce the gendered burden of reproductive health. Addressing gender roles and expectations can lead to more equitable decision-making regarding SRH.

By adopting these strategies, the accessibility and utilization of SRH services in rural areas like uMkhambathini and eNkanyezini can be significantly improved, fostering better health outcomes for women and the broader community.

Participants, 10, 12, 13 and 16

"Weh, hah, I think maybe lets us promote SRH services in families and train people in the community especially these nurses to not judge us" (Participant 10)

"We want our leaders especially those politicians to account for our health crises and maybe more women will attend the issues of SRH, maybe teenage pregnancy can be decreased even our partners need to be taught" (Participant 12)

" Hhah maybe we start telling nurses to stop gossiping or judging us especially the older nurses, it hard we can also educate men they do not understand reproductive complications"(Participant 13)

"Build more clinics for a start, inform people in the community in detail, uMkhambathini is a huge area, we have a lot of people, many women are not using SRH services because that place is always full" (Participant 16)

The response above reflects some of the suggestions provided by women in uMkhambathini and eNkanyezini regarding their access to and use of Sexual and Reproductive Health (SRH) services. These suggestions stem from concerns about the existing healthcare and cultural limitations that contribute to the poor access to SRH services for women. Cultural limitations involve the

perceptions held by nurses, men, and the broader community regarding SRH services. Increased information may help reduce the hesitancy and stigma surrounding SRH services among men and some healthcare workers. Healthcare limitations, particularly the lack of resources, can be addressed by building the necessary healthcare infrastructure. Participants emphasized that resource allocation and knowledge sharing are key factors in resolving some of the challenges related to SRH service access and utilization. It is crucial to contextualize public participation in addressing health crises, ensuring that the urgency of these challenges is recognized and acted upon.

6.4.1 Access to SRH Knowledge

Gender Theory, in conjunction with Critical Medical Anthropology and the Anthropology of Women, offers valuable insight into the challenges faced by rural women, particularly concerning health literacy, which is critical for accessing sexual and reproductive health (SRH) information. As Kalua and Nyasulu (2007) and Rincón Uribe et al. (2021) highlight, health attitudes serve as a bridge between health behavior and health knowledge. A person's attitude, shaped by their beliefs or evaluations—whether positive or negative—directly influences their behavior, determining whether they seek or avoid healthcare services.

In the context of SRH, attitudes play a pivotal role in shaping how individuals perceive and engage with healthcare services. For instance, following an educational campaign, individuals who initially held negative views on issues like HIV or reproductive health became less stigmatized and more open to seeking care. Participants in the experimental group showed significant behavioral changes, becoming more accepting of SRH services, while the control group remained unaffected (Kalua & Nyasulu, 2007; Rincón Uribe et al., 2021). This demonstrates that educational interventions can shift health attitudes and behaviors, ultimately improving healthcare access and utilization.

Health knowledge itself is a fundamental factor in this process. As noted by Kalua and Nyasulu (2007) and Rincón Uribe et al. (2021), health knowledge includes a comprehensive understanding of diseases—encompassing their origins, prevalence, risk factors, symptoms, prevention strategies, transmission routes, treatment options, and available healthcare services. It also involves awareness of patients' rights. Evidence suggests that increasing health knowledge within communities leads to improved health outcomes by empowering individuals to make informed decisions and adopt preventive measures. By enhancing health literacy and addressing misconceptions or stigma

surrounding SRH services, communities can become more proactive in seeking necessary services, thereby improving overall public health outcomes, particularly for women in rural areas like uMkhambathini and eNkanyezini.

Participants 15, 18, 20, 22, 26 and 29

"I feel after you explained, we need to discuss these issues of SRH, especially for us rural women, who are not educated, we tend not to be exposed to this information. Bafazi (referring to other women participanting int study, I am realizing that there is a lot that we don't know about health. Impela sibulawa ukuthi asinikeziwe ulwazi lwezempilo ingakho singcwatshwa imihla namalanga singabantu besifazane" (Participant 15)

"Oh hhai, I think the clinic staff should stop judging us and be educated. I am not sure now whether they are adequately trained, they need more training, so they will share information without judgement, now it like they sharing information to save their jobs, not to help us. You won't believe that Ive never done pepsmear which is a critical examination for women. This is because I am afraid of exposing my private part. Our religious beliefs have encouraged to keep our private parts as private as they are placed. As we are sitting here, we don't know wherether we have cervical cancer or not. Sadly, many women in our community have gave birth to still born babies what remains a point of comfort is that uNkulunkulu uthathile ngobayena ubengapha uma ubethanda. There is no health advocacy about family planning in our community because there are many misconceptions that are attached to the use of such services. (Participant 18)

Thina we live on community knowledge, uthola emvakwesikhathi that what was commonly knowledge was just misconceptions. Let me tell you something, in this community, it has been recent that we have accepted that people die because of untreated HIV/AIDS. But we still don't know benefits of adhering to your HIV/AIDS medication hence other people find it easy to default. On radio, MEC is talking about having one sexual partner. In our community, many people still believe in multiple sexual partners and unprotected sex. She also speaks about PreP. Noone has bothered to educate us about this pill. If we continue not to have information on sexual reproductive health, we will continue to die like fumigated ants, sizofa bafazi futhi akuzogcina kithina nathi sizozalela amaliba ngoba nezinga zethu zizofa. Lesizwe sosala singenantu noma siyosala namadoda

kuphela ngoba iwona nje okubukeka sengathi ayasinda ekufeni. (Particpant 30).

"Ehm, ahhm, we need more information to be shared on SRH services. Even in cases of wanting to use the services, one would not need to ask or ask freely and ask the kind of SRH service you require" (Participant 20)
"All I can say is we need clinic staff to freely share this SRH information; from what I see, it is very important to share this SRH service information; beyond our beliefs, we have challenges such as GBV and reproductive, and we want to learn about it and also no judgement" (Participant 22) "I want the knowledge to be shared by clinic staff; they share some information they think is necessary about SRH services. We need it to happen regularly; we do not need to visit urban clinics to hear this or be part of the study. Receiving this information will really save our lives. The very same information could also save our young girls. Why is information not part of the teaching curriculum at school? This would beneficial because since our local clinics are under-resourced, educators could help in informing our girls at school. They can share the information with us who have never received formal education" (Participant 26)

"Clinic staff must be detailed about this SRH service information, be patient with our problems especially because they are health care workers. You get at the clinic and the health care worker is anti-social. You can't even ask because you immediately feel unwelcomed. They tell you that they don't have the whole day with you. If it happens that they give you some pamphlets, they are written in English. Why are we given information that is written in English? Why can't we get information that is written in all official languages? Thina izinto sizifihlelwe esilungwi. Uma ungafundile la eSouth Africa awuthathwa njengomuntu ofanele ukwazi. We often hear urban talking about fibroids and how dangerous this is but thina la emakhaya no one has ever bothered to raise awerenss. Asazi noma sinawo noma asinawo yini." (Participant 29)

"My worry about us being uninformed or non-knowledgeable rural women is that, amaphutha nezigameko ezenzeke kuthina zizoba izigameko ezizokwehlekela amantombazane esiwazele. If you see the pattern of teenage pregnancy. This pattern is not new, we are the same generation. No one educated us about family planning. No one spoke openly about taking contraceptives hence some of us are having more than 3 children. In our community, some women are known to be izinyumba "infertile) because no one is openly talking about the existing medical help that is easily accessible"

(Participant 13).

The rate of the lack or the absence of health information in our community is deeply worrying, when a person becomes skinny, we the community jokingly say she has amagama amathathu "implying that she is HIV positive), without assisting or finding health interventions or solutions we stigmatise her. Others are quick to dismiss that HIV is a slow killer, people continue to deny the spread of HIV in our community. When someone finds herself in a sickly situation, we are comfortable in saying abaphansi "ancestors" bamhleli. We continue to be in the dark, hence today I am enlightened to believe that majority of our community members particularly women have been claimed by premature death. By premature death, I mean to say, they died from illnesses and diseases that should have received medical attention. The dissemination of health information in our community will help improve life expectancy, which is currently declining. Having access to health literacy will not only benefit us as rural women "izinzala bantu" but our children will be part of a healthy community where illnesses and diseases are treated.

The responses provided by participants highlight a significant gap between uMkhambathini and eNkanyezini regarding the education and dissemination of information about Sexual and Reproductive Health (SRH) services. Section 27 of the Constitution of South Africa guarantees every individual the right to access healthcare services, including reproductive healthcare (Shozi, 2020). This includes protections for sexual and reproductive health rights, ensuring that every South African has the freedom to make decisions about their own body and the right to receive appropriate healthcare services.

However, as noted by Mohammed et al. (2023), a lack of accelerated health knowledge can lead to misinformation, which in turn delays or discourages health-seeking behaviors, particularly among women in rural areas. The responses in this study underscore the critical gap in health education that exists at the clinics in these regions. The staff behavior is identified as one of the primary factors contributing to the challenges in accessing SRH services. Improving the attitudes and conduct of healthcare workers is essential in bridging this gap. The importance of patient safety is paramount in any healthcare setting, and it aims to minimize the risk of harm from medical care. As Mohammed et al. (2023) highlight, this includes ensuring that the information available, the resources at hand, and the evaluation of the healthcare provided are all aligned to prevent unnecessary risks. Without

proper care and support, patients may face increased risks, particularly those requiring SRH services, who are vulnerable to harmful experiences that could lead to adverse outcomes. For example, individuals admitted to healthcare facilities or those using medications may be at higher risk of experiencing adverse events or drug reactions, which can be exacerbated in settings where healthcare is not delivered with sufficient care.

Moreover, current estimates show that unsafe medical treatment results in more harm in developing countries than in developed ones, highlighting the need for urgent attention to patient safety in rural healthcare settings. Many higher education institutions require healthcare professionals to take courses in patient safety to mitigate such risks. Importantly, patient safety efforts should not exclude the acceleration of SRH services or the provision of necessary help to women in need. To address these gaps, the focus should be on enhancing health education, improving staff attitudes, and ensuring that healthcare facilities are equipped to provide safe, timely, and supportive SRH services for all individuals, particularly those in rural communities like uMkhambathini and eNkanyezini.

6.5 Chapter Conclusion

This chapter focused on presenting and analyzing data collected from 30 participants in the rural uMkhambathini area. The data was organized into tables, which provided essential demographic information, including participants' age, marital status, and the specific Sexual and Reproductive Health (SRH) services they utilized. The table also explored the influence of religious beliefs, underscoring their potential impact on the use of SRH services in uMkhambathini and eNkanyezini. The data was derived from five focus group interviews, each consisting of six participants, offering rich insights into various themes. A key finding was the prominent role of socio-cultural factors, which emerged as significant determinants influencing women's access to SRH services. These factors, particularly those linked to social and cultural norms, play a crucial role in shaping healthcare behaviors and decisions. The combination of these factors illustrates how social behavior and cultural practices can either enable or hinder women's access to healthcare.

One notable subtheme was personal attitudes and beliefs, which reflected the interplay between different religious systems—including traditional beliefs, Christianity, and Nazareth-related faiths—in the context of uMkhambathini and eNkanyezini. This system, as described in the study, provides

an umbrella concept to understand the various religious beliefs influencing health decisions within these communities. Additionally, the theme of pressure factors was crucial in exploring the societal challenges that women face in accessing SRH services. Stigma, discrimination, and judgment were identified as major barriers, not only affecting women's willingness to seek care but also reflecting deep-seated prejudices that exist within society regarding specific health needs. In rural areas, these societal pressures often shape both individual and collective attitudes toward healthcare, perpetuating an environment where stigma and discrimination persist. The next chapter will build on this analysis by presenting case studies from selected women in eNkanyezini, offering deeper insights into individual experiences. Chapter 6 will continue to explore these themes and expand on the data analysis and presentation.

CHAPTER SEVEN

Contributions and Findings

7.1 Introduction

This chapter focuses on the contributions and findings derived from the engaged data set, which are crucial for successfully implementing and realizing sexual and reproductive health (SRH) services as a benefit for the rural women of uMkhambathini and eNkanyezini. The data analysis presented in this thesis aligns with the advocacy of feminist anthropology and the anthropology of women, which emphasizes the need for uncompromised healthcare services for rural women. The two previous chapters of data analysis played a significant role in establishing the framework generated by the study conducted in uMkhambathini and eNkanyezini. These chapters revealed numerous findings related to healthcare accessibility and the availability of SRH services. The rich qualitative data collected through fieldwork further contributed to this process. The focus groups provided valuable insights, as they were based on participants' first-hand experiences, leading to a deeper understanding of the challenges and opportunities for SRH service delivery.

This chapter introduces the **Framework for Localized Reproductive Health and Support Structure (FLRHSS)**, a unique framework developed by the study. Additionally, the implementation of the framework and key findings from the research will be presented in detail. The chapter will also address the methodological limitations encountered during the research process, which at times required the researcher to revise certain strategies in order to better meet the study's aims and objectives.

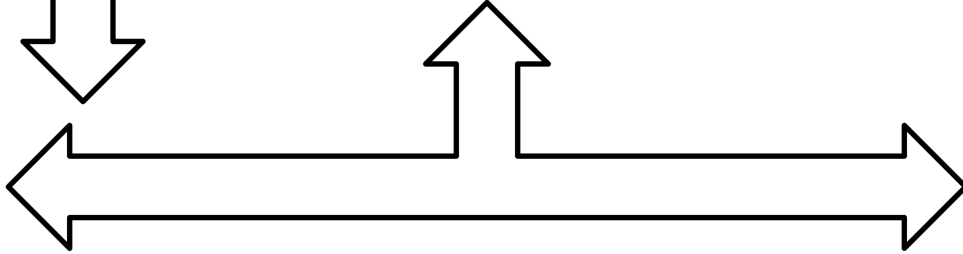
FRAMEWORK FOR LOCALISED REPRODUCTIVE HEALTH AND SUPPORT STRUCTURE

Accessible SRH knowledge to all rural women should be a Basic Human Right

Implementation of SRH

- SHR information should written in all official languages in South Africa.
- SHR information should be disseminated in all official languages in South Africa.
- SRH information should be disaggregated according to age so that women of different ages can be comfortable enough to access such services.
- SHR should be tailored in the religion and in sports teachings.
- SHR should be tailed in the Life Orientation schooling curriculum across all grades.
- School-going children should be appointed as Advocates/champions of SRH so that the information spread quickly.
- Women's economic agency should be prioritised so that they would be able to afford health services.
- Rural health facilities should have enough personnel that holistically understand SRH.
- SHR issues should be part of marriage counselling services.
- SRH should be part of local izimbizo.

Realization of SRH



7.2 IMPLEMENTATION OF THE FRAMEWORK FOR LOCALISED REPRODUCTIVE HEALTH AND SUPPORT STRUCTURE (IFLRHSS)

- **Framework for Localized Reproductive Health and Support Structure (FLRHSS)**

This framework is designed to address the challenges faced by women in uMkhambathini eNkanyezini regarding access to Sexual and Reproductive Health (SRH) services. It draws on the four identified stages of health care engagement and aims to provide localized, context-specific solutions, addressing systemic issues and cultural factors that impact SRH service delivery.

Introduction to FLRHSS

Purpose: The FLRHSS aims to improve access to SRH services for women in rural communities, especially uMkhambathini eNkanyezini, by creating a framework that integrates cultural sensitivity, social factors, and health system improvements.

Context: This framework is informed by the study's findings, which highlight key challenges such as limited access to SRH services, the impact of social stigma, and healthcare system inefficiencies. The framework is also rooted in the Anthropology of Women and Feminist Anthropology, which emphasize the need for a gender-sensitive approach to healthcare that supports marginalized women in rural settings.

Goals:

- To minimize stigma and discrimination around SRH services.
- To ensure that SRH services are more accessible, acceptable, and culturally relevant to the community.
- To involve local stakeholders in the development and implementation of SRH services.

Key Components of FLRHSS

Stage 1: People Becoming Patients

Challenges:

Poor Service Delivery: Local clinics are often understaffed, overcrowded, and unable to provide adequate SRH services (e.g., long wait times, lack of medications).

Social Stigma: Discrimination, especially towards individuals living with HIV or TB, deters people from seeking care at nearby clinics.

Clinic-Switching: The lack of efficient service delivery leads to patients switching clinics frequently, exacerbating overcrowding and prolonging wait times.

Interventions:

Improved Service Delivery:

Staffing and Training: Prioritize the recruitment and training of healthcare staff to ensure that clinics are adequately staffed and provide a high level of care.

Efficient Service Scheduling: Implement scheduling systems to reduce waiting times and improve patient flow.

Medication Stock Management: Ensure that essential SRH medications, including contraceptives and HIV treatment, are consistently available in local clinics.

Community-Based Education:

- Educate the community about SRH services to reduce stigma, particularly for patients with HIV and TB.
- Promote community health outreach programs to improve understanding of available services and their importance.

Referral and Network Systems:

- Develop a referral system that facilitates smoother transitions between clinics, reducing clinic-switching behavior and ensuring continuity of care.
- **STAGE Two: SRH Service Support Structure**

Challenges:

- **Limited Awareness**: Women, particularly in rural areas, are often unaware of the available SRH services.
- **Lack of Education:** There is a significant gap in sexual education, especially for youth, which contributes to poor knowledge about SRH services and sexual health risks.

Interventions:

Outreach and Education Programs:

- SRH Education: Create community-based health education programs focusing on HIV, family planning, maternal care, and STI prevention.
- Youth Engagement: Develop age-appropriate educational materials that address the specific SRH needs of young people, including information on consent, contraception, and HIV prevention.

Collaboration with Local Institutions:

- Partner with religious organizations, schools, and community centers to disseminate SRH information and raise awareness.
- Train local leaders to become ambassadors for SRH service promotion, reducing barriers such as cultural taboos and stigma.

Inclusive Outreach:

- Focus on marginalized groups, such as unmarried women or young mothers, who may face additional social stigma in accessing SRH services.
- Use culturally appropriate language and methods to communicate information about SRH services, addressing traditional beliefs and taboos.

- **STAGE THREE: LOCALIZED SRH Health Services**

Challenges:

- Healthcare Workforce Shortages: There is a shortage of skilled healthcare professionals, particularly in rural areas.

- Resource Constraints: Local clinics face challenges in accessing adequate resources, such as medications, medical equipment, and infrastructure.

Interventions:

- **Localized Healthcare Delivery:**
  - Strengthening Local Health Infrastructure: Invest in building or upgrading healthcare facilities that cater to the SRH needs of the community, ensuring the availability of basic healthcare services such as maternal care, family planning, STI treatment, and HIV services.
  - Mobile Clinics: Deploy mobile health units to reach remote areas, providing SRH services like contraception, STI screenings, and HIV testing in underserved communities.
- **Local Workforce Development:**
  - Training Local Healthcare Providers: Invest in training local healthcare workers to address the specific SRH needs of the community. This will ensure that healthcare professionals understand the local context, culture, and health needs.
  - Capacity Building: Develop local capacity for health education, counseling, and support, ensuring that healthcare workers are equipped to handle sensitive SRH issues.
- **Resource Management:**
  - Local Resource Mobilization: Promote community involvement in fundraising and resource mobilization to ensure sustainable healthcare delivery.
  - Health Partnerships: Collaborate with NGOs and other stakeholders to supplement resources and provide continuous support for SRH programs.
- **STAGE 3: SRH Healthcare Provision**

Challenges:

- Inadequate Quality of Care: The quality of SRH care is often compromised by understaffing, lack of resources, and poor training.
- Cultural Sensitivity Issues: SRH services may not be fully aligned with local cultural practices or gender norms, making it difficult for some individuals to access services.

Interventions:

- Culturally Sensitive Care:
    1. Cultural Competency Training: Provide healthcare workers with training on cultural competency, ensuring that SRH services are delivered in a culturally respectful and sensitive manner.
    2. Gender-Sensitive Care: Implement policies that ensure gender equality in SRH service provision, especially in addressing women's reproductive rights and health needs.
- Comprehensive SRH Service Delivery:
    1. Integrating SRH Services: Ensure that SRH services (e.g., family planning, maternal care, STI treatment, HIV prevention) are integrated and available at every level of healthcare delivery.
    2. Patient-Centered Care: Prioritize a holistic approach to care, addressing the physical, emotional, and psychological needs of patients. This includes offering counseling services and addressing gender-based violence.
- Quality Monitoring and Accountability:
    1. Monitoring and Evaluation: Develop a robust system for monitoring the quality of SRH services, including patient feedback mechanisms and regular evaluations of service delivery.
    2. Community Feedback: Use community feedback to continuously improve services, ensuring that they are responsive to the community's needs and expectations.

- **STAGE FOUR: SRH Service Healthcare Provision**

Local clinics in rural areas like eNkanyezini must prioritize the provision of high-quality, localized healthcare services that respond directly to the specific needs of their communities. These clinics

are critical in ensuring the accessibility of essential services, particularly Sexual and Reproductive Health (SRH) services, in areas where access to healthcare may already be limited. The study emphasizes that the direct experiences of women seeking SRH services are heavily influenced by the healthcare environment, which in turn affects their ability to receive timely and effective care.

Key findings from the study highlight that negative behaviors and attitudes from healthcare providers can be significant barriers to women accessing SRH services. This issue is particularly pronounced among young women, who may feel discouraged from seeking the care they need due to stigmatization and negative judgment. As a result, many women delay seeking necessary care, which can exacerbate preventable health conditions and lead to worse health outcomes in the short and long term. Such delays in care are considered harmful behaviors that perpetuate health inequities, undermining efforts to achieve positive health outcomes in rural areas.

When local healthcare providers can meet the healthcare needs of the eNkanyezini population, not only does it contribute to reducing health disparities, but it also aligns with broader health objectives aimed at improving the overall health of the community. The study underscores the importance of embedding public health initiatives within healthcare services, ranging from disease prevention to health promotion. In eNkanyezini, prioritizing public health risks such as communicable diseases, injury prevention, and equitable access to SRH services is crucial. By focusing on these areas, local clinics can play an essential role in enhancing health outcomes and contributing to the larger public health goals set by international organizations such as the World Health Organization (WHO).

Moreover, the study reveals that the equity of healthcare services, especially regarding the capacity to reduce health severity and disparities, is directly influenced by the strength of primary care resources in rural communities. The availability of skilled healthcare providers, adequate medical supplies, and well-functioning clinics can significantly impact the reduction of health inequities. Strengthening primary care in rural areas, where healthcare infrastructure is often under-resourced, is vital to ensuring that services are not only available but also effective in improving long-term health outcomes for the community.

A critical aspect of overcoming these challenges is the creation of a healthcare system free from

stigma and discrimination. Establishing a stigma-free, non-discriminatory environment within local clinics can help remove barriers preventing individuals, especially those from marginalized or vulnerable groups, from seeking care. This is especially important for addressing the specific needs of women who seek SRH services, such as contraceptive methods, PreP (pre-exposure prophylaxis), and abortion services. By reducing the stigma surrounding these services, clinics can improve access to care and encourage the utilization of these vital services without the fear of judgment or discrimination.

The study also highlights that the healthcare system in the uMkhambathini area faces significant equity challenges, particularly concerning resource allocation and access to high-quality care. Rural communities often deal with unique challenges such as limited healthcare infrastructure, inadequate funding, and difficulty attracting skilled healthcare workers. These issues are compounded by urban bias in healthcare provision, where resources are typically concentrated in urban centers, leaving rural areas underserved. Addressing these disparities requires targeted interventions that prioritize equity in healthcare service delivery, ensuring that rural communities like eNkanyezini have access to the same level of care and resources as their urban counterparts.

The ultimate goal is to improve health outcomes and eliminate health disparities through equitable healthcare services. This requires tackling systemic barriers that prevent people in rural areas from accessing the care they need. A focus on equity, particularly in rural healthcare settings, is essential to ensuring that all individuals, regardless of their geographic location or socioeconomic status, receive the care they deserve. The study's findings suggest that strengthening primary care resources, promoting equity in healthcare access, and fostering a stigma-free environment are critical steps toward improving healthcare delivery and addressing the unique needs of rural communities like eNkanyezini. By cultivating a more inclusive and equitable healthcare system, local clinics can play a pivotal role in improving population health outcomes and reducing health disparities in the area.

Promote Community Engagement and Support

- Community Participation and Ownership:

1. Community Involvement: Actively involve community members in the planning, implementation, and evaluation of SRH services. This ensures that services are tailored to the community's needs and are more likely to be accepted and utilized.
2. Health Committees: Form local health committees made up of community leaders, healthcare workers, and patients to monitor healthcare provision and advocate for improved SRH services.

- Psychosocial Support:
    1. Addressing Mental Health: Integrate mental health support into SRH services, providing counseling and support for women dealing with issues like unwanted pregnancy, gender-based violence, or HIV.
    2. Psychosocial Training for Healthcare Workers: Equip healthcare providers with skills to recognize and address the emotional and psychological aspects of SRH care.
- Sustainability:
    1. Local Resource Generation: Focus on local resource mobilization and sustainability, ensuring that SRH services are not reliant on external funding alone but have long-term local support.
    2. Advocacy for Policy Change: Work towards advocating for policy changes that prioritize reproductive health in rural communities and secure increased funding for SRH services.

Monitoring and Evaluation

- **Community Feedback Mechanisms**: Regularly assess the impact of SRH programs through surveys, focus groups, and interviews to gather feedback on service satisfaction and areas for improvement.

  Data Collection and Analysis: Establish systems for collecting demographic and health data to track service utilization and health outcomes over time. Focus on indicators like maternal mortality rates, STI prevalence, and contraceptive use will be accessible to all rural women of uMkhambathini.

7.3 Recommendations

7.3.1 Recommendations on Perceptions

In several high-burden communities within uMkhambathini, particularly in eNkanyezini, there exists notable ambiguity and inconsistency in attitudes toward the age of consent for HIV and sexual and reproductive health (SRH) services, particularly regarding oral PrEP. Policies enabling task-shifting are essential in these rural communities for reducing barriers to integrated service delivery. Local clinics in uMkhambathini may face challenges in offering comprehensive HIV prevention and SRH services due to resource limitations. However, the implementation of evidence-based policies and stable funding is crucial to ensuring the continued availability of these services. Shared community beliefs significantly influence individual behaviors, as people often align with prevailing values shaped by both healthcare facilities and local norms. These collective perceptions play an integral role in shaping community attitudes toward healthcare and ultimately impact the effectiveness of health interventions, including the uptake of services.

7.3.2 Recommendation on SRH Service Users

Women expressed a strong interest in messages surrounding pregnancy prevention, making family planning an effective entry point for discussions on HIV prevention. Additionally, women noted that they often attribute side effects to oral contraceptives, particularly when also using contraception. Consistency in the staff at health facilities, as well as establishing rapport, ensuring privacy, and showing respect, were identified as factors that positively influence their experience with SRH services. The integration of SRH services has been shown to increase patients' trust and ensure confidentiality, which plays a significant role in improving service uptake.

7.3.3 Recommendation on the role of non-clinical staff and peer mentorship in enhancing access to SRH Services.

Non-clinical staff, such as health systems navigators and mentors, play an essential role in improving the accessibility and effectiveness of sexual and reproductive health (SRH) services in communities like eNkanyezini. These individuals are responsible for outreach, education, counseling, and referrals, which help reduce the burden on healthcare providers by handling critical non-medical tasks. By integrating these roles into the healthcare system, a more comprehensive and efficient service delivery model is established. This approach allows

healthcare providers to focus on clinical care, while non-clinical staff engage with the community to promote SRH services. Mentors, in particular, are invaluable as they offer guidance and motivation, particularly to young people and women, drawing from shared cultural backgrounds or age. This peer-to-peer approach fosters trust and encourages individuals to access SRH services. Additionally, mentorship and peer support contribute to a culture of continuous learning, empowering individuals to stay informed and make decisions regarding their sexual and reproductive health. Through outreach, education, and mentorship, non-clinical staff and mentors create a supportive environment that enhances community engagement with SRH services, ultimately contributing to long-term improvements in health outcomes.

7.3.4 Recommendation on Health Systems

Improving SRH Access through Alternative Healthcare Models

Many women seeking sexual and reproductive health (SRH) services prefer non-traditional settings outside of the local clinic for several reasons. These alternative environments offer a more accessible and less intimidating space, which is especially appealing to women who may feel uncomfortable or stigmatized in traditional healthcare facilities. Community-based initiatives or mobile health units, for example, provide a more familiar, private, and supportive atmosphere for women to receive care. Expanding SRH services to include reproductive, maternal, neonatal, and child health professionals, alongside local healthcare workers like nurses from eNkanyezini, could significantly reduce the pressure on overburdened health systems, both locally and nationally. By decentralizing services and offering them in non-traditional settings, these interventions can improve access to care, reduce long wait times, and create a healthcare experience that better meets the specific needs of women. This approach not only improves health outcomes but also empowers women by giving them more control over their healthcare choices, ensuring that services are delivered in a way that aligns with their needs and preferences.

7.4 Link Framework and recommendations

Stage 1 (People Becoming Patients):

> The involvement of non-clinical staff, such as health systems navigators and mentors, is instrumental in overcoming the initial barriers to accessing services. By offering education and support to patients before they formally engage with clinical staff, these roles help ease

the transition into the healthcare system. However, the lack of adequate training or resources for non-clinical staff can hinder their ability to effectively reach people early in the service access process, limiting their impact on overall service engagement.

- **Stage 2 (SRH Service Support Structure):**

  Mentorship and peer support programs can strengthen this stage by facilitating better communication between providers and service users. These programs foster a sense of shared experience and motivate continued service utilization. However, limited resources or inadequate training for peer mentors and health navigators can reduce their effectiveness, preventing them from guiding people efficiently through the support structure and diminishing the overall impact of these initiatives.

- **Stage 3 (Local SRH Service Access within the Community):**

  Many women express a preference for non-traditional settings when accessing health services, highlighting the need for more flexible service delivery models that extend beyond the traditional local clinic. Expanding community-based outreach and education is essential to meet the diverse needs of the population. Under-resourced local clinics, especially in rural areas, often struggle to provide adequate services, leading some women to seek care outside the formal health system in search of more accessible options.

- **Stage 4 (SRH Healthcare Provision):**

  Expanding SRH training for healthcare providers, particularly at the local level, could help alleviate the pressures faced by overburdened systems. Proper training would ensure that providers are equipped to address the full spectrum of SRH needs, including maternal, neonatal, and child health. However, systemic issues such as insufficient staffing, inadequate infrastructure, and limited funding can undermine the effectiveness of health system interventions, even with expanded training. These challenges must be addressed to ensure that healthcare services are both comprehensive and sustainable.

7.5 **Barriers and Solutions to Accessing SRH Services for Rural Women**

1. **Discrimination Across Stages:**

   Discrimination remains a persistent issue throughout all four stages of the healthcare journey. Whether it occurs at the point of becoming a patient, receiving support, accessing services locally, or in the provision of care, discrimination acts as a significant barrier to equitable service delivery. The challenge lies in developing strategies to address discrimination effectively, ensuring that individuals feel more comfortable and supported as they navigate through each stage of their healthcare experience.

2. **Socio-Cultural Expectations and Health-Seeking Behaviour:**

   The suggestion to minimize discrimination through behaviors such as marriage, having children, or becoming sexually active illustrates how socio-cultural expectations influence health-seeking behavior. These expectations often shape individuals' willingness to seek care. Interventions should take these cultural norms into account to help shift attitudes and reduce stigma, particularly in sensitive areas such as HIV prevention and family planning. This approach would help promote more inclusive and supportive healthcare environments. According to data analysis, the awareness of sexual and reproductive health (SRH) among rural women is critically limited. This lack of awareness is primarily driven by a combination of marginalization, exclusion, misunderstandings, misinformation, and deeply ingrained beliefs, all of which contribute to poor health-seeking behavior among women in the rural areas of uMkhambathini and eNkanyezini. These challenges are further exacerbated by harmful restrictions that hinder the timely delivery of SRH services to the women who need them most. The ability to access healthcare can vary significantly based on a variety of factors, including geographic location, economic status, and societal norms.

3. **Framework for Implementing SRH Services:**

   The proposed framework aims to provide a clear and actionable plan for the effective implementation of SRH services that directly benefit rural women. By placing the focus on the actual beneficiaries—rural women—and the tangible benefits they will experience

from these services, the framework ensures that SRH implementation is aligned with the real needs of the community. It emphasizes the importance of centering rural residents in the execution process and understanding that focusing on primary beneficiaries will yield more substantial and sustainable results.

Additionally, the framework highlights key sectors that must be prioritized for the successful implementation of SRH programs for rural women. These sectors include healthcare, education, and legislative support. To ensure that SRH services are effectively delivered and recorded, the framework suggests integrating legislative initiatives aimed at promoting regional reproductive healthcare systems specifically designed for rural communities. It also identifies areas of attention that need to be addressed when developing SRH service support systems in rural areas, such as eNkanyezini. These areas include overcoming the environmental, social, and economic barriers that often prevent women from accessing essential healthcare services.

4. **Solutions to the needs of marginalized rural women of uMkhambathini:**

One of the primary focuses of the framework is to address the needs of marginalized and underserved populations, particularly young people, who face significant challenges in accessing SRH services. Therefore, through prioritizing the delivery of age-specific SRH interventions, the framework ensures that rural women in uMkhambathini are able to access high-quality, locally available healthcare services. This approach aims to reduce stigmatization and create an inclusive environment where women of different ages can feel comfortable seeking SRH care. The implementation of age-based SRH services can significantly increase access to care for women at different stages of life, ultimately improving health outcomes across the community.

5. **Integrating SRH Education into Schools and Communities:**

In addition to healthcare interventions, the inclusion of SRH topics in the Life Orientation curriculum in schools is another critical step toward promoting better health knowledge. Integrating SRH into the school curriculum can maximize the dissemination of information

and create knowledge corridors that extend into communities. By educating school-age children about SRH, it is possible to cultivate a generation of SRH advocates or champions who will spread awareness and dispel myths. This process can reach every household with a child enrolled in school, significantly contributing to the reduction of health-related marginalization and exclusion. Furthermore, as parents gain knowledge through their children's education, levels of misinformation and social isolation within the community will likely decrease, fostering a more supportive environment for SRH.

6. **Economic Empowerment as a Pathway to Improved Healthcare Access:**

In rural areas like uMkhambathini, women often face severe economic challenges that negatively affect their ability to access healthcare institutions offering advanced medical treatments. This economic disparity further exacerbates the gap in health outcomes between urban and rural women, with urban women typically enjoying better access to healthcare services (Ndlovu, 2022). As such, the framework emphasizes the importance of promoting rural women's economic empowerment, arguing that when women are economically active, they are more likely to access SRH services, even from private healthcare providers. This, in turn, can reduce the pressure on public healthcare systems that are often overstretched and underfunded.

7. **The Role of Religion in Shaping Health Decisions:**

Religion plays a pivotal role in shaping individuals' social identities and influencing their healthcare decisions. In rural communities, religion serves as an important platform for conveying SRH information and challenging misconceptions. The framework recognizes religion as a powerful tool for increasing access to and utilization of SRH services. By aligning SRH education with religious beliefs and practices, it is possible to overcome cultural barriers and dispel myths that undermine the effectiveness of health programs. In particular, religious beliefs and patriarchal norms significantly influence women's decisions regarding reproductive healthcare, including issues like contraception and abortion. In communities such as eNkanyezini, where such topics are often taboo, women

are more likely to face stigma and limited options, which increases their vulnerability to diseases and unintended pregnancies. Married women, however, may experience less stigma and discrimination, as their social status may afford them more respect and access to healthcare services.

7.6 Triangulated Discussion (Conceptual and Theoretical Framework)

The intersection of gender theory, social constructivism, and critical medical anthropology provides a robust framework for analyzing the challenges faced during focus group interviews on sexual and reproductive health (SRH) with rural women in uMkhambathini. Gender theory delves into how power dynamics within focus groups mirror broader societal structures, particularly patriarchy, which can discourage women from sharing personal experiences and fully participating in discussions. This power imbalance often leads to disparities in participation, reinforcing gender inequalities in healthcare access.

Social constructivism highlights the influence of cultural beliefs and local norms in shaping SRH perceptions. In rural communities, these cultural influences can foster a groupthink mentality, where participants conform to prevailing community viewpoints rather than expressing individual concerns. This homogeneity in perspectives can limit the depth of insights necessary for crafting effective SRH interventions.

Critical medical anthropology offers a lens through which to understand the structural barriers rural women encounter when seeking SRH services. These barriers include economic inequality, inadequate healthcare infrastructure, and socio-cultural constraints that marginalize rural populations. The study emphasizes the need for a tailored approach, namely the Framework for Localized Reproductive Health and Support Structure (FLRHSS), to address these structural challenges. This framework is designed to ensure that SRH information is adapted to the specific needs of different demographic groups, integrated within religious and educational institutions, and supported by initiatives that foster economic empowerment.

By aligning the framework with the tenets of critical medical anthropology, the study stresses the importance of dismantling systemic barriers to healthcare. It also underscores the intersectionality of gendered power relations, social constructs, and institutional deficiencies that hinder rural

women's access to SRH services. To improve reproductive healthcare access and agency, the framework advocates for holistic interventions that tackle these interconnected factors. By prioritizing the needs of rural women and establishing the necessary support systems, it is possible to make significant progress in reducing health disparities and improving the overall well-being of these communities.

7.6 Chapter Conclusion

This chapter has outlined the key contributions and findings derived from the research objectives, offering valuable insights into the experiences of women in uMkhambathini and eNkanyezini. A primary contribution of the study is the development of a newly generated framework that emerged from an in-depth analysis of these women's experiences with healthcare services. The framework focuses on localized health inquiry and advocates for a shift in perspective among both patients and healthcare workers, emphasizing the importance of understanding health within the context of local realities and challenges.

The findings highlighted several obstacles women face at various stages of the healthcare process. The four stages identified (1) becoming a patient, (2) the provision of healthcare, (3) the support structure, and (4) local community dynamics—provide a clear understanding of the multiple layers involved in healthcare access and delivery. Additionally, the study revealed persistent challenges around the age of consent for HIV and SRH services, with unclear and inconsistent perceptions particularly regarding oral PrEP in high-burden areas like uMkhambathini and eNkanyezini.

The research also found that women are generally more receptive to messaging around pregnancy prevention, which positions family planning as a crucial entry point for discussions on HIV prevention. This finding suggests that targeting family planning services could be an effective strategy for addressing broader sexual and reproductive health concerns in these communities.

Furthermore, the chapter reflects on the methodology employed in this research, particularly the use of focus group interviews as a data collection tool. These interviews proved to be an effective means of exploring women's experiences and gaining valuable insights from the target audience. However, several challenges and pitfalls were encountered throughout the data collection process, which are important to acknowledge as part of the research journey. These challenges provide

valuable learning opportunities for future studies, particularly in the context of rural health research, where socio-cultural dynamics and logistical constraints must be carefully navigated.

CHAPTER EIGHT
Summary, Recommendations, and Conclusion

8.1 Introduction

The study employed qualitative research methodologies to explore women's experiences concerning Sexual and Reproductive Health (SRH) services in the rural areas of Umkhambathini, KZN, South Africa. This research serves as an empirical contribution to literature on the anthropology of women and feminist anthropology. The study contextualized the anthropology of women/feminist anthropology and focused on intersecting SRH issues affecting women, aiming to contribute practical solutions. Thirty rural women were sampled using the purposive snowballing sampling technique. Three theoretical frameworks—Social Constructivist Theory, Critical Medical Anthropology (CMA) Theory, and Gender Theory—guided the scholarly evidence of the research findings.

8.2 Chapter One Summary

This opening chapter critically contextualized the problem statement that led to the study. It introduced the concept of SRH services, defining SRH as encompassing both physical and mental well-being. Topics such as preventing unintended pregnancies, unsafe abortions, HIV/AIDS, and all forms of sexual assault and coercion were also explored. The chapter outlined key objectives and questions that guided data collection, and it set the foundation for understanding SRH services. The study aimed to uncover grassroots, localized sociocultural perceptions that contribute to the lack of awareness regarding SRH services and rights in Umkhambathini. The chapter also shared the study's objectives, which included investigating rural women's experiences in accessing and utilizing SRH services. It briefly introduced the qualitative research design and methods of data collection, such as focus groups and thematic analysis, and provided an overview of the theoretical frameworks employed in the study. The chapter concluded with a justification for the study's epistemological approach and sensitivity to the subject matter, preparing the reader for the literature review in the next chapter.

8.3 Chapter Two Summary

Chapter Two focused on the literature review, addressing several themes relevant to the study. These included global and national health issues concerning women in rural areas. Rural communities face significant challenges, and only a few countries have recognized SRHR as a critical health indicator. South Africa has committed to SRHR through both the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs), incorporating policies such as Family Planning 2020 and the National Contraception and Fertility Planning Policy. The literature highlighted the exceptional laws, policies, and guidelines in South Africa that support SRH services, as well as the importance of a rights-based framework for delivering healthcare. Other themes included the political economy of women, unemployment, development, and the health challenges faced by rural women in South Africa. The chapter also discussed the international commitment to SRHR, using China as an example, and examined how stigma and discrimination within healthcare settings influence women's choices regarding SRH services.

8.4 Chapter Three Summary

Chapter Three detailed the advantages of qualitative anthropological research. It explained the research methods used in the study, including the phenomenological research design and the interpretive approach. The chapter also discussed the recruitment strategy employed to find research volunteers and highlighted the benefits of using focus groups in qualitative research. Additionally, it addressed the strengths of thematic analysis in processing and structuring the data collected through the focus groups.

8.5 Chapter Four Summary

This chapter outlined the study's theoretical framework, examining the relevant theories that guided the research. It explained the relationship between theory, the problem statement, the research methodology, and data analysis. The chapter focused on the use of Gender Theory, Critical Medical Anthropology (CMA) Theory, and Social Constructivism Theory. These theoretical frameworks helped the study understand how national political systems, global power structures, community-level power structures, and patriarchal institutions negatively affect women

in rural African contexts. The Social Constructivist Theory, in particular, helped capture the emic perspectives of rural women and their cultural norms and values surrounding SRH.

8.6 Chapter Five Summary

Chapter Five presented the data collected from 30 participants, illustrating key participant demographics such as age, marital status, and religious beliefs. The chapter also examined the SRH services utilized by women in the Umkhambathini area. Data collected from five focus group interviews revealed socio-cultural factors influencing SRH service use. The chapter highlighted the social and cultural barriers that prevent women from accessing healthcare and the need for a more supportive healthcare environment.

8.7 Chapter Six Summary

Chapter Six presented case studies of thirty women from eNkanyezini, providing narrative data on their experiences with SRH services. The case studies explored the structural barriers to accessing SRH services, including negative attitudes from healthcare providers and the lack of access to care. It also documented how rural women navigated these challenges and attempted to overcome the obstacles to receiving SRH services.

8.8 Chapter Seven Summary

Chapter Seven discussed the contributions and findings of the study, particularly the development of a framework based on the experiences of women in Umkhambathini. This framework centers rural women as the primary beneficiaries of SRH services, guiding the study’s focus on healthcare provision, support structures, and access to services. The framework is structured in four stages, with the first stage focusing on rural women as patients, the second on the healthcare system’s support structure, the third on local service access, and the fourth on healthcare provision. The findings also revealed that women's attitudes toward SRH services are shaped by their experiences with healthcare providers and local health facilities, which often contribute to delayed or inadequate care.

8.9 Recommendations for Future researchers

Future researchers in anthropology are encouraged to continue to investigate and expand the understanding of sexual and reproductive health (SRH) in rural communities, particularly focusing on the experiences of women. Some possible areas for future research include:

- **Longitudinal Study on SRH Behavior Change**

  Researchers could conduct a longitudinal study to track the changes in SRH behaviors, perceptions, and attitudes over time among women in these communities. This could include evaluating the long-term impact of interventions, such as education on family planning, HIV prevention, and the availability of SRH services. By measuring behavioral changes, future research could identify the factors that lead to sustained improvements in health-seeking behavior and the effectiveness of SRH outreach programs.

- **Exploring the Role of Religion in SRH Decision-Making**

  Building on the influence of religious beliefs noted in the current data, future studies could delve deeper into the role of religion in shaping SRH decisions, especially in rural, faith-driven communities. Research could investigate how religious leaders, institutions, and faith-based organizations either hinder or facilitate access to SRH services. This could help develop strategies to integrate religious perspectives into SRH education and outreach, ensuring more inclusive healthcare delivery.

- **Impact of Socio-Cultural Norms on Health-Seeking Behavior**

  The data highlights the impact of socio-cultural norms on women's health-seeking behavior. Future researchers could explore in more depth how traditional practices and cultural expectations shape women's willingness to access SRH services, especially in the context of family planning, HIV prevention, and sexual health. This research could include examining the intersectionality of gender, culture, and age to provide a more nuanced understanding of the barriers faced by different groups of women.

- **Gender Dynamics and SRH Access**

  Future research could investigate how gender dynamics, particularly the intersection of patriarchy and SRH access, affect women's ability to seek care. Studies could explore the power relations within households and communities that influence women's health decisions, including how gender roles within the family and local society create challenges for women to access healthcare services. This could be done by examining decision-making processes regarding health choices, and the role of male partners or community leaders in those decisions.

- **Economic Barriers to Accessing SRH Services**

  Given the findings that economic challenges prevent women in rural areas from accessing healthcare, future studies could explore the role of economic empowerment in improving access to SRH services. Researchers could analyze the links between women's economic status, employment opportunities, and their ability to seek SRH care, as well as the potential impact of micro-financing or economic empowerment initiatives on improving access to SRH services in rural communities.

- **Evaluating the Effectiveness of Community-Based SRH Interventions**

  Since the data suggests that community-based interventions may be more effective in rural settings, future researchers could focus on evaluating the effectiveness of community-driven initiatives in improving SRH outcomes. Research could assess how community health workers, local leaders, and peer mentorship programs influence women's engagement with SRH services. The impact of community-based health models, such as mobile health clinics or decentralized service delivery, could also be explored to understand how they increase access to SRH care in underserved areas.

- **Access to SRH Services for Young Women and Adolescents**

The data highlights the need to focus on age-specific SRH services, particularly for young women and adolescents. Future research could explore how the availability of youth-friendly SRH services affects the sexual and reproductive health outcomes for this demographic. Research could examine the barriers that prevent young women from accessing SRH care, including issues of confidentiality, peer pressure, and societal stigma, and how these barriers can be addressed through targeted interventions.

- **Integration of SRH Education into Schools and Communities**

Future researchers could explore the effectiveness of integrating SRH education into school curricula and community programs. By evaluating the impact of early education on SRH awareness and behavior, future studies could determine whether school-based programs create long-lasting changes in attitudes toward sexual health and promote healthier behaviors in adolescence and adulthood. This research could also assess how education at the community level, particularly through local media or community gatherings, influences attitudes toward SRH.

- **Intersectionality of Health Inequities and Access to Care**

An intersectional analysis could be conducted to explore how various forms of inequality (such as gender, class, ethnicity, and geographic location) intersect to create unique barriers to SRH care for rural women. This research could provide a more detailed understanding of how compounded vulnerabilities (e.g., being young, economically disadvantaged, or from a marginalized ethnic group) further limit access to SRH services and could inform policies to address these compounded inequalities.

- **Policies and Structural Interventions for Rural SRH Services**

  Future research could focus on evaluating the effectiveness of existing policies and structural interventions aimed at improving SRH access for rural women. This could include examining the impact of National Health Insurance schemes, policies targeting rural health infrastructure, and local legislative frameworks on women's access to SRH services. Research could assess whether these policies meet the specific needs of rural women, identify gaps in service delivery, and propose adjustments or improvements to existing frameworks.

By exploring these areas, future researchers can deepen the understanding of SRH challenges in rural communities, uncover underlying factors that influence health-seeking behaviors, and propose actionable solutions to improve SRH access and outcomes for women in uMkhambathini, eNkanyezini, and similar rural areas.

8.12 Conclusion

This thesis has aimed to contribute to the anthropology of women, with a focus on combating the marginalization of women in the healthcare sector. This marginalization arises from a variety of factors, including gender, race, class, and economic status, particularly in relation to Sexual and Reproductive Health (SRH). For SRH policies and programs to be effective, they must recognize and address the unique challenges that rural women face when accessing healthcare services. The qualitative research design and methods employed in this study allowed for a thorough collection and thematic analysis of focus group interview data from 30 female participants. This approach has enabled the exploration of under-explored topics, such as the SRH experiences of women in uMkhambathini and eNkanyezini, shedding light on their personal experiences, individual actions, and insights. These findings enrich the broader understanding of the challenges rural women face in accessing SRH services.

A major contribution of this study is the development of the Sexual Reproductive Health Framework, which places rural women at the centre as primary beneficiaries of SRH services. This framework is a key outcome of the research, providing actionable solutions to improve both the

accessibility and effectiveness of SRH services in rural settings. It is anticipated that this framework will be adopted and implemented by health policymakers, local health authorities, NGOs focused on women's health, and healthcare providers working in rural or underserved areas. These stakeholders are in a strategic position to advocate for and facilitate changes in SRH service delivery, addressing both healthcare infrastructure and socio-cultural barriers. By integrating this framework into policy and practice, it is hoped that substantial improvements will be made in the health and well-being of rural women.

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APPENDIX A: Ethical clearance letter

17 August 2023

Philani Goodman Kuluse (212522336)
School Of Social Sciences
Pietermaritzburg Campus

Dear PG Kuluse,

Protocol reference number: HSSREC/00005485/2023
Project title: Probing sexual and reproductive health services: experiences of women at uMkhambathini eNkanyezini, KwaZulu-Natal-South Africa.
Degree: PhD

Approval Notification – Full Committee Reviewed Protocol

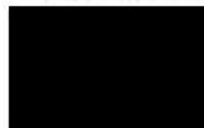
This letter serves to notify you that your response received on 12 July 2023 to our letter of 05 May 2023 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted **FULL APPROVAL**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

This approval is valid for one year until 17 August 2023
To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

HSSREC is registered with the South African National Health Research Ethics Council (REC-040414-040).

Yours faithfully



....

Professor Dipane Hlalele (Chair)

/dd

APPENDIX B: IsiZulu interview schedule

- Iyini i-Sexual and Reproductive health services?
- Usuke wali sebenzisa uhlelo le Sexual and Reproductive health services?
- Iziphi isigqinamba obhekana nazo uma ufuna ukusebenzisa umtholampilo ozimele?
- Iziphi isigqinamba eziletha ubunzima bokuthola usizo emtholampilo esisuka eMphakathini?
- Ulithola kanjani uLwazi nge- SRH?
- Iziphi izindlela ozisebenzisile ukuthola ngohlelo lwe- Sexual and Reproductive services?
- Kungabe abazali noma umuntu ohlekisana naye uyazazi yini lezi zinhlelo ze Sexual and Reproductive health services?
- Iyiphi indlela ongaqhamuka nayo ukuze uqhube izinkulumo ngohlelo le SRH phakathi kwakho nomzali noma umuntu ohlekisana naye?
- Iziphi izingqinamba obhekana nazo ukuthola uhlelo le-SRH?
- Iziphi izingqinamba obhekana nazo uma ufuna ukusebenzisa uhlelo le-SRH?
- Ikuphi ongakubeka onolwazi ngakho mayelana nokusebenza kwezinhlelo ze-SRH?
- Iziphi iziphakamiso onazo bayelana nokutholakala nokusetshenziswa kohlelo lwe- SRH?
- Kolwakho Ulwazi kungabe ikuphi oke ubhekane nakho uma usebenzisa izinhlelo ze-SRH lapha endaweni?
- Kungabe kukhona ongaku nezelela mayelana nohlelo esiqeda ukukufaka imibuzo ngalo le - SRH?
- Kungabe kukhona ofisa ukunezelela mayelana nalolu daba lwe SRH.
- Kungabe uzazo iziphakamiso ezingaba nomthelela kuhlelo lwe SRH endaweni yangakini?
- Ngabe unayo eminye imibono?

APPENDIX C: English interview schedule

Research questions

- What is your knowledge about the Sexual and Reproductive Health services?
- Have you ever used SRH services?
- What are the challenges of getting private health care for SRH services?
- What are the challenges that results in health care barriers that emerge from the community?
- Does your partner support family planning?
- What is your knowledge of contraceptives?
- Do you engage in any family planning?
- What is your perspective on unplanned pregnancy?
- How do you access information about the SRH services?
- What sources of information do you use to learn about SRH services?
- Do your parents or partner know about SRH service issues?
- What methods would you suggest improving discussions on sexual and reproductive health with your community?
- What benefits would you gain from discussing sexual and reproductive health with your community?
- What are the challenges you face in accessing the SRH services?
- What are the challenges you face when using the SRH services?
- Do you feel any support in the community to accessing and using the SRH services?
- What is your experience as a rural young woman or woman in accessing and using SRH services?
- What are recommendations for the issue of accessing and using SRH services in your area?
- Are there any other comments you wish to make or questions you wish to ask on the topic?

APPENDIX D: IsiZulu Consent form

UKZN HUMANITIES AND SOCIAL SCIENCES

Consent form for participation in the study/

Ikhasi Lemininingwane Kanye Nemvume Yokubamba Iqhaza Kucwaningo

Date: 12 August 2022

Ngiyanibingelela

Igama lami ngingu Philani Goodman Kuluse Umfundi owenza iziqu ze-PhD kwi-Anthropology ngaphansi kwesikole seSayensi yezenhlalakahle Enyuvesi yaKwaZulu-Natali.
Imininingwane yami:

Cell: [redacted]
E-mail: 212522336@stu.ukzn.ac.za/Kulusep@ukzn.ac.za

Lolucwaningo ngilwenza ngaphansi kwesandla sika Dr BP Zondi ongumphathi wami ekubhekeleleni inqubo yalolucwaningo. Inininingwane yakhe imi kanje:

Cell: [redacted]
E-mail: zondil4@ukzn.ac.za

Umenywa ukuba ube yingxenye noma ubambe iqhaza kulolu cwaningo olumayelana nokutholakala kanye nokusetshenziswa kwezinhlelo ze-SRH kubantu besifazane abancane nabakhulile. Inhloso nesizathu salolucwaningo ukuzwa izimvo nokuphatheka kwabantu besiazane ukuthola usizo emtholampilo emphakathini ngenxa yalesi simo sokungaphumeleli kwabo, ikakhulukazi njengoba izimo sentuthuko zihlasimulisa umzimba. Nalezi zidingo zokungatholi usizo zintulisa wonke umphakathi waseMkhambathini, nokugcina sekuholela abesifazane bathunyelwe emadolobheni ngento abangathola usizo layo endaweni. Ngalokhu-ke ucwaningo luzama ukunxenxa izishayamthetho ukuba zibone isidingo sokuthi kuhlelwe kangcono izihlelo ezizo siza abesifazane kanye namantombazane kulezi zidingo zomthola mpilo. Lolucwaningo lubona kubalulekile ukuqoqa lezi zimo noma ukuphatheka kwabesifazane ngenxa yokuntuleka kosizo oluzobhekelana nomthola Mpilo.

Lolucwaningo lunethemba lokuthi ukuzwakala kwemizwa yabesifazane ngalesi simo sokungahleleki kwezinhleo ze-SRH. Lokhu kungaholela ekutheni izishayamthetho zezempilo zilusukumele loludaba lokungatholakali noma likungasetshenizwa kwzinhlelo ze- SRH.

Lolucwaningo luhlolisisiwe kabanzi futhi luphasiswe yithimba elibhekelela izimiso zokuhle enyuvesi i-UKZN Humanities and Social Sciences Research Ethics Committee (inombolo eqinisekisayo_____).

Ezikhathini lapho kubonakala khona izinkinga noma ukungacaci abazali bangadlulisa lezo zikhalo noma imibuzo ngokuxhumana nami ocingweni ku[redacted] noma nge E-mail 212522336@stu.ukzn.ac.za noma Kulusep@ukzn.ac.za noma bangaxhumana nenyuvesi ngalemininingwane elandelayo ethi: UKZN Humanities & Social Sciences Research Ethics Committee.

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus

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4000

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Email: HSSREC@ukzn.ac.za

Ukubamba iqhaza kulolucwaningo kuzoba ngemvume yakho, hhayi ngempoqo. Ababamba iqhaza bavumelekile ukubuza imibuzo lapho kuzoba nesidingo khona futhi bavumelekile ukweqa imibuzo ababuzwa yona noma ukuhonxa kulolucwaningo lapho befisa khona ngezimo zokungakhululeki. Lokhu kuzokwenzeka ngale kokuhlawuliswa noma ukunqabelwa ukuba yingxenye yenzuzo engenziwa yiloluncwaningo. Impumelelo yalolucwaningo incike kakhulu kulwazi nemininingwane eyaziwa noma ebonwa ababambi beqhaza, lokhu kusho ukuthi lolucwaningo lungathikamezeka ekutheni luthole ulwazi olwanele olungasiza umphakathi wonkana ukuthi ulethelwe izinguquko uma owesifazane noma abesifazane bekhetha ukungazibandakanyi nhlobo noma ukuhoxa kulolucwaningo ngokuthi izinkinga ezibhekana nezomthola mpilo ngenxa yokuntuleka kwezinsiza emphakathini esemakhaya ngeke zaziwe noma zifinyelele ezindlebeni zeziphathimandla zomthola Mpilo.

Kulindelekile abesifazane ababamba iqhaza kulolucwaningo bazithole esesimweni sokungakhululeki noma kuvuke imizwa engemihle yize lokhu kungeyona inhloso yalolucwaningo.

Ulwazi oluzokolekwa noma olukolekiwe luzogcineka luyimfihlo phakathi kwabesifazane nomqoqi wolwazi futhi luzosetshenziswa ngokuhlobene nocwaningo kuphela.

Imvume

Mina…………………………………… (igama lombambi weqhaza) ngazisiwe ngoncwaningo olumayelana nokukolekwa kwemizwa yabesifazane nama ntombazane ekusetshenziseni kwezinhlelo ze-SRH, uMxolisi Gwala.

Ngiyayiqonda inhloso nenqubo yalolucwaningo oluthinta imizwa yami ngesimo esibhekene nesimo sokusetshenziswa nokutholakala kohlelo le-SRH.

Nginikeziwe ithuba lokuthi ngiphendule imibuzo mayelana nalolucwaningo futhi ngiphendule ngendlela engigculisayo.

Ngiyaqinisekisa ukuthi ukubamba kwami iqhaza kulolucwaningo kungemvumo yami futhi ngazisiwe ukuthi ngingahoxa kulolucwaningo noma kunini ngale kokuhlawuliswa noma ukuthinteka kwamalungelo ami.

Ngazisiwe ngobungozi obungalandela noma imizwa engavuka ngenxa yokuzibandakanya kwami kulolucwaningo.

Lapho nginemibuzo noma ukukhathazeka khona mayelana nalolucwaningo ngiyazi ukuthi ngingaxhumana nomkoleki wolwazi ngalezi zindlela zokuxhumana

Ucingo: [redacted]
Noma nge E-mail: 212522336@stu.ukzn.ac.za noma Kulusep@ukzn.ac.za

Ngiyazi ukuthi uma kwenzeka ngiba nemibuzo noma ukukhathazeka ngamalungelo ami ngokubamba iqhaza kulolucwaningo noma enye ingxenye ethinta lolucwaningo noma umkoleki wolwazi uqobo ngingaxhumana nethimba lenyuvesi elibhekelela izimiso zokuhle kulemininingwane elandelayo:

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Research Office, Westville Campus

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Private Bag X 54001
Durban
4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557 - Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Ngiyavuma ukubamba iqhaza kulolucwaningo

______________________ ______________________

Sayinda (uMbambi weqhaza) **Usuku**

______________________ ______________________

Sayinda (utolika) **Date**

(Uma ekhona)

APPENDIX E: English consent form

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL

For research with human participants

INFORMED CONSENT FORM

Information Sheet and Consent to Participate in Research

Date:12/08/2022

Dear Participant

The researcher, who is a student at the University of KwaZulu Natal, Graduate School of Social Science, Philani, Goodman Kuluse is inviting you to consider participating in the research project entitled: Pr**obing Sexual and Reproductive Health (SRH) services: experiences of women at Umkhambathini eNkanyezini, KZN-South Africa.**

THE AIM OF THE STUDY:

The study aims to explore the utilisation and the accessibility of Sexual and Reproductive health services for young women in the Umkhambathini rural area in Pietermaritzburg. This will share health care limitations in rural spaces.

THE OBJECTIVES OF THE STUDY INCLUDE:

1.7 Key objectives are as follows:

- To probe the experiences of rural women in accessing and using SRH services.

Secondary objectives are as follows:

- To understand structural factors that inhibit women from accessing and utilising the SRH services at uMkhambathini community.
- To record detrimental factors that have been women's experiences because of not having access to SRH at uMkhambathini community.
- To establish how rural women have navigated these SRH conditions over time at uMkhambathini community .

- To contribute recommendations to the issue of accessing and using SRH services at uMkhambathini community.

The study will not involve any risks and discomforts, you may opt to discontinue participating or withdraw from the study at any time with no negative consequence. There will be no monetary gain from participating in this research. Confidentiality and anonymity of records identifying you as a participant will be maintained by the researchers undertaking this research project who are from the School of Social Science, UKZN.

The interviews will be contact meeting and should take 20 minutes to complete. I hope you will take the time to participate in this study.

The study seeks to understand the structural and functional limitations of SRH in rural areas for women and girls, which subjects women to all forms of social and health detriments. Women and girls in uMkhambathinni confront various problems, with age, disability, geography, and other factors influencing their conditions and prospects.

The exploration of SRH rests on the devising measures to be taken to expand its availability in rural areas. However, the issues remain on the poor health care system; thus, sharing knowledge on the system can acknowledge shortcomings in South African health care.

Should you need any further information or seek clarity, questions, or concerns about participating in this study, you may contact the researcher on [redacted] or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

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4000

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Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

CONSENT

I ………………………………………………………. have been informed about the study entitled (provide details) by (provide name of researcher/fieldworker).

I understand the purpose and procedures of the study (add these again if appropriate).

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at (provide details).

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

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4000

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Tel: 27 31 2604557 - Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Additional consent, where applicable

I hereby provide consent to:

Audio-record my interview / focus group interviews YES / NO

Video-record my interview / focus group interviews YES / NO

Use of my photographs for research purposes YES / NO

_____________________ _____________________

Signature of Participant **Date**

_____________________ _____________________

Signature of Witness **Date**

(Where applicable)

_____________________ _____________________

Signature of Translator **Date**

(Where applicable)

APPENDIX F: EGLISH PLEDGE OF CONFIDENTILITY FORM FOR INDIVIDUAL INTERVIEW

ENGLISH

PLEDGE OF COMFIDENTILITY FORM FOR FOCUS GROUPS

In order to ensure that the Researcher of the University of KwaZulu-Natal fulfill their obligations to the

Study Participants, anyone with access to confidential information of third parties must make this Pledge

of Confidentiality.

1. I,________________________________, recognize and acknowledge that in the course of my

participation as a member of uMkhambathini in the answering of SRH services questions together to

certain "Confidential Information" (as defined below). I will not use this Confidential Information or

talk about people's response with respect to the Research Study.

2. I will not share any Confidential Information in any way at any time to anyone else. I will continue to

keep this information confidential even after I am no longer involved with the Research Study.

3. "Confidential Information" means information may learn as you participate in the Research Study.

This information may be the private information of an individual which is of a confidential or secret

nature and that may be related to the Research Study

4. I acknowledge that I have had sufficient time to review this Agreement and fully understand its

contents and its effect on me.

5. This Agreement is signed prior to participation in the study.

PARTICIPANT RESEARCHER

__________________________ ____________________________

Printed name of Participant Printed name of Researcher

APPENDIX G: ISIZULU PLEDGE OF CONFIDENTILITY FORM FOR INDIVIDUAL INTERVIEW

ISIZULU

ISIVUMELWANO SEZIMFIHLO ZOCWANINGO

Ukuze mina njenge lunga le University yakwaZulu-Natal ngenze umsebenzi wami. Wonke umuntu

ozobamba iqhaza kulolu cwaningo agcine izimfihlo kumele afunge loku okulandelayo.

1. Mina____ ngiyavuma ukubamba iqhaza lokuphendula

imibuzo njenge lunga lomphakathi wase Mkhambathini ohlangene nohlelo lwe SRH, ngiphinde

ngigcine izimfihlo. Angeke ngasebenzisa lolu lwazi noma ngikhulume ngabantu abazobe bekhona.

2. Angeke ngazise muntu ngolwazi engilithole kuwo lomuhlangano wokuphendula imibuzo.

3. Imfihlo yolwazi ozobe uyizwa ngokuqhubeka kocwaningo izobe ihlanganisa izimpendula zalaba

ababambe iqhaza bevula isifuba ngezimfihlo zabo.

4. Ngiyavumaukuba ngibe nesikhathi esanele ukuba ngibhekisise lesisivumelwano futhi ngiyawubona

umthelela woncwaningo empilweni yami.

5. Lesi isvumelwano sisayinwa ngaphambi kokubamba iqhaza kucwaning

UMUBAMBI WEQHAZA UMCWANINGI

________________________________ ___________________________________

Igama eliphelele lomubambi weqhaza Igame eliphelele lomucwaningi

APPENDIX H: Gatekeeper's letter

Mkhambathini Municipality
for the Community

Physical address
18 Old Main road, CAMPERDOWN, 3720
Postal address
Private bag X04, CAMPERDOWN, 3720
Telephone: 031 785 9300
Fax: 031 785 2121

Enquiries: Director Community Services
Imibuzo:
Navrae:

My reference: Gate Keepers Letter
Inkomba yami:
My verwysing:

Contact No: 031 785 9309

10 AUGUST 2023

Attention:
Mr PG Kuluse
University of KwaZulu-Natal
Cell phone: (
Email: kulusep@ukzn.ac.za

RE: GATEKEEPER'S PERMISSION TO CONDUCT RESEARCH IN MKHAMBATHINI AREA

Your request dated 08 August 2023 is reference.

Kindly be advised that permission is hereby granted for Mr PG Kuluse to conduct here research on a study titled ***Probing Sexual and Reproductive Health (SRH) services and experiences of women at Umkhambathini eNkanyezini, KwaZulu-Natal-South Africa*** to be conducted within the area of Mkhambathini Municipality.

We further request that you share the results of the study with the municipality in the interest of learning and knowledge management.

Should you need further assistance, kindly liaise with the Community Services Director, Ms NS Mkhize on mkhizen@mkhambathini.gov.za or 031-785 9309.

Yours faithfully,

NS MKHIZE
DIRECTOR COMMUNITY SERVICES

APPENDIX I: Editor Certificate

LANGUAGE EDITOR'S LETTER

NDLELA EDITING SERVICES
Winterton, 3340

Date: 27 October 2024
TO WHOM IT MAY CONCERN

This is to certify that I have duly edited the thesis in partial fulfilment of the requirements for a PhD in the College of Humanities at the University of KwaZulu-Natal titled:
Probing Sexual and Reproductive Health (SRH) services: experiences of women at Umkhambathini eNkanyezini, KZN-South Africa by Philani Goodman Kuluse

I have a Masters' degree in Anthropology from the University of Pretoria, Honours in English Language from the University of South Africa (Unisa).

Throughout my 3-year full-time career and the more than 6 years since, I have been involved with the process of academic writing, editing language or lecturing in the fields of Anthropology, Supply chain, Management, English, Sociology and Political Science at other tertiary institutions - for 6 years - (University of KwaZulu-Natal, Durban University of Technology, Boston College, Damelin College, Rosebank College and College Campus) as well as editing documents, dissertations, thesis and mini-thesis for University students around Pietermaritzburg and Durban.

Yours sincerely,

Mandla Ndlela

Ndlela@gmail.com

APPENDIX F: Turnitin slip

Match Overview

12%

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